



**Health Sector  
Improvement Program  
Trust Account: End of  
Investment Evaluation**

**Human Development Monitoring and Evaluation Services**

**15 December 2023**

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## Abbreviations and acronyms

| Term            | Definition   |
|-----------------|--|
| <b>ADB</b>      | Asian Development Bank   |
| <b>AHC</b>      | Australian High Commission [Port Moresby]                                |
| <b>AIDS</b>     | Acquired Immune Deficiency Syndrome                                      |
| <b>AIHSS</b>    | Accelerated Immunisation and Health System Strengthening                 |
| <b>AIP</b>      | Annual Implementation Plan   |
| <b>ARoB</b>     | Autonomous Region of Bougainville  |
| <b>AusAID</b>   | Australian Agency for International Development                          |
| <b>BDoH</b>     | Bougainville Department of Health  |
| <b>BMU</b>      | Basic Management Unit  |
| <b>CAP</b>      | Corrective Action Plan   |
| <b>COI</b>      | Certificate of Inexpediency  |
| <b>DAC</b>      | Development Assistance Committee   |
| <b>DFA</b>      | Direct Funding Agreement   |
| <b>DFAT</b>     | Department of Foreign Affairs and Trade [Australia]                      |
| <b>DNPM</b>     | Department of National Planning and Monitoring                           |
| <b>DPM</b>      | Department of Personnel Management                                       |
| <b>DP</b>       | Development Partner  |
| <b>DSIP</b>     | District Services Improvement Program                                    |
| <b>EOI</b>      | End of Investment  |
| <b>EOPO</b>     | End of Program Outcome/Objective   |
| <b>ERP</b>      | Emergency response plan [for COVID-19]                                   |
| <b>FBO</b>      | Faith-based organisation   |
| <b>GEDSI</b>    | Gender equality, disability and social inclusion                         |
| <b>GFATM</b>    | Global Fund to Fight AIDS, TB and Malaria                                |
| <b>GoA</b>      | Government of Australia  |
| <b>GoPNG</b>    | Government of Papua New Guinea   |
| <b>HDMES</b>    | Human Development Monitoring and Evaluation Services                     |
| <b>HFG</b>      | Health Function Grant  |
| <b>HHISP</b>    | Health and HIV Implementation Services Provider                          |
| <b>HIV</b>      | Human immunodeficiency virus   |
| <b>HSACC</b>    | Health Sector Aid Coordination Committee                                 |
| <b>HSDP</b>     | Health Sector Development Program  |
| <b>HSFC</b>     | Health Services Finance Committee  |
| <b>HSIP</b>     | Health Sector Improvement Program  |
| <b>HSIP-EPS</b> | Health Sector Improvement Program Expanded Program of Support (HSIP-EPS) |
| <b>HSIP TA</b>  | Health Sector Improvement Program Trust Account                          |
| <b>HSPC</b>     | Health Sector Partnership Committee                                      |

| <b>Term</b>    | <b>Definition</b>   |
|----------------|---|
| <b>IFMS</b>    | Integrated Financial Management System                    |
| <b>INGO</b>    | International non-government organisation                 |
| <b>ISP</b>     | Immunisation service provider                             |
| <b>KEQ</b>     | Key Evaluation Question                                   |
| <b>KRA</b>     | Key Result Area   |
| <b>MDG</b>     | Millennium Development Goal                               |
| <b>M&amp;E</b> | Monitoring and evaluation                                 |
| <b>MEF</b>     | Monitoring and Evaluation Framework                       |
| <b>MFAT</b>    | Ministry of Foreign Affairs and Trade [New Zealand]       |
| <b>MNCH</b>    | Maternal, newborn, and child health                       |
| <b>MTR</b>     | Mid-Term Review   |
| <b>NCC</b>     | National Control Centre                                   |
| <b>NCD</b>     | National Capital District                                 |
| <b>NDoH</b>    | National Department of Health                             |
| <b>NEC</b>     | National Executive Council                                |
| <b>NEFC</b>    | National Economic and Fiscal Commission                   |
| <b>NGO</b>     | Non-government organisation                               |
| <b>NHIS</b>    | National Health Information System                        |
| <b>NHP</b>     | National Health Plan                                      |
| <b>NPA</b>     | National Procurement Act                                  |
| <b>OECD</b>    | Organisation for Economic Co-operation and Development    |
| <b>PAF</b>     | Performance Assessment Framework                          |
| <b>PATH</b>    | Papua New Guinea–Australia Transition to Health           |
| <b>PEOC</b>    | Provincial Emergency Operations Centre                    |
| <b>PER</b>     | Provincial Expenditure Report                             |
| <b>PFM</b>     | Public Financial Management                               |
| <b>PFM Act</b> | <i>Public Finances (Management) Act 1995</i> , as amended |
| <b>PGAS</b>    | Provincial Government Accounting System                   |
| <b>PHA</b>     | Provincial Health Authority                               |
| <b>PHO</b>     | Provincial Health Office                                  |
| <b>PNG</b>     | Papua New Guinea  |
| <b>PPF</b>     | PNG Partnership Fund                                      |
| <b>PSIP</b>    | Provincial Services Improvement Program                   |
| <b>SBS</b>     | Sector budget support                                     |
| <b>SDG</b>     | Sustainable Development Goal                              |
| <b>SEM</b>     | Senior Executive Management                               |
| <b>SIA</b>     | Special Immunisation Activities                           |
| <b>SOE</b>     | State of Emergency  |
| <b>SPAR</b>    | Sector Performance Annual Review                          |

| <b>Term</b>   | <b>Definition</b>                                  |
|---------------|--|
| <b>STC</b>    | Short-Term Contractor                              |
| <b>SWAp</b>   | Sector-Wide Approach                               |
| <b>TA</b>     | Trust Account                                      |
| <b>TB</b>     | Tuberculosis                                       |
| <b>TOR</b>    | Terms of Reference                                 |
| <b>UNFPA</b>  | United Nations Population Fund                     |
| <b>UNICEF</b> | United Nations Children’s Fund                     |
| <b>USAID</b>  | United States Agency for International Development |
| <b>WHO</b>    | World Health Organization                          |

## Terminology used in this report

| Term  | Meaning  |
|---|--|
| Development Partners (DPs)                                | Organisations, including donors, foundations, local and international non-government organisations (NGOs), managing contractors, local churches and others, contributing and supporting the development activities of the Government of Papua New Guinea (GoPNG).  |
| Development Partner Coordination                          | Development partners aligned with GoPNG policies, strategies, and priorities, and collaborating with GoPNG departments, donors and implementing partners, to avoid misalignment or duplication.  |
| Direct Funding Agreement (DFA)                            | The overarching funding agreement between the Government of Australia, currently through the Department of Foreign Affairs and Trade (DFAT)/formerly through the Australian Agency for International Development (AusAID), and GoPNG, represented by the National Department of Health (NDoH), to support identified health sector activities through the Health Sector Improvement Program Trust Account (HSIP TA).   |
| Earmarked Funds   | Funds channelled through pooled accounts for specific activities.  |
| Health Sector Improvement Program (HSIP)                  | The program of support for GoPNG's health sector-wide approach (SWAp), in which funds from DPs and GoPNG are funnelled through the NDoH systems, to support and improve the health sector. The HSIP provides an alternative to donor-funded bilateral and multilateral grants or loans, implemented by non-government agencies, partners, and managing contractors.  |
| Health Sector Improvement Program Trust Account (HSIP TA) | The HSIP TA is the NDoH mechanism that holds monies directly received from contributing partners. The Trust Account principles include GoPNG ownership, alignment to GoPNG systems, managing for results, and mutual accountability. Development partners provide support to the SWAp and work in alignment with the latest National Health Plan (NHP), PNG <i>Public Finances (Management) Act 1995</i> , as amended (PFM Act), and GoPNG planning systems. |
| Modality  | Systems and approaches used by DPs to deliver donor funding for intended purposes. Modalities in PNG include project support, sector-wide support, sector budget support, and general budget support.  |
| Parallel Systems  | Structures and approaches used by donors that duplicate central government systems, including budgeting, procurement, accounting, and auditing.  |
| Pooled Funds  | A collaborative financial approach where multiple DPs contribute financial resources to a common or pooled fund. In combining the funding into one account, the different sources are indistinguishable.   |
| Sector Budget Support (SBS)                               | Where funding from DPs is channelled through the central government systems (consolidated revenue) for use by a specific sector. The objectives of sector budget support are to: (i) eliminate parallel systems and strengthen government systems; (ii) support the sector strategic plan of the government; and (iii) shift dialogue from individual projects to long-term strategic plans.   |
| Sector-Wide Approach (SWAp)                               | A development partner coordination mechanism to promote the pursuit of a strategic plan. A SWAp aims to emphasise the priorities of the sector plan and reduce fragmentation and duplication of development partner efforts.   |

## Executive summary

The Health Services Improvement Program (HSIP) is an initiative of the Government of Papua New Guinea (GoPNG) to enable funds from GoPNG and donors to be pooled for national and sub-national health sector priorities. The HSIP Trust Account (HSIP TA), through which the funds are channelled, is managed by the PNG National Department of Health (NDoH). This report presents the evaluation findings on the investment and outcomes of AUD68,246,628 funds provided to the HSIP TA by the Government of Australia (GoA) through the Department of Foreign Affairs and Trade (DFAT)<sup>1</sup>, for the period 2013–2022.

### Background

Australia has been channelling funds through the HSIP TA since 2000.<sup>2</sup> In 2012, the HSIP was re-designed as the refreshed financing mechanism for GoPNG's health sector-wide approach (SWAp). The re-design aimed to review TA functionality and performance and align the HSIP TA more directly with GoPNG systems.

Australia's investments through the HSIP TA were established through a Direct Funding Agreement (DFA) signed between the GoA and GoPNG in October 2013. The agreement sets out the purpose, objectives, and principles underpinning the arrangement. The initial strategic objectives and policy priorities (2013–2017) of the HSIP TA were focused on: (i) increasing access for the poor to effective health services in rural areas; (ii) increasing the absorptive capacity of the health sector to achieve GoPNG commitment to the National Health Plan (NHP) on a sustainable basis; and (iii) improving the performance and governance of the HSIP itself. While the SWAp was initiated to facilitate the engagement of a wide range of donors around GoPNG health priorities, this broad funding base never eventuated. While GoPNG was the main contributor across the period of this evaluation (70 per cent of funds), GoA contributed overall eight per cent of total funds.<sup>3</sup>

Australia's support for the TA was through three mechanisms:

1. Direct funding through the HSIP TA, which has agreed targeted health objectives. Ten per cent of this funding was allocated to the management of the TA. For Australia, this included funding the audits of the TA.
2. Funding for seven positions in the HSIP TA Management Team in the NDoH, providing executive and administrative support for the TA. This was later reduced to three funded positions after DFAT froze its funding in the HSIP TA in March 2016, with salaries covering two in-line positions and one adviser.
3. Funding for the development of the HSIP TA Manual of Procedures and training for GoPNG staff at a provincial level in how to comply with the HSIP TA management processes.

The primary focus of all the funding channelled through the TA by GoPNG, DFAT, and other development partners (DPs), has been on providing direct support to the 21 Provincial Health Authorities (PHAs) and the Autonomous Region of Bougainville (ARoB) to assist in meeting the objectives of the NHP for 2011–2020, and most recently, 2021–2030.<sup>4</sup> In March 2016, DFAT froze its funds in the TA in response to a qualified 2014 and 2015 audit report. DFAT funding to the TA was

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<sup>1</sup> DFAT merged with the Australian Agency for International Development (AusAID) in November 2013, and the HSIP TA Re-design was implemented prior to this under AusAID.

<sup>2</sup> The Trust Account was established in 1996 as a Sector-Wide Approach for Asian Development Bank (ADB) funds.

<sup>3</sup> A range of DPs contributed to the HSIP TA between 2013 and 2022. Current contributors include DFAT, United Nations Population Fund (UNFPA), New Zealand's Ministry of Foreign Affairs and Trade (MFAT), the World Health Organization (WHO), United Nations Children's Fund (UNICEF), and the United States Agency for International Development (USAID).

<sup>4</sup> See Government of PNG, NDoH. (2021). *National Health Plan 2021–2030*. [https://www.health.gov.pg/pdf/NHP\\_1A15.pdf](https://www.health.gov.pg/pdf/NHP_1A15.pdf)



frozen from March 2016 to June 2018. When the DFAT funds were unfrozen, unspent funds from earlier years were made available for use. Subsequently, donors decided to channel their funding for responding to COVID-19 through the HSIP TA.

### Evaluation aim and methods

This evaluation focuses on DFAT's contribution to the health sector through the HSIP TA mechanism. It covers the 10-year period from 2013 to the end of 2022, although at times earlier elements are referenced, such as the HSIP Re-design in 2012. It assesses relevance, effectiveness and efficiency, and documents lessons learned (see **Annex 1** for KEQs).

The evaluation methodology included a desk review of HSIP TA financial and narrative documents; NDoH, PHA, DFAT, and other DP documents; key informant interviews; and site visits to four provinces. The evaluators reviewed data from eight PHAs – four of which included field visits (Western, Western Highlands, Manus, and Morobe) and four through desk reviews (ARoB, East Sepik, Hela, and Milne Bay). Interviews were undertaken with 72 informants (in person or virtually) from a range of organisations and agencies, including the NDoH, GoPNG departments, DP and multilateral organisations, implementation partners, and PHA leaders and staff (**Annex 2** provides the full interviewee list).

### Limitations

Evaluation limitations existed in relation to the length of the period being evaluated. Not all key informants could be located, and with staff changes and variable knowledge management practices there were large documentation gaps across much of the evaluation timeframe. A second limitation relates to substantive gaps in data. Even though the DFA provided a Monitoring and Evaluation Framework (MEF) with indicators and data sources and frequency of data collection through NDoH mechanisms, the framework was not fully implemented, and subsequent amendments did not address the monitoring and evaluation (M&E) gap. The scheduled mid-term review (MTR) of HSIP TA was a critical milestone scheduled for 2016, but was not undertaken, which presented a significant gap in information and findings from the earlier phase of the evaluation.

### Key findings

#### Relevance

The relevance of the HSIP TA was affected by a number of contextual changes over the 10 years (2013 to 2022) covered by this evaluation. These included the decentralisation of the health sector, resulting from the *Provincial Health Authorities Act 2007* (PHA Act), including transferring the governance and budget control for health services from the national and provincial governments to a provincial health body. The COVID-19 pandemic was another major contextual change, but this had a positive impact on the HSIP TA, as donors chose to channel funding through the TA in support of the pandemic response.

The HSIP TA is a pooled funding arrangement that finances the health sector SWAp (HSIP). The interventions by DFAT through the HSIP TA did reflect GoPNG's health sector policy and priorities. Furthermore, using the modality of direct sector support through a pooled fund and earmarking funds for key areas was a relevant approach at the time of the re-design. The focus of the HSIP TA was well aligned to GoPNG's National Health Plans, and the modality rightly sought to combine donor efforts, while reinforcing the leadership of NDoH and providing funding directly to PHAs, recognising their autonomy.

The benefits of the HSIP TA included that it operated effectively as an emergency funding mechanism for providing COVID-19 support and has become an integral part of the PNG health financing

landscape. The imperative to get things done during the COVID-19 national emergency, coupled with less stringent oversight of the administrative processes, and a mobilised workforce to respond to the pandemic, meant the TA was more used and effective during this period. However, and despite this, the lack of strong GoPNG leadership and consistent funding, and PHA capacity weaknesses, have constrained its effectiveness and undermined its relevance.

### **Effectiveness**

The HSIP TA was mostly ineffective at achieving strategic objectives and policy priorities in the early and middle years of the implementation (2013–2019), but improved in the latter years (2020–2022). Barriers to effectiveness were a combination of contextual factors, and execution issues.

The key contextual constraints across the evaluation period included: health sector reform and decentralisation commencing at the same time as the HSIP TA Re-design; the funding freeze in the middle years, which thwarted momentum and confidence; the administrative details of the GoPNG public financial management (PFM) processes, which PHAs were unfamiliar with; and the lack of an MEF and MTR, which compromised learning and reflection.

The execution issues were varied, but in combination diminished the TA's effectiveness as a SWAp financing mechanism. Key committees were established but did not function as intended. The Health Sector Partnership Committee (HSPC) referenced in the re-design and the DFA was created as a mechanism to drive the SWAp agenda. Later, in 2018, the Health Sector Aid Coordination Committee (HSACC) was created to replace the HSPC but the committee only met three times – once each in 2018, 2019, and 2022. This lack of coordination had an impact on the predictability of funding, with funds deposited in a mostly ad hoc manner. On average, there were only four DPs providing funds every year, and of those DFAT provided the largest proportion. Although DFAT's investment was substantial, momentum was compromised by PHA readiness and capacity, and interviews revealed that there was a loss of confidence in accessing the funding after the freeze. The health sector improvements envisioned in key areas of high need were not realised, such as facility rehabilitation in disadvantaged districts, and improved basic health infrastructure and staff housing. Disbursements suffered from a lack of co-funding (kina-for-kina) and limited capacity of some PHAs to deliver the requisite PFM administration, due to their lack of organisational readiness early in the decentralisation agenda. Moreover, on seeking to assist districts with high poverty indexes, the geographic remoteness, lack of logistics, and insufficient range of appropriate companies, added to the procurement challenges.

However, the TA was partially effective in focusing NDoH attention on improving financial governance structures and mechanisms, and reporting lines and accountability within the NDoH. Annual audits were completed by the NDoH, although some were delayed (for example, those for 2014 and 2015 were completed in 2016), provincial audits were undertaken, non-compliance cases were reported, and actions were executed by the HSIP team. The HSIP TA Manual of Procedures was updated by GoPNG in 2013 and training was rolled out by the HSIP team, but weaknesses have persisted at the PHA level.

The TA was most effective during COVID-19 and delivered over PGK117.6 million in total funding to the PNG health sector to support the GoPNG response. The mechanism functioned effectively and capitalised on a mobilised stakeholder environment, and PHAs were well engaged through online cluster meetings to plan and prepare for the funds. While all appropriations were not fully used, there were significant improvements in the use of funds compared to earlier years. In 2020, PGK19.25 million was allocated to the COVID-19 Emergency Response for PHAs, and was transferred from the parent to the subsidiary accounts by May 2020. By year end, the PHAs had spent

45.17 per cent of the funds. In 2021, with additional DFAT funds, they had spent 44 per cent of all funds, and at year end in 2022 the spend rate was 68 per cent. Funding for the COVID-19 Vaccine Roll-out was allocated, but the outcomes were impeded by widespread vaccine hesitancy and misinformation, not by PFM processes, which were simplified to respond to the emergency.

### **Efficiency**

While the HSIP TA enabled an efficient approach for PHAs to readily access funds for long-neglected health sector needs, the disbursement process was inefficient for much of the period 2013 to 2018 for the same reasons listed above for effectiveness. The funding freeze created a barrier to efficiency, resulting from NDoH not cascading consistent and repeated communication to PHAs about the freeze, and not providing alternative funding arrangements.

At the national and PHA levels, the TA managed financial risks efficiently, but was less successful in managing program risks. Fiduciary measures were regularly applied and consistently adhered to in accordance with the GoPNG *Public Finances (Management) Act 1995*, as amended (PFM Act), and checked by the Office of the Auditor-General. This was attributable to the TA being mostly perceived as a financial mechanism, rather than as a SWAp focused on health sector issues, and staffed with accountants.

Efficiency gains could be achieved by integrating the HSIP TA within the GoPNG Integrated Financial Management System (IFMS), which would allow PHAs to electronically manage all documentation and authorisations. More recently, during COVID-19, the HSIP TA became more efficient at supporting objectives and outcomes, by streamlining the PFM process. Rather than having multiple tranches requiring a 60 per cent spend and 80 per cent reporting compliance, one tranche was transferred, allowing PHAs to draw down on their total funds.

### **Aid principles**

The HSIP TA operated mostly in accordance with the DFA principles. These were important to NDoH officials and a wide range of interviewees. Aid effectiveness principles concerning partnership through alignment and harmonisation, government leadership and ownership, managing for results and mutual accountability, and promoting transparency and trust were often mentioned, and positively correlated with the TA. An agreed performance assessment framework and stronger donor coordination to guide and embed the TA within the DP community would likely have contributed to TA effectiveness as a mechanism for development.

### **Sustainability**

The GoPNG, specifically the NDoH, sees the HSIP TA as an important means through which to channel donor funding for sector priorities and thus is interested in the continuation of the TA, especially since there is no other mechanism that allows the NDoH to access, disburse and manage funds for sector outcomes in a direct and expedient manner. In as much as the TA has become an integral part of the health sector and uses GoPNG PFM systems, it is likely that the TA will continue to operate, even if DFAT funding were to be allocated elsewhere. On the other hand, the TA relies on the support of DPs, especially DFAT, to fund essential staff, core operations and capacity building. If DFAT were to focus engagement in other health priorities, alternative funding sources would need to be secured by NDoH to fund these crucial functions and ensure that the mechanism continues to comply with the GoPNG PFM Act and to provide assurance to stakeholders. As such, some HSIP TA elements will likely be sustained, while others might not.

## **GEDSI**

GEDSI was considered in the HSIP TA Re-design document but was not prioritised, other than through an emphasis on primary health care and maternal, newborn, and child health (MNCH) services, with women and children as the greatest number of beneficiaries. The lack of GEDSI-sensitive and GEDSI-supportive outcomes in the programming compromised equity and inclusiveness credentials.

### **Monitoring and evaluation**

The DFA set out a reasonable MEF and recommended using GoPNG sector-based indicators from existing systems, but the MEF was not implemented. The HSIP TA was largely perceived as a financial instrument, and so a copious number of financial reports were produced but little was done to assess the TA's effectiveness as a mechanism to deliver on its development outcomes. A mid-term review was expected in 2016 and could have captured early challenges and changes, and supported programmatic decision-making, accountability, and learning and adaptation. However, the MTR was not undertaken by the NDoH. At the end of the 10-year implementation period from 2020 to 2022, several small reports were commissioned<sup>5</sup>, which provided independent evidence and analysis, but given the late timing of these their value was limited for enhancing HSIP TA performance and results. Consequently, these deficits meant that the HSIP TA could not benefit from and respond to the insights typically provided through a strong M&E approach.

### **Lessons**

In practice, the implementation of the HSIP TA mostly led to NDoH focusing on strengthening accounting systems, and while this is necessary it is not sufficient for the mechanism to successfully deliver health outcomes. The critical areas of donor and partner coordination, government leadership, and M&E of program performance to inform strategic and tactical developments over the 10-year period, were weak. Moreover, there was little explicit acknowledgement and engagement that health system change takes time. Government systems are complex, and establishing an enabling environment in which partners can collaborate actively to reinforce system strengthening and policy dialogue is key, but takes decades. Strengthening GEDSI will require targeted support. The TA is unlikely to have a meaningful focus on GEDSI without dedicated funding and technical assistance to NDoH and the PHAs in the implementation and execution of their policies and priorities. This evaluation surfaced current discussion and interest from NDoH and DPs to (re)consider establishing a meaningful SWAp, pooled account, or approach to shared funding and mutual accountability.

### **Conclusions**

The HSIP TA is an important mechanism that enables donors to provide direct financing to the health sector. Since general budget support is not a feasible option, given GoPNG financial and health systems' weaknesses, sector budget support (SBS) to the NDoH or PHAs remains pertinent.

The re-designed HSIP TA of 2012 was an appropriate and relevant mechanism to deliver direct financing to the GoPNG health sector, and the effectiveness and efficiency of TA funding persisted throughout most of the period, from 2013 up to 2020. However, challenges with the decentralisation process and PHAs' lack of readiness to meet most of the HSIP TA administration requirements continued. DFAT's freezing of its funding in the account due to the delayed 2014 and 2015 audits led to a loss of confidence in the HSIP TA and a slowing of expenditure rates. Even after the freeze was

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<sup>5</sup> See HDMES. (2021). *COVID-19 in Papua New Guinea and Australia's response: A rapid review. Final Report*; also PATH. (2022). *HSIP process review, national level (HSIP funding flow) and related reports*.

lifted, the expenditure rates did not improve. The administrative burden of sequential tranches of funding that required PHAs to coordinate and collate multiple and repeated administration also compromised the efficiency of disbursements under the TA, and thus also affected effectiveness.

The funding channelled in response to COVID-19 was much more efficient and effective, as it was more aligned with the intention of a pooled fund as outlined in the 2012 HSIP TA Re-design document. During this period, donor coordination was strong, administrative requirements were streamlined, and there was a single process to apply for all COVID-19 funds. Furthermore, additional guidance was provided to PHAs about how to access and manage this funding.

DFAT support for HSIP TA management and administration, including support directly to the provinces to comply with HSIP TA administration requirements, has been essential to the TA's success. The future sustainability of the HSIP TA is likely to be significantly compromised without an NDoH sustainability plan for the future of these HSIP TA team positions. Given DFAT's continued commitment to the GoPNG health sector and the TA, in combination with the current DFA ending in October 2023, GoPNG and DFAT will need to collaborate on how the Australian Government can best support the NDoH through either a SWAp, pooled funding, and direct sector or budget support.

## Recommendations

### **Recommendation 1: DFAT should continue to support the Health Sector Improvement Program as a sector-wide approach for the National Department of Health in Papua New Guinea.**

Through the Health Sector Aid Coordination Committee and the Health Sector Partnership Committee, DFAT should advocate for and support the SWAp mechanism, and encourage other health sector donors to engage with the NDoH in the SWAp and use it as a mechanism for donor contributions, coordination and engagement on health sector priorities.

### **Recommendation 2: DFAT should continue to deliver direct funding through the pooled fund of the HSIP Trust Account.**

To maximise the effectiveness and efficiency of this approach, DFAT should commence a design process to inform the next Direct Funding Agreement, which includes the following:

- Encourage other donors to channel their funding through the HSIP TA, so it operates more effectively as an overall donor mechanism.
- Collaborate with other donors to ensure the identified system improvements to the HSIP TA are implemented and regularly reviewed.
- Update the HSIP TA Manual of Procedures to align it with any changes in GoPNG financial system practices. For greater efficiency, aim for PFM processes and steps that are simplified to facilitate the disbursement of HSIP TA funding, while balancing fiduciary risk.
- Seek to provide greater predictability of funding to GoPNG through forward estimates in coordination with other donors.
- Collaborate and seek agreement with other donors and GoPNG on a shared approach to the current funding of adviser support for the administration of the pooled fund through the PATH program and provision of technical support to the provinces.
- With other development partners and GoPNG, discuss the option and viability of funding an allocated GEDSI adviser position in the HSIP TA Secretariat, who can work directly with NDoH and the provinces to better mainstream GEDSI in their work.
- Discuss and seek agreement with donors on how to strengthen M&E. This can be through funding technical advisers to strengthen GoPNG M&E and reporting, and through regular independent reviews of HSIP TA performance.

# 1. Overview of the Health Services Improvement Program Trust Account

The Health Services Improvement Program Trust Account is Papua New Guinea's health sector-wide approach financing mechanism. The HSIP TA is an instrument owned by GoPNG and managed by the NDoH. It follows the GoPNG PFM Act procedures, which are outlined in the HSIP TA Manual of Procedures (2013). The HSIP TA is administered by the NDoH and supports GoPNG national and provincial health priorities.

The aim of the HSIP TA is to *'Improve access to rural health services, particularly in disadvantaged districts through providing targeted funding and improving the implementation, reporting and governance of the Trust Account at the National and Provincial Levels'*. HSIP TA has three strategic objectives:

1. Increasing access for the poor to effective health services.
2. Increasing the absorptive capacity of the health sector to achieve GoPNG commitment to the NHP on a sustainable basis.
3. Improving performance and governance of the HSIP.<sup>6</sup>

GoPNG and development partners both contribute and pool funds. Most funds in the HSIP TA come from the GoPNG. Among the DPs, the Australian Government through DFAT contributes the most<sup>7</sup> (see Table 1).

Even with shifts in priorities and timelines in the decade following the 2012 HSIP TA Re-design, the TA has continued to be used by DPs, including: bilateral donors (DFAT, MFAT, and USAID); UN agencies (including UNFPA, UNICEF, WHO, and USAID); Gavi, the Vaccine Alliance (Gavi); and others, including the Global Fund to Fight AIDS, TB and Malaria (GFATM).<sup>8</sup> An average of four donors have contributed to the account each year between 2012 and 2020.

Apart from the financial processes, the TA operations are largely donor-funded. Given that the TA is a repository for DP funds, there is an additional workstream to report on donor requirements. The HSIP TA team engages in financial administration, planning and reporting activities, alongside NDoH staff who also work on planning, budgeting, and resource procedures. Through the DFAT-funded PATH program, salaries are covered for several NDoH HSIP TA Management Team positions, and costs for activities such as provincial visits, audits, and office operations.

Table 1 provides a summary of the support provided by DPs between 2012 and 2020.

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<sup>6</sup> The full objectives, outcomes and outputs are presented in **Annex 3**.

<sup>7</sup> Through AusAID initially and then through DFAT in 2014.

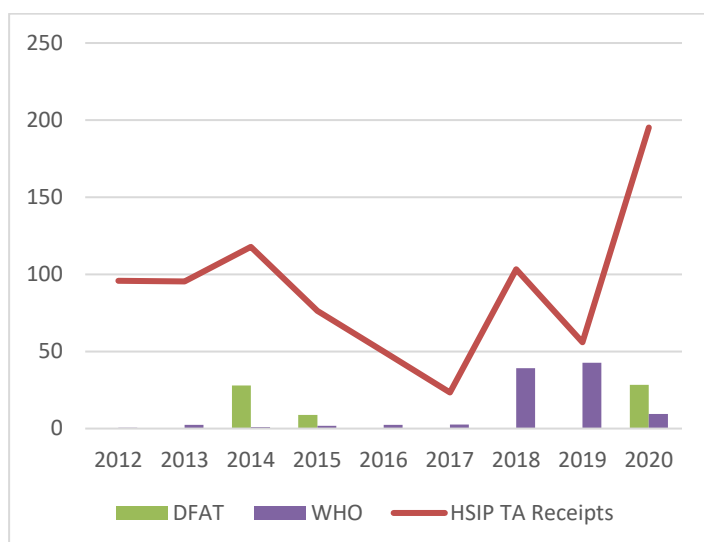
<sup>8</sup> Other donors that contributed to the HSIP TA included the ADB, UNFPA, MFAT, and WHO.

**Table 1: Receipts and payments (PGK million) through the HSIP TA 2012–2020<sup>9</sup>**

| Partner                                       | 2012  | 2013  | 2014  | 2015 | 2016 | 2017 | 2018  | 2019 | 2020  |
|---|-------|-------|-------|------|------|------|-------|------|-------|
| GoPNG   | 84.9  | 87    | 76.5  | 62.6 | 29.8 | 18.5 | 57.5  | 6.5  | 144.8 |
| DFAT  | –     | –     | 28.02 | 8.87 | –    | –    | –     | –    | 28.4  |
| WHO   | 0.61  | 2.4   | 1     | 1.9  | 2.4  | 2.7  | 39.1  | 42.7 | 9.5   |
| UNICEF  | 0.2   | 0.6   | 0.9   | 0.4  | 4.9  | 1.97 | 6.54  | 5.95 | 3.2   |
| UNFPA   | 0.38  | 0.13  | 0.3   | 0.27 | 0.25 | 0.14 | –     | –    | 0.1   |
| Gavi  | –     | 0.47  | 7.5   | 1.99 | –    | –    | –     | –    | –     |
| NZAID   | 8     | 4     | –     | –    | –    | –    | –     | –    | 6.4   |
| SPC   | 0.5   | –     | –     | –    | –    | –    | –     | –    | –     |
| USAID   | –     | –     | –     | –    | –    | –    | –     | 0.7  | –     |
| Total receipts to parent account              | 95.8  | 95.4  | 117.9 | 76.4 | 49.9 | 23.4 | 103.2 | 56   | 195.2 |
| Payments to subsidiary accounts and suppliers | 123.2 | 100.4 | 143.2 | 80.2 | 74.3 | 40.2 | 104.1 | 75.1 | 144.9 |

Source: HSIP TA Audit Reports. Figures have been rounded to one decimal place.

In 2014, when the HSIP TA received its largest annual contribution (prior to COVID-19 related contributions), the TA provided the equivalent of eight per cent of the total appropriated budget for health services in PNG.

**Figure 1: Relative annual contributions of the two major HSIP TA donors (PGK million)**

<sup>9</sup> This table does not extend to 2022, as the evaluators only had access to audit reports up to 2020.

In 2012, the HSIP TA was re-designed to better align its management processes with GoPNG financial and planning systems, and agreed PNG priorities.<sup>10</sup> The review for the re-design presented several findings based on evidence from a variety of sources, including AusAID policy documents, GoPNG data, HSIP reports and options papers, and presented a range of findings and recommendations. It drew attention to a lack of evidence of aid effectiveness, sustainability, high transaction costs, complex management requirements within the NDoH and provincial systems, and a lack of donor confidence in the health sector. The re-design's proposed program logic sought to address these findings, balancing operational and aspirational requirements. The re-design led to increased confidence in the TA, appealing to GoPNG and donors alike. It recommended a shift to GoPNG financial systems in the medium-term, but the TA remained an NDoH mechanism, with some parallel administrative systems.

### **Australian support to the HSIP TA**

In October 2013, following the re-design in 2012, AusAID (now DFAT) signed a Direct Funding Agreement with GoPNG representatives from the NDoH, which outlined the overarching mechanism for Australia's direct financing to the health sector. The DFA committed AUD48.73 million in the form of annual and quarterly tranches across a four-year period (2013–2017). The agreement outlined the objectives, focus, mechanisms, and values underpinning the support to the HSIP TA. Three core streams were outlined:

1. Support to recurrent health services as untargeted funding.
2. Direct funding through the HSIP TA with agreed targeted health objectives.
3. Direct funding for training of GoPNG personnel at the provincial level in how to comply with the HSIP TA management processes and increase absorptive capacity.

DFAT also supported the TA by providing direct funding for seven in-line technical advisers in the HSIP TA Management Team located in the NDoH, providing executive and administrative support for the TA management. This was later reduced to three funded positions after DFAT froze HSIP TA funding in March 2016. The salaries of these advisers are paid through DFAT-funded programs (originally the Health and HIV Implementation Services Provider (HHISP) program and now PATH).

The key principles of the DFA emphasised aid effectiveness, as advised in the HSIP TA Re-design, including: partnerships, use of GoPNG systems and processes, alignment of support with GoPNG needs and priorities, transparency and trust, joint M&E, capacity building, and activities that were appropriate and responsive to the absorptive capacity of the GoPNG. These principles are based on good practice in aid effectiveness, and are consistent with the Paris Declaration, Accra Agenda, and Busan Partnerships.

In March 2016, DFAT froze its funds in the TA in response to delayed 2014 and 2015 audit reports. DFAT ceased funding contributions for more than three years from March-2016 to June 2018. When the freeze was lifted, PGK17.16 million of unspent funds from earlier years was made available.

This evaluation focuses on DFAT's contribution to the health sector through the HSIP TA mechanism and covers the 10-year period from 2013 to the end of 2022. It includes the original DFA and six subsequent amendments that modified funding amounts, specified activities, intended outcomes, and the end of investment (EOI) date. The most recent amendment extended the EOI to 30 October 2023. Table 2 summarises the DFA phases, activities, and funding through the TA.

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<sup>10</sup> See Richards S., et al. (2012). *Re-design of the Health Services Improvement Program (HSIP) Trust Account*.



**Table 2: Amendments to DFAT funding in the HSIP TA (2013–2022)**

| Agreement/<br>amendment                                 | Date        | Value<br>(AUD<br>million) | Objectives   |
|---|-------------|---------------------------|--|
| Direct Funding Agreement; AusAID Agreement number 68768 | 31 Oct 2013 | 48.73                     | <p>Outcome 1:<br/>Increased access for the poor to effective health services in rural areas.</p> <ul style="list-style-type: none"> <li>• Recurrent health services using National Economic and Fiscal Commission (NEFC) cost of services framework, shifting to development budget.</li> <li>• Emergency obstetric transfers to health centres and hospitals.</li> <li>• Minor refurbishment to 300 health facilities and 80 staff houses.</li> <li>• Major refurbishment of health facilities in the 20 most disadvantaged districts (kina-for-kina).</li> </ul> <p>Outcome 2:<br/>Increased absorptive capacity of the health sector to achieve GoPNG's commitment to the National Health Plan on a sustainable basis.</p> <ul style="list-style-type: none"> <li>• Key NDoH functions (sector performance reviews, coordinating national training, and public health).</li> <li>• Rural Health Facility Management Training for District Health Coordinators and Officers-in-Charge.</li> <li>• In-service training for 220 Community Health Workers.</li> </ul> <p>Outcome 3:<br/>Improved performance and governance of the HSIP Trust Account.</p> <ul style="list-style-type: none"> <li>• Support to HSIP TA operational costs and compliance processes.</li> </ul> |
| Amendment 1   | 17 Oct 2017 | 16.53                     | <ul style="list-style-type: none"> <li>• Reflections on freeze of DFAT funds in HSIP TA in March 2016, due to a delayed and qualified audit opinion and slow expenditure of funds and decision to unfreeze the funding.</li> <li>• No changes or revisions to End of Program Objectives.</li> <li>• Decision not to contribute any further funds above AUD16.53million.</li> <li>• Fiduciary risk control implemented.</li> <li>• End date of agreement extended to 31 October 2018 to provide time to expend remaining funds.</li> </ul>  |
| Amendment 2   | 29 Oct 2018 | Nil                       | <ul style="list-style-type: none"> <li>• AUD6.91 million unspent in account.</li> <li>• Revised areas of focus for remaining funds.</li> <li>• End date of agreement extended to 30 June 2020.</li> </ul>  |
| Amendment 3   | 14 Apr 2020 | 23.0                      | <ul style="list-style-type: none"> <li>• Scope of agreed activities expanded to incorporate: (i) COVID-19 preparedness and response funding; and (ii) Accelerated Immunisation and Health Systems Strengthening (AIHSS) program.</li> <li>• Additional funding provided to support the new activities.</li> <li>• Legacy funding and activities remain.</li> </ul>   |

|                            |                  |       |  |
|----------------------------|------------------|-------|--|
|                            |                  |       | <ul style="list-style-type: none"> <li>• End date of agreement extended to 30 June 2022.</li> </ul>  |
| Amendment 4                | 15 Apr 2021      | 20.15 | <ul style="list-style-type: none"> <li>• Further scope to increase COVID-19 and health system support to PHAs, and additional funding for COVID-19 vaccine roll-out. Direct support to Emergency Response Plans with PHAs.</li> <li>• Additional contingent funding for future needs or to support national efforts to prevent and/or contain COVID-19 in PNG, including through National Operations Centre, NDoH, and WHO.</li> </ul> |
| Amendment 5                | 7 Jun 2021       | 0.66  | <ul style="list-style-type: none"> <li>• Scope extended to include payments for National Capital District (NCD) PHA TB Programs Clinical Staff Support.</li> </ul>   |
| Amendment 6                | 9 Jun 2022       | 7.89  | <ul style="list-style-type: none"> <li>• Additional funding to support PHAs and the Bougainville Department of Health (BDoH) in its COVID-19 vaccination program.</li> <li>• Funding from Vaccine Access and Health Security Initiative.</li> <li>• End date of agreement extended to 30 October 2023.</li> </ul>  |
| <b>TOTAL revised value</b> | <b>2013–2022</b> | 68.25 | –  |

The report provides more details on the chronology of the HSIP TA, activities, funding commitments, and MEF of the Direct Funding Agreement to the HSIP TA.

## 2. Methodology

This final evaluation of the HSIP TA was conducted by independent external evaluators from December 2022 to August 2023. The evaluation scope covers 2013 to 2022 and is divided into three periods:

- **2013 to late 2015 (Period 1/P1):** This period incorporates the 2012 re-design of HSIP TA and its SWAp, leading into the AusAID 2013 DFA and the first grants made. It extends until the DFAT funds channelled through the HSIP TA were first frozen.
- **Late 2015 to June 2018 (Period 2/P2):** DFAT funds channelled through the HSIP TA were mostly 'frozen', although there was a brief period around June and July 2017 where funds were 'unfrozen'<sup>11</sup> and then frozen again until June 2018.
- **July 2018 to end December 2022 (Period 3/P3):** Some of the original unspent DFAT funds were reprogrammed, and additional funds with a health security and communicable diseases focus were provided, leading into the period from early 2020, which included support for responding to the COVID-19 pandemic.

The evaluators undertook a desk review of approximately 83 documents, including HSIP TA financial and narrative documents, and NDoH, PHA, DFAT, and other DP documents; conducted face-to-face or virtual interviews with 72 purposively-selected key informants from a range of organisations and agencies, including the GoPNG departments (especially the NDoH), PHAs, DPs, and implementing organisations; and visited four provinces (Western, Western Highlands, Manus, and Morobe).

<sup>11</sup> It is unclear whether any transactions or activities were undertaken in this period.

Data from eight PHAs, including ARoB, East Sepik, Hela, Manus, Milne Bay, Morobe, Western, and Western Highlands, was collected and analysed.<sup>12</sup> Six programs were selected by DFAT, representing different periods and contexts, as programmatic examples funded through the HSIP TA for analysis. Each program was assessed in relation to its objectives, timelines, budget, activities, outcomes, challenges, and lessons learned, where data was available. These programs are discussed in more detail in the Annexes. Programs included:

1. PHA/Provincial Health Office (PHO) activities, which involved direct support to PHAs for Annual Implementation Plans (AIPs), including maternal, child health, and disease control programs (public health disease surveillance).
2. Priority funding for 20 disadvantaged districts and provincial building maintenance.
3. Funding for NDoH functions, including planning, HSIP operational costs, HSIP provincial monitoring, recruitment, training, annual audits, and the development of National Health Plans.
4. Funding for the 22 provincial COVID-19 Emergency Response Plans since 2020.<sup>13</sup>
5. Funding for the COVID-19 vaccine roll-out support to the 22 provinces since 2021.
6. Immunisation and control of major communicable diseases through the AIHSS program and support to staff employment in the TB program in the NCD PHA.

Sector budget support is mentioned in four of the five sub-questions related to relevance. To adequately respond to the sub-questions and discuss the relevance of HSIP TA, the following framing of SBS was used:

1. Sector budget support as an aid modality is where financial support is provided and funnelled to a partner government's sector through its consolidated revenue accounts. DPs transfer funds to the recipient government's treasury accounts, with the agreement that the same amount will be forwarded to the specified sector. In PNG, SBS requires the funds to go through the Department of Treasury, then Department of Finance, before being received by the NDoH. These contributions are unearmarked, and policy dialogue is intended to happen alongside this as to the sector-specific development outcomes that might be achieved.<sup>14</sup>
2. Direct-funded sector support, or direct sector support, is when a DP directly transfers funds to an autonomous account, managed jointly with other donors and/or the recipient. When multiple DPs deposit funds into a single account, this is pooled funding.

## Limitations

There were several limitations, given that the evaluation was to examine events over a 10-year period, across multiple organisations, while major health sector reform was underway. Consequently, not all key informants could be located; there were gaps in knowledge management and staff changes across all organisations that resulted in large documentation gaps across much of the evaluation timeframe. As such, the evaluation team was constrained in its capacity to fully explore and analyse the HSIP TA.

A second limitation relates to M&E data. Even though the DFA provided a MEF with indicators, data sources and frequency of data collection through NDoH mechanisms, periodic data was not tracked. Indeed, the MEF was not fully implemented, and subsequent amendments did not address the M&E

<sup>12</sup> The selection of provinces was identified by the Australian High Commission (AHC) and HDMES and based on the following rationale: two PHAs per PNG region; a mix of those displaying higher and lower spending capacities; number of years of establishment as a PHA; and a range of involvement with the six key programs selected by the AHC for this evaluation.

<sup>13</sup> This builds on the HDMES COVID-19 Rapid Review undertaken in 2020.

<sup>14</sup> See DFAT. (2019, 10 April). *Assessing and using partner government systems for public financial management and procurement. Guideline.*

gap. This significantly constrained the evaluation team's capacity to assess DFAT's investments in the HSIP TA against the intended outcomes. The anticipated MTR and end of program evaluation expected in 2015 and 2017 did not eventuate, further compounding the M&E program gaps.

### 3. Findings and conclusions

This section discusses the findings and conclusions for the evaluation questions.

#### 3.1 Relevance (KEQ 1): To what extent has Australian funding through the HSIP TA been a relevant approach to address GoPNG health sector priorities?

##### Main conclusions and key findings

The HSIP TA and the subsidiary accounts at the PHA level have been a relevant and appropriate mechanism, as these accounts channel funds to address and support key GoPNG development objectives, NDoH National Health Plans (especially NHP 2011–2020), and priorities agreed by GoPNG and GoA. However, given that Australian funds were necessarily frozen for more than three years of the 10-year timeframe, the effectiveness and efficiency of pooled funding and the direct sector support approach was compromised. (See sections 3.2 and 3.3 for a discussion of effectiveness and efficiency.)

- The HSIP TA uses direct sector support and is a pooled fund to facilitate donor funding for the PNG Health Sector SWAp. It is not sector budget support, as DP funds circumvent PNG's central finance channels. The HSIP TA was rather a pooled fund.
- The account has specific purposes, modes of disbursement, and accountability mechanisms, and a limited timeframe.<sup>15</sup> It set out to introduce tagged funding to increase and strengthen donors' appetite, so they would contribute to the PNG Health Sector SWAp. As such, it attempts to balance fiscal risks with the benefits of channelling finance directly to NDoH and PHAs for the implementation of health services.
- The TA has consistently emphasised health services for rural populations, improved quality of provincial health facilities, support to disadvantaged districts, promotion of population health, and control of communicable diseases. These key health challenges align with GoPNG priorities, as articulated in the National Health Plan.

##### 3.1.1 What have been the key contextual and policy changes since the development of the HSIP TA and how have these effected the TA's relevance and appropriateness?

There have been several policy and contextual changes that have affected the HSIP TA, most notably the health sector reform and decentralisation. The overlap of the HSIP TA with reform and decentralisation challenged the TA's relevance and appropriateness, due in part to variability in PHA readiness for TA engagement and the negative impact of this variability on the uptake of funding streams. The second major contextual change was the retreat and withdrawal of large DPs such as World Bank and Global Fund as contributors to the account, due to concerns around timeliness,

<sup>15</sup> See DFAT. (2019, 10 April). *Assessing and using partner government systems for public financial management and procurement. Guideline.*

accountability, transparency, and efficiency. The withdrawals strengthened the resolve of the NDoH to better manage the TA and informed the 2012 HSIP TA Re-design. A third major contextual change was COVID-19, which motivated the development community to pool technical and financial resources for GoPNG to respond to the pandemic. This resulted in the TA fully realising its potential and operating at its most effective and efficient.

The HSIP TA adheres to the GoPNG PFM Act. While the TA existed from 1996, as the Health Sector Development Program under the auspices of the Department of Finance, it moved to NDoH in 2004 where it assumed its current name. The HSIP TA underwent a review in 2012, funded by DFAT. The review led to a strengthened, comprehensive, and detailed direction, which commenced in 2013. The HSIP Re-design theory of change is attached as **Annex 4** and the HSIP establishment timeline in **Annex 5**. Contextual changes have impacted on the HSIP TA's effectiveness and efficiency capability. The most significant of these are outlined below.

**Provincial Health Authorities Act 2007:** The PHA Act triggered the largest health sector reform experienced by the NDoH in recent times. This took place at the same time as the HSIP TA Re-design commenced and was a key contextual theme throughout the entire period of this review (2013–2022). The shifts resulting from the PHA Act included transferring the governance and budget control for health services from the national and provincial governments to a provincial health body. This reform required 21 provinces, and AROB to establish PHAs and undertake a complete organisational restructure at the sub-national level. This subsequently had implications at the national level, requiring central agencies including the Department of Personnel Management (DPM) to change their ways of working, and divest their powers and authority to PHAs. While this has been a positive shift for provincial health, the realisation has been slow and affected the effectiveness and efficiency of the DFAT support. The shift did not change the relevance and appropriateness of the HSIP TA and DFAT's investments in it. Indeed, without this support, there would have been almost no other major donors involved in the TA, as the World Bank, ADB and Global Fund had already withdrawn due to slow spending, administrative inconsistencies, and lack of capacity to manage funds.

**Development Partners:** Prior to 2013, the NDoH TA received grants from large DPs, including the Global Fund, ADB, and the World Bank. When these DPs withdrew their support to the TA, this had two implications. First, it signalled reduced confidence in the TA. Second, it mobilised NDoH leadership to make positive changes to their management of the TA. NDoH revised its approach to the TA's financial management and processes, with a more consistent approach than prior to the re-design. This resulted in the completion of independent audits for the period between 2012 to 2020, although 2014 and 2015 were delayed and completed in 2016.<sup>16</sup>

**COVID-19 pandemic (2020–2022):** The onset of COVID-19 had a profound but positive impact on the HSIP TA. For the first time, the TA realised its full intent and potential in a more complete manner, with DPs mobilised to support GoPNG in its response to the pandemic. NDoH and the National Control Centre (NCC) led the government's response, and DPs were galvanised in support, providing financial and technical resources. While there were challenges in collaboration and coordination, and less stringent financial mechanisms given that funding was required for an emergency setting, there was greater aid alignment and donor coordination during this time. This further demonstrated the TA's relevance.

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<sup>16</sup> At the time of writing, the 2021 audit report was pending and the 2022 audit is underway.

### 3.1.2 What are the benefits and limitations of DFAT providing sector budget support versus other modalities of health sector support?

The different funding modalities discussed in this evaluation – direct sector support using pooled funding, sector budget support, a SWAp and project support – all have different benefits and limitations based on their purpose and desired development outcomes. **Annex 6** provides an overview of these modalities. The benefits and limitations are summarised below.

The benefits of **pooled funding** are that it leverages DPs to work to one agenda through partner government systems to effect sector change. Importantly, pooled funding should not be earmarked for specific projects, and the donor is therefore unable to trace results to their funding. This modality relies on joint effort with shared or contribution-based results. As many donors prefer attribution results, the HSIP TA Re-design introduced tagged funds to incentivise DPs to use the mechanism. Pooled funding uses a collaborative approach and coordination mechanisms and requires adept stakeholder management. The partner government must have the political will to drive change and implementation with clear leadership, stable management, and robust systems. The donor plays a secondary supporting role through a transformational rather than transactional approach. The costs of running the specific management and disbursement arrangements are higher than when using SBS.

Sector budget support does not require all DPs to work together and relies on the transfer of money between governments. For that reason, there is a higher fiduciary risk due to lower visibility of funds as they are transferred through the partner government's financial systems. Mitigating the risks can be achieved with responsive and transparent relationships, which can increase trust and political currency between the governments.

The benefits of direct sector support using pooled funds is that it reduces donor domination and aid fragmentation. This also applies to SBS, but without DP collaboration. Sector budget support can be earmarked for a specific issue, but ideally is not earmarked. Project support, in contrast, is a more agile modality, given it is usually smaller in scope and scale. It has lower fiduciary risks but higher transaction costs due to multiple contracts, bank accounts and fees, separate administration, and auditing costs. Moreover, when there are multiple projects, this can lead to aid fragmentation without a strong strategic direction. Selecting and applying the right modality, and aligning it with the setting and objectives, is critical when considering gains in effectiveness and efficiency.

### 3.1.3 To what extent is sector budget support a relevant approach for Australia to address GoPNG health sector priorities?

Using the modality of direct sector support through a pooled fund and earmarking funds for key areas was a relevant approach at the time of the re-design. The intention to bring together different DPs and combine their technical and financial resources into a single account to support the vision of the NDoH NHP 2011–2020 was relevant because it sought to:

- Focus contributing DPs attention on the NHP 2011–2020.
- Combine collective efforts to support rural health service delivery.
- Reinforce NDoH leadership.
- Respond to health sector reform and the decentralisation agenda.
- Provide direct funding to PHAs.
- Strengthen PHA autonomy.

However, although the interventions supported by DFAT through the HSIP TA reflected GoPNG health sector priorities, and while the intention envisioned for the modality was relevant in 2013, the way in which implementation/uptake unfolded was not exactly as intended (see section 3.4 for a summary and the Effectiveness and Efficiency sections).

The vision of the NHP 2011–2020 was to *‘Strengthen primary health care for all and improve service delivery for the rural majority and urban disadvantaged’*. The HSIP TA objectives and outputs, with their focus on health services in rural areas, reflected the NHP. DFAT supported specific needs in this area by funding a range of interventions through the TA to buttress the NHP rural health outcomes. In P1 and P2, this support included funding for: recurrent provincial health services (AUD15.75 million); emergency obstetric transfers (AUD1.3 million); minor refurbishments for 300 health facilities (including functioning water supply, electricity, and radio) and 80 staff houses (AUD13.3 million); and major refurbishments of 35 health facilities and 30 staff houses in the 20 most disadvantaged districts (AUD10.7 million). These projects directly respond to two key result areas (KRAs) in the NHP: (i) improve service delivery; and (ii) strengthen health systems (financing and infrastructure). In addressing these KRAs, which are cross-cutting and complementary to other KRAs, the interventions indirectly strengthened other KRAs, specifically: (iii) improve child survival; (iv) improve maternal health; and (v) reduce burden of communicable disease.<sup>17</sup>

The current NHP 2021–2030 has broader intentions but similar building blocks to the prior NHP. The current goal is *‘Leaving no-one behind is everyone’s business’*, which has an implicit rural focus given that 85 per cent of PNG’s population continues to live in rural areas. The KRAs are also broader but with the same intent, including: KRA 1 Healthier communities; KRA 2 Working together in partnership; KRA 3 Increase access to quality and affordable health services; KRA 4 Addressing disease burdens and targeted interventions; and KRA 5 Strengthening health systems. In P3, the DFAT-funded investments echoed these directions, specifically: COVID-19 Vaccination Roll-out (AUD20.5 million); COVID-19 Response and Preparedness (AUD27.5 million); TB Clinical Support Program (AUD 661,000); and AIHSS (AUD1.5 million).

### **3.1.4 To what extent is the HSIP TA the most appropriate mechanism for delivering sector budget support for GoPNG health sector priorities?**

When the HSIP TA Re-design was written in 2012, it offered the most appropriate mechanism to support health sector priorities, because it provided a means to respond to DPs’ concerns about fiduciary risk and enabling the NDoH to mitigate GoPNG funding gaps and fund sector priorities. The re-design strengthened the SWAp by introducing earmarked contributions for specific health sector needs outlined in the NHP. Moreover, the unearmarked funding was to be phased out by 2016, when it was hoped GoPNG core funding would be delivered on time and on budget. The re-design provided assurance to DPs on three fronts: it increased oversight on funding contributions; it enabled monitoring of how the funds contributed to the sector and health outcomes; and it signalled a strong message that DP funds to the TA would not supplement core government funding indefinitely.

The HSIP TA Re-design addressed these concerns with a range of provisions, including a dedicated team with financial and accounting skills embedded within the NDoH and accountable to the Director of Corporate Services and the Health Services Financial Committee. The program logic provided indicators on receiving tagged funds, complementarity between the TA and GoPNG health appropriations, and a range of administrative and compliance activities. DPs were provided with a clear line of sight regarding how funds would be managed and protected. This approach provided

<sup>17</sup> See Government of PNG, NDoH. (2011). *National Health Plan 2011–2020: Volume 1 Policies and Strategies*.

governance, and operational processes and checks and balances, when the fiduciary risk profile was high and the NDoH financial systems weak.

The other modalities were less appealing to DPs and the NDoH. Project support would not enable collective leverage and scale, and SBS was too high a risk given weaknesses with the financial systems. Given there was little assurance in the SBS modality, and the need to scale up investment to address the dire state of rural health services, the most viable solution was pooled funding that could be tagged. This was most appropriate because it endeavoured to:

- Respond to the lower risk appetite following the exit of the World Bank, ADB, and others, prior to 2013.
- Leverage DP impact through pooled contributions and a combined investment.
- Manage aid fragmentation by bringing DPs together under a unified plan.
- Minimise multiple, smaller, individual projects for a larger sector response.
- Rally DPs behind the NHP 2011–2020.
- Provide additional funds for the NDoH to supplement GoPNG funding gaps.

### 3.1.5 What are the benefits and limitations of the HSIP TA, versus other mechanisms, to provide sector budget support?

This section summarises the benefits and limitations of the HSIP TA as it unfolded, not just as it was envisioned (sections 3.1.3 and 3.1.4). The benefits and limitations of the HSIP TA versus other mechanisms is discussed above (section 3.1.2).

**Benefits:** At this juncture, the TA is now a well-established mechanism and part of the PNG health sector and health financing landscape. Nearly all interviewees spoke highly of the mechanism and DFAT’s enduring support. There was widespread confidence in the TA’s functionality and a strong conviction of its importance in the health financing landscape. There were DPs who commented that their commitment was dependent on DFAT’s sustained and continuing role in the TA development. While some sub-national staff interviewed mentioned the heavy burden of documentation, others recognised and supported the necessity of transparent financial compliance.

The HSIP TA worked well as an emergency funding mechanism, because it provided a readily available and functioning SWAp with strong compliance measures in place for the pooled finances. During P3 in the COVID-19 emergency, the TA harnessed the focus and investment of donors and partners alike, and for the first time operated as a platform for a large pool of stakeholders. For example, cluster meetings frequently had over 50 online attendees from dozens of international and national organisations. The TA managed to capitalise on its functionality and good fiduciary record and provided a ready-to-use mechanism during a time of need.

**Limitations:** The HSIP TA needs a stable sector, consistent funding, and strong leadership from the NDoH and PHAs for it to realise its aspirations. The combined impact of the lack of strong NDoH leadership and PHA capacity in the face of decentralisation, as well as the funding freeze, constrained the TA from delivering on its health sector outcomes. PHA readiness to respond to financial assistance was low in P1, largely due to the timing which coincided with PHA establishment. Had the modality of assistance through the TA commenced later, after PHAs were more established, it is possible that the uptake of funds would have been better.

The mechanism relies on strong sector leadership across the NDoH, GoPNG agencies, and DPs to ensure coordination mechanisms are effective: this leadership was missing in P1 and P2. Many



stakeholders across the sector recognised that DP coordination led by the NDoH is extremely weak. An NDoH executive commented that this is *'something we've not done well at'*, adding that *'[It is] quite a mammoth task'*. Interviewees were concerned about the lack of functional GoPNG and DP coordination structures. The development cooperation structures envisioned to have been operational at the time of and following the 2012 HSIP TA Re-design were largely ineffective, as have been most coordination structures subsequently established in the health sector. Both DPs and the NDoH noted the inadequacy of resources specifically devoted to aid coordination. When the leadership kicked into action during COVID-19, it was not because pre-existing coordination mechanisms were effective, but rather because the stakeholder environment was fully mobilised.

In combination, these limitations strip the TA of its SWAp intent. There is a risk that the TA could become only a financial disbursement mechanism without the requisite DP cohesion, funding predictability, and broad sector vision with GoPNG at the helm. Without these elements in place, the TA risks being simply a conduit for donor funds unable to control some of the issues it set out to address – aid fragmentation and donor domination.

### **3.2 Effectiveness (KEQ 2): To what extent was the HSIP TA effective in delivering Australia's contribution towards GoPNG health sector policy priorities and outcomes?**

#### **Main conclusions and key findings**

The HSIP TA was largely ineffective at achieving its strategic objectives and policy priorities throughout P1 and P2; however, there was some improvement in effectiveness in P3, largely due to the response to the COVID-19 pandemic.

- Slow progress in achieving strategic outcomes in P1 and P2 were attributable to a combination of factors that delayed or compromised the expenditure rate and therefore project implementation. Only 32 per cent of P1 funds were committed and these remained unspent as at 31 December 2022. The health sector reform and decentralisation agenda, a necessary albeit slow process (spanning the entire country and evaluation period), resulted in PHAs being at different stages of readiness and capability to respond to GoPNG PFM processes. PHAs struggled to meet the PFM requirements and the technical support provided to them to meet these was insufficient to bridge that gap.
- The funding freeze initiated by DFAT from March 2016 to June 2018 further exacerbated delays in TA spending and project progress. Indeed, the period from 2016 to 2018 revealed a clear downscaling of all donor receipts that compromised effectiveness in achieving development outcomes. The mechanisms responsible for donor coordination, such as the HSPC, appear to have functioned but minutes and reports could not be cited. The MEF was not implemented, which compromised access to data on outcomes and assessment of progress.
- In P3, the amended TA objectives, program changes, and response to emergency events, specifically COVID-19, provided evidence of improved effectiveness of the HSIP TA mechanism in contributing towards achieving the objectives associated with funded activities. This improvement is attributable to the heightened urgency and need for an 'all-hands on deck' approach, high level coordination through the COVID-19 Cluster health sector meetings, and relaxation of the requirement to adhere to the 60 per cent expenditure and 80 per cent satisfactory acquittal reporting required in the usual PFM process.

The effectiveness of the TA achievements needs to be considered against the program logic outlined in the HSIP TA Re-design and the DFA program MEF. As effectiveness was compromised by some key constraints, these are discussed first.

### **Constraint 1: Health sector reform and decentralisation**

At the same time as the HSIP TA Re-design came into effect, the PNG health sector was undergoing major reforms (refer to section 3.1.1 above). This slow and complex process spanned the entire timeframe of the evaluation period (P1–P3) and impacted the effectiveness of the HSIP TA. There have been periods of time where essential positions within the PHAs were vacant, delaying management decisions and compromising capacity to legitimately sign off on strategic directions and funding commitments. High staff turnover and constant changes resulted in corporate knowledge gaps or limited expertise to perform functions. Subsequently, there were frequent delays in producing AIPs, reports, budgets, and acquittals, all of which were central to HSIP TA functions and programs.

### **Constraint 2: Alignment between PHAs and central agencies**

The establishment of systems to support the necessary actions required during this transition have been slow. There are many areas where PHAs rely on central agencies to advance the decentralisation agenda, but progress has not always been made. For example, approval of PHA Boards and organisational structures by the National Executive Council (NEC) was slow. Working with the DPM to retire staff and hire and contract new staff has been a protracted process that was further compounded by DPM's freeze on recruitment in 2016. The NDoH Provincial Health Reform Unit was a key support in the success of early PHA transitions (Eastern Highlands, Milne Bay, and Western Highlands), but the unit was downsized, leaving subsequent PHA transitions without vital support. Continued delays and inadequacies in the speed of central agency support were often mentioned in interviews. These negatively affected the ability of PHAs to plan, manage, monitor, and report on health sector strategies generally and HSIP TA projects specifically.

### **Constraint 3: PFM processes to access funds**

Interviewees indicated that the slow expenditure rate of HSIP TA funds was largely due to the long and unwieldy PFM processes required to access funds for health services and sector priorities. Additional constraints included low spending due to limited provincial capacity to tender for and contract maintenance work, as well as difficulty in meeting co-funding policy arrangements. For PHAs to seek funds, they are required to submit AIPs on time and to follow all of the PFM procedures as per GoPNG guidelines and the HSIP TA Manual of Procedures (2013) (these steps are outlined in **Annex 7**). Key steps must be completed to trigger the release of funds from the HSIP parent account (national level) to the subsidiary accounts (provincial level). The key constraints included:

- AIPs submitted late due to staffing and decentralisation pressures.
- Shifting financial authority, functions, and personnel, from the more mature provincial government systems to the newly-established PHAs with often less experienced staff. New PHA Finance Officers were unable to complete all of the administrative requirements for every funding application, as the burden of work exceeded their capability. Interviews indicated that to manage workloads when faced with multiple funding applications those with the highest monetary value were prioritised.
- The compliance requirement that a new tranche be allocated only if the prior tranche report had been 60 per cent expended. This triggered the PHA to request an audit from the HSIP TA team, and if the expenditure report was 80 per cent satisfactory (record-keeping and compliance) the next tranche would be released.

- The use of Excel spreadsheets and paper administration is time consuming, especially with multiple funding sources.
- The requirement to source no less than three quotes for procurement, especially in provinces where there were limited numbers of alternative providers.
- Districts and facilities requiring either manual cheques to be paid to suppliers or cash advances to staff, due to constraints in accessing banks.

#### **Constraint 4: Changes to DFAT funds envisaged under the DFA**

DFAT funds were frozen between March 2016 and June 2018, in response to concerns about fiscal management and audits not undertaken for 2014 and 2015. The freeze further contributed to underuse of funds. Official communications regarding the reasons for the funding freeze were discussed between the partner governments, but communication was not cascaded more broadly within the sector. Interviewees indicated this resulted in a loss of confidence in the TA, especially from some PHA teams who had consistently adhered to administrative and PFM processes. This loss of confidence and deterioration of staff morale further compounded low expenditure rates. When the funds were unfrozen in June 2018, confidence was slow to return, and fund usage remained sluggish up to 2020. Due to the large amount of unspent funds and concerns with an annual audit, DFAT subsequently revised down its overall intended contributions to the account from AUD48.73 million (2013) to AUD16.53 million (2017), reflecting what had been transferred into the account before funds were frozen. It was only when the COVID-19 pandemic commenced in 2020 that use of TA funds recommenced in earnest. The TA was the only mechanism that ensured funds could be directly channelled to PHAs and DFAT could funnel significant contributions to the COVID-19 response and directly support COVID-19 vaccinations and the immunisation program.

#### **Constraint 5: M&E and measuring effectiveness**

Given that the TA is a pooled funding mechanism, it was not required to track and report on individual investments, but rather the overall health sector impacts. As is good practice with pooled funds, the DFA includes an MEF, with indicators drawn from GoPNG health information systems. Unfortunately, the MEF was not operationalised and overall TA impact cannot be easily determined (see section 3.7 M&E Framework).

#### **Constraint 6: COVID-19 emergency and effectiveness**

During P3, existing and planned activities and uptake of associated funding (including 'legacy funds' or unspent project funding) were disrupted by COVID-19. Despite this situation, P3 provides the best available evidence of the effectiveness of the HSIP TA mechanism. The imperative to get things done during a national emergency coupled with less stringent oversight of the administrative processes, and a mobilised workforce to respond to the pandemic, meant the TA was better used and more effective. Refer to section 3.2.2 later in this report for more analysis on the effectiveness of HSIP TA support to the COVID-19 response.

### **3.2.1 Extent to which DFAT funding through the HSIP TA contributed to the achievement of HSIP strategic objectives and policy priorities.**

This section considers the HSIP TA contribution against objectives and priorities in the 2012 HSIP TA Re-design.

**Strategic objective 1: Increase access to effective health services in rural areas, for those who are considered poor.**

This objective focused on two outcomes: firstly, increase access to health services, and improved service delivery for rural populations; and secondly, improve health services in the 20 most disadvantaged districts. The anticipated design outputs associated with these outcomes are provided in **Annex 8.1**.

### Main conclusions and key findings

Although the HSIP TA has a focus on the poorest districts, it was ineffective in providing improved basic health infrastructure for poor and remote areas. The funding allocated for this in the HSIP TA was barely used. This was the result of: (i) lack of co-funding (kina-for-kina); (ii) limited capacity of some PHAs to develop plans that could be implemented and managed; (iii) logistics and remoteness; and (iv) lack of absorptive capacity within the PHAs/PHOs to access and use the funding available under the HSIP TA.

**Access to health services and improved service delivery for rural populations and improved health services in the 20 most disadvantaged districts:** For this strategic objective, if reviewing the NDoH Sector Performance Annual Review (SPAR) reports, some insights can be drawn from the sample of suggested indicators for the DFA MEF. Comparing national results from 2011 as a baseline against 2020 following nine years of pooled funding, there are consistent declines.

For example:

- Percentage of rural clinics open and functioning went from 67 per cent to 57 per cent.
- Percentage of health facilities with running water went from 48 per cent to 41 per cent.
- Percentage of health facilities with functioning radios went from 71 per cent to 57 per cent.
- Outpatient visits per person per year by province went from 1.31 visits to 1.08 visits.
- Number of people accessing health facilities in HSIP TA districts/provinces indicate improvement only in Manus. The other three of the four selected provinces showed a decrease:
  - Manus – 1.65 people to 2.11 people
  - Milne Bay – 1.63 people to 1.40 people
  - Morobe – 0.99 people to 0.85 people
  - Western Highlands – 1.16 people to 0.99 people.

Bearing in mind that National Health Information System (NHIS) results need to be qualified in light of quality and integrity that possibly mask true performance, this data indicates an overall deterioration. An assessment of performance by each disadvantaged district could not be determined, as the SPAR reports mostly provide national and provincial data, and only a selection of district indicators that not included in the DFA MEF.

There was an overwhelmingly slow expenditure rate on these projects. PGK22.27 million was allocated for disadvantaged districts under the DFA, but the first tranche of funding was only released in 2014. Financial reports and interviews confirmed that, at the end of 2015, PGK2.4 million was allocated for five of the 20 disadvantaged districts and PGK2.1 million for provincial building and maintenance. The remainder was reallocated after the funding freeze ended in June 2018. As of 31 December 2022, there were approvals by NDoH in 2014 and 2015 for seven of the 20 disadvantaged districts, but these approvals were yet to be fully expended for the original purpose. Based on Finance and Planning Sub-committee documentation, the amounts approved by NDoH in 2014 and 2015 were only 10 per cent and eight per cent respectively of the original funding pool in 2013. In 13 out of 20 disadvantaged districts, approvals to pre-commit funds were not provided, indicating that districts were either unable to secure co-funding or develop plans required for approval. PHA capacity constraints likely contributed to the ineffectiveness of this approach.

Another reason for slow spending and progress on outcomes was that, in many disadvantaged and remote areas of PNG, there is limited availability of service providers with skills to upgrade health facility infrastructure, and install radios and water tanks. Accessing local trades and companies with the requisite necessary documentation required to satisfy PFM requirements is a major challenge, as the few that exist are often fully committed.

In summary, the targeted objective of increasing access to rural health services was not achieved, as the funds were barely used despite the extended timeframes in amendments to the end of program. This was reflected in the interview data. Many interviewees reported that the targeted support for the disadvantaged districts faced governance (accessing Service Improvement Program funds) and system constraints (refer to section 3.2 above).

**Strategic objective 2: Increase the absorptive capacity of the health sector to achieve GoPNG commitment to the National Health Plan on a sustainable basis.**

This objective sought to achieve three outcomes: (i) to increase the predictability of donor funding to the sub-national level; (ii) to increase the ability of staff at the facility level to plan, budget, acquit and report on funds; and (iii) to align TA funds so they complement GoPNG funding allocated through Health Function Grants (HFGs) and improve the reliability of cash flow. The anticipated outputs associated with these outcomes are provided in **Annex 8.2**.

**Main conclusions and key findings**

Donor funding through the HSIP TA has been mostly ineffective in increasing the absorptive capacity of the health sector to deliver health outcomes on a sustainable basis, particularly in P1 and P2. The DFAT-funded HSIP Expanded Program of Support (HSIP-EPS), under the umbrella of the PATH program, will go some way towards addressing these needs during its implementation period (2023 to 2025).

- There have been some improvements in P3, where PHAs responded to the COVID-19 Emergency Response Plan in a swift manner.
- Prior to 2020, and COVID-19, the predictability of funds was not realised, and DPs often committed funds in an ad hoc rather than staged and planned manner.
- Even though the DFAT-funded HSIP TA Management Team focused on increasing capability in relation to the funding mechanism, the capacity of PHAs to absorb and manage funds has remained weak.

The following information discusses the findings and conclusions in relation to progress on the three outcomes for this strategic objective.

**Predictability of donor funds:** The HSIP TA did not increase the predictability of donor funding, and indeed donor funds fluctuated considerably across the evaluation timeframe (see Table 1). Interviews noted that, although coordination between DPs and GoPNG is of critical importance, it was poorly done by NDoH, and was also impacted by the slow expenditure rates in P1 and P2, which minimised the overall need for additional funds. Interviews affirmed that while DPs funnelled money through the TA, this was on an ad hoc basis, especially up until 2020 COVID-19 funding deposits. Moreover, the NDoH position responsible for donor coordination within the Strategic Planning and Policy Division was vacant at the time of this evaluation.<sup>18</sup> While it is doubtful this position would

<sup>18</sup> The position has been vacant or temporarily filled for several years.

have single-handedly made donor contributions more predictable<sup>19</sup>, the role is critical when coordinating committees and DPs who have committed funds. In P3, donors returned to the TA with significant financial commitments, largely because there was global consensus to address COVID-19 and alternative coordination mechanisms were in place for donor collaboration.

**Improving facility-level staff capability to plan, budget, acquit, and report:** The HSIP TA did not improve facility-level planning, budgeting, and reporting, as this was an overly ambitious endeavour given the backdrop of health sector reform and decentralisation at the time. In 2014, the NDoH-based HSIP TA team visited 20 provinces to strengthen financial management and compliance capacity. Given there were only 10 staff<sup>20</sup> delivering training, this was inadequate to meet sub-national needs (refer to the Constraints section above). There was no evidence of actions or assessments by NDoH or others to optimise these training activities, measure competence, or support the absorptive capacity of PHAs/PHOs to effectively use program funding and adapt projects as needed in relation to spending and the success or lack of success of projects. The DFAT-funded HSIP Process Review (2022)<sup>21</sup> under PATH outlined practical solutions and recommendations to strengthen the mechanism at the sub-national level. Once implemented, this will go some way towards providing the necessary support.

**Align HSIP TA funds with Health Function Grants and improve the reliability of cash flow:** Since the inception of the HSIP TA Re-design in 2013, cash flow through the PNG HFGs has improved. Provincial Expenditure Reports (PER) indicate improvement at the national level for percentage of funds expended against estimated cost of services:

- 2011: 52.8 per cent expended (47.2 per cent unspent)
- 2012: 64 per cent expended (36 per cent unspent)
- 2013: 68.9 per cent expended (31.4 per cent unspent)
- 2014: 77.2 per cent expended (22.8 per cent unspent)
- 2015: 81 per cent expended (19 per cent unspent).<sup>22</sup>

In this period, there were a mix of provinces demonstrating consistent improvement in expenditure. Some stayed stable, while others declined (see Constraints section above for multiple reasons). From 2013 onwards, HFGs began to flow directly to PHAs after they were established. PHAs were not required to report to provincial governments and given that HSIP TA funds are not integrated into provincial government reports, there was a gap in reported data.

Notably, a PHA CEO indicated that the HFGs are now enabling cash flow and that PHAs are receiving up to PGK7 million per year, which they are using to sustain routine public health activities. It was further noted that the TA performed well as a 'gap filler' when there is an unexpected, urgent, and high funding need over and above standard costs; i.e. COVID-19.

### **Strategic objective 3: Improve performance and governance of the HSIP.**

<sup>19</sup> For example, the World Bank, Global Fund, and ADB were significant contributors up to 2010, but withdrew their funds to be allocated and expended through other modalities. Often these decisions are made for multiple reasons and are not solely dependent on GoPNG.

<sup>20</sup> Of these staff, seven of the roles were funded by DFAT and three by GoPNG.

<sup>21</sup> See PATH. (2022). *HSIP process review, national level (HSIP funding flow) and related reports*.

<sup>22</sup> More recent data was unavailable to the evaluators at the time of writing. Provincial Expenditure Reports were generated from the Provincial Government Accounting System (PGAS) (linked to the provincial governments, not PHAs). The roll-out of the Integrated Financial Management System, the replacement system to PGAS, is ongoing and as a result expenditure data from PHAs and the HSIP TA was unavailable.

This objective sought to achieve three outcomes: (i) to improve management and coordination of the TA; (ii) to facilitate better information on expenditure and development impacts; and (iii) to improve NDoH and PHA compliance with PFM processes. The anticipated outputs to these outcomes are provided in **Annex 8.3**.

### Main conclusions and key findings

At the national level, there have been improvements in governance of the TA mechanism and performance around the governance mechanism has been mostly solid, although weaknesses at the PHA level persisted.

- While there were delays in some years (2014 and 2015), ultimately all annual audits were done, provincial audits were done, non-compliance cases were reported, and actions were taken. The HSIP TA team in NDoH ensured the HSIP TA Manual of Procedures was updated in 2013 and training was rolled out.
- Since 2019, DFAT-funded health projects have been taking a stronger health systems approach and using the HSIP TA to fund activities, such as the AIHSS project.

**Improve NDoH and PHA compliance with PFM processes.** The HSIP Process Review (2022) found that HSIP TA has strengthened governance structures over the years, and these have improved oversight and adherence to compliance matters. It also affirmed that the HSIP system is well-structured overall around the GoPNG Health Policy Framework and administered well in accordance with the PFM Act. Ultimately, the NDoH Secretary is the custodian of the TA and is responsible for ensuring adherence to GoPNG processes and systems to protect funds from misuse. The HSIP TA team reports to the NDoH Senior Executive Management (SEM), specifically to the Director of Corporate Services (an SEM member), who in turn reports to the Secretary. Interviews indicated the TA Financial Controller has been a regular attendee at the NDoH Health Sector Finance Committee (HSFC) monthly meetings. The HSIP TA is also aligned with the Audit Committee and Health Sector Partnership Committee. DFAT has contributed to these mechanisms by funding activities that have delivered on key compliance outputs such as audits, training activities, and provincial visits. Documents from the Auditor-General's Office and HSFC indicate all independent audits, with GoPNG's support, were completed and unqualified, except for the 2014 financial year, which was qualified and later unqualified in 2016 after the queries were addressed.

There are partnership agreements in place with DPs and these provide guidelines for funding provision and performance management. The evaluators could not determine how well these are being adhered to, monitored, or revised.

**Improve management and coordination of the TA:** There was improved coordination and management of the TA through a substantial financial support to provide a dedicated HSIP TA team and requisite TA activities. Between 2012 and 2015, DFAT funded seven of the 10 HSIP TA officers. Three were embedded within NDoH, and four in the DFAT-funded HHISP program. When the funding freeze commenced in March 2016, the number was rationalised to retain the three NDoH positions. In 2020, DFAT funded eight of the 13 HSIP TA team members and the other five are NDoH officers on the GoPNG payroll. These staff perform vital functions, including managing the accounts of the TA instrument (five on the parent account and three on the subsidiary accounts), and supporting activities (as described previously) that are key to effective management and coordination.

HSIP TA effectiveness was compromised by a lack of donor coordination. The Health Sector Aid Coordination Committee was a key committee for the HSIP TA and was established with a Terms of Reference in 2018, superseding the Health Sector Partnership Committee. Interviewees indicated the HSPC rarely met, with only one meeting in 2019 and another in 2022. On the other hand, the Health

Sector Finance Committee met regularly with the HSIP TA as a standing agenda item. Meeting discussions were largely of a financial nature and not about progress on development outcomes.

A 2022 assessment of the HSIP TA processes<sup>23</sup> at the national and provincial level found that management was stronger at the national level and weaker at the provincial level. DFAT has committed to funding an additional six staff under PATH to implement the HSIP-EPS for two years to support PFM processes through the TA. As the project only commenced in early 2022, significant improvement is yet to be seen. A recent PATH report (2023) indicated the following achievements through the HSIP-EPS:

- Considerable improvements in the use and reporting of DFAT funds from the HSIP TA at the provincial level.
- Better and more focused financial support to the provinces.
- PHAs submitting timely and more accurate month-end reports.
- DFAT Legacy Project Funds now accessed by respective PHAs for facility rehabilitation works.
- Improvement in the expenditure of DFAT funds in 10 of the 11 PHAs/BDoH (ARoB, East New Britain, Gulf, Jiwaka, Manus, Morobe, Oro, Simbu, Western, Western Highlands, and West Sepik).

**Better information on expenditure and development impacts.** Information on expenditure did improve over the course of the HSIP TA, but information on development impacts appeared to be missing. While there were many financial reports, there were no program reports available about the specific tagged projects (for example, targeted funding for the maintenance and building program, and impacts on targeted facility rehabilitation in the disadvantaged districts). While the DFA MEF intended that the NDoH would analyse development data through the NHIS and SPAR, the evaluators could not find evidence of this. HSIP TA staff focused on data and information of a financial and compliance nature. Their reports focused on annual expenditure for DPs, annual reports for the Department of Finance, annual management reports to the NDoH, and annual audit reports to the Office of the Auditor-General. Documentation indicated that reports were consistently produced and delivered by the HSIP TA team, and evidence of these was recorded in NDoH Finance and Planning Sub-committee and the Resource Committee meeting minutes.

### 3.2.2 To what extent was the HSIP TA effective in supporting the provincial implementation of COVID-19 response and vaccination roll-out plans?

#### Main conclusions and key findings

The HSIP TA provided an effective mechanism for facilitating the COVID-19 Emergency Response across PNG in the first two years of the pandemic (2020 and 2021).

- The TA was chosen to deliver this funding, as it was an established mechanism and familiar to PHA staff. While there were appropriations not fully expended, there was a significant improvement in the use of funds during COVID-19. For example, PGK19.25 million was transferred from the parent to the subsidiary accounts by May 2020. By year end, PHAs had expended 45.17 per cent of the funds and in 2021, with additional DFAT funds, PHAs had spent 44 per cent of all funds. At the end of 2022, the expenditure rate was 68 per cent.
- While funding for the COVID-19 vaccine initiatives was available, the outcomes were impeded by widespread vaccine hesitancy and misinformation. In addition, the timeframe for the Vaccine

<sup>23</sup> See PATH. (2022). *HSIP process review, national level (HSIP funding flow) and related reports*.



Micro-Plan funding was received and allocated to PHAs (July and September 2022 respectively), but was too short a timeframe to facilitate optimal use of these funds.

DFAT funding for COVID-19 activities was funnelled through the HSIP TA to support the GoPNG response to the COVID-19 pandemic. This included COVID-19 preparedness, PHAs Emergency Response Plans, and the COVID-19 vaccine roll-out. The total investment was PGK117.6 million broken down as follows:

- COVID-19 preparedness and response: By 31 December 2022, DFAT had funnelled through the HSIP TA a total of PGK65.5 million in three tranches – PGK21.45 million (April 2020), PGK3.3 million (June 2020), and 40.73 million (May 2021).
- Vaccine program: By 31 December 2022, DFAT had funnelled PGK52.06 million<sup>24</sup> of financial support to the GoPNG through the HSIP TA in three tranches – PGK13.92 million in April 2021, PGK19.57 million in September 2021 to support vaccine supply and management, and PGK18.56 million<sup>25</sup> specifically for PHA micro-planning in July 2022.

Details of the HSIP TA support for provincial COVID-19 Emergency Response activities are outlined in **Annex 8.4**, and COVID-19 Vaccination Roll-out in **Annex 8.5**.

The HSIP TA was used for COVID-19 activities, even though a proposal for a separate trust account was suggested by the NCC, GoPNG's designated authority to lead the COVID-19 response. This reflected the confidence of NDoH in the HSIP TA, PHAs' familiarity with the TA, and DPs' confidence in the TA as a mechanism for rapid funds dispersal. A WHO Briefing Note on 7 December 2020 observed that:

*'Among the most notable features of the GoPNG's emergency response has been the reliance on the HSIP Trust Account – a parallel budget execution mechanism. This has allowed health-related funds to move quickly to where they are needed by circumventing the need to use the slow and often unwieldy warrant-based system of budget execution.'*<sup>26</sup>

### Strengths of the HSIP TA for provincial implementation

In broad terms, the use of the HSIP TA for the provincial implementation of COVID-19 response and vaccine roll-out was effective as it enabled: (i) the swift mobilisation of DFAT contributions. Over the three and a half-year period, this amounted to PGK115.9 million, which was a significant scale-up compared to P1 and P2 (PGK28 million); (ii) extensions of the end of program timeframe to 30 June 2022, and then to 30 October 2023 to support the health system's response to COVID-19 (coincidentally allowing more time for other expenditures to take place); and (iii) support to be provided to other COVID-19 contributions, such as from MFAT.

These achievements occurred largely for two reasons. Firstly, the overarching DFA was sufficiently flexible to enable the TA mechanism to re-allocate PGK11.7 million of unused DFAT funds (from 2014) for the emergency response in April 2020. This flexibility, and the sector familiarity with the mechanism meant that a further PGK24.8 million was deposited by DFAT into the HSIP TA parent account in 2020. As a result, 87.4 per cent of the combined funds were committed, allocated, or expended by PHAs by 31 December 2022. Secondly, there was a simpler, more straightforward application process. PHAs submitted their COVID-19 Emergency Response Plans, and once approved the full funds were transferred to the subsidiary account as one complete deposit. By removing multiple tranches, the 60 per cent spending and 80 per cent acquittal requirements were lifted, so

<sup>24</sup> AUD21,592,592.

<sup>25</sup> AUD7,699,965.

<sup>26</sup> See WHO. (2020, 7 December). *PNG's health financing response to the COVID-19 emergency. Briefing note.*

PHAs could focus on implementation of activities. This demonstrated that disbursement could occur effectively through the HSIP TA parent account to the subsidiary accounts for emergency preparedness and response plans.

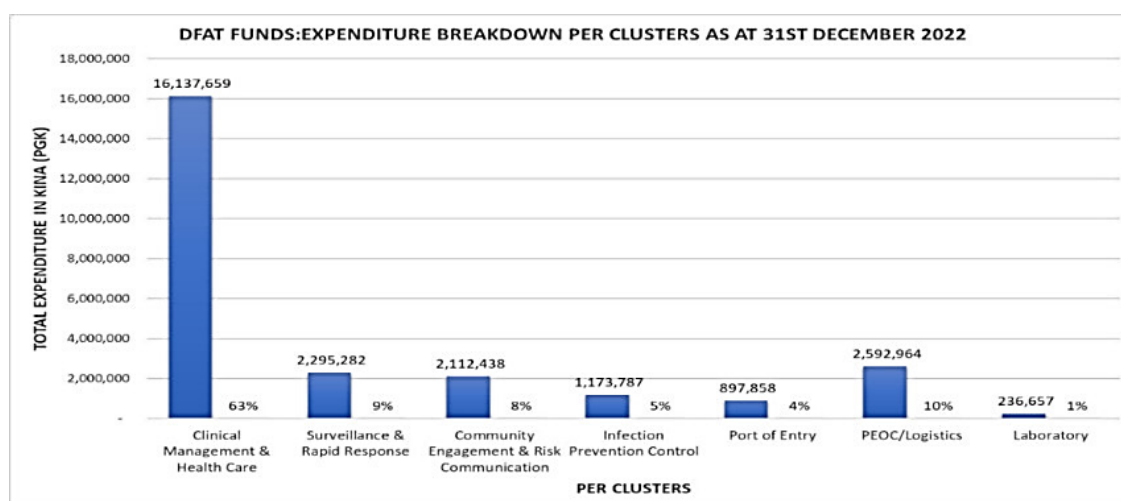
Success factors in the implementation of DFAT's support to the COVID-19 response, which contributed to improved effectiveness of the TA mechanism, included:

- Effective communication and involvement of PHAs in the weekly COVID-19 Cluster meetings, ensuring awareness and confidence in strategic direction.
- Flexibility in how funds could be used at the sub-national level for specific priorities, as long as these were broadly in line with the approved COVID-19 Emergency Response Plans.
- More flexible compliance requirements following the initial State of Emergency declaration and subsequent Certificate of Inexpediency (COI), which enabled faster usage of funds and urgent procurement early in the response.
- Using a mechanism and structure for COVID-19 support to PHAs that was familiar, which facilitated a more fluid response than using an alternative unfamiliar and unestablished TA.
- Provision of a toolkit and templates for the HSIP TA to guide PHA programming and expenditure.

### Challenges and limitations of the HSIP TA for provincial implementation

**COVID-19 response and preparedness:** The COVID-19 pandemic highlighted health system weaknesses and challenges, as well as deficiencies in PFM capabilities, especially in weaker PHAs. Noting that there were other contributing factors to slow expenditure rates, such as significant staff absenteeism, role shifting, job sharing, travel restrictions, and reduced outreach patrols due to community stigma, interviewees noted that the PFM processes did pose some difficulties in absorbing and expending allocated funds. Of the PGK77.2 million received into the HSIP TA for the COVID-19 Emergency Response, PGK52.5 million (68 per cent) was expended, committed or allocated to PHAs as at 31 December 2022, and 32 per cent remained in the parent account. There were wide variations in expenditure across provinces, with some PHAs spending less than five per cent of allocated funding, and a further eight provinces less than 50 per cent. There were also differences in the expenditure rate across cluster areas, as illustrated in **Figure 2**.

**Figure 2: Expenditure of COVID-19 funds by category as at 31 December 2022\***



\*Reproduced from NDoH HSIP TA Expenditure Report on DFAT Funding as at 31 December 2022.

COVID-19 vaccine roll-out: DFAT deposited a total PGK52.06 million into the HSIP TA parent account, of which PGK29.5 million (56.6 per cent) was expended or allocated to PHAs by the end of 2022, with

43.4 per cent remaining. At the time of this report, data on PHA expenditure of vaccine roll-out funds was unavailable, so individual PHAs effectiveness could not be assessed. While PHAs were provided with flexibility in how to spend vaccination funding, including integrating COVID-19 vaccine delivery and communications into routine immunisation and other primary health care services, suspicion and misinformation around COVID-19 had an impact on the uptake of other essential health services, including vaccinations.<sup>27</sup> The NDoH HSIP TA Expenditure Report (2021) also cited vaccine hesitancy, security risks for vaccinators, and use of other donor funds, as reasons for the slow provincial spending of DFAT funding on COVID-19 vaccinations in 2021.

### **Funding for health system strengthening**

On 26 May 2021, DFAT PGK40.7 million was deposited in the HSIP TA for health system strengthening, half of which remained in the parent account as at 31 December 2022. The NDoH 2021 and 2022 HSIP TA Expenditure Reports do not provide specific insights into the reasons for the slow uptake of these funds. However, other reports identify inadequate staff capacity in PHAs, several of which had no expertise in financial management to follow the required procedures. Further information on the objectives, activities, and anticipated use of funds, such as details of PHA spending to indicate how these funds were allocated, was not available to evaluators.

### **Funding for Vaccine Micro-Plans**

In July 2022, DFAT deposited funds totalling PGK18.56 million into the HSIP parent account for COVID-19 Vaccine Roll-out Micro-Plans. Transfers to the PHA subsidiary accounts occurred in September 2022, totalling PGK8.85 million. However, only PGK28,702 million was spent, given there was only three months left to spend funds by year end. As at 31 December 2022, 48 per cent of all funds were spent.

These funds were supplemented with DFAT-funded capacity support. PATH Provincial Facilitators and COVID Task Force Provincial Advisers (in NCD and PATH focus provinces) supported vaccination micro-planning, monitoring funding flow, and completion of financial reports, and encouraged regular HSIP meetings. The HSIP-EPS also provided capacity support to all PHAs to promote more effective use of the HSIP TA. Despite this, expenditure remained low.

The HSIP TA team and the PATH Program conducted a 'HSIP Funding Flows and Usage – Quick Survey 2022' to gain insights into the slow movement and/or expenditure of funds, but this survey was not shared with the evaluation team. Detailed financial tables on the funds provided to PHAs and the expenditure at different levels are outlined in Annex 7.1 and Annex 7.2 and provide the amounts, timing of uptake of funds, patterns of expenditure, and the funds remaining on 31 December 2022.

## **3.2.3 What positive and negative changes were produced by the HSIP TA directly or indirectly, intended, or unintended?**

### **Positive changes**

Positive changes noted during this evaluation period include: (i) stronger financial governance systems in place; (ii) improved adherence to PFM principles and processes, even though these were time consuming; (iii) better support provided to the NDoH through the HSIP TA Management Team, which will be further buttressed by the HSIP-EPS in 2022; (iv) diligent continuing effort by the HSIP TA Management Team to support PHAs, despite this being difficult at key times; and (v) the development of materials (toolkit during P3) to supplement the 2013 HSIP TA Manual of Procedures

<sup>27</sup> See the *HDMES AIHSS Evaluation Report* (draft), December 2022.

and support use of funds. However, these are all related to financial management rather than health system impacts.

### Areas for improvement

The lack of an MEF as intended in the DFA was a key weakness in trying to determine the effectiveness of the HSIP TA (see the section on M&E). In the absence of the MEF, the assessment of the effectiveness and performance of the TA is compromised, as it is based on inconsistent and piecemeal data, with multiple gaps. Future DFAT financial sector support must be paired with an MEF and M&E Plan to better gauge effectiveness of outcomes.

DP coordination remained an area for improvement for the NDoH, especially in P1 and P2. HSACC and HSPC mechanisms were established by NDoH but rarely met, which rendered the SWAp without the leadership and donor collaboration it required. This highlights both the limitations of the TA as a SWAp and the need for alternatives for sector support. DPs could funnel project funds to PHAs for targeted health objectives like the AIHSS model. This would both support the broader health objectives and priorities of NDoH, as well as support PHAs' mandate to manage finances and implement health projects.

DP reporting could be streamlined. There is recognition that donors have specific reporting needs, no matter the size of their contribution, but there are GoPNG governance and reporting requirements as well. In combination these have resulted in duplicated administration and over-burdening the HSIP TA team. There is scope for DPs to either: (i) provide additional support to the HSIP TA team; or (ii) streamline their reporting requirements so they are aligned with the data collected by the team.

### Unintended consequences

The most critical unintended consequence of the HSIP TA was the freezing of the DFAT funds. While this was a legitimate action to manage fiduciary risk and well-communicated at the highest levels, the lack of a clear message cascaded to PHAs had a negative impact on the HSIP TA. Not only was momentum stalled in the early years (P1 and P2), when committed funds could not be accessed and implementation halted, there was also reputational damage that resulted in a loss of confidence in the TA and DFAT's commitment.

## 3.3 Efficiency (KEQ 3): To what extent was the HSIP TA efficient in delivering Australia's contribution towards GoPNG health sector policy priorities and outcomes.

### Main conclusions and key findings

For P1 and P2, the HSIP TA was slow and inefficient in delivering DFAT's contribution to GoPNG health sector priorities, irrespective of the DFAT funding freeze.

- This was due to constraints around PFM processes and procedures, mostly at the sub-national level, which impacted funding flows from the parent account to provincial subsidiary accounts. Only a small proportion of allocated funds were used for approved activities in provinces during P1, and this hampered the delivery of activities and services, diminishing program outcomes.
- The 3 years when DFAT funds were frozen during P2 further complicated and undermined PHAs' confidence in the HSIP TA mechanism, further reducing usage of funds. More recently, however, during P3, the HSIP TA has become more efficient at supporting objectives and outcomes, triggered by amendments to the DFA.

- In addition to this, improvements can also be linked to: (i) improved sub-national support mechanisms; (ii) more mature PHAs with embedded structures and processes; and (iii) the development of DFAT's Health Portfolio Plan 2018–2023, which provided both GoA and GoPNG with clarity around mutual strategic focus through agreed objectives and specific outcomes.
- The mechanism was most efficient when dealing with communicable diseases, especially outbreaks, given: (i) perceived urgency; (ii) involvement of PHAs in structuring programs and funding mechanisms; and (iii) more flexibility in processes and systems in responding to COVID-19.

### 3.3.1 To what extent has the HSIP TA been an efficient mechanism for enabling the flow of DFAT funds from national to provincial and service levels?

#### Main conclusions and key findings

At the time of this report, the HSIP TA is functioning in a reasonably efficient manner, and distributing funds from the national to the provincial level.

- Inefficiencies and use of HSIP TA funds were most evident during P1 and P2. Many PHAs struggled to complete all processes and had difficulties in fulfilling all requirements for the release and use of funds.
- These sub-national conditions resulted in delays at the national level, as the lack of 60 per cent spending, and 80 per cent acquittal meant the national level could not release the next funding tranche.
- The freeze of DFAT funds in P2 exacerbated these problems. It was after the freeze was lifted in June 2018, during P3, with a new set of programs identified, that efficiencies began to improve. These were most evident in responses to health emergencies and outbreak responses.

This section discusses the efficiency or timeliness of funding flows, from the TA parent account to sub-national subsidiary accounts.

For the most part, the HSIP TA functioned well at the national level. Interviewees indicated tranches were dispatched promptly from the parent account to the PHA subsidiary accounts where the PHAs had met the management requirements for the funds. This was confirmed in audits, NDoH internal documents, and HSIP TA expenditure and annual reports. National-level reports captured funding source, receipts for money received, total amounts spent, and transferred amounts to NDoH programs and PHAs, with details on appropriation, authorisation, expenditure, and account balances. This happened across all years.

There were, however, two issues that did impact funding flows at the national level. The first was the freezing of DFAT funds from March 2016 to October 2018, when committed and unspent funds were inaccessible and resulted in no flow of DFAT money during this period. Following the unfreezing, the requirement to re-cost and resubmit documentation and budgets was largely met with indifference. Subsequently, many de-prioritised the request, leading to an underuse of these funds. The second area that compromised national funding flows was late submissions of provincial AIPs and delayed provincial financial reports and acquittals. These compliance issues required the TA team to hold funds until the requisite processes were complete. This had a negative impact on the speed at which funds were disbursed.

In 2020, with the onset of the COVID-19 pandemic, DFAT funds through the HSIP TA started to be used at a reasonably efficient rate with the parent account promptly funnelling money to PHAs, and

these in turn receiving and using the resources. Moreover, at the same time other DPs were also using the TA and the TA began to function more effectively and efficiently. The flow of DFAT's and other DPs' emergency response funds and vaccine support through the mechanism was well-received by PHAs. Contributing factors to this include: (i) the perceived urgency of dealing with conditions of significant public health concern; (ii) direct involvement of PHAs in structuring programs and funding mechanisms, which increased their readiness; and (iii) more flexibility in processes and systems in responding to COVID-19. These are described in more detail in the sections below.

### 3.3.2 To what extent has the HSIP TA supported efficient approaches to health sector service delivery and system strengthening?

#### Main conclusions and key findings

The HSIP TA enabled an efficient approach for PHAs to readily access funds for under-funded and neglected health sector needs, such as building and maintenance, staff housing, or facility rehabilitation. These, however, were mostly inefficient in P1 and P2, given the constraints of the health sector reform, the decentralisation agenda, and PHA readiness.

- The multiple PFM steps required to access GoPNG and HSIP TA funds exposed blockages that impacted accessing funds and achieving policy priorities and outcomes.
- In addition, the funding freeze had ramifications on the overall efficiency of the TA at the sub-national level. After the freeze, the DFAT Authorised Delegate was an additional step, but this was mostly efficient as these were available at the national level if a sub-national one was unavailable. On the other hand, the freeze on DFAT funds had a negative impact, as it stalled momentum at the early stage of the HSIP TA and had subsequent ramifications.

This section discusses the efficiency of accessing HSIP funds at the sub-national level and compares the different approaches of administering funds for the different health outcomes under HSIP TA. While some funds were tagged for use over a four-year period and received in annual tranches that could be rolled over year-to-year, other funds were allocated as unearmarked for greater flexibility but had to be used by year end. While all of these approaches used GoPNG PFM principles and processes, some of the approaches were not fit for purpose given the constraints of the health sector reform, the decentralisation agenda, and readiness of key stakeholders. Moreover, the multiple PFM steps required to access GoPNG and HSIP TA funds exposed blockages that impacted accessing funds and achieving policy priorities and outcomes. In addition, the funding freeze had ramifications on the overall efficiency of the TA at the sub-national level.

Before discussing the different approaches for administering the funding, it is important to acknowledge that the HSIP TA for the first time embedded PFM procedures within the sub-national health sector. Prior to the decentralisation reform of the health sector, this function was carried out by the provincial governments. The PFM steps are outlined in **Annex 7**, but in summary include: submitting to the NDOH Strategic Policy and Planning Division the AIP, which covers the agreed activities and budget; authorisation to request budget; quotes and invoices (usually 3); 3 levels of sign-off by an Executive, a Senior Examiner and Financial Delegate; sign-off from a DFAT Authorised Delegate (after 2018); and a letter to the bank and two bank signatories. Once these are completed, then the funds are released. Use of these funds requires 60 per cent spending, which then triggers the PHA to request an audit from the HSIP TA team. If the expenditure report is 80 per cent satisfactory, then subsequent tranches of funds can be received.

A variety of approaches to access the funds through the HSIP TA and their efficiency are discussed here.

**Recurrent PHA/PHO support:** HSIP TA budgeted PGK32.8 million to be administered as pooled funding for four years (2013–2017). DFAT deposited one year of funding in 2014 into the HSIP parent account, and each province was allocated a ceiling amount. PHAs could request funds by identifying the activity and budget in their AIP and if this was approved then the funds could be released, and the TA team would support the financial processes. The funds were ‘unearmarked’, in that they were not targeted and available to PHAs for any activity as long as it aligned with the Health Secretary’s direction.<sup>28</sup> The caveats for use of the funds included: (i) they had to be used in the 12-month period; (ii) unused funds could not be rolled over; and (iii) unused funds would be returned to the parent account.

While this approach may have been efficient in that it allowed the PHAs to fill program gaps, it required PHAs to be sufficiently nimble to respond within the timeframe. Shortly after provinces had submitted their requests in 2015, the funding freeze commenced in March 2016 and only one year of the four years of available funding was committed. Of the total PGK25.51 million of unspent DFAT funds, PGK2.70 million remained at year end in 2015, and this was later reprogrammed. When the funding freeze was lifted in June 2018, out of PGK10.2 million in unallocated DFAT funds, PGK7.80 million was reallocated to recurrent health support. While PHAs struggled to meet the GoPNG PFM requirements to expend this money in P1, interviews indicated these processes are now well used by Public Health Units to support services, demonstrating an efficiency gain more recently.

**Provincial building and maintenance:** This project budgeted PGK27 million for minor refurbishment of 300 health facilities and 80 staff houses to ensure functioning water supply, lighting, and radios. Notably, for this funding modality, PHAs could retain the money in their subsidiary account, and roll it over year-to-year, allowing them the time to initiate, implement, and finalise activities. The process required PHAs to apply for activities within the budget ceiling (in 2015 the NDoH Budget Instruction indicated this was PGK140,000) and request funds by submitting a scope of works completed by a qualified tradesman, coupled with a costing schedule and quotes.

The AIP had to include the activity, and the documentation had to be submitted either with the AIP or later. In 2015, six provinces had submitted all of the documentation and met all of the PFM requirements. These provinces were committed PGK2.46 million, but the projects were not implemented, for reasons such as PHAs’ varying capacity to contract and implement maintenance and building projects, and funds were retained in the parent account. At the end of 2015, there was a balance of uncommitted PGK3.09 million retained in the parent account, which was reprogrammed in 2018. After the freeze was lifted, the provinces that had committed funding had to resubmit costings and documentation, but only PGK0.25 million was used, and a total of PGK2.2 million remained committed but unspent in the parent account at the end of 2022. In terms of efficiency, the targeted funding for projects was a new approach that required more input from PHA Corporate Services that were unfamiliar with the budgeting and request forms etc. Coupled with the restructuring of PHAs, and limited capacity for project management, there was low efficiency.

**Disadvantaged districts and major refurbishments:** This project budgeted PGK22.27 million for major refurbishments of 35 health facilities and 30 staff houses in PNG’s 20 most disadvantaged districts. To access HSIP TA funds, the same procedures for building and maintenance applied (see

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<sup>28</sup> For example, in July 2014 the NDoH Provincial Budget Instructions for 2015 budget planning were: (i) cold chain rehabilitation; (ii) National Health Services Standard roll-out/facility assessment and service planning; and (iii) hospital and rural health services combined outreach and supervision.

above). The co-funding element of the Kina-for-Kina approach was to supplement DFAT funding with GoPNG funds by leveraging Services Improvement Program funds. These funds are held by parliamentary members, who are required to spend a portion on health in their electorate.

In 2014, seven of the 20 districts had successfully submitted all of the documentation and PGK403,406 was allocated per district. These committed funds, however, were retained in the parent account due to the funding freeze. In 2015, there was an additional PGK3.7 million that was uncommitted and held in the parent account for later use or to be reprogrammed. By 2019, after the freeze, PHAs were informed that the money was available, but they would have to resubmit reviewed costings. Given that many had spent the SIP co-funding, or it was withdrawn and spent elsewhere, there was a delay from the PHAs to relocate more co-funding and review and prepare documentation. Interviews confirmed that the fund freeze did compromise confidence to resubmit, although three districts did access their funding in 2022 and received PGK1.2 million. As of the end of 2022, PGK0.9 million remained committed but unspent.

While this approach was conceptually valid, it did not advance the objectives of improving access to rural and remote health facilities. Interviewees indicated that, in hindsight, the approach needed greater consideration with engaging elected delegates and their available funding. No amendments were made to the approach, despite these shortcomings. Overall, the approach was not effective and efficient in delivering Australia's support for these objectives.

**COVID-19 preparedness and response, and vaccine roll-out:** DFAT funnelled an estimated total PGK65.5 million through the HSIP TA to support COVID-19 preparedness and response activities and PGK52.06 million for COVID-19 vaccine roll-out support. Seven key areas were identified for preparedness and response and PHAs had to submit Emergency Response Plans to NDoH for approval, then the HSIP TA management for action. Once the plans were approved, the full payment was deposited in the subsidiary accounts for use and implementation. The PFM processes and reporting requirements remained the same. The HSIP TA Management Team developed a Toolkit for PHAs as a guide for this process, to which PHAs responded positively.

Notably, the COVID-19 emergency preparedness and response funding was released as a single complete transfer to the subsidiary accounts. In 2020, after the tranche was transferred, the total expenditure across all PHAs was 45.17 per cent (April to December). In 2021, DFAT provided additional funds to PHAs and by year end the spend rate was 44 per cent. In 2022, no new funds were transferred and PHAs were required to spend remaining money in their accounts. By year end in 2022, the expenditure rate was 68 per cent.

For COVID-19 vaccination roll-out, in 2021 the total amount transferred from the parent to the subsidiary accounts was PGK26.46 million, and of this PGK7.1 million was expended (27 per cent expenditure rate). In 2022, PGK12.7 million was transferred from the parent account and by year end, the expenditure was PGK1.97 million (16 per cent expenditure rate). At the end of 2022, PGK7.6 million of unallocated funds remained in the parent account.

Overall, it is clear that DFAT funding through the HSIP TA was expended more efficiently during COVID-19 in P3 than for any of the earlier priorities in P1 and P2. The spending for COVID-19 preparedness and response varied from 45 per cent (2020) to 44 per cent (2021), and then to 68 per cent (2022) in the final year. However, the expenditure rates for the seven different cluster areas ranged significantly. At the end of 2022, the highest spending was in clinical management and health care (63 per cent), which included activities associated with staff training and recruitment and establishing COVID-19 triage, quarantine, and isolation facilities. The second highest spending was for the Provincial Emergency Operations Centre (PEOC), followed by logistics (10 per cent) and all



other clusters (less than 10 per cent).<sup>29</sup> COVID-19 vaccination spending was consistently lower at 27 per cent in 2021 and 16 per cent in 2022. This slower expenditure was not due to HSIP TA or PFM challenges, but to vaccine hesitancy and other externalities.

In this way, the HSIP TA started to be used as a reasonably efficient funds flow mechanism for PHAs. Some interviewees asserted that the earlier 2019 distribution of funds from WHO and UNICEF to tackle polio and enhance vaccine distribution had contributed to the TA being seen as a 'go to' mechanism for emergency funding. It was suggested by several stakeholders that the HSIP TA be used to address urgent communicable disease needs. It is notable that the HSIP TA team was not expanded during COVID-19, but two core factors contributed to the more efficient spending: (i) the perceived urgency of dealing with conditions of significant public health concern; and (ii) closer alignment between the PHAs, NDoH, and PNG NCC, in structuring programs and requisite funding with regular cluster meetings enabling more cohesive coordination among PHAs and DPs.

In conclusion, these case studies affirm that the HSIP TA had some success with the different funding models. The following summarises observations about the HSIP TA's efficiency:

- In P1 and P2, many PHAs struggled with PFM requirements due to the contextual constraints of health sector reform and decentralisation. This was more of a barrier to efficiency in P1 than it was in P3, as PHAs had become more stable in their governance and administrative processes.
- Unearmarked funds are needed by PHAs, but many lacked the agility in P1 to spend while adhering to compliance processes within a 12-month period. It is possible that some PHAs may have the required agility now.
- In P1 and P2, all of the projects were compromised by the DFAT funding freeze that affected the momentum of and confidence in the TA. This resulted in continuing underspending in reprogrammed legacy funding.
- Co-funding with GoPNG delegates provides a novel approach, but a deeper and more comprehensive analysis of processes, risks, and stakeholder readiness would be advantageous.
- The slow rate of spending in earlier periods and faster rate of spending in the latter period could be indicative that the HSIP TA may perform better as a gap filler between government funding cycles. Alternatively, it may also suggest that the TA functions more effectively and efficiently as an emergency funding mechanism when all stakeholders are mobilised, and PFM requirements are simplified. This, however, presents fiduciary risks that would need to be managed.
- Core GoPNG funding through the HFGs and other grants has improved but may not be enough to support health system strengthening.

### 3.3.3 To what extent have risks been mutually monitored and managed in line with the HSIP TA risk management plan?

#### Main conclusions and key findings

- The HSIP TA had a Program Risk Management Plan with potential risks and proposed mitigation strategies identified early in P1. There were clear risk management mechanisms in place for financial processes, but the risk management plan was not regularly updated and there was no evidence of regular discussion of risks between partners. Moreover, it was unclear to the evaluators how or whether non-financial risks were implemented and embedded.

<sup>29</sup> See the NDoH *HSIP TA Expenditure Report on DFAT Funding 2022*.

- The HSIP TA Management Team focused on identifying financial risks, and undertook regular audits, visits to and training for PHAs, and would cease funding flows in the absence of appropriate expenditure and acquittals.
- The freezing of DFAT funds through the HSIP TA to manage fiscal risk may have inadvertently increased other types of risk, most notably around reputation for GoA, DFAT, and the HSIP TA, which has negatively affected funding disbursement.

The HSIP TA Re-design (2012) identified that the risk environment around the HSIP TA is high, with a poor capacity within NDoH to manage, control, monitor and report on all health activities, including the HSIP TA.<sup>30</sup> The DFA (2013) recommended that program risk management be shared by GoPNG and GoA, with both jointly responsible.<sup>31</sup> Internal documents from 2013 outline the risk management strategy and identified five key areas. These are outlined below, with a summary of activities.

**HSIP funds are used for unauthorised purposes and do not directly contribute to improved service delivery:** DFAT funded the cost of the audits and the NDoH was required to undertake the audits in a timely manner; in this way, the GoPNG and GoA collaborated on financial risk. At the time of the evaluation, annual audit reports were completed between 2012 and 2020, although 2014 and 2015 audits were delayed by two years.

At the time of writing this evaluation report, the 2021 audit had been completed and the report was pending and the 2022 audit was underway. This work was achieved mutually with DFAT funding audits and NDoH facilitating the process. Another shared risk activity is financial reporting processes, which are undertaken by both the HSIP TA Management Team and PHAs. Annual reports revealed that provincial drawdown requirements are being followed on usage of funds, and reporting requirements on these adhered to. Indeed, one stakeholder commented that the slow drawdown of funds signified that the HSIP TA PFM processes were being followed. DFAT supported the development of the HSIP TA Manual of Procedures review in 2013 and interviewees indicated that the HSIP TA Management Team actively collaborates with the NDoH Provincial Accounts Team and PHAs using the manual.

**Procurement processes in disadvantaged districts are high risk:** Throughout the evaluation period, five priority provinces, many of which have disadvantaged districts – Western Highlands, Eastern Highlands, Milne Bay, Bougainville, and Western Provinces – have been supported by DFAT investments, specifically HHISP between 2012 and 2020, and PATH from 2020 up to the time of this report. The evaluators had limited information regarding the disadvantaged districts and, although procurement audits may have been completed to mitigate this risk, these were unavailable at the time of this evaluation.

**NDoH and HSIP audits do not improve and fewer DP funds are committed through the coordinated pool:** DFAT has provided external support through the HHISP by funding a Finance and Audit Adviser, from 2014 to 2020. The role was embedded within the NDoH to provide support to the NDoH and HSIP TA, with a respective 70:30 time commitment. The annual HSIP audits have all been unqualified, apart from those in 2014 and 2015, which were later unqualified in 2016. This indicates that the HSIP team and the NDoH SEM are committed to compliance and risk in a sustained manner. This support is continuing with the HSIP-EPS through the PATH program.

**Provinces remain dependent on HSIP for recurrent funding of health services:** Part of the HSIP TA exit strategy was that DFAT pooled funding would be gradually reduced, and that GoPNG core

<sup>30</sup> See Richards, S., et al. (2012). *Re-design of the Health Services Improvement Program (HSIP) Trust Account*, p 74.

<sup>31</sup> See Direct Funding Agreement, in relation to HSIP TA Funding (p.5, clause 35).

funding would improve in consistency and amounts. It was also hoped that more DPs would support the TA. DFAT sought to collaborate with the World Bank, National Research Institute, National Economic and Fiscal Commission, and other institutions, to support key health financing analytical work to influence GoPNG policy on health, but the evaluators could not determine if this was done.

DPs and GoPNG will not be able to report on the efficient use of HSIP funds and the development outcomes in PNG: Monitoring and reporting only focused on financial reporting being in line with GoPNG Trust Account requirements, not health or development outcomes. While the GoA was to fund these, GoPNG were responsible for implementing them. Annual financial reviews, reporting and audits were eventually all done, as well as in-service PFM training at the provincial level, and the NDoH SPAR reports were completed by the NDoH Monitoring and Evaluation Unit. However, there was no evidence that these were reviewed by NDoH to assess progress on investments or whether there was wider consultation and discussion about progress in areas funded by the HSIP TA.

The HSIP TA risk management strategy was in place and mitigation approaches outlined, but there was little evidence that any were done apart from the financial reporting aspects at the parent account level. The slow drawdown of funds at the provincial level and heavy reliance on the HSIP TA Management Team for ongoing queries and support demonstrates continuing constraints around sub-national organisational and staff capability. Updating the HSIP TA Manual of Procedures, given that it was last reviewed in 2013, would improve risk management so that processes are reflective of current systems. It was clear through multiple documents and interviews that financial risk is being shared by both GoPNG and GoA, but not in HSIP TA health indicators and outcomes.

### 3.3.4 To what extent are the HSIP TA governance arrangements fit for purpose?

#### Main conclusions and key findings

The documented governance arrangements at the PHA level appear to be fit for purpose. Theoretically these should work well when PHAs have their full organisational structure in place, and seek approvals and decision-making through appropriate committees and the board.

The evaluation team could not fully gauge the effectiveness of these governance arrangements, however, due to lack of access to meeting minutes and related materials. Reports from the HSIP TA Management Team provided some insights into activities and accounts performance, but broader governance processes such as those relating to decision-making, prioritisation, or DP coordination were not cited.

The HSIP TA has a strong fiscal policy framework and is embedded in a series of GoPNG legislative and technical policy documents. This includes the *National Health Administration Act 1997*, *Public Hospitals Act 1994*, and PHA Act 2007, and PFM Act 1995 (as amended 2016). Key guiding programmatic documents include the National Health Plan, National Health Service Standards (2021), and other associated GoPNG and NDoH documents. Specific joint financing agreements between DPs and GoPNG are in place, and in the case of DFAT this resulted in the DFA signed in 2013. The evaluators consider that the HSIP TA governance arrangements were appropriate in design, as they outlined adequate structures and forums for dialogue on management, compliance, and reporting. However, the implementation of fiduciary risks was addressed with greater diligence than the programmatic risks.

At the HSIP TA team level, annual and audit reports to partners and the NDoH SEM and DFAT are undertaken and completed, although there were some not completed in the required timelines with several completed after significant delays. At the strategic level, several mechanisms exist to bolster

the SWAp. The HSACC is supposed to mobilise NDoH and sector partners to discuss activities and areas of mutual collaboration and coordination, but it has only met twice since 2019. The NDoH HSFC, Finance and Planning Sub-committee, and Project Implementation Group are key governance committees that provide regular oversight and support for both HSIP and recurrent funded activities. HSIP financial reports are tabled at each HSFC meeting as a standing agenda item, along with other reports requiring the attention of the committee.

Governance structures are built into the PHA organisational structure, for approvals and decision-making through the PHA Board and committees, including the Health Sector Partnership Committee, Audit Committee, and the Health Sector Finance Committee. According to the PATH HSIP Process Review<sup>32</sup>, these should work well where the PHA has its governance structures in place. Successful examples include Milne Bay Province, which accessed and managed its full quota of HSIP TA funds for PHA/PHO support, due to effective governance mechanisms that supported the necessary processes. Western Highlands passed an independent, external assessment of its financial systems and was able to lead its AIHSS activities with DFAT support and without an NGO (one other was supported to lead with Gavi funding, and 10 of the 12 PHAs were paired with an NGO). East New Britain PHA had 75–80 per cent of relevant committees established and similar findings were observed in Manus, Western, and Western Highlands PHAs. The effectiveness of these committees could not be determined but the PATH PFM TA Process Mapping (2021) indicated they were working well and with PFM strengthening would be critical for future improvements.

### 3.3.5 Which parts of the HSIP TA process could be streamlined to improve efficiency?

#### Main conclusions and key findings

The HSIP TA is part of a bigger system seeking to deliver outcomes and enhance the achievement of health and development objectives. The competent operation and management of the HSIP TA is helpful but not sufficient in promoting effectiveness and efficiency in DFAT funding to achieve the health, development, and health system outcomes desired from this mechanism. The TA needs to be reconsidered in terms of how it can be revised and optimised. At an operational level, efficiencies could be garnered by integrating the HSIP TA into the GoPNG IFMS, updating the HSIP TA Manual of Procedures to reflect the new PHA reality, and optimising the PHA Partnership Committees.

The HSIP TA has sought to address a wide range of objectives over the course of the six DFA amendments. Half of these amendments occurred in P3 when the TA was used as a health emergency account for DFAT to pool unspent legacy and new funds. The flexibility and breadth of the DFA has enabled responsive and adaptive changes according to GoPNG needs. The underspending resulting from the accrual of past underspending should be cautiously interpreted as inefficiencies at the PHA level, given that data quality, gaps and lack of consistent monitoring around development outcomes masked the reality.

To enhance the efficiency of HSIP TA's accounting role, it could be integrated into the GoPNG online IFMS, which would streamline financial processes and reporting. The IFMS facilitates faster planning and approvals, and tracking and analysing of financial information and expenditure.

Efficiencies could be gained if the HSIP TA Manual of Procedures were to be reviewed by the GoPNG (NDoH and Department of Finance) and simplified to reflect current PHA realities, current capacity,

<sup>32</sup> See PATH. (2022). *HSIP process review, national level (HSIP funding flow) and related reports*.

and staff turnover. Optimising the PHA Partnership Committee to table shared outcomes could also provide efficiencies by improving visibility of TA activities and its progress on health indicators.

It is important to signal that the proposed NDoH restructure to increase the TA team and integrate it alongside the Strategic Policy and Planning Division is a positive step towards improving efficiency. However, any restructure will rely on the GoPNG and NDoH capacity to adequately fund positions and address the lack of capacity in the Planning and Policy Division.

### 3.4 Aid principles (KEQ 4): To what extent has the HSIP TA operated in line with DFA guiding principles?

#### Main conclusions and key findings

The HSIP TA operated mostly in accordance with the DFA principles, and these were and will remain important. Aid effectiveness principles were often cited concerning partnership through alignment and harmonisation, government leadership and ownership, managing for results and mutual accountability, and promoting transparency and trust, and positively correlated with the TA. An agreed performance assessment framework and stronger donor coordination to guide the TA and embed it within the DP community would have benefited TA effectiveness as a development mechanism.

The Implementing Principles articulated in the DFA accord with good practice in aid effectiveness. They are aligned with the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) and are echoed in international and PNG-based declarations as far back as 2008; for example, the Kavieng Declaration. Interviewees affirmed that the TA did support GoPNG leadership and ownership and other key partnership principles, which was appreciated by NDoH staff and officials. **Table 3** outlines how the principles have been applied in the context of the HSIP TA.

**Table 3: Alignment between DFA Implementing Principles and HSIP TA**

| DFA Implementing Principles                       | HSIP TA   |
|---|---|
| 1. Implementation based on a partnership approach | A selection of projects and funding appropriations were negotiated in high-level meetings between GoA (DFAT) and GoPNG (NDoH). Decisions and mitigating actions were not always cascaded broadly, which impacted on transparency and, in turn, undermined confidence, especially during P2 when DFAT froze its financial contributions.                                 |
| 2. GoPNG ownership and maximising GoPNG systems   | The HSIP TA is owned and governed by NDoH. Although it is a parallel mechanism, it follows the GoPNG PFM Act and is aligned with GoPNG PFM procedures. Continuing support provided to PHAs/PHOs confirms that the TA did focus on strengthening sub-national systems, although the effectiveness of this varied across PHAs.  |
| 3. Support aligned to GoPNG needs and priorities  | Changing iterations of GoA support – ranging from infrastructure and refurbishments to emergency obstetric transfers, multi-drug resistant tuberculosis, COVID-19 emergency response measures, and routine immunisation – all responded to emerging or persisting GoPNG health sector needs and priorities, which were all aligned with the GoPNG National Health Plan. |
| 4. Transparency, accountability, and mutual trust | Sustained adherence to audits and other governance measures underscored mutual accountability. The TA management reported to the NDoH HSFC and regularly discussed TA issues comprehensively. However, the functionality of the overarching   |

| DFA Implementing Principles                         | HSIP TA  |
|---|--|
|   | HSPC, responsible for coordinating DPs with GoPNG could not be determined, as meeting minutes were not cited. The funding freeze did impact on trust (for GoPNG), but the resumption of use during P3 reflected a return of confidence and mutual trust in the mechanism.  |
| 5. Sustainable and equitable development            | The HSIP TA is embedded within GoPNG structures. However, given that its operations have been almost 100 per cent DP-supported, its functionality over time cannot be assumed. DFAT is supporting salaries, operations and core activities, both in the national team and through implementing partners, such as the COVID-19 Task Force and HSIP-EPS support under PATH. If GoPNG takes carriage of these functions, then there is an opportunity for equitable development outcomes. |
| 6. Strategic orientation of policies and strategies | HSIP TA projects and appropriations are aligned with GoA Health Portfolio Plans and the GoPNG National Health Plan. Key investments are all in step with specific sector needs.  |
| 7. Effective and efficient use of program resources | The TA resources, including staff time and use of funds, are becoming more efficient as PHA structures are strengthened. Effectiveness is still compromised by gaps in GoPNG project management and sub-national PFM administrative requirements. If support for the HSIP TA had more financial and project management support, investments could be optimised.  |
| 8. Commitment to joint M&E within agreed PAF        | A joint performance assessment framework was proposed in the DFA, but this was not cited and interviewees indicated that it had not been implemented. The scheduled MTR in 2015 was not undertaken. These are critical oversights that must be addressed in future iterations of direct financing support.   |
| 9. Implementation aligned with absorptive capacity  | Repeated support through the HSIP TA for PHA/PHO strengthening across the evaluation period (from P1 to P3) indicates a sustained effort to strengthen absorptive capacity. At the national level, the TA is yet to be fully immersed in NDoH systems, such as IFMS, NDoH Planning Unit, and NDoH donor coordination committees.   |
| 10. Based on sector policy and plans through NHP    | HSIP TA funded projects were aligned with the PNG NHP 2011–2020 and, most recently its successor, the NHP 2021–2030. All of the activities have aligned with the vision and strategies of both NHPs.   |

### 3.5 Sustainability (KEQ 5): To what extent are the impacts of the HSIP TA likely to be sustained.

#### 3.5.1 What is the likelihood of the HSIP TA continuing to operate effectively, manage financial risks and deliver development outcomes if DFAT funding was discontinued?

Questions 3.5 and 3.5.1 have been answered together, given the overlap in content.

#### Main conclusions and key findings

The HSIP TA is partially sustainable, in as much as it is an integral part of the health sector and uses GoPNG PFM systems. Thus, it is likely that the TA would continue to operate across different funding periods, and after the current DFA ends in 2023. The TA currently relies on the support of DPs, especially DFAT, to fund essential staff, core operations and capacity support. If DFAT were to focus

engagement and support on other priorities alternative funding sources would need to be secured by NDoH to fund the crucial functions currently directly supported by DFAT. This would be needed to ensure the mechanism continues to comply with the GoPNG PFM Act and provide assurance to stakeholders both within and external to the PNG health sector.

The GoPNG, specifically the NDoH, sees the HSIP TA as an important means through which to channel donor funding for sector priorities.

Multiple GoPNG interviews indicated a strong desire to retain and build upon the TA mechanism and continue to funnel donor funds through the TA for national and provincial priorities, to supplement government funding. Assurance of GoPNG core funding still remains fragile, even though one PHA CEO asserted core funding is improving (refer to section 3.2.1 Health Function Grants and Cash Flow). The current warrant system is reliant on GoPNG's fiscal position and has often disbursed inadequate or delayed funds, which has compromised services and sector activities. From the perspective of the NDoH, the TA remains a preferred mechanism to channel funds to the PHAs, because it facilitates direct control over funds by NDoH and provides a buffer to gaps in GoPNG appropriations. NDoH has demonstrated its desire to preserve the TA. This includes a proposed restructure and to finance HSIP TA positions currently funded by DFAT. Adequately financing operations, however, will remain critical.

It was well recognised in many interviews that, while GoPNG provides the majority of funding through the HSIP TA (see Table 1), DFAT provides substantial funding to support the mechanism. Several interviews shared that DFAT's involvement was central to the TA and has been pivotal in improvements over the past decade. Indeed, DFAT's role led some informants to mistakenly report that the HSIP TA is a DFAT rather than GoPNG mechanism. If NDoH were to involve other DPs in supporting the HSIP TA team, and its activities, this could contribute to developing momentum around shared accountability, improved communication, engagement, collaboration, and coordination. While DPs expressed a desire to continue to support the HSIP TA, many were not forthcoming in terms of the extent or manner of this.

As a modality, the HSIP TA is partially sustainable, in as much as it is an integral part of the health sector. It is a long held and well-established element of the PNG health financing landscape and complies with the GoPNG PFM Act. It is likely to continue to operate but it is unclear for how long and at what standard. If DFAT were to focus engagement on other health priorities, alternative funding would need to be secured by the GoPNG and NDoH to support the core functions directly funded by DFAT, such as annual audits. Without this funding, the integrity gains of the last 10 years could be damaged. DFAT's steadfast support, despite the fluctuations in funding from other donors, has enabled the mechanism to endure, and mostly comply with international PFM requirements, benefiting both the PNG health sector and DPs alike, which have used the TA.

### **3.6 Equity (KEQ 6): To what extent has the HSIP TA incorporated a GEDSI lens in its design, implementation and reporting?**

#### **Main conclusions and key findings**

While gender and other cross-cutting issues were considered in the 2012 HSIP TA Re-design document, GEDSI has not been prioritised, other than through an emphasis on primary health care and MNCH services, where women and children are the greatest beneficiaries. Promoting GEDSI-

sensitive and GEDSI-supportive outcomes in future programming, with support from the NDoH and PHAs, is needed if equity is to be adequately addressed.

Gender, disability, and other cross-cutting intentions were not articulated in the DFA. The DFA MEF provided multiple organisational, administrative, financial and health sector indicators but the End of Program Objectives (EOPOs) and strategic outcomes were not defined in relation to gender and there were no inclusiveness indicators.

The HSIP TA Re-design did reference equity and inclusiveness in the MEF, as well as the theory of change; for example, in Poverty (4.2.2), Gender (4.2.1), Equity (4.2.3), Child Protection (4.2.4), Disability (4.2.5), and Climate Change (4.2.6). Subsequent activities were designed and selected to address both GoPNG priorities and cross-cutting themes such as poverty, women, men, and child protection. These did not translate to HSIP TA funded interventions, apart from women and children, and rural people receiving services. There was very little evidence on whether the activities implemented considered GEDSI or made a difference. There was little gender-disaggregated data available in relation to HSIP TA initiatives, nor was there evidence of applying GEDSI-sensitive approaches. Promoting GEDSI-sensitive and GEDSI-supportive outcomes in future programming, with support from the NDoH and PHAs, is needed if equity is to be adequately addressed.

### **3.7 M&E (KEQ 7) To what extent are the monitoring and evaluation arrangements fit for purpose for supporting program decision-making, accountability, learning and adaptation?**

#### **Main conclusions and key findings**

The DFA set out a reasonable MEF and recommended using GoPNG sector-based indicators from existing systems, but this was not implemented.

- The HSIP TA was largely perceived as a financial instrument, and so many financial reports were produced, but little was done to assess the TA effectiveness as a mechanism to deliver on its development outcomes.
- An MTR was due in 2016, but was not undertaken. An MTR could have captured early challenges and changes and supported programmatic decision-making, accountability, and learning and adaptation.
- In P3, a number of small reports were commissioned, and these provided independent evidence and analysis, but these were at the tail end of the 10-year period. All of these combined to weaken the learning and knowledge that could have been generated about the mechanism.

The 2012 DFA and the 2013 HSIP TA Re-design both proposed sound M&E arrangements. The HSIP TA provided a theory of change, and the DFA a reasonable MEF, and this is included in **Annex 9**. The MEF indicated that GoA would be responsible for funding the cost of relevant M&E activities and GoPNG would organise and conduct the annual, mid-term, and end of program reviews.

The HSIP TA aimed to complement and strengthen existing national, NDoH and provincial monitoring activities, using monitoring and reporting processes available at national and sub-national levels. The intended summative evaluation after 2016 was not undertaken<sup>33</sup>, missing an opportunity to assess how best to address weaknesses and/or modify the activities and promote continuous improvement.

<sup>33</sup> At the end of the DFA period, 2013–2016 (DFA, p.5).



The AHC received limited information on health outcomes from the HSIP TA. While DFAT's internal Aid Quality Checks for 2015–2017 indicated concerns around effectiveness (dropping from five in 2015 to three in 2017), and efficiency (dropping from five to one over the same period), the ratings for M&E were even lower, dropping from three at the start to one in 2017.

There are some positives to report: considerable learning has been accrued, especially in relation to the HSIP TA as an accounting mechanism; there was strong HSIP TA financial reporting to the NDoH SEM, DFAT, and the HSFC; strong monitoring of sub-national PFM procedures; and prompt follow up on non-compliance cases. In P3, in 2021, the first review was commissioned to assess DFAT's support to GoPNG's COVID-19 response and the provision of support to PHAs through the HSIP TA.<sup>34</sup> Whether this report was used to inform strategic decisions or adapt processes is unknown. This was followed in 2022 with the DFAT-funded national-level HSIP Process Review and a series of provincial-level HSIP Process Reviews. Learning from these reviews has informed DFAT to continue to support sub-national PFM capacity through the PATH HSIP-EPS. This is much needed and will make an important contribution to consolidating lessons and facilitating change.

### 3.8 Future (KEQ 8): What are the lessons and recommendations for future DFAT support to the health sector.

#### Lessons

**The HSIP TA has operated most effectively for emergency funding.** Although the HSIP TA is a pooled fund that uses its own modes of disbursement and accountability mechanisms, it has operated most effectively in response to emergencies such as COVID-19. The administrative processes to access funding were less burdensome with a single tranche of funding for all COVID-19 expenditure and a single set of management requirements. Furthermore, where PHAs are sufficiently supported with technical assistance to access the funds, and there is strong sector coordination among donors, HSIP TA has operated at its most effective.

**Donor coordination and engagement is critical to the effective management of the pooled fund and delivery of efficiency benefits.** Ensuring there is strong donor commitment and engagement with the pooled fund is critical to the longer-term benefits of the modality. This includes encouraging donor use of the fund, so it does provide efficiency benefits to both GoPNG and DFAT, and other donors, as the major mechanism for channelling donor funding. Furthermore, a joint commitment to supporting the management costs of the fund, promoting predictability of donor funding, and ensuring strong coordination as to the focus of the fund, are critical to its effectiveness.

**Ensuring ongoing relevance and alignment of the mechanism is vital.** Any support for the HSIP TA mechanism should ensure that the design arrangements are continuously updated to take into account contextual changes, such as new policies, to ensure it remains relevant and effective, including responding to regular monitoring information.

**Technical assistance to support the administration of the fund has been essential.** The PATH-funded positions at the NDoH and advisers in the provinces have universally been agreed to support the effectiveness of HSIP TA through facilitating the effective disbursements of funding.

**M&E of pooled funds can be challenging.** It is difficult for partner government data and reporting systems to meet the needs of donors. A much more hands-on approach needed to be applied to the M&E of the TA. Additional reporting mechanisms could be effective at providing the level of detail

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<sup>34</sup> See HDMES. (2021). *COVID-19 in Papua New Guinea and Australia's response: A rapid review. Final Report.*

donors require about effectiveness and efficiency, drawing on the data collected through partner government systems.

**Strengthening GEDSI will require targeted support.** The TA is unlikely to have a meaningful focus on GEDSI without dedicated funding and technical assistance to NDoH and the PHAs in the implementation and execution of their policies and priorities.

### **Recommendations:**

#### **Recommendation 1: DFAT should continue to support the Health Sector Improvement Program as a sector-wide approach for the National Department of Health in Papua New Guinea.**

Through HSACC and the HSPC, DFAT should advocate for and should support the SWAp mechanism, and should encourage other health sector donors to engage with the NDoH in the SWAp, and use it as a mechanism for donor contributions, coordination, and engagement on health sector priorities.

#### **Recommendation 2: DFAT should continue to deliver direct funding through the pooled fund of the HSIP Trust Account.**

To maximise the effectiveness and efficiency of this pooled funding approach, DFAT should commence a design process to inform the next DFA, which includes the following:

- Encourage other donors to channel their funding through the HSIP TA, so it operates more effectively as an overall donor mechanism.
- Collaborate with other donors to ensure the identified system improvements to the HSIP TA are implemented and regularly reviewed.
- Update the HSIP TA Manual of Procedures to align it with any changes in GoPNG financial system practices. For greater efficiency, aim for PFM processes and steps which are simplified to facilitate the disbursement of HSIP TA funding, while balancing fiduciary risk.
- Seek to provide greater predictability of funding to GoPNG through forward estimates in coordination with other donors.
- Collaborate and seek agreement with other donors and GoPNG on a shared approach to the current funding of adviser support for the administration of the pooled fund through PATH and provision of technical support to the provinces.
- With other development partners and GoPNG, discuss the option and viability of funding an allocated GEDSI adviser position in the HSIP TA Secretariat, who can work directly with NDoH and the provinces to better mainstream GEDSI in their work.
- Discuss and seek agreement with donors how to strengthen M&E. This can be through funding technical advisers to strengthen GoPNG M&E and reporting, and through regular independent reviews of HSIP TA performance.

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# Annexes

## Annex 1: Key evaluation questions and sub-questions

| DAC/DFAT criteria                        | Key evaluation questions (KEQs) and sub-questions (SQs)  |
|--|--|
| Relevance                                | <p><b>KEQ1: To what extent has Australian funding through the HSIP TA been a relevant approach to address GoPNG health sector priorities?</b></p> <ul style="list-style-type: none"> <li>• SQ1.1 What have been the key contextual and policy changes since the development of the HSIP TA? How have these affected the TA's relevance and appropriateness?</li> <li>• SQ1.2 To what extent is sector budget support a relevant approach for Australia to address GoPNG health sector priorities?</li> <li>• SQ1.3 What are the benefits or limitations of DFAT providing sector budget support, versus other modalities of health sector support?</li> <li>• SQ1.4 To what extent is the HSIP TA the most appropriate mechanism for delivering sector budget support for GoPNG health sector priorities?</li> <li>• SQ1.5 What are the benefits or limitations of the HSIP TA versus other mechanisms to provide sector budget support?</li> </ul>  |
| Effectiveness (and Evaluation Purpose 1) | <p><b>KEQ2: To what extent was the HSIP TA effective in delivering Australia's contribution towards GoPNG health sector policy priorities and outcomes?</b></p> <ul style="list-style-type: none"> <li>• SQ2.1 To what extent has DFAT funding through the HSIP TA contributed to the achievement of the HSIP strategic objectives and policy priorities? <ul style="list-style-type: none"> <li>▪ Objective 1: Increase access to effective health services in rural areas, for those who are considered poor.</li> <li>▪ Objective 2: Increase the absorptive capacity of the health sector to achieve GoPNG commitment to the National Health Plan on a sustainable basis.</li> <li>▪ Objective 3: Improve performance and governance of the HSIP. (This will include consideration of how funds were used and by whom, achievement of outcomes under each of the objectives (see Annex 2), and an assessment of whether the objectives are likely to be achieved by end 2022.)</li> </ul> </li> <li>• SQ2.2 To what extent was the HSIP TA effective in supporting the provincial implementation of COVID response and COVID vaccination roll-out plans?</li> <li>• SQ2.3 What positive and negative changes were produced by the HSIP TA, either directly or indirectly, intended or unintended?</li> </ul> |
| Efficiency (and Evaluation Purpose 2)    | <p><b>KEQ3: To what extent was the HSIP TA efficient in delivering Australia's contribution towards GoPNG health sector policy priorities and outcomes?</b></p> <ul style="list-style-type: none"> <li>• SQ3.1 To what extent has the HSIP TA been an efficient mechanism for enabling flow of DFAT funds from national to provincial and service level?</li> <li>• SQ3.2 To what extent has the HSIP TA supported efficient approaches to health sector service delivery and systems strengthening?</li> <li>• SQ3.3 To what extent have risks been mutually monitored and managed in line with the HSIP TA risk management plan?</li> <li>• SQ3.4 To what extent are the HSIP TA governance arrangements fit for purpose? (Including mechanisms for GoPNG engagement, governance and management of investments, and donor coordination.)</li> <li>• SQ3.5 Which parts of the HSIP TA process could be streamlined to improve efficiency?</li> </ul>  |

|  |   |
|--|---|
| <b>Effectiveness/<br/>Efficiency</b>           | <p><b>KEQ4: To what extent has the HSIP TA operated in line with Direct Funding Agreement guiding principles?</b></p> <ul style="list-style-type: none"> <li>• Government leadership and ownership</li> <li>• Alignment/harmonisation with government systems</li> <li>• Management for results</li> <li>• Mutual accountability.</li> </ul> <p>(The guiding principles are described in more detail in Point 11 of the HSIP TA Direct Funding Agreement, October 2013. The answer to this KEQ should also explore the extent to which DFAT has managed engagement and resourced the HSIP TA to operate in line with these principles.)</p> |
| <b>Sustainability</b>                          | <p><b>KEQ5: To what extent are the impacts of the HSIP TA likely to be sustained?</b></p> <ul style="list-style-type: none"> <li>• SQ5.1 If DFAT funding to the HSIP TA was discontinued, how likely would the HSIP TA continue to operate effectively, manage financial risks, and deliver development outcomes?</li> </ul>  |
| <b>Gender, Disability and Social Inclusion</b> | <p><b>KEQ6: To what extent has the HSIP TA incorporated a GEDSI lens in its design, implementation and reporting?</b></p> <p>(Noting that there is no requirement for GoPNG to adhere to DFAT GEDSI guidelines and standards.)</p>  |
| <b>Monitoring and Evaluation</b>               | <p><b>KEQ7: To what extent are monitoring and evaluation arrangements fit for purpose for supporting program decision-making, accountability, learning and adaptation?</b></p>  |
| <b>Evaluation Purpose 3</b>                    | <p><b>KEQ8: What are lessons and recommendations for future DFAT support to the health sector?</b></p>  |

## Annex 2: HSIP TA Evaluation interview list

The following tables list the people interviewed as part of this evaluation.

### NDoH

| Interview type | Name and position   |
|----------------|---|
| Individual     | <ul style="list-style-type: none"> <li>Elva Lionel, Deputy Secretary – Corporate Services, Policy and Planning Wing</li> <li>Ken Wai, Deputy Secretary Policy</li> <li>Navy Mulou</li> <li>Zerah Lauwo, HSIP Account Manager</li> </ul> |
| Group          | <ul style="list-style-type: none"> <li>Sybila Tulem, Provincial Accounts</li> <li>Laiva Ona, Accountant – HSIP Account</li> </ul>   |

### Department of Finance

| Interview type | Name and position   |
|----------------|---|
| Individual     | <ul style="list-style-type: none"> <li>Samson Metofa, First Assistant Secretary – Financial Reporting and Compliance</li> </ul> |

### NEFC

| Interview type | Name and position  |
|----------------|--|
| Group          | <ul style="list-style-type: none"> <li>Mala Marere, Policy Analyst</li> <li>Erwin Pouru, Principal Policy Analyst</li> </ul> |

### Western PHA

| Interview type | Name and position  |
|----------------|--|
| Individual     | <ul style="list-style-type: none"> <li>Authur Amot, Director Corporate Services</li> </ul>   |
| Group          | <ul style="list-style-type: none"> <li>Dr Niko Wuatai, Chief Executive Officer</li> <li>Willy Vagi, Executive Officer to the CEO</li> <li>Dr Mathias Bauri, Director – Public Health</li> <li>Gabriel Kama, Coordinator – Disease Control</li> <li>Segela Gagole, Coordinator – COVID-19 Response</li> <li>Dibili Wagumisi, Acting Finance Manager</li> <li>Edison Bama, HSIP Finance Officer</li> </ul> |

### Manus PHA

| Interview type | Name and position  |
|----------------|--|
| Individual     | <ul style="list-style-type: none"> <li>Dr Angela Seginami, Director Curative Services (Acting CEO)</li> <li>Ms Maryanne Kundi, Manager – Finance</li> </ul>  |
| Group          | <ul style="list-style-type: none"> <li>Changol Amaj, Director – Public Health</li> <li>Ella Michael, Deputy Director – Public Health</li> <li>Julius Sapau, Environmental Health Officer</li> <li>Songan Pokawin, Provincial Cold Chain and Logistics Officer</li> </ul> |

### Morobe PHA

| Interview type | Name and position  |
|----------------|--|
| Individual     | <ul style="list-style-type: none"> <li>Patricia Mitiel, Family Health Services Coordinator</li> <li>Edwin Benny, Provincial Disease Control Coordinator</li> </ul> |
| Group          | <ul style="list-style-type: none"> <li>Aung Kumal, Director Corporate Services/Acting CEO</li> <li>Tony Supan, Accountant</li> </ul>                               |

| Interview type | Name and position   |
|----------------|---|
|                | <ul style="list-style-type: none"> <li>Wendy Punumping, HSIP Clerk</li> </ul>   |
| Online         | <ul style="list-style-type: none"> <li>Douglas Apeng, PATH Provincial Facilitator</li> <li>Mathew Moylan, Former Provincial Health Adviser (now with PATH)</li> </ul> |

**Hela PHA**

| Interview type | Name and position  |
|----------------|--|
| Online         | <ul style="list-style-type: none"> <li>Dr James Kintwa, Hela PHA CEO (and former WHP PHA CEO)</li> </ul> |

**NCD (TB Program)**

| Interview type | Name and position   |
|----------------|---|
| Group          | <ul style="list-style-type: none"> <li>Dr Steven Yennie</li> <li>Dr Michael Dokup</li> <li>Dr Rose Morre Vaieke Vani</li> </ul> |

**PATH**

| Interview type | Name and position   |
|----------------|---|
| Online         | <ul style="list-style-type: none"> <li>Geoff Miller, Health Security Lead</li> <li>Luke Elich, Program Delivery Adviser</li> <li>Elizabeth Boyd, Expanded Support to the HSIP TA – Adviser</li> <li>Kelwyn Browne, PATH Health Security Adviser – Western Province</li> </ul> |

**DFAT**

| Interview type | Name and position  |
|----------------|--|
| Online         | <ul style="list-style-type: none"> <li>David Slattery, Director, Human Development and Strategy, PNG Branch</li> <li>Anna Gilchrist, First Secretary</li> <li>Aedan Whyatt, Former First Secretary Health – AHC</li> <li>Geoff Clarke, Former DFAT Health Counsellor – AHC</li> </ul>            |
| Group          | <ul style="list-style-type: none"> <li>Dr Lara Andrews, Health Counsellor</li> <li>Elise Newton, First Secretary</li> <li>Gertrude N'Dreland, Program Manager</li> <li>Daisy Rowaro, Senior Program Manager</li> <li>Ali Kevin, Program Manager</li> <li>Theresa Reu, Program Manager</li> </ul> |

**Oil Search Foundation**

| Interview type | Name and position  |
|----------------|--|
| Online         | <ul style="list-style-type: none"> <li>Ingrid Glastonbury, former HHSIP Adviser</li> </ul> |

**ADB – HSSDP**

| Interview type | Name and position   |
|----------------|---|
| Group          | <ul style="list-style-type: none"> <li>Rob Akers, Team Lead</li> <li>Dorothy Memti, Accounts Officer</li> </ul> |
| Online         | <ul style="list-style-type: none"> <li>Jeremy Syme, Project Manager – Rural Enclaves Program</li> </ul>         |

**World Bank**

| Interview type | Name and position  |
|----------------|--|
| Online, group  | <ul style="list-style-type: none"> <li>Rochelle Se Yun Eng, Health Economist</li> <li>Dr Edith Kariko, Senior Health Specialist</li> </ul> |

**WHO**

| Interview type | Name and position   |
|----------------|---|
| Online         | <ul style="list-style-type: none"> <li>Anna Maalsen, Team Leader – Health Planning, Systems and Governance</li> </ul> |

**Other**

| Interview type | Name and position  |
|----------------|--|
| Online         | <ul style="list-style-type: none"> <li>Mr Billy Naidi, former PHA CEO – Milne Bay PHA</li> </ul>                                       |
| Online         | <ul style="list-style-type: none"> <li>Gabrielle Crick, former HHISP Adviser</li> <li>Ricardo Atencia, former HHISP Adviser</li> </ul> |

**UNICEF**

| Interview type | Name and position  |
|----------------|--|
| Online         | <ul style="list-style-type: none"> <li>Dr Satish Gupta, Health Lead</li> </ul> |

**NZ MFAT Post**

| Interview type | Name and position   |
|----------------|---|
| Online         | <ul style="list-style-type: none"> <li>Megan Levers, First Secretary</li> </ul> |

**Global Fund**

| Interview type | Name and position  |
|----------------|--|
| Online         | <ul style="list-style-type: none"> <li>Elin Bos, PNG Country Fund Manager</li> </ul> |

**Field trip, Western Highlands PHA**

| Interview type    | Name and position   |
|-------------------|---|
| Individual, group | <ul style="list-style-type: none"> <li>Jane Holden, Acting Chief Executive Officer</li> <li>Dannex Kupamu, Acting Director Public Health</li> <li>Nellie Newman, Family Health Services Coordinator</li> <li>John Pilamb, Project Officer</li> <li>Fredah Pyanyo, Deputy Director Health Promotion</li> <li>Mark Dupi, Provincial TB Coordinator</li> <li>Jokeybeth Damieng, Deputy Director – Finance and Administration</li> <li>Steven Andandi, HSIP Officer</li> <li>Julie Bengi, A/Director Policy Planning and Monitoring</li> <li>Elizabeth Aveling, Provincial Information Officer</li> </ul> |



## Annex 3: Objectives, Outputs and Outcomes set out in the HSIP TA Re-design document (2012)

### Objective 1: To increase access for the poor to effective health services in rural areas

#### Outcome 1.1

HSIP funding increases access to health services and improved service delivery for rural populations.

#### Outputs:

#### Outcome 1.2

Health services are improved in the 20 disadvantaged districts.

#### Outputs:

### Objective 2: To increase the absorptive capacity of the health sector to achieve GoPNG commitment to the NHP on a sustainable basis

#### Outcome 2.1

Increase predictability of donor funding to the sub-national level.

#### Outputs:

#### Outcome 2.2

Staff at facility level are better able to plan, budget, acquit, and report.

#### Outputs:

#### Outcome 2.3

HSIP complements HFGs and improves the reliability of the cashflow.

#### Outputs:

### Objective 3: To improve performance and governance of the HSIP

#### Outcome 3.1

Improved management and coordination of HSIP TA.

#### Outputs:

#### Outcome 3.2

Better information on expenditure and development impact to GoPNG and development partners.

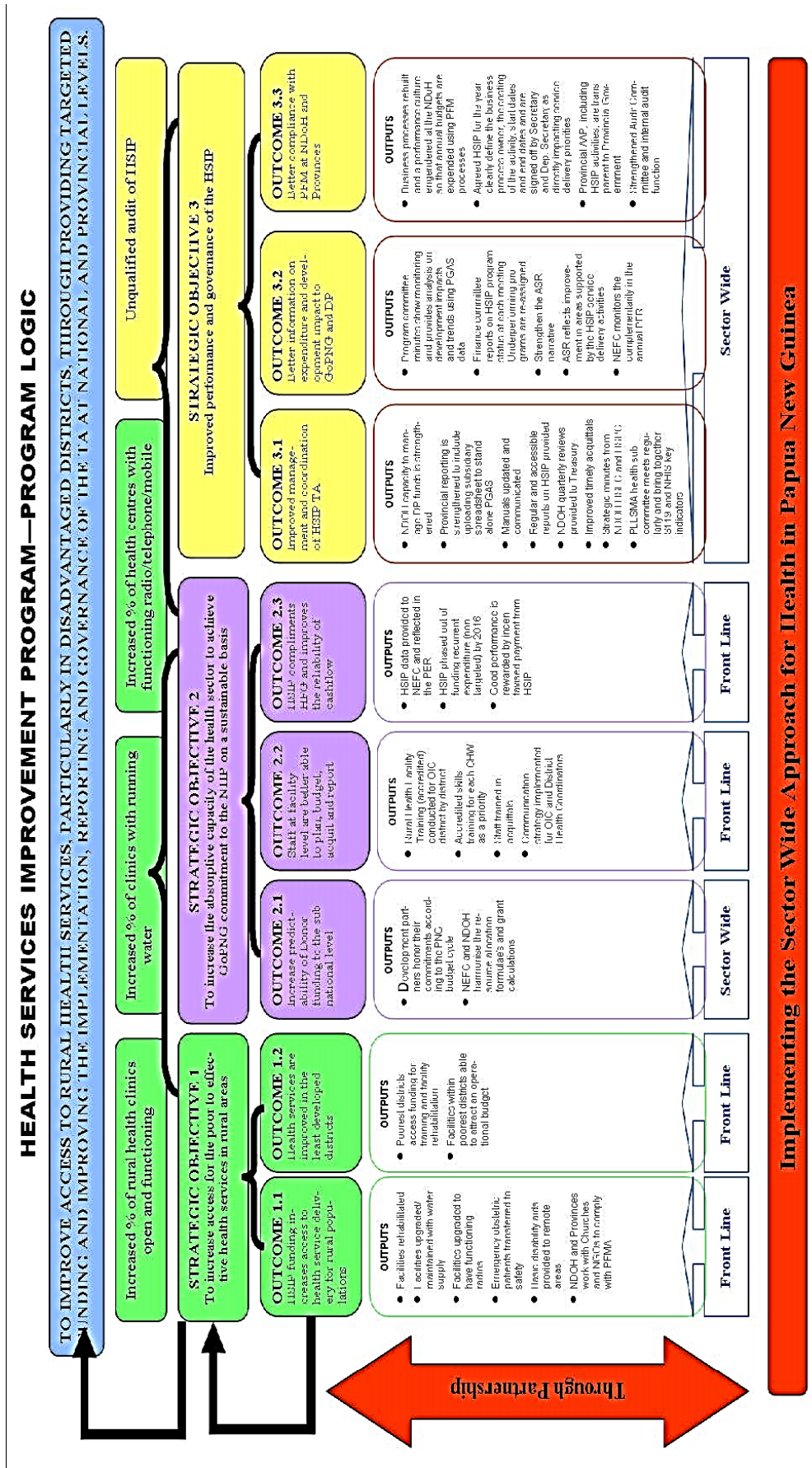
#### Outputs:

#### Outcome 3.3

Better compliance with PFM at NDoH and provinces.

#### Outputs:

# Annex 4: HSIP TA Re-design (2012) Theory of Change



## Annex 5: Chronology in the establishment of HSIP and HSIP TA

| Year | Activity   |
|------|--|
| 1996 | <ul style="list-style-type: none"> <li>Set up as a trust account by the ADB as a temporary mechanism to strengthen public financial systems. Designed to channel aid through government systems in aligned and harmonised manner as part of the ADB Health Sector Development Program (HSDP), the first sector-wide approach in the sector. Support to implementation of the GoPNG <i>National Health Plan 1996–2000</i> comprised policy-based work (USD50 million) and a USD10 million loan targeting human resource development.</li> </ul>   |
| 2000 | <ul style="list-style-type: none"> <li>AusAID commenced discussions with NDoH and the Department of National Planning and Monitoring (DNPM) about the feasibility of shifting a portion of health sector support into a SWAp building on HSDP.</li> </ul>  |
| 2001 | <ul style="list-style-type: none"> <li>HSIP Phase 1: Intent was to channel funds from GoPNG and DPs through the TA to complement the HFGs approved by NEC. AusAID, NZAID, and ADB transfer funds.</li> </ul>   |
| 2004 | <ul style="list-style-type: none"> <li>HSIP Phase 2: Five development partners signed code of conduct; Global Fund assessed and agreed to use HSIP for malaria and HIV funding.</li> </ul>   |
| 2005 | <ul style="list-style-type: none"> <li>HSIP Management Branch and Secretariat established in NDoH.</li> </ul>  |
| 2007 | <ul style="list-style-type: none"> <li>Global Fund put TB grant (USD8,143,112) through the HSIP TA.</li> </ul>   |
| 2009 | <ul style="list-style-type: none"> <li>NDoH led and coordinated a review of the SWAp as part of its efforts to improve DP support for implementing the <i>National Health Plan 2011–2020</i>. NHP was fully costed with appropriate budget framework based on the medium-term expenditure framework.</li> <li>OECD Review of SWAp found that HSIP TA was not operating as a SWAp mechanism, but rather as a ‘super project’.</li> <li>Global Fund put malaria grant through HSIP TA, bringing total for three grants to USD41.7 million.</li> </ul>  |
| 2012 | <ul style="list-style-type: none"> <li>Re-design of HSIP TA: Aimed to undertake further technical and operational analysis at national and provincial levels on HSIP and HSIP TA functionality and performance in line with agreed financing options. Sought to identify financing options and align more directly with GoPNG systems; also recommended a prioritisation and sequencing plan to shift from use of the HSIP to GoPNG financial systems in medium-term.</li> <li>HSIP TA funds received: PGK95,753,120, comprising GoPNG component (PGK84,900,000), NZAID (PGK4,000,000), and other DP funding.</li> <li>HSIP became less significant in funding operational activities in rural health in 2011–2012; focus was on re-design process.</li> </ul>         |
| 2013 | <ul style="list-style-type: none"> <li>DFAT support to HSIP through TA: four-year (2013–2017) Direct Funding Agreement (AUD48.73 million) signed with GoPNG; majority of funds to sub-national level to complement GoPNG HFGs for recurrent cost support to meet minimum cost of services delivery.</li> <li>DFAT targeted investments to emergency obstetrics transfers for rural/remote locations, in-service training for primary health care workers and managers, minor health facilities refurbishment, and health facility and staff housing refurbishment in the 20 most disadvantaged districts.</li> <li>DFAT made modest funding available for NDoH to focus on strengthening key national functions in support of sub-national health services.</li> </ul> |
| 2014 | <ul style="list-style-type: none"> <li>HSIP TA receipts for 2014: PGK117,735,688 received; PGK117,735,688 expended.</li> <li>HSIP became significant contributor to recurrent operational functions in 2014; PGK18 million received by the provinces. East Sepik, Madang, Milne Bay, Morobe and Simbu Provinces received approximately PGK1.2 million, PGK1.3 million, PGK1.4 million, PGK2</li> </ul>   |

| Year        | Activity   |
|-------------|--|
|             | <p>million, and PGK1.2 million, respectively, while other provinces received amounts of less than PGK1 million. Under the program, PGK1.6 million was provided by GoPNG to Morobe in 2014.</p> <ul style="list-style-type: none"> <li>DFAT transferred PGK28,010,517 of pre-committed funds into TA in three tranches.</li> </ul>  |
| <b>2015</b> | <ul style="list-style-type: none"> <li>HSIP TA parent account received PGK78,400,062; payments made PGK80,187,503.</li> <li>HSIP TA received PGK8,879,744 as final tranche payment for 2014 (received in 2015).</li> <li>DFAT froze funds in the HSIP parent account (July 2015); PGK12.1 million remained in parent account.</li> </ul>   |
| <b>2016</b> | <ul style="list-style-type: none"> <li>HSIP parent account received PGK49,896,929; payments made PGK74,341,372.</li> <li>DFAT funds frozen across the sub-national and national levels (March 2016); other DPs (UNICEF, WHO, UNFPA) and GoPNG continued to use mechanism.</li> </ul>   |
| <b>2017</b> | <ul style="list-style-type: none"> <li>HSIP TA parent account received PGK23,435,467; PGK40,227,770 expended. UN organisations continued to use HSIP TA.</li> <li>DFAT freeze continued with initial DFA ending that year; steps taken to unfreeze funds; October 2017 correspondence approved extension of one year to October 2018 to enable utilisation of funds already in account (PGK12.1 million).</li> <li>DFAT funds: of AUD48,730,000 committed, only AUD16,535,628.91 transferred in 2014 and 2015.</li> <li>Amendment 1 to DFA (17 October 2017) stated that due to difficulty in expending earlier transferred amount and other challenges, there would be no further funding available. End date extended from 20 October 2017 to 31 October 2018 to enable expenditure of remaining funds.</li> </ul> |
| <b>2018</b> | <ul style="list-style-type: none"> <li>DFAT funds unfrozen in June 2018.</li> <li>Amendment 2 to DFA (29 October 2018) extended end of program from 31 October 2018 to 30 June 2020.</li> <li>Additional oversight mechanisms to manage fiduciary risks implemented.</li> <li>DFAT identified three new areas of focus: (i) improving health systems to deliver rural primary health care; (ii) controlling major communicable diseases; and (iii) increasing coverage and standards of reproductive, maternal, newborn, and child health.</li> </ul>  |
| <b>2019</b> | <ul style="list-style-type: none"> <li>DFAT and other grantee, Gavi, agreed to use the HSIP TA to channel funding to PHAs for the AIHSS program; PHAs applied and were assessed by an independent expert as having sufficient PFM standards in place.</li> <li>Large portion of funds (PGK39,065,628) channelled through HSIP TA in 2019 from parent to subsidiary accounts by WHO for polio response campaign.</li> </ul>   |
| <b>2020</b> | <ul style="list-style-type: none"> <li>Amendment 3 to DFA (14 April 2020) extended end date to 30 June 2022 and added AUD23 million for COVID-19 Response and AIHSS program.</li> <li>DFAT provided funds for AIHSS program through PHA for Western Highlands PHA (PGK3,626,646); Gavi used HSIP TA to support Eastern Highlands PHA.</li> <li>COVID-19 funds channelled through HSIP TA for disbursement to subsidiary accounts. Total receipts in 2020: PGK195,213,770 including funds from GoPNG, bilateral and multilateral partners, and other stakeholders. Provincial accounts received their components and expenditure for that year.</li> </ul>  |
| <b>2021</b> | <ul style="list-style-type: none"> <li>Amendment 4 to DFA (15 April 21) added an additional amount of AUD20.15 million for COVID-19 preparedness and the COVID-19 vaccine roll-out and other essential health services, including AIHSS.</li> <li>Amendment 5 to DFA (7 June 2021) added AUD661,000 to support the NCD TB project to cover shortfall in short-term contractor salaries previously supported under the Emergency TB project.</li> </ul>   |

| Year        | Activity  |
|-------------|---|
|             | <ul style="list-style-type: none"> <li>Expanded Program of Support to the HSIP budgeted at AUD 2.5 million. Purpose: to strengthen financial systems around the use of the HSIP TA. Proposed main activities: Joint development of project implementation plan and recruitment of positions under the project, endorsement of proposed TORs, and joint participation and decision-making on selected projects, joint review of the project approximately six months into implementation.</li> </ul> |
| <b>2022</b> | <ul style="list-style-type: none"> <li>Amendment 6 to DFA (9 June 2022) extended end date from 1 July 2022 to 30 October 2023 and added AUD7,875,628 (PGK18,567,555) for COVID-19 vaccination support. Funding paid to PHA subsidiary accounts for these activities, in line with COVID-19 Vaccine Micro-Plans.</li> </ul>  |

## Annex 6: Benefits and limitations of funding modalities

| Funding modality                                   | Benefits  | Limitations  |
|--|---|--|
| <b>Direct-Funded Sector Support Pooled Funding</b> | <ul style="list-style-type: none"> <li>• Collaborative financial mechanism where multiple DPs combine financial resources in a common or pooled fund.</li> <li>• Funds managed by the sector, not Treasury.</li> <li>• Purpose and benefit of pooled funding is to: (1) promote collaboration; (2) enhance coordination; and (3) reduce transaction costs.</li> <li>• Uses coordination mechanisms, rather than multiple one-on-one agreements with each donor.</li> <li>• Affirms commitment to the sector and enables close collaboration and engagement between DPs and donors.</li> <li>• Seeks to minimise donor dominance where DPs consider entire envelope of resources available and work together to address the most pressing sector needs.</li> <li>• Success relies on collaboration and coordination to achieve single shared vision.</li> <li>• Costs shared among donors to support single funding platform, single audit mechanism, single management structure, and single reporting system.</li> <li>• Reduces transaction costs for partner government by eliminating individual funding arrangements and contracts with multiple grantees.</li> <li>• Increases funding predictability through shared, long-term financing estimates and commitments.</li> <li>• Joint efforts = shared results.</li> <li>• Reduced fiduciary risk for donors through having separated management arrangements and additional oversight of these.</li> </ul> | <ul style="list-style-type: none"> <li>• Medium fiduciary risk with separate management arrangements for managing the disbursement of funds and accountability mechanisms under pooled funds. These reduce the financial risk of direct sector funding; e.g. separate audit arrangements.</li> <li>• Development risk is medium in that additional financial management requirements can be burdensome, leading to low disbursement of funds (as occurred in P1 and P2).</li> <li>• Pooled funds cannot be traced to the donor, so can only track sector results not donor results.</li> <li>• Results are contribution-based, rather than attribution.</li> <li>• Can be compromised by weak donor coordination and commitment to the pooled fund.</li> </ul> |
| <b>Sector-Wide Approach</b>                        | <ul style="list-style-type: none"> <li>• A coordinating mechanism to manage DPs and government-led sector priorities.</li> <li>• Used to reduce overly prescriptive donor assistance.</li> <li>• Used to reduce program fragmentation.</li> <li>• Seeks to build consensus and policy change.</li> <li>• SWAp can use DP funding, or not, and pooled funding strengthens a SWAp.</li> <li>• DPs can distinguish individual financial contributions and therefore attribute results to funding.</li> </ul>   | <ul style="list-style-type: none"> <li>• Relies on strong government leadership and donor transparency.</li> <li>• Compromised by lack of political will to drive sector agenda.</li> <li>• Lacks agility to respond to emergencies and crises.</li> </ul>   |

| Funding modality             | Benefits  | Limitations   |
|------------------------------|---|---|
| <b>Sector Budget Support</b> | <ul style="list-style-type: none"> <li>• Relies on partner government system with funds transferred to consolidated revenue account.</li> <li>• Creates incentives for donors to strengthen the partner government's financial systems.</li> <li>• Agreement that funds will be transferred to sector account.</li> <li>• Increases engagement between partner governments and builds trust.</li> <li>• Efficient in funnelling money to sectors.</li> <li>• Reduced transaction costs through the use of the existing partner government financial systems.</li> </ul> | <ul style="list-style-type: none"> <li>• High fiduciary risk as donor has no visibility over funds.</li> <li>• Partner government controls funding flows.</li> <li>• Can displace partner government funding – the partner government may choose to reduce funding to a particular sector as they know donor funding is available.</li> </ul> |
| <b>Project Support</b>       | <ul style="list-style-type: none"> <li>• Higher control over budget envelope and program outcomes with one-on-one contracts, agreements or arrangements.</li> <li>• Due diligence of independent management mechanisms enables higher visibility of risks.</li> <li>• Can use flexible funding arrangements, such as reimbursement mechanisms, or co-funding.</li> <li>• DPs can cherry pick part of strategic plan or geographic area, rather than support entire strategic plan.</li> </ul>   | <ul style="list-style-type: none"> <li>• High transaction costs, as each project funds a separate management structure.</li> <li>• Risk of donor dominance.</li> <li>• Risk of aid fragmentation.</li> </ul>  |

## Annex 7: PHA process to access HSIP TA funds

To access funds, all PHAs are required to follow the HSIP TA Manual of Procedures (2013) that has been developed in line with the PNG *Public Finances (Management) Act 1995*, as amended. PHAs can access one of two streams of funding – targeted and untargeted. The Secretary for Health issues Budget Instructions annually, in June, detailing the priority programs and districts for targeted funding in the next year. Then, at the provincial level, PHAs undertake planning and budget activities for the following year and allocate the percentage of targeted funds for priority areas for the following year. These are agreed to in Provincial Health Sector Partnership Committees on an annual basis. When PHAs develop Annual Implementation Plans, targeted priority areas are identified for HSIP TA funds, and all other untargeted activities receive GoPNG funding. At the provincial level, there are eight steps required to access these funds, through the HSIP TA. Following the freeze period, a further step was added to access DFAT funding – the AusAID/DFAT financial delegate sign-off (introduced after October 2018).

There are eight processes to access HSIP TA funds at the PHA level:

1. Identify and budget relevant activities in accordance with DP and NDoH agreements and guidelines.
2. Authorisation to request funds.
3. Provision of documentation, including invoices, three quotations and other required materials for authorisation.
4. Authorisation and sign-off by Executive Manager or Director.
5. Certification and examination, during which payment claims are reviewed by the Senior Examiner to ensure the validity and compliance of all documentation.
6. Review by the financial delegate of the expenditure account code to confirm the availability of funds.
7. Commitment Clerk enters the claim into the system to allow the funds to be committed.
8. Bank sign-off by two signatories, requesting a direct transfer of the authorised amount from the parent account to the relevant subsidiary account. An alternative requires a cheque to be printed for that claim and signed by relevant signatories.



## Annex 8: Case studies on DFAT-supported programs through the HSIP TA

### Annex 8.1: Support to 20 most disadvantaged districts

The Poverty Mapping in Rural PNG research (2004) brings together previous poverty studies by district and combines the household expenditure and population census to provide a list of the 20 most disadvantaged districts in PNG (Gibson et al., 2005). The HSIP TA Re-design used this together with the National Economic and Fiscal Commission's identification of least developed districts as a basis for the 20 disadvantaged districts selected for funding under this program.<sup>35</sup>

Many of the 20 disadvantaged districts also share the problems of remoteness as well as declining health indicators. The impact of distance, cost and difficulty of transportation means that barriers are exacerbated and special effort is needed to address disadvantage in access to health services.

Increases in GoPNG funding have had little impact on expenditure and the state of facilities, particularly in the rural and remote areas. Major limitations include dilapidated facilities, uninhabitable housing and lack of running water. District service delivery in these rural and remote areas is almost non-existent because of the high cost of overcoming these barriers.

#### Timeframe

The Disadvantaged Districts program was to provide funding of PGK22 million over a four-year period from 2014 to 2017, to 20 disadvantaged districts over 12 provinces and ARoB. In 2014, PGK6,283,791 was received for this purpose, and in 2014 and 2015 seven districts submitted their proposals and had funding committed for activities. In March 2016, there was a freeze on the DFAT funding and these activities were stalled. At the end of P1, there was PGK2.5 million that was committed for the activities and PGK3.1 million unallocated and unspent in the parent account. The unallocated funding (PGK3.1 million) was reprogrammed in 2018. In line with the extensions of time for expenditure on programs approved under the HSIP TA Re-design, the Disadvantaged Districts program was extended until 30 October 2023, the end of the current funding cycle.

#### Program objectives/outcomes

The HSIP TA Re-design identified a strategy for targeted interventions in the 20 disadvantaged districts that would ensure a quarantined annual allocation of funding to address key health facility improvements, including staff housing. Health sector improvement was seen as dependent on change at the district and health facility levels, with provinces saying that unless training and housing was provided at these levels, attracting and retaining staff with the skills and motivation to improve the health of rural and remote communities would continue to fail.<sup>36</sup>

The disadvantaged districts intervention falls under *End of Program Outcome 1: Increased access for the poor to effective health services in rural areas*<sup>37</sup>, of the Re-design of the Health Services Improvement Program (HSIP) Trust Account 2012 (the HSIP TA Re-design). The program was to provide funding for major refurbishment of 35 health facilities and 30 staff houses in PNG's top 20 disadvantaged districts. This funding recognised the higher cost of upgrading infrastructure in these areas and the poorer condition of this infrastructure relative to other districts.

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<sup>35</sup> See Gibson, J., et.al. (2005). Mapping poverty in rural Papua New Guinea. *Pacific Economic Bulletin*, 20(1).

<sup>36</sup> See Richards, S., et.al. (2012). *Re-design of the Health Services Improvement Program (HSIP) Trust Account*.

<sup>37</sup> See Richards, S., et.al. (2012). *Re-design of the Health Services Improvement Program (HSIP) Trust Account*.

Due to historic and ongoing neglect of maintenance of existing buildings and limited new infrastructure development over the last 30 years, a significant gap had developed between the condition of rural health facility infrastructure and the *National Health Service Standards 2011–2020*. Recurrent cost estimates for health facility maintenance have been insufficient to bring facilities up to a basic (and far from minimum) standard. In addition, development budget funding had increased at the start in 2013 (the start of this program), but faced challenges of effective management.

## Approach

The Disadvantaged Districts program was designed to incorporate:

- Refurbishment and maintenance of existing registered facilities
- Officer-in-charge remote houses (refurbish existing).<sup>38</sup>

There were two key features of this support. They were:

- Direct payment to suppliers from the HSIP parent account
- Kina-for-kina policy, where districts had to match the funding that they were requesting from the HSIP TA. The counter-funding was intended to be leveraged from Services Improvement Program funding.<sup>39</sup>

Activities that were funded were to be reflected in the PHA AIPs. The kina-for-kina policy required districts to source the equivalent amount of funding from sources such as provincial government, the District Services Improvement Program (DSIP), and Provincial Services Improvement Program (PSIP).

## Provinces funded, total funds allocated, and expenditure to date

Total funding of PGK22.7 million was budgeted for this activity for implementation over the four-year period (2013–2017). In 2014, when the first year of funding of the DFA was given, PGK5.6 million was allocated for this activity. Seven districts qualified and had funding committed for activities (PGK403,406 per district) in the year 2015. A total of PGK2.5 million was committed for these projects and at the end of 2015 this amount was quarantined, including the remainder of PGK3.9 million that was unallocated.

At the end of the freeze in June 2018, the committed funding was unquarantined and the PHAs were informed about the availability of funds. The unallocated funding was reprogrammed into other areas. At the end of 2022, of the PGK2.1 million committed, the expended amount was PGK1.2 million, and PGK0.9 million remained unspent.

The following table indicates the provinces funded and the disadvantaged districts identified for funding support:

| Province and District     | Total allocation 2014–2022 (PGK) | Expenditure to 31 Dec 2022 (PGK) | Balance to be paid (PGK) |
|---------------------------|----------------------------------|----------------------------------|--------------------------|
| Western – Middle Fly      | <i>No funding received</i>       | –                                | –                        |
| Western – Telefomin       | <i>No funding received</i>       | –                                | –                        |
| Western – South Fly       | <i>No funding received</i>       | –                                | –                        |
| West Sepik – Vanimo-Green | 403,406                          | 0                                | 403,406                  |
| West Sepik – Nuku         | 403,406                          | 0                                | 403,406                  |

<sup>38</sup> See Richards, S., et.al. (2012). *Re-design of the Health Services Improvement Program (HSIP) Trust Account*.

<sup>39</sup> See DFAT. (2013). *Minute to authorise and approve spending for current and future financial years (FMA Reg 9 & 10)*.

| Province and District               | Total allocation<br>2014–2022 (PGK) | Expenditure to<br>31 Dec 2022<br>(PGK) | Balance to be<br>paid (PGK) |
|-------------------------------------|-------------------------------------|--|-----------------------------|
| West Sepik – Aitape-Lumi            | –                                   | –                                      | –                           |
| Madang – Rai Coast                  | 403,406                             | 403,406                                | 0                           |
| Madang – Bogia                      | 403,406                             | 403,406                                | 0                           |
| Madang – Middle Ramu                | 403,406                             | 403,406                                | 0                           |
| Jiwaka – Jimi                       | –                                   | –                                      | –                           |
| Hela – Koroba Lake Kopiago          | <i>No funding received</i>          | –                                      | –                           |
| Southern Highlands – Kagua-Erave    | –                                   | –                                      | –                           |
| East Sepik – Ambunti Drekikir       | <i>No funding received</i>          | –                                      | –                           |
| Morobe – Kabwum                     | <i>No funding received</i>          | –                                      | –                           |
| Western Highlands – Tambul-Nebilyer | <i>No funding received</i>          | –                                      | –                           |
| Simbu – Karamui Salt Nomane         | 108,796                             | 0                                      | 108,796                     |
| Central – Abau                      | –                                   | –                                      | –                           |
| Central – Goilala                   | –                                   | –                                      | –                           |
| ARoB – Central Bougainville         | 403,406                             | 403,406                                | 0                           |
| Eastern Highlands – Oburo-Wonera    | –                                   | –                                      | –                           |
| <b>TOTAL</b>                        | <b>2,529,232</b>                    | <b>1,613,624</b>                       | <b>915,608</b>              |

In 2014, only seven disadvantaged districts of the 20 identified were allocated funding: Central Bougainville, Nuku Aitape-Lumi, Vanimo-Green, Karamui Salt Nomane, Bogia, Middle Ramu, and Rai Coast. This allocation was on the basis of proposals submitted to the NDoH, tabled and approved at the Finance and Planning Sub-committee.

In relation to the eight focus provinces for this evaluation, disadvantaged districts were identified in six of these provinces (including ARoB). However, Central Bougainville in ARoB was the only district in the focus provinces to receive funding, which was fully expended.

A total of **PGK22,272,500**<sup>40</sup> of DFAT funding was authorised for this program. This amount was to be made available over a four-year period, based on districts within the PHA/PHO.

The NDoH Budget Instruction<sup>41</sup> advising Provincial Health Administrations and PHA Boards of the HSIP TA allocations for 2014 to 2017 saw provinces advised that an amount of PGK32,272,500 was available across the 20 districts for the four-year period. This was to be matched kina-for-kina by a co-contribution from government sources. According to the NDoH Budget Instruction, **PGK8,068,125** was to be given annually over a four-year period from 2014 to 2017. The districts were to receive PGK403,406 per year for each of the 20 districts over the four-year period.

Disadvantaged districts funding over the course of the HSIP TA Re-design period (2014–2017, extended to 30 October 2023, following amendments) is summarised in the following table.

<sup>40</sup> Minute to Authorise and Approve Spending for Current & Future Financial Years (FMA Reg 9 & 10), 2 July 2013.

<sup>41</sup> Secretary Budget Instruction 2013/02, 1 August 2013.

| Date        | Action   | Amount (PGK)     | Percentage of authorised funds |
|-------------|--|------------------|--------------------------------|
| July 2013   | HSIP TA Agreement 68768 – Disadvantaged districts funds authorised – PGK1,113,625 per district | 22,272,500       | –                              |
| 2014–2017   | Funds paid to HSIP TA for disadvantaged districts  | 6,283,791        | 28.2%                          |
| 2017        | Funds reprogrammed to other activities   | 3,754,557        | 16.8%                          |
| 2017        | Disadvantaged districts funding committed  | 2,529,234        | 11.4%                          |
| 31 Dec 2022 | YTD expenditure from funds paid to HSIP TA 2014–2017   | 1,613,624        | 7.3%                           |
|             | <u>Balance to be paid (outstanding commitments)</u>  | <u>915,608</u>   | <u>4.1%</u>                    |
|             | <b>Total expenditure and commitments</b>   | <b>2,529,234</b> | <b>11.4%</b>                   |

Of the PGK6,283,791 paid to the HSIP TA for disadvantaged districts, PGK2,529,234 (40.3 per cent) was either been spent or committed. Of the authorised funding at the commencement of the program in 2014, 11.4 per cent was spent or committed as at 31 December 2022.

### Key issues/challenges

Funding for this activity was based on the kina-for-kina funding model, requiring provinces to source funding equal to DFAT funding from counterparts (e.g. provincial government or DSIP). This policy resulted in constraints for provinces in accessing available DFAT funds through the HSIP TA, as securing funding from provincial governments and other sources presented a challenge. The freezing of DFAT funds in 2015 and 2016 further added to the difficulties of accessing and using the available donor funding.

The Secretary for Health, Pascoe Kase, commented in a letter to DFAT on 8 July 2015:

*‘The accumulation of funds within the HSIP has occurred for several reasons one of which is the limited capacity in provinces to tender and contract maintenance work as well as the difficulty in meeting the kina-for-kina policy arrangements. However some of the funds were always expected to accumulate as they are multi-year activities, such as disadvantaged districts initiative, facility rehabilitation and training.’<sup>42</sup>*

Capacity issues in tendering and contracting for projects at the sub-national level have impacted on the ability of PHAs/PHOs to prepare the technical plans, tender and contract documents to enable projects to proceed with NDoH approval.

Some districts did not use their allocation due to the documentation for payments, such as invoices and scope of works, not being received on time. All districts were affected by the funding freeze.

Hela Province had funding approved by the NDoH in February 2015 for the building of a new health centre in Koroba Kopiago District and for aid posts within the district, budgeted to cost PGK756,000. An allocation of PGK403,406 was budgeted to be met by Disadvantaged Districts funding. Counter-funding for initial works (PGK28,000) had been provided by North Koroba Local Level Government. However, no funding has been provided towards the proposed project through the HSIP TA mechanism. It is not known whether this was due to the absence of counter-funding for the remainder of the proposed project.

<sup>42</sup> NDoH, Office of the Secretary, Letter to Christine Sturrock, DFAT.

## Summary comments

The Disadvantaged Districts program has neither been effective nor efficient in delivery of program outputs or contributing to outcomes identified in the HSIP TA Re-design. This program falls under End of Program Objective 1, Outcome 1.2 – see the following table.

| <b>Objective 1: To increase access for the poor to effective health services in rural areas</b>   |
|---|
| <p><b>Outcome 1.1</b><br/>HSIP funding increases access to health services and improved service delivery for rural populations</p> <p><b>Outputs:</b></p> |
| <p><b>Outcome 1.2</b><br/>Health services are improved in the 20 disadvantaged districts</p> <p><b>Outputs:</b></p>                                       |

The program sought to quarantine access to funding for the 20 poorest districts, to enable health facility rehabilitation and maintenance. Funding available for each of the 20 districts over the four-year period was PGK1,113,625. After eight years, expenditure or commitment of funds has only occurred in seven districts across four provinces (including ARoB). Projects have been completed in only four of the 20 districts.

There has been no improvement in health services associated with this program in 13 of 20 districts (or, if viewed by province, in nine of 13 provinces including ARoB). On this basis, the program has had limited effectiveness in improving health services in the target districts.

In those districts where funding was expended or committed, the amounts that have been used have been far below the funds available under the program. In six districts, PGK403,406 was spent or committed; just 36 per cent of funds available (PGK1,113,625). In one district, commitments of PGK108,796 represented only 10 per cent of funds available.

The efficiency of the funding mechanism was undermined by several factors:

1. Co-funding from government funds was problematic for provinces. This program was designed to provide a quarantined source of funding that was not forthcoming from routine provincial allocations for health facility maintenance or from SIP funds (DSIP and PSIP), both of which require a percentage of funds to be spent on provincial health projects. The kina-for-kina model was a major blocker, as the program was identified as necessary due to the lack of funding from provincial and other government sources in prior years. Requiring PHOs/PHAs to guarantee funding from this previously unreliable source prevented the majority of target districts from being able to participate in the program and access DFAT funding.
2. The approval processes for access to funding required the PHAs/PHOs to prepare the technical specifications and plans, run either a quotation or tender process, develop contracts, and monitor and oversee progress of works. It is unclear whether PHAs/PHOs had the resources and capacity to manage these projects in the most disadvantaged districts of each province – the evidence would suggest not.
3. Any proposed building works under this program were to be carried out in areas that suffered from remoteness and lack of transport and other infrastructure, as well as difficulty in engaging reputable contractors to perform the works to an acceptable standard. These factors created further cost and difficulty in successful implementation.

The program has been ineffective in the majority of provinces and districts where funding was not accessed and no refurbishments of health facilities occurred – 13 of the 20 districts received no support from the program. The seven districts that received some funding received far less than was

available over the extended life of the program, with only four of the seven districts expending the funds that were provided (three districts had funds committed as at 31 December 2022, but payments had not been made for completed works at that date).

M&E or other assessments of the actual works completed had not been reported, nor had details of the quality, standard or usefulness of the works undertaken.

## Annex 8.2: Support to PHAs and PHOs through the HSIP TA

### PHA/PHO activities (direct support to PHAs for Annual Implementation Plans under the TA), including maternal, child health and disease control programs (public health disease surveillance)

**Relevance:** Untargeted provincial allocations were to decline during the four-year transitional phase according to the 2012 HSIP TA Re-design and targeted activities funding will increase. This recommendation was made due to a lack of reporting and difficulty in establishing the impact of pooled funding.

**Effectiveness:** Ineffective in all three time periods. In 2014 when the DFAT funding was first received, provinces were informed of funding availability through the NDoH channels in the previous year and up to 10 provinces provided their AIPs reflecting the targeted areas. There was some movement of funds, but that was short lived due to the freeze in DFAT funds in 2015. Post-freeze and reprogramming of funding saw very slow uptake of funding by PHAs.

**Efficiency:** Inefficient as most of the provinces only got the first tranche of funding and were unable to access the next two tranches because of non-fulfilment of reporting requirements.

**Lessons learned and recommendations:** Pooled funding to provincial levels began in 2003 and was intended to become the main mechanism for disbursing external development partner support through the SWAp. There were challenges with the uptake of funding and spending has always been around 40 per cent of levels in the budget. The aim of the HSIP TA Re-design was to build on the GoPNG commitment to decentralisation, the *National Health Plan 2011–2020*, the health reforms, and others to move from untargeted funding to targeted. While there was traction in the beginning of the program in 2014 and 2015, the freeze that commenced in March 2016 led to a total standstill of the funding during the freeze period, and when the funds were unfrozen and available for access there was a very slow uptake of the funds being accessed.

### Background

Pooled funding through the HSIP TA was initiated in 2003 and was intended to become the main mechanism for disbursing external development partner support to the SWAp by channelling additional funding to support provincial operating budgets. Apart from AusAID, other donors including Global Fund and New Zealand provided support through pooled funding. There were challenges in the beginning with expending the funding for this purpose. Since the pooled funded was based on an advance and replenish system, no new funding is released until acquittals are complete.

The 2012 HSIP TA Re-design recommended a shift from provincial pooled funding to targeted funding into identified areas with specific strategies. The DFA provided both targeted and untargeted funding, with the latter providing support to PHAs/PHOs. This pooled funding intervention supported EOPO 1 on 'Increased access for the poor to effective health services in rural areas'. An amount of AUD15,700,000 (PGK32,800,000) was allocated to support this intervention under the DFA. Only a year's funding was given for this purpose in 2014 and by late 2015, when the funds were frozen, PGK2,033,247 remained for this activity.

In 2018, after the DFAT funding was unfrozen and reprogrammed, an additional amount of PGK5,766,573 was directed to PHA/PHO support to supplement the remaining balance, raising the total available to PGK7.8 million.

## Timeframe

Support to PHAs/PHOs (PGK32,800,000) was to be used between July 2013 and June 2017 according to the DFA. An annual transfer of PGK8,200,000 was envisaged; by the end of 2015 the remaining balance was PGK2,033,247. The timeframe for this activity has been extended by subsequent amendments to the DFA and is now scheduled to conclude by October 2023.

Given the freezing of funds in P2 and the subsequent reprogramming in P3, this component of the original funding is now referred to as 'legacy DFAT funding'. Additional funding was provided for this purpose, bringing it to a total of PGK7,800,000 and, as of December 2022, a balance of PGK3,645,661 remains in the parent account for this activity, while in the subsidiary accounts a total of PGK686,271 remains.

## Program objectives/outcomes

The initial program objective as outlined in the Direct Funding Agreement is to support the recurrent health services calculated as part of the NEFC cost of services framework. Pooled funding was provided to support the implementation of Annual Implementation Plan activities. The re-design saw a reduction in the amount made available for pooled funding, as the focus shifted to more targeted and earmarked funding. The re-design in 2012 noted that, although there had been funding put through for the untargeted activities such as supporting AIP activities, there had been little improvement evident in the limited data collected. Therefore, there were several targeted interventions identified in the re-design with the aim of having targeted activities that could contribute directly to improving service delivery, while maintaining a certain amount for the recurrent activities under the pooled funding support.

## Approach

According to the 2015 Budget Instructions circulated by NDoH in July 2014, the pooled funding component priorities for 2015 were: cold chain rehabilitation; national health services roll-out/facility assessment and service planning; and hospital and rural health services combined outreach and supervision. The 2015 Budget Instructions further informed PHAs to prepare AIPs accordingly, noting these changes and priorities.

Post-2018 and the reprogramming of remaining DFAT funds, an added amount provided to this activity in the areas of focus for the PHA/PHO activities included: (i) enhancing cold chain and immunisation systems; (ii) enhancing provincial surveillance and laboratory capacity; (iii) in-service training to improve provincial capacity to prevent, monitor, and treat communicable diseases, and respond to major outbreaks. Provinces were expected to provide their AIPs, and reflect activities in line with these priorities in the workplan, to be able to access this funding. Use of funding and acquittals have to be made in line with the PFM Act guidelines and subsequent tranches were to be released after these requirements were met.

Prior to the re-design, most of the funding that went through the HSIP TA, including DFAT funding, was untargeted. The re-design and other documents noted the ineffectiveness of such funding, in line with the difficulties in reporting outcomes of this funding. All provinces accessed the first tranche of funding, but only half of them continued to receive the second tranche and only one PHA received the final tranche.

## Provinces funded – total allocated to date

Activities are expected to be integrated within the PHA-prepared AIPs, which then are submitted to the Planning and Monitoring Branch of the NDoH and the HSIP Management Team, should they want to access funding from this activity. At sub-national level, the PHAs are responsible for preparing



their own AIPs, but are provided guidance through the NDoH Planning Team on priorities, and these are in turn guided by overarching objectives, such as the National Health Plan, strategic plans, and provincial-level objectives and priorities.

The process of accessing the funds has been the same from both pre- and post-reprogramming, whereby there should be a 60 per cent spend and the PHA will request NDoH to conduct an audit, and once there is an 80 per cent satisfactory requirement the next tranche of funding will only be provided after satisfactory acquittals are made by the provinces. From 2018, allocations of PGK354,545 were to be made to each province, divided into three tranches of PGK118,000. Payment of subsequent tranches were to be processed in line with HSIP TA requirements.

From the total allocated for this activity, both from the initial pooled funding and post-reprogramming of legacy funds, a total of PGK7,800,000 was allocated, of which PGK2,457,088 was transferred from the first tranche payments, PGK1,180,000 was transferred in the second tranche, and PGK118,000 paid for third tranche payments as of December 2022. A balance of PGK3,645,661 remains in the parent account to be disbursed. All 22 provinces have received the first tranche payment; 10 provinces also received the second tranche; while only one province (Milne Bay) received the third and final tranche. Most transfers were actioned in 2019 and 2020. Below is a table showing the last expenditure report from December 2022.

| PHA                               | Total Allocation | TRANCHE 1        |                  |                | TRANCHE 2        |                |                | TRANCHE 3      |               |               | Balance Yet to be Transferred | Date of Last Transfer |
|-----------------------------------|------------------|------------------|------------------|----------------|------------------|----------------|----------------|----------------|---------------|---------------|-------------------------------|-----------------------|
|                                   |                  | Transferred      | Expenditure      | Balance        | Transferred      | Expenditure    | Balance        | Transferred    | Expenditure   | Balance       |                               |                       |
|                                   | (K)              | (K)              | (K)              | (K)            | (K)              | (K)            | (K)            | (K)            | (K)           | (K)           |                               |                       |
| Western Province                  | 354,545          | 118,000          | 52,257           | 65,743         | -                | -              | -              | -              | -             | -             | 545                           | 29.04.19              |
| Gulf province                     | 354,545          | 118,000          | 118,000          | -              | -                | -              | -              | -              | -             | -             | 236,545                       | 29.04.19              |
| Central Province                  | 354,545          | 118,000          | 118,000          | -              | 118,000          | -              | 118,000        | -              | -             | -             | 118,545                       | 21.04.20              |
| National Capital District (PHA)   | 354,545          | 73,840           | 48,294           | 25,546         | 118,000          | -              | 118,000        | -              | -             | -             | -                             | Parent Act.           |
| Port Moresby General Hospital     |                  |                  |                  |                |                  |                |                |                |               |               |                               |                       |
| Milne Bay Province                | 354,545          | 118,000          | 118,000          | -              | 118,000          | 118,000        | -              | 118,000        | 22,800        | 95,200        | 545                           | 01.04.20              |
| Oro Province                      | 354,545          | 23,248           | 23,248           | -              | -                | -              | -              | -              | -             | -             | 331,297                       | 04.12.19              |
| Southern Highlands                | 354,545          | 118,000          | 86,000           | 32,000         | -                | -              | -              | -              | -             | -             | 236,545                       | 12.04.19              |
| Hela Province                     | 354,545          | 118,000          | 105,547          | 12,453         | 118,000          | 21,281         | 96,719         | -              | -             | -             | 118,545                       | 16.04.20              |
| Enga Province                     | 354,545          | 118,000          | 118,000          | -              | 118,000          | 39,517         | 78,483         | -              | -             | -             | 118,545                       | 21.04.20              |
| Western Highlands Province        | 354,545          | 118,000          | 118,000          | -              | 118,000          | -              | 118,000        | -              | -             | -             | 118,545                       | 21.04.20              |
| Jiwaka Province                   | 354,545          | 118,000          | 93,000           | 25,000         | 118,000          | 74,017         | 43,983         | -              | -             | -             | 118,545                       | 21.04.20              |
| Simbu Province                    | 354,545          | 118,000          | 28,466           | 89,534         | -                | -              | -              | -              | -             | -             | 236,545                       | 17.06.19              |
| Eastern Highlands Province        | 354,545          | 118,000          | 118,000          | -              | -                | -              | -              | -              | -             | -             | 236,545                       | 09.04.19              |
| Morobe Province                   | 354,545          | 118,000          | 118,000          | -              | -                | -              | -              | -              | -             | -             | 236,545                       | 08.04.19              |
| Madang Province                   | 354,545          | 118,000          | 20,000           | 98,000         | -                | -              | -              | -              | -             | -             | 236,545                       | 17.06.19              |
| East Sepik Province               | 354,545          | 118,000          | 106,301          | 11,699         | -                | -              | -              | -              | -             | -             | 236,545                       | 10.10.19              |
| West Sepik (Sandaun) Province     | 354,545          | 118,000          | 115,774          | 2,226          | -                | -              | -              | -              | -             | -             | 236,545                       | 05.05.19              |
| Manus Province                    | 354,545          | 118,000          | 108,149          | 9,851          | 118,000          | 102,957        | 15,043         | -              | -             | -             | 118,545                       | 21.04.20              |
| New Ireland Province              | 354,545          | 118,000          | 117,958          | 42             | 118,000          | 118,000        | -              | -              | -             | -             | 118,545                       | 21.04.20              |
| East New Britain Province         | 354,545          | 118,000          | 74,380           | 43,620         | -                | -              | -              | -              | -             | -             | 236,545                       | 10.10.19              |
| West New Britain Province         | 354,545          | 118,000          | 111,157          | 6,843          | -                | -              | -              | -              | -             | -             | 236,545                       | 20.04.19              |
| Autonomous Region of Bougainville | 354,545          | 118,000          | 117,016          | 984            | 118,000          | 115,157        | 2,843          | -              | -             | -             | 118,545                       | 21.04.20              |
| <b>Grand Total</b>                | <b>7,800,000</b> | <b>2,457,088</b> | <b>2,033,547</b> | <b>423,542</b> | <b>1,180,000</b> | <b>588,929</b> | <b>591,071</b> | <b>118,000</b> | <b>22,800</b> | <b>95,200</b> | <b>3,645,661</b>              |                       |

Table showing PHA/PHO support balances as at December 2022.

## Key activities

From the initial funding, as outlined in the NDoH 2015 Resources Committee Report for February 2015, most provinces were ready to receive their second tranche of funding and for other provinces it was anticipated that PHAs would be getting their third tranche of funding by the end of 2015.

The NDoH Budget Minute for 2020 outlined key areas that the untargeted funding would be used for and these were: cold chain rehabilitation; national health services roll-out/facility assessment and service planning; and hospital and rural health services combined outreach and supervision. However, each province was able to request these funds as long as the activity involved was tied in with the PHA's AIPs.

From the 2018 reprogramming, the following areas were identified for this funding: (i) enhancing cold chain and immunisation systems; (ii) enhancing provincial surveillance and laboratory capacity; and (iii) in-service training to improve provincial capacity to prevent, monitor, and treat communicable diseases, and respond to major outbreaks.

## Key achievements

While it is difficult to track the implementation of activities under pooled funding, there was improvement in associated activities, such as submission of AIPs from provinces reflecting key areas in the Budget Minutes that NDoH circulates towards the end of the year. The 2015 HSIP TA Annual Management Report indicated that there had been an increase in the number of PHAs submitting their AIPs, as they were informed through the NDoH circular in the previous year on the available funding for the year.

Interviews with PHAs yielded that pooled funding was one of their main supports for their immunisation patrols in the years prior to the re-design. After the re-design some of the activities in public health continued to be supported by this mechanism, but on a more ad hoc basis, depending on when there was funding available.

## Key issues/challenges

All provinces accessed the first tranche of funding, a good uptake in the initial year of implementation (2015). The 2015 HSIP Program Report to the Finance and Budget Sub-committee Meeting, dated 27 February 2015, indicates that AIPs were being received and at the time of the meeting 10 provinces had submitted, which included, AROB, East Sepik, Oro, Central, Jiwaka, Eastern Highlands, West Sepik, NCD, Western Highlands, and Madang Provinces.

With regard to what was achieved with these funds, this is not possible to assess, as the funds allocated by DFAT through the HSIP TA formed one portion of the broader AIP from each province, and reports on outcomes and achievements have not been accessible. Interviews with personnel in the focus PHAs for this evaluation indicate that this funding has been accessible to support public health programs when necessary. These informants also noted, however, that there are many other related activities, funded either through the government or other DPs, or other DFAT projects that also contribute, often with substantially more funds, and therefore it is not possible to directly link the funds to outcomes in terms of key indicators.

The table showing PHA balances above shows that all PHAs accessed the first tranche of funding in 2019 and 2020, but then only half of them continued to access the second tranche. The main reasons for not accessing subsequent tranches of funding were reportedly due to the slow rate of submitting details of how these funds were acquitted, thus undermining potential for the second tranche to be submitted. Find below a table showing the transfers made to PHAs for the PHA/PHO support and the balance remaining.

## Summary comments

Pooled funding was a mechanism that was intended to disburse funds to the sub-national levels to support provincial operational funding. The 2012 HSIP TA Re-design recommended that this component be reduced, and the focus be put on targeted activities. Funding for the first year was given in 2014 and 2015, and at the time of the freeze in March 2016 the funds remaining in the parent account for this purpose were PGK2,033,247. After the reprogramming of DFAT funding post-freeze, an additional amount of PGK5,766,573 was directed to PHA/PHO support activity to supplement the remaining balance, raising the total available for this intervention to PGK7.8 million.

The GoPNG processes that guide the use of the HSIP TA and its subsidiary accounts have to be followed and some provinces have faced difficulty in meeting the PFM capacity. Given the limited public health, financing, and planning personnel at the PHA level, the focus could be on other activities and funding sources and not so much this intervention. In interviews with the Western PHA team, one of the examples that was provided related to the immunisation programs by World Vision

with DFAT funding it was shared that the PHA also sourced funding through the HSIP TA for immunisation activities. The requested funding was provided but not appropriately used, as the immunisation patrols were already done by the partner.

The HFGs now cover most of the activities, as do other projects funded by partners. For example, the Eastern Highlands PHA in 2021 received a total of PGK7,339,100 in funding for its public health activities, and also received AIHSS funding that supported immunisation patrols and mobile clinics. Financial management resources are limited and focused on accessing and managing those available funds that cover the bulk of the activities. The freezing of DFAT funding in late 2015, the whole of 2016, most of 2017, and half of 2018, contributed to a slow uptake of available funds across P1 and P2 and even in P3 after the funding again became available.

Information on the availability of funding is one of the important ways that PHAs would be able to incorporate it into their planning for the year to be able to access this funding. PHAs that have used this funding both before and after the re-design have indicated that once they were informed of the availability of funding, they worked towards implementing the activities they planned to implement in the year. According to two PHA CEOs, the clarity of information on available funding and the purposes of its use was important, and proper planning was the key in accessing the DFAT funding.

## Annex 8.3: Support to NDoH through the HSIP TA

### Funding for NDoH functions including planning and HSIP TA operational costs, provincial monitoring, recruitment, training-finance and procurement, HSIP TA annual audits, and the funding of the development of the National Health Plan

**Relevance:** Support to NDoH and the HSIP TA management is vital, as it is aimed at supporting and improving the HSIP TA functions at the management level in NDoH, as well as the absorptive capacities at the PHA level through training at the provincial and facility levels on HSIP processes and procedures.

**Effectiveness:** The effectiveness of the activities under this intervention in the different timeframes varies, however, when considering how activities such as supporting the National Health Plan (2011–2020 and 2021–2030), and the planning and monitoring support, fill important systems gaps. It has been effective in both the P1 (2012–2015) and P3 (2018 to present) periods in ensuring that the Trust Account mechanism is functioning.

**Efficiency:** The efficiency of this support has been considerably more than the other projects. By late 2015, when the funds were frozen, spending for these support areas was higher than the other interventions.

**Lesson learned and recommendations:** The support was essential in supporting the whole program and the implementation of the other activities as well. It is important to note that the functions that relied on this funding at the national level were heavily reliant on this support, and so the freezing of funds in late 2015 had an impact on their operations. Proper planning and information sharing with PHAs paramount in using these funds.

### Background

There were two aspects to the support to NDoH functions under the 2012 HSIP TA Re-design, including allocations to contribute to EOPO 2 (Increased absorptive capacity of the health sector to achieve GoPNG commitment to the National Health Plan on a sustainable basis) and EOPO 3 (Improved performance and governance of the HSIP TA). This activity had a total budgeted amount of PGK4,545,000 and the key objectives were:

- Integrated annual implementation planning and reporting of all provincial funds.
- Performance monitoring and evaluation of the HSIP interventions.
- Strengthening audit and acquittal processes at both central level and in all provinces.
- Support to sector performance reviews and coordination of national training and public health programs.
- Accredited Rural Health Facility Management Training for 140 District Health Coordinators and 360 Health Officers-in-Charge.
- In-service training for 220 Community Health Workers.

Total funding of PGK4,965,000 for these activities was received in 2014, and at the end of 2015 an amount of PGK250,000 remained for these activities. After the freeze and the subsequent reprogramming, further funding was given, including:

- Support to the *National Health Plan 2021–2030* and other NDoH activities (PGK1.8 million).
- HSIP Annual Audit and Operations (PGK667,800).

## Timeframe

As per the initial Direct Funding Agreement of 2013 between GoPNG and DFAT, this funding was from July 2013 to June 2017. Subsequent amendments to the Direct Funding Agreement and the reprogramming of funds into these areas set the current program end date to 30 October 2023.

## Program outcomes/objectives

The 2012 HSIP TA Re-design document identifies EOPO 3 on 'Improved performance and governance of the HSIP Trust Account' and three key activities to achieve that outcome. The key intervention activities were targeted at contributing to this EOPO. They included interventions at both the national and provincial levels, and covered a range of activities from operations to training and monitoring, including the re-design roadshow and activities aligned with the re-design socialisation at PHAs.

Program objectives post-reprogramming of funds was aimed around the same objectives and for EOPO 2 the focus was on the development of the *National Health Plan 2021–2030*.

## Approach

This support was given to the HSIP TA Management Team as part of the program management support for their activities, including the HSIP TA management implementation plan, performance monitoring and evaluation of the HSIP interventions, and strengthening audit and acquittal processes. For increasing absorptive capacity, training was to be provided for Rural Health Facility Management and for Community Health Workers in an effort to improve requesting and reporting capacity at the health facility levels.

After the 2012 HSIP TA Re-design, this support was targeted at HSIP operations to improve reporting, coordination, and absorptive capacity. Support was provided for the implementation of the *National Health Plan 2011–2020* through sector performance reviews, and training was supported at both central and sub-national levels. Respective branches would work with the HSIP TA team to submit requests to support activities. Training occurred with the Training and Development Branch of the Human Resources Division, while activities involving planning and monitoring were undertaken with the Planning Branch.

## Activities funded – total allocated to date

As mentioned above, the total allocated funds from the 2013 DFA were not provided, but in 2014 an amount of PGK4,482,500 was paid to the HSIP parent account to support these activities. At the time DFAT funding was frozen, the following amounts were in the account for the activities:

| Activity                              | Balance remaining at end of 2015 (PGK) |
|---------------------------------------|--|
| Secretary's Emergency Fund            | 267,000                                |
| PHA Provincial Monitoring             | 35,493                                 |
| Provincial Capacity Building          | 574,206                                |
| Provincial Visit (Re-design Roadshow) | 267,502                                |
| Reprogrammed HSIP Design              | 3,545                                  |
| Capacity Building Training            | 4,671                                  |
| HSIP Operational Costs                | 5,481                                  |
| Staff Training (HSIP)                 | 2,721                                  |
| NDoH – HSIP TA                        | 109,830                                |
| Conference Cost (HSIP)                | 4,830                                  |

|              |                  |
|--------------|------------------|
| <b>TOTAL</b> | <b>2,305,905</b> |
|--------------|------------------|

### Key outputs/achievements

The 2015 HSIP TA Annual Management Report outlines some of the activities, including all 21 provinces that were visited in 2015, and which received pooled funding and the reduction of acquittal backlogs. Technical support to build capacity was also done in some provinces (ARoB, Jiwaka, Hela, and Southern Highlands). This saw timely disbursements of funds to provinces and other NDoH programs for health service delivery, and monthly and quarterly financial reports were completed on time, despite some issues experienced in the PHAs. At the national level, compliance activities included ensuring compliance with the HSIP TA Manual of Procedures, PFM Act and other regulations, and conducting the external audit of HSIP for the financial year 2014–15.

In P3 of the reprogramming of DFAT funds, the funding for the HSIP TA operation supported the same key priorities of improving internal and external working relationships and encouraging improved reporting and acquittals from provinces, continuing monthly and quarterly reports to donors, and the audit processes.

Annual audits were delayed in 2014, but were completed with DFAT support in 2016, together with the 2015 audit. An allocated amount of PGK270,000 was provided for this activity, of which PGK160,170 was expended in 2017 for these purposes.

The *National Health Plan 2021–2030* was also supported with funding for regional to national consultations, and other support provided required for the document’s development. Interviews with NDoH noted that there was support from DFAT through HSIP for the development of the NHP 2021–2030 that included consultations, review workshops, and other activities.

There were nine line items that these priorities were placed under after the reprogramming. The table below shows the appropriations and expenditure in PGK for 2019, 2021, and 2022.

| Activity                             | Appropriation 2019 | Total expenditure 2019 | Appropriation 2021 | Total expenditure 2021 | Appropriation 2022 | Total expenditure 2022 |
|--------------------------------------|--------------------|------------------------|--------------------|------------------------|--------------------|------------------------|
| National Health Plan                 | 500,000            | 200,373                | 104,368            | 81,212                 | 23,156             | –                      |
| Governance and Oversight Activities  | 69,813             | 66,559                 | –                  | –                      | –                  | –                      |
| HSIP Provincial Financial Monitoring | 100,000            | 90,854                 | 351,505            | 93,402                 | 258,103            | 105,758                |
| Training – Finance and Procurement   | 100,000            | 32,050                 | 34,864             | –                      | 38,864             | –                      |
| Planning                             | 100,000            | 69,755                 | –                  | 351,505                | 560                | –                      |
| Monitoring                           | 200,000            | 46,154                 | 7,101              | 7,000                  | 101                | –                      |
| HSIP Annual Audit                    | 600,000            | 164,210                | 435,790            | 421,995                | 13,795             | –                      |

| Activity                        | Appropriation 2019 | Total expenditure 2019 | Appropriation 2021 | Total expenditure 2021 | Appropriation 2022 | Total expenditure 2022 |
|---------------------------------|--------------------|------------------------|--------------------|------------------------|--------------------|------------------------|
| HSIP Operational Cost           | 67,880             | 37,804                 | 3,259              | 3,008                  | 251                | –                      |
| Provincial Training Fund – 2014 | 60,232             | 60,232                 | –                  | –                      | –                  | –                      |
| <b>TOTAL</b>                    | <b>1,798,016</b>   | <b>767,991</b>         | <b>1,030,289</b>   | <b>958,122</b>         | <b>334,830</b>     | <b>105,758</b>         |

### Key activities

This support covered HSIP TA management, including governance, financial monitoring, operational costs, and annual audits. For training, there was a focus on finance and procurement training to improve reporting and streamline the process, and also targeted training for Officers-in-Charge and Community Health Workers at health facilities. Among the main activities of 2015 was included coordination of funding from development partners to the provinces from GoPNG, DFAT, Gavi, WHO, UNICEF, and UNFPA. Achievements noted for provincial visits included reduction of acquittal backlogs. All of the 21 provinces were visited in 2015 and received the pooled funding. Some provinces like Milne Bay and Eastern Highlands were visited twice in a year. The team also provided technical support to build capacity in the provinces. This was provided to ARoB, Jiwaka, Hela, and Southern Highlands among others.

Support for the *National Health Plan 2021–2030* was provided, including funding for regional and national consultations, which were all NDoH-led and partner-supported.

### Key issues/challenges

One of the key features from P1 was the change from pooled funding to earmarked activities that were targeted for specific areas. The HSIP TA Management Team had to work with provinces to inform them of the activities and the requirements. Reports from 2014 and 2015 indicate that there were still delays in getting through the provincial AIPs and working through systems and processes. Establishment of PHAs and the integration of financial management systems was also one of the key features of this period.

P2 presented the most challenge, as the freeze of DFAT funds affected the management of the HSIP TA, given the bulk of the operations funding would have been from the DFAT funding. Although work within the HSIP TA continued, the operations were affected, as they relied heavily on DFAT funding to run operations such as purchasing printing supplies.

In P3, key challenges were those posed by COVID 19, which meant that the team was unable to carry out the provincial visits to conduct activities, including provincial checks on subsidiary accounts. One of the challenges that continued from P1 was the transition of Provincial Health Offices to Provincial Health Authorities and the subsequent transfer of financial powers to the PHAs. The HSIP TA subsidiary accounts were set within the provincial government systems and the signatories. Were based within this system and that function had to be transferred over. To date, there are still PHAs in the process of integrating their accounts fully into the PHA.

### Summary and recommendations

The 2015 HSIP TA Annual Management Report outlines some of the activities, including all 21 provinces that were visited in 2015, and received pooled funding and the reduction of acquittal

backlogs. Technical support to build capacity also occurred in some provinces (ARoB, Jiwaka, Hela, and Southern Highlands). This saw timely disbursements of funds to provinces and other NDoH programs for health service delivery, and monthly and quarterly financial reports were completed on time despite some issues experienced in the PHAs. At the national level, compliance activities included ensuring compliance with the HSIP TA Manual of Procedures, PFM Act and other regulations, and conducting the external audit of HSIP for the financial year 2014–15.

In P3 of the reprogramming of DFAT funds, the funding for the HSIP TA operation supported the same key priorities of improving internal and external working relationships and encouraging improved reporting and acquittals from provinces, continuing monthly and quarterly reports to donors, and the audit processes.

Annual audits were delayed in 2014, but occurred with DFAT support in 2016, together with the 2015 audit. An allocated amount of PGK270,000 was provided for this activity, of which PGK160,170 was expended in 2017 for these purposes.

The *National Health Plan 2021–2030* was also supported by funding regional to national consultations, and other support required for the document's development. Interviews with NDoH noted that there was support from DFAT through HSIP for the activities in the development of the NHP 2021–2030, such as consultations.



## Annex 8.4: COVID-19 response support through the HSIP TA

### Timeframe

The timeframe for DFAT support to the COVID-19 Emergency Response commenced on 14 April 2020, with the third amendment to the HSIP TA Agreement 68768. At this time, the agreement was extended another two years until 30 June 2022. Three subsequent amendments to the agreement extended the timeframe for use of DFAT funding within the HSIP TA to 30 October 2023. This included funding that had not been expended up to that date on all current programs, including the COVID-19 Emergency Response Plans.

### Program objectives/outcomes

The Australian Government, through DFAT, is providing ongoing support to GoPNG to strengthen its preparedness, response, and protection against COVID-19. This support is aligned with the Government of PNG's national strategies and targeted support in the establishment and operationalisation of national plans at the sub-national and organisational levels.<sup>1</sup>

### Approach

The State of Emergency Controller approved the disbursement of DFAT funds to PHAs through the HSIP TA.<sup>43</sup> The funding provided to provinces and ARoB for priority areas in sub-national Emergency Response Plans was required to be spent on the following expenditure clusters:

- Clinical management and health care – including activities associated with staff training and recruitment, and establishing triaging, quarantine, and isolation facilities.
- Surveillance and rapid response – including support for rapid response teams.
- Community engagement and risk communication.
- Infection prevention and control – including waste management/disposal.
- Ports of entry – including surveillance at airports, ports, and land borders.
- Logistics (while not in the Terms of Reference for this review, the expenditure was included in allocation of PGK22.25 million and so is included here).<sup>44</sup>

Funds were received from DFAT on 29 April 2020 and deposited to the HSIP TA parent account. The allocation for PHAs was then transferred to the sub-national HSIP TA accounts. As NCD PHA does not have an HSIP TA, its allocation of funds remained in the parent account for processing through a separate sub-ledger. Funds for Port Moresby General Hospital were transferred to the nominated hospital project account.

Each PHA could decide on the amount to be spent on each cluster, with all workplans being reviewed and approved by HSIP TA Management Team. The HSIP TA team with DFAT's assistance developed a toolkit to support the implementation of funding. The toolkit conformed with the GoPNG *Public Finances (Management) Act 1995*, as amended, the Financial Instructions, and DFAT's fiduciary control requirements, in accordance with the HSIP TA Manual of Procedures. It consisted of general instructions and seven new or re-designed HSIP TA forms.<sup>45</sup>

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<sup>43</sup> NDoH Circular Instruction No 39/2020, 27 April 2020.

<sup>44</sup> See HDMES. (2021). *COVID-19 in Papua New Guinea and Australia's response: A rapid review. Final Report.*

<sup>45</sup> See HDMES. (2021). *COVID-19 in Papua New Guinea and Australia's response: A rapid review. Final Report.*

All claims were to continue to be approved by the DFAT Authorised Delegate and the PHA CEO prior to payment. Where no DFAT Authorised Delegate was available or present within the province, scanned documents could be sent to the NDoH HSIP TA team to facilitate approval.<sup>46</sup>

A further funding pool of PGK40,738,634 for COVID-19 and Health System Strengthening was provided by DFAT by deposit to the HSIP parent account on 26 May 2021. As at 31 December 2021, approximately PGK21.5 million of Health System Strengthening funding remained unallocated to activities. The extent to which this had changed by 31 December 2022 is presently unclear.

The expenditure of this pool of funding for Health System Strengthening across the PHAs and ARoB was supported by the PATH program. A financial management team of five people, embedded within the NDoH, are supporting the integrity of the HSIP TA. Through this mechanism, DFAT disburses funds to the PHAs and manages capacity building, accountability, and reporting.<sup>47</sup>

### Provinces funded

This funding was provided to all 21 provinces in PNG and ARoB.

### Total funds allocated and expenditure to date

Between April 2020 and 31 December 2022, DFAT made available a total of PGK134,659,941 via the HSIP TA, including an amount of PGK11,685,411 of reprogrammed 2014 funds that had remained in the HSIP TA since early 2020.

The 2020 injection of funds to the HSIP TA was the first additional amount transferred since before the freezing of DFAT funds in 2015. Funds were made available for the COVID-19 Emergency Response as follows:

| HSIP TA Parent Account  | Date received | Approved DFAT funding allocation PGK | Expenditure & commitments, PHA allocations            | Balance 31 Dec 2022  |
|---|---------------|--------------------------------------|---|----------------------|
| Reprogrammed funds from 2014 reallocated to PHAs for Emergency Response Plans | 14 Apr 2020   | 11,685,411                           | 7,984,049   | 3,701,362            |
| 29 Apr 2020 – COVID-19 Preparedness and Response Funding                      | 29 Apr 2020   | 21,452,845                           | 20,750,000  | 702,845              |
| 11 Jun 2020 – Additional Funding for COVID-19                                 | 11 Jun 2020   | 3,348,122                            | 3,195,597   | 152,525              |
| COVID-19 and Health Systems Strengthening                                     | 26 May 2021   | 40,738,634                           | 20,542,110  | 20,196,524           |
| <b>TOTAL</b>  | –             | <b>77,225,012</b>                    | <b>52,471,756</b><br><i>68% expended or allocated</i> | <i>32% remaining</i> |

The following table shows DFAT funds that have been deposited to the HSIP TA parent account for the COVID-19 Emergency Response and appropriated to the accounts of PHAs and ARoB (with NCD PHA funds managed within the HSIP parent account, as the NCD PHA Trust Account has not yet been set up).

<sup>46</sup> NDoH Circular Instruction No 39/2020, 27 April 2020.

<sup>47</sup> See HDMES. (2021). *COVID-19 in Papua New Guinea and Australia's response: A rapid review. Final Report.*

| Province                      | PHA allocation to 31 Dec 2022 (PGK) | Expenditure to 31 Dec 2022 (PGK) | Balance at 31 Dec 2022 (PGK) | % of allocation spent |
|-------------------------------|-------------------------------------|----------------------------------|------------------------------|-----------------------|
| Western                       | 1,813,316                           | 1,136,852                        | 676,464                      | 63%                   |
| Gulf                          | 505,742                             | 82,485                           | 423,258                      | 16%                   |
| Central                       | 965,759                             | 271,859                          | 693,900                      | 28%                   |
| NCD PHA                       | 3,564,889                           | 3,564,889                        | –                            | 100%                  |
| Port Moresby General Hospital | 3,640,020                           | 3,640,020                        | –                            | 100%                  |
| Milne Bay                     | 1,406,038                           | 1,101,714                        | 304,324                      | 78%                   |
| Oro                           | 658,772                             | 196,172                          | 462,600                      | 30%                   |
| Southern Highlands            | 937,742                             | 15,742                           | 922,000                      | 2%                    |
| Hela                          | 1,229,628                           | 313,428                          | 916,200                      | 25%                   |
| Enga                          | 1,374,880                           | 813,217                          | 561,663                      | 59%                   |
| Western Highlands             | 3,707,000                           | 3,146,384                        | 560,616                      | 85%                   |
| Jiwaka                        | 1,058,372                           | 364,471                          | 693,901                      | 34%                   |
| Simbu                         | 714,700                             | 20,800                           | 693,900                      | 3%                    |
| Eastern Highlands             | 1,675,072                           | 1,503,458                        | 171,614                      | 90%                   |
| Morobe                        | 3,131,586                           | 1,576,680                        | 1,554,906                    | 50%                   |
| Madang                        | 1,593,035                           | 1,097,004                        | 496,031                      | 69%                   |
| East Sepik                    | 1,642,575                           | 978,377                          | 664,198                      | 60%                   |
| West Sepik                    | 1,969,884                           | 1,044,684                        | 925,200                      | 53%                   |
| Manus                         | 912,211                             | 449,607                          | 462,604                      | 49%                   |
| New Ireland                   | 912,600                             | 450,000                          | 462,600                      | 49%                   |
| East New Britain              | 1,405,366                           | 1,346,327                        | 59,039                       | 96%                   |
| West New Britain              | 1,062,854                           | 899,229                          | 163,625                      | 85%                   |
| ARoB                          | 1,450,000                           | 1,433,248                        | 16,752                       | 99%                   |
| <b>TOTAL</b>                  | <b>37,332,041</b>                   | <b>25,446,646</b>                | <b>11,885,395</b>            | <b>68.2%</b>          |

Of the funds transferred for PHA Emergency Response Plans and Health System Strengthening activities, 68.2 per cent have been used at the sub-national level as of 31 December 2022. The extent to which PHAs have been able to use this funding has varied widely, as is shown by the percentages of allocations spent in the table above. It should be noted that PHAs may be in receipt of funds from other donors and DPs and underuse of funding may reflect inability to manage additional projects and activities. This reinforces points made elsewhere in this evaluation regarding the need for higher level coordination of both funding and activities at national and PHA levels.

### Key activities

Areas of expenditure were identified for the Emergency Response Plans of GoPNG and the PHAs. However, the recipients of funding (PHAs and ARoB) could determine the amount that they committed to each of the areas of their COVID-19 response. These clusters included: Clinical Management and Health Care; Surveillance and Rapid Response; Risk Communication and Community Engagement; Infection Prevention and Control; and Port of Entry. The total amount spent by PHAs and ARoB was PGK25,446,646. This amount was spent across the following areas, with the percentage of total expenditure shown below.

| Clinical Management & Health Care | Surveillance & Rapid Response | Community Engagement & Risk Communication | Infection Prevention & Control | Port of Entry | PEOC/ Logistics | Laboratory |
|-----------------------------------|-------------------------------|---|--------------------------------|---------------|-----------------|------------|
| 16,137,659                        | 2,295,282                     | 2,112,438                                 | 1,173,787                      | 897,858       | 2,592,964       | 236,657    |
| 63.4%                             | 9.0%                          | 8.3%                                      | 4.6%                           | 3.5%          | 10.2%           | 1.0%       |

It is unclear how any Health System Strengthening funds that may have been transferred to the PHAs and ARoB have been used or to what extent. The PHA expenditure data indicates that the emergency response areas for approved expenditure account for all of the expenditure by PHAs and ARoB.

### Key outputs/achievements

GoPNG and PHAs were able to use the first two allocations of emergency response funding (April and June 2020) quite effectively and efficiently. Of the amounts received, totalling PGK24,800,967, 96.6 per cent of this funding was fully expended by 31 December 2022.

In 2020, the first year of the emergency response, the first allocation of DFAT funding of PGK21,452,845 was processed quickly and efficiently through the HSIP TA parent account for sub-national support. By 31 December 2020, 85.7 per cent of the first receipt of DFAT funds had been provided to PHAs and ARoB (including additional support to NCD PHA).

### Key issues/challenges

The funding received in May 2021 for COVID-19 and Health System Strengthening – an amount of PGK40,738,634 – has not been effectively used during this 19-month period, with 49.6 per cent of this allocation still to be expended as at 31 December 2022.

In April 2020, conflicting advice was issued by the NDoH on the trust account management of COVID-19 funding. A Finance Instruction on the establishment of a separate trust account for the COVID Emergency Response was issued, indicating that a new trust account mechanism would be set up at the national and sub-national levels. However, this did not occur and the HSIP TA mechanism, which was already established and operating within well-known guidelines and processes, was used for the COVID-19 Emergency Response.

The issue of having access to an Authorised Delegate at the PHA level was addressed by processes allowing scanned documents to be sent to and approved by the NDoH HSIP team.

With regard to procurement, a State of Emergency (SOE) was declared from 27 March to 16 June 2020, and emergency measures were put in place to enable Certificate of Inexpediency provisions to be implemented, with changed approval thresholds and streamlined procurement processes. This allowed for the suspension of regular tendering processes until the *National Pandemic Act 2020* (NPA) was passed on 12 June 2020.

Procurement limits that applied during this period were outlined in Finance Instruction 04/2020 of 17 April 2020. The following limits were applied and overrode the PFM Act and *National Procurement Act 2018*:

- The Emergency Controller – PGK10 million
- Provincial Procurements – PGK5 million
- District Development Authority Procurements – PGK2.5 million.

These emergency measures, increasing procurement expenditure limits, require tolerance of a higher level of risk around procurement and expenditure. It is not known whether these GoPNG measures were employed for the DFAT funding through the HSIP TA, or whether DFAT established or maintained a framework that aligned with its risk management strategies throughout the HSIP.

In the absence of the usual tendering processes during the SOE, COIs — a provision under the PFM Act intended to circumvent the tendering process — was used. Additionally, the new NPA provided for the suspension of the PFM Act if a pandemic is declared. Both COIs and the NPA bypass the tender processes that were set up to ensure transparency, and aggregate power to fewer individuals.<sup>48</sup>

### Summary comments

Conclusions from the HDMES Rapid Review (finalised 18 October 2021) provide a useful insight into the initial emergency response funding, excluding the subsequent Health System Strengthening Funds. The rapid review found that:

*'The HSIP TA offered a mechanism to provide fast and relevant support for PHAs in their responses to COVID-19. As an established and familiar mechanism, it provided a quick provision of COVID-19 emergency funding and a sense of reassurance and protection that was important as the pandemic approached.'*<sup>49</sup>

Further findings of the rapid review in relation to the HSIP TA mechanism were:

- The review found considerable variance in the amount of expenditure undertaken between PHAs (evident in the above table).
- An interesting mix was apparent in the procurement choices, demonstrating the different contexts and needs of PHAs and the value of flexibility within the funding model.
- Australia's financial advisers seem to have accommodated higher volumes of PHA transactions. This was positive in its facilitation of expenditure in some provinces, while some PHAs were still struggling with the requirements of the funding process.
- The impact of the HSIP TA was disappointing in five of the 22 PHAs, where less than 50 per cent of their allocation was spent since June 2020. Reasons for this low uptake should be clarified.

Despite the HSIP TA modality being established and familiar, compliance still requires strengthening. Accountability in funds management remains an issue across the board.

<sup>48</sup> See [https://dpa.bellschool.anu.edu.au/experts-publications/publications/7658/ib-202021-circumventing-tender-process-why-png-should-be-cautious-with-the-administration-of-coronavirus-\(covid-19\)-funds](https://dpa.bellschool.anu.edu.au/experts-publications/publications/7658/ib-202021-circumventing-tender-process-why-png-should-be-cautious-with-the-administration-of-coronavirus-(covid-19)-funds).

<sup>49</sup> See HDMES. (2021). *COVID-19 in Papua New Guinea and Australia's response: A rapid review. Final Report.*

## Annex 8.5: COVID-19 vaccine roll-out support through the HSIP TA

### Funding for the COVID-19 vaccine roll-out

#### Timeframe

COVID-19 vaccine deployment commenced in Papua New Guinea in late March 2021 on a limited geographical scale, and expanded nationwide in May 2021, using the AstraZeneca vaccine.<sup>50</sup>

DFAT funding for the COVID-19 vaccine roll-out was first made available on 23 April 2021, through a deposit to the HSIP parent account. This was authorised by Amendment 4 to the DFA. Further amendments approved by DFAT on 9 June 2022 (Amendment 6) increased the funds available for the vaccine roll-out and revised the end date to 30 October 2023, the end of this current Direct Funding Agreement cycle.

#### Program objectives/outcomes

DFAT funding for the vaccine roll-out was to support PNG's preparations for a COVID-19 vaccination campaign and to assist with the procurement and delivery of vaccine doses. The first disbursements from the HSIP TA to the PHAs and ARoB aimed to support preparation for the vaccine roll-out and the delivery costs associated with vaccinating the initial target group, as identified in the *PNG National Deployment and Vaccination Plan for COVID-19 Vaccine*. The initial target group was health workers and other essential workers, estimated at three per cent of PNG's population.

Additional vaccine roll-out funding was provided on 29 September 2021, with the third allocation of DFAT vaccine roll-out support deposited to the HSIP TA on 11 July 2022. This final allocation was for Vaccine Micro-Plans in 2022. The micro-plans developed with this funding were to supersede previous micro-plans developed in 2021 by the PHAs and ARoB. All remaining expenditure and allocated funds following the development of the 2022 micro-plans were to be in line with the PHAs' 2022 micro-plan budgets.

#### Approach

DFAT's funding for the COVID-19 vaccination support was to follow the requirements of the HSIP TA Manual of Procedures, the Toolkit for PHAs (for DFAT COVID-19 funds), and Emergency Orders and Financial Instructions issued as part of the COVID-19 response.<sup>51</sup>

Funding to the NDoH was provided to align with the standard categories in the template for PHA immunisation micro-plan budgets, and the HSIP team can break down budgets according to these categories for each province. The categories were:

- Capacity building for vaccine management and quality control in the NDoH
- Generator maintenance, including fuel for the national store
- Vaccine and cold chain handling at the storage site
- Community engagement and advocacy
- Supervision.

Following approval of the first disbursement of DFAT funds for COVID-19 vaccination support to provinces on 16 April 2021, DFAT advised provinces by emailed letters of the expenditure areas that were covered by the funding, including:

- Provincial generator maintenance

<sup>50</sup> See UNICEF. (2021). *UNICEF Country Office Annual Report 2020: Papua New Guinea*.

<sup>51</sup> See UNICEF. (2021). *UNICEF Country Office Annual Report 2020: Papua New Guinea*.

- Provincial preventive and corrective maintenance for cold chain equipment for Q1 and Q2
- Vaccine and cold chain handling at storage site
- Domestic shipping of vaccines and relevant supplies from province to district
- Community engagement and advocacy – advocacy meetings and community leaders’ training
- Orientations and capacity building – trainers’ fee and logistics for training sessions of health functionaries involved in vaccination and social mobilisation
- Operational costs
- Training costs
- Surveillance costs
- Waste management costs.

## Provinces funded

This funding was provided to all 21 provinces in PNG and ARoB.

## Total funds allocated and expenditure to date

| HSIP TA Parent Account                         | Date received – Parent Account | Approved DFAT funding allocation (PGK) | Expenditure and commitments, PHA allocations (PGK) | Balance 31 Dec 2022 (PGK) |
|--|--------------------------------|--|--|---------------------------|
| COVID-19 Vaccine Roll-out                      | 23/4/2021                      | 13,922,587                             | 4,988,361  | 8,934,226                 |
| COVID-19 Additional Vaccine Roll-out Funds     | 29/9/2021                      | 19,577,841                             | 15,632,254   | 3,945,587                 |
| Support to Vaccine Micro-Plan 2022 (Taskforce) | 11/7/2022                      | 18,567,555                             | 8,853,545  | 9,714,010                 |
| <b>TOTAL</b>                                   | –                              | <b>52,067,983</b>                      | <b>29,474,160</b>                                  | <b>22,593,823</b>         |
| <b>% of available funds</b>                    | –                              | –                                      | <b>56.6%</b>                                       | <b>43.4%</b>              |

Note: The balance of funds remaining from 23/4/21 receipts PGK8,934,227, comprises the following:

- COVID-19 Vaccination to 21 PHAs and NDoH: PGK6,916,720
- COVID-19 Vaccination to NCD PHA: PGK54,388
- COVID-19 Vaccination to NCD PHA RCCE: PGK742,159
- COVID-19 Vaccination to NDoH Activities: PGK5,653
- COVID-19 Vaccination to Short-Term Contractors (STCs) and Vehicle Hire: PGK158,407
- COVID-19 STC, International Vaccine Cards: PGK19,994
- COVID-19 Vaccine Roll-out, Motu Koita: PGK1,036,906.

An amount of PGK9,714,010 for Vaccine Micro-Plans in 2022 remained in the HSIP TA parent account at 31 December 2022. Of the PGK8,853,545 transferred to PHAs, only PGK28,702 was spent (East Sepik PHA). Due to protracted delays in GoPNG internal approvals of provincial micro-plans outside of HSIP control, this funding was transferred to the PHAs on 26 September 2022, leaving little time for PHAs to initiate the planning and budgeting to use these funds before 31 December 2022. The Vaccine Micro-Plan 2022 funding rules required PHAs to spend at least 80 per cent of the funds that had been transferred to them before requesting additional funding.

## Key activities

There is limited information on the activities that have been conducted. The NDoH HSIP TA 2022 Expenditure Report states that PHAs have flexibility in how to spend the available funding. Expenditure areas are outlined above. They have the option of integrating COVID-19 vaccine delivery and communications activities into routine immunisation and other primary health care services.

The following information has been extracted from the NDoH HSIP TA Expenditure Reports for 2021 and 2022. Each table appears to show activity for one year only (i.e. is not cumulative).

| Expenditure 2021                     | Allocated (PGK)  | Expenditure to 31 Dec 2021 (PGK)              | Balance 31 Dec 2021 (PGK)                                    |
|--------------------------------------|--|---|--|
| Transfer to 21 PHAs                  | <b>17,673,661</b>  | <b>4,646,080</b>                              | <b>13,027,581</b>  |
| NCD PHA                              | 6,055,050  | 1,166,131                                     | 4,888,919  |
| NDoH Programs                        | 605,000  | 587,555                                       | 17,445   |
| EPI Program STCs and Hire Vehicles   | 254,988  | 79,200  | 175,788  |
| Motu Koita Assembly                  | 1,807,625  | 602,542                                       | 1,205,083  |
| International Vaccine Cards STC NDoH | 66,010   | 13,244  | 52,766   |
| <b>TOTAL 2021</b>                    | <b>26,462,334</b><br>(Unallocated from 31 Dec 2021 funds PGK7,083,095) | <b>7,094,752</b><br>(27% of allocation spent) | <b>19,367,582</b><br>(73% of allocation remains 31 Dec 2021) |

In 2021, transfers to PHAs for the vaccine roll-out totalled PGK17,673,661. This has been confirmed with reference to the HSIP Direct Payments 2021 spreadsheet maintained by the NDoH. Following expenditure through 2021 by PHAs, an amount of PGK13,027,581 remained in PHA accounts for vaccine roll-out activities. Only 26 per cent of this allocation was spent by provinces in 2021. Overall in 2021, expenditure from allocated HSIP TA funds (parent account) and from PHA transfers was only 27 per cent. Note that expenditure for the NCD occurred through the parent account, as NCD did not have an HSIP TA established at that time. Other allocations were made from the parent account for national functions, as per the table.

The NDoH HSIP TA Expenditure Report for 2021 cites vaccine hesitancy, the security of vaccinators, and some PHAs using funds from other sources, as reasons for the slow expenditure rate on vaccination in 2021 within the provinces. Performance varied across provinces and that was influenced by these externalities.

| Expenditure 2022                     | Allocated (PGK)   | Expenditure to 31 Dec 2022 (PGK)              | Balance 31 Dec 2022 (PGK)                                    |
|--------------------------------------|---|---|--|
| Transfer to 21 PHAs – 26 Sep 2022    | <b>8,853,545</b>  | <b>28,702</b>                                 | <b>8,824,843</b>   |
| NCD PHA RCCE                         | 1,051,894   | 309,735                                       | 742,159  |
| NDoH Programs                        | 605,000   | 599,347                                       | 5,653  |
| EPI Program STCs and Hire Vehicles   | 254,988   | 96,581  | 158,407  |
| Motu Koita Assembly                  | 1,807,625   | 770,719                                       | 1,036,906  |
| International Vaccine Cards STC NDoH | 187,385   | 167,391                                       | 19,994   |
| <b>TOTAL 2022</b>                    | <b>12,760,437</b><br>(Unallocated from 2022 funds PGK7,586,952) | <b>1,972,475</b><br>(15% of allocation spent) | <b>10,787,962</b><br>(85% of allocation remains 31 Dec 2022) |



On 11 July 2022, further vaccine roll-out funds totalling PGK18,567,555 were deposited to the HSIP parent account to support COVID-19 Vaccine Roll-out Micro-Plans. These funds were not allocated to PHAs until 26 September 2022. Transfers to PHAs in 2022 totalled PGK8,853,545, of which only PGK28,702 was spent, leaving a balance from the 2022 allocation of PGK8,824,843 in PHA accounts.

### **Key outputs/achievements**

DFAT support to the vaccine roll-out through the HSIP TA mechanism has been coordinated with the NDoH and the National COVID-19 Vaccine Taskforce, with approved funding based on a target of 25 per cent coverage. The 2022 target for *'at least one dose and fully vaccinated'* in the table above was not met, with only seven per cent and five per cent respectively achieved across PNG against the target number of vaccines for the year.

Funding through the HSIP TA enabled PHAs to have direct control and access to funding to support the COVID 19 roll-out. All of the PHAs were able to access this funding and COVID-19 preparedness funding because the existing HSIP TA mechanism enabled the flow of funds to the PHA level in a timely manner and enabled better reporting of funds used.

### **Key issues/challenges**

During the COVID-19 vaccine roll-out in PNG, misinformation and anti-vaccine propaganda led to perception of high risk, vaccine hesitancy, and conspiracy theories among the general population. There continued to be high levels of vaccine apathy and hesitancy fuelled by misinformation and fear of the vaccine. Numerous incidents of hostility against vaccination teams were reported in several provinces, which led to scaled down or discontinuation of the mobile vaccination activities in some provinces. Health workers play a very important role in providing information on the safety and efficacy of vaccination and in assisting people to make informed choices, yet vaccination hesitancy among this group remained high.<sup>52</sup>

The misinformation about the COVID-19 vaccine has translated in some people's attitude to other vaccines, including those intended for children. It was reported that people were avoiding immunisations for other diseases like tetanus and measles because of the hesitancy and concerns around the COVID-19 vaccine.<sup>53</sup>

Due to protracted delays in GoPNG internal approvals of provincial micro-plans, the DFAT funding support for Vaccine Micro-Plans in 2022 was not transferred to PHAs until 26 September 2022, leaving little time for the provinces to use these funds by 31 December 2022. While it was not feasible to align the provision of emergency support with the planning and budget cycle, this factor would have challenged the PHAs to use the vaccine funding in a timely way, particularly the micro-plans 2022 funding.

In 2022, it was also the year of elections in PNG and this potentially disrupted efforts towards increasing vaccination awareness and uptake across the country.

Many donors were involved in providing support to PNG throughout the COVID-19 pandemic, with WHO, UNICEF, and MFAT also providing funding through the HSIP TA.

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<sup>52</sup> See UNICEF. (2021). *UNICEF Country Office Annual Report 2020: Papua New Guinea*.

<sup>53</sup> See HDMES. (2021). *COVID-19 in Papua New Guinea and Australia's response: A rapid review. Final Report*.

## Annex 8.6: Support to the NCD TB Program through the HSIP TA

### Background

NCD is home to only five per cent of the country's population, but contributes to one in five of all TB cases nationally. NCD is the most important and visible 'TB hotspot', with TB case detection rates that are more than three times higher than the national average (1,215/100,000 population compared to the national average of 351/100,000 population in 2016).

NCD is also a key transmission 'hot spot' that could act as an epidemic amplifier. It is therefore a priority area for focused and enhanced TB control efforts. A weak TB response in NCD has the potential to accelerate the transmission of TB, due to the region's role as the central transport hub of PNG, with TB patients potentially travelling to other provinces and internationally.

In 2016, a five-year TB Strategy was launched by the NCD Health Service, outlining a costed plan to scale up services and sustainably manage the disease. The NCD TB Strategic Plan 2016–2020 has the goal of *'reducing the impact of TB in terms of infections, suffering, deaths and discrimination'*.

To support implementation of the strategy, Australia is providing grants to three NGOs to establish and support basic management units (i.e. clinics with specialist TB services), and to conduct community outreach and patient identification activities. Direct funding through the HSIP TA parent account commenced in 2021 for payments to contracted short-term TB program staff.

In 2019, a review of DFAT's contribution to the prevention and control of TB in PNG was carried out.

The use of the HSIP TA mechanism in 2021–2022 to pay short-term salaries of staff engaged in the NCD's TB program was not part of this review. DFAT's TB investment in PNG over this review period largely involved the funding of not-for-profit technical partners to support GoPNG implementation, rather than the engagement of managing contractors or the provision of direct funding support through GoPNG mechanisms.

### Timeframe

By an Exchange of Letters commencing on 10 June 2021, DFAT and the NDoH effected the fifth amendment to the HSIP Direct Funding Agreement 68768. The timeframe was from 1 May 2021 to 30 June 2022, the end date of this amendment. The DFAT approval letter of 17 May 2021 advised that the support of PGK1.8 million (AUD 661,000) was for an 18-month period to 30 October 2022, as a one-off arrangement.

### Program objectives/outcomes

The NCD TB Program has yielded positive results, with an increase in the treatment success rate from 50 per cent in 2016 to 85 per cent in 2020. However, these good results could be eroded by a gap in services if the contracted short-term TB program staff were not able to be funded. These staff were funded through the Emergency Response for TB (ERT) funds for a period of 12 months, expiring at the end of April 2021. ERT funds were fully exhausted and this DFAT funding through the HSIP TA filled the funding gap to ensure continuity of services and continued increases in the treatment success rate.

### Approach

Funding was provided to NCD PHA to support 27 short-term contracts for salaries of staff engaged in the TB Basic Management Units (BMUs) to cover the shortfall within the Emergency Response TB Program in NCD. Approved funds were provided through the HSIP TA to ensure continuation of services under NCD's TB program.

This was a one-off arrangement. It was expected that NCD PHA would prioritise its restructure and enable the absorption of these positions into the PHA structure.<sup>54</sup> The NCD PHA did not have an HSIP TA established to receive this funding. As a result, the funding was paid from the HSIP TA parent account directly to the PHA, once claims were submitted from the NCD PHA Finance Team to the NDoH HSIP TA team. Cheques were then drawn through the usual GoPNG processes for payment of staff by NCD PHA.

### **Provinces funded**

The funding was provided to the NCD TB Program, managed by the NCD PHA. However, since the NCD PHA did not have an operating subsidiary account, this payment was made on a monthly basis from the parent account where the funds were being held, based on claims submitted by the NCD PHA.

### **Total funds allocated and expenditure to date**

Funds allocated under the NCD TB Program totalled AUD661,000 (PGK1,740,298). Funds were fully expended on short-term staff salaries by 30 October 2022.

In 2023, no long-term solution for this was arranged and DFAT has allocated an additional support of PGK900,000 to be provided in 2023. This will be for 23 Short-Term Contractors, three Health Extension Officers, five Nursing Officers, eight Community Health Workers, three Medical Lab Technicians, one driver, one accounts clerk, and one project officer. This additional support does not come under Amendment 5, as the amendment was supposed to be for a one-off payment, but will go through the HSIP TA mechanism and the same processes will be followed.

### **Key activities**

The funding was used to pay the salaries of 27 short-term contracted staff supporting the Emergency TB program in NCD. These staff range from medical officers, to other support staff who work in some capacity around the 40 BMUs in NCD.

### **Key outputs/achievements**

The NCD TB Program aims to reduce the impact of TB in terms of infections, suffering, deaths and discrimination. NCD Health's vision is that all people with TB are provided the care they need. To achieve this will require a long-term and coordinated effort between government, NGO, donor, private sector and community partners.

The funding through the HSIP TA has enabled continuation of program activities carried out by 27 short-term program staff over a period of 18 months. However, it is only a minor component of funding provided by a range of donors (including DFAT) through other mechanisms.

To the extent that the contracted staff were able to continue to carry out TB program activities, it is likely that this funding would have contributed to program outcomes. However, there is no evidence to this effect and the overall improvements in TB treatment programs are likely to be attributed to the combined efforts of all partners, providing support through other funding mechanisms.

### **Key issues/challenges**

- NCD PHA did not have a HSIP TA at the time of funding. This gap increased the time that it took for claims to be processed, as they had to be prepared and approved within NCD PHA and then

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<sup>54</sup> Letter dated 17 May 2021, from Dr Lara Andrews, Australian High Commission, Port Moresby, to Mr Ken Wai, Acting CEO, NCD PHA.

submitted to NDoH for clearance and payment. The contract staff paid under this arrangement were paid monthly, which is not aligned with the fortnightly pay cycle of the public sector.

- Since the NCD PHA does not have a subsidiary HSIP TA, decisions were made at the NDoH level with little or no visibility at the program level within the PHA. Communication was between DFAT and NDoH and sometimes there was a delay in the information at NDoH reaching the PHA on funding availability.
- In terms of sustainability, NCD PHA plans to absorb these contract staff positions into the structure once it is approved. However, approval of the structure may not result in the required additional funding from GoPNG, as the filling and funding of positions across PHAs has been an ongoing issue impacting on capacity. This could jeopardise program outcomes in the future.

### **Summary and way forward**

This contribution is a small portion of the overall Emergency TB Support to NCD that is being financed by the World Bank and DFAT and implemented through NDoH, the PHA, and implementing partners (World Vision, Save the Children, and Médecins Sans Frontières). All of the funding for this project is provided outside the government system and through the implementing partners. Coordination is provided by the TB Program in NDoH and technical coordination from the NCD PHA.

While there are challenges in accessing and using this portion of funds for this activity, there is evidence to show that there is potential for more funding to this investment to go through the HSIP TA and to be managed by the PHA.

## Annex 8.7: Immunisation support and AIHSS and the HSIP TA

### Accelerated Immunisation and Health Systems Strengthening program

Immunisation rates in Papua New Guinea (PNG) are below national and international targets. There was a drastic deterioration in routine immunisation coverage in PNG, from 60 per cent to 37 per cent, between 2013 and 2017.<sup>55</sup> To support efforts to improve routine childhood immunisation rates in the first year of life, the Governments of PNG, Australia, and New Zealand, as well as Gavi, formed a partnership to deliver AIHSS. This was a three-year (2019–2022) PGK51 million initiative. The program was initially delivered under the PNG Partnership Fund, then transitioned to management under PATH in November 2020.

AIHSS was implemented in 11 selected provinces by the PHAs and BDoH, with support from NGO immunisation support providers (ISPs). The AIHSS program was designed to promote increased coverage in the 12 provinces in PNG where immunisation rates were lowest.

The AIHSS receives technical support from WHO and UNICEF. In addition, Gavi and UNICEF provide support to purchase, procure and distribute vaccines and cold chain equipment. This unique partnership therefore brings together funding from three donors and technical advice from two UN agencies into one program to support and ensure a harmonised and strengthened approach to immunisation.

For this HSIP TA Evaluation, Western Highlands and Eastern Highlands Provinces were selected to receive funding through the HSIP TA mechanism. DFAT funding was used in Western Highlands, while Gavi funding was used in the EHP PHA. The only PHA that falls into the eight focus provinces selected for this evaluation and was a direct recipient of program funds through the HSIP TA mechanism was Western Highlands.

### Timeframe

The AIHSS program was a three-year program planned for the period 2019 to December 2022. An extension was granted to June 2023 due to delays in implementation, mostly due to PHA readiness and the impact of COVID-19. The program commenced in July 2019. In the focus province of Western Highlands, the AIHSS program did not commence until the first quarter of 2021.

### Program objectives/outcomes

The End of Investment Outcome for AIHSS is increased vaccination coverage of the direct beneficiary population in target provinces, with a target of at least 80 per cent immunisation coverage in each province.

To achieve this, the AIHSS program seeks to support PHAs to lead efforts and increase immunisation coverage and health system capacity. Where possible, the AIHSS supports implementation through national and provincial health systems, including financial management systems. This includes the provision of additional support to PHAs to strengthen financial systems to ensure adequate financial management standards are in place. AIHSS's work covers the following Health Systems Output areas:

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<sup>55</sup> NDoH, Population and Family Health Services. (2022, 27 September). *Analysis on zero-dose children and missed communities in Papua New Guinea: Summary findings* [Presentation].

1. Improved governance, planning, financial management, and supervision.
2. Improved cold chain and vaccine management and procedures.<sup>56</sup>
3. Effective monitoring and reporting mechanisms to health information systems.
4. Effective outreach service within the target province.

## Approach

At the provincial level, AIHSS is delivered through two different management models:

1. A PHA-led model in which funding is provided directly to the PHA, and immunisation service delivery is managed by the PHA (Western Highlands Province, Eastern Highlands Province).
2. An ISP/PHA-led model in which funding is provided through the ISP (or a modality outside of the HSIP TA), and immunisation service delivery is jointly managed by the PHA in partnership with NGO ISPs (Gulf, West Sepik, East Sepik, Jiwaka, Western, Central, Southern Highlands, Morobe, and Madang Provinces, and ARoB). Within the ISP/PHA-led model, some provinces (Southern Highlands, Morobe, and Madang) are transitioning towards the PHA-led model, based on evidence of strengthened PHA financial management. Under this model, involving 10 out of 12 recipients, funds are not managed by the PHA through the HSIP TA and PHA processes and systems, but are received and managed by the ISP. The delivery of immunisation services under the program is carried out by PHA staff.

## Provinces funded

The AIHSS program was carried out in 11 provinces (Gulf, West Sepik, East Sepik, Jiwaka, Western, Central, Southern Highlands, Morobe, and Madang Provinces) and ARoB. A total of PGK51 million was initially budgeted for the program.

In Western Highlands and Eastern Highlands Provinces, the PHAs were not partnered with an ISP and received funds to implement the program from the HSIP TA parent account to the PHA HSIP TA. In the remaining nine provinces and ARoB, the program was implemented by PHAs in partnership with ISPs, with funding received and managed by the contracted ISP through non-PHA mechanisms.

The extent to which ISPs and PHAs have worked effectively together, shared information, and participated in capacity building activities, has varied across PHAs.

## Total funds allocated and expenditure to date

| Province  | Budget    | Tranches  | Expenditure |
|---|-----------|-----------|-------------|
| Morobe – World Vision                               | 6,190,423 | 6,190,423 | 5,800,014   |
| Madang – World Vision                               | 4,090,724 | 4,090,724 | 3,641,016   |
| Western Province – World Vision                     | 5,477,824 | 5,477,824 | 5,511,626   |
| West Sepik Province – World Vision                  | 4,350,972 | 3,000,000 | 3,853,742   |
| Gulf Province – Oil Search Foundation               | 3,380,405 | 3,380,405 | 2,497,441   |
| Jiwaka – Save the Children                          | 4,406,070 | 3,800,000 | 3,607,696   |
| East Sepik Province – Save the Children             | 5,048,802 | 4,600,000 | 3,865,701   |
| Southern Highlands – Oil Search Foundation          | 3,895,062 | 3,339,728 | 2,733,650   |
| Central Province – Clinton Health Access Initiative | 4,944,822 | 4,200,000 | 3,736,737   |
| Eastern Highlands PHA                               | 2,783,323 | 2,415,783 | 1,755,914   |

<sup>56</sup> Cold chain equipment and vaccine supplies are not funded through AIHSS. However, AIHSS seeks to strengthen systems and processes related to cold chain and vaccine management; e.g. processes to ensure cold chain equipment functioning.

| Province                                     | Budget            | Tranches                          | Expenditure                       |
|--|-------------------|-----------------------------------|-----------------------------------|
| Western Highlands PHA                        | 3,700,000         | 2,081,000                         | 1,413,895                         |
| ARoB – Bougainville Catholic Health Services | 3,980,000         | 2,880,000                         | 1,386,422                         |
| <b>TOTAL</b>                                 | <b>52,248,427</b> | <b>45,455,887</b><br><b>(87%)</b> | <b>39,803,854</b><br><b>(76%)</b> |

Funding is provided in tranches to the PHAs and ISPs, with the first tranche being paid within 30 days of execution of the Grant Agreement. Subsequent tranches are paid to ISPs and PHAs when expenditure and acquittal milestones are met, requiring 75 per cent of previously received funds to be expended, fully acquitted, and the uncommitted fund balance reported.

Up to November 2022, AIHSS provinces and ARoB have received, on average, 87 per cent of the tranches of available funding. The PHA-led provinces of Western Highlands and Eastern Highlands have received 56 per cent and 87 per cent respectively of available funding. While the late start date of Western Highlands PHA in the AIHSS program of Quarter 1, 2021 may explain the relatively low percentage of available funds received, Eastern Highlands, also a PHA-led province, commenced just one quarter earlier in Quarter 4, 2020 and had received 87 per cent of available funding.

Payment of subsequent tranches depends on expenditure and acquittal milestones, and Western Highlands PHA appears to have taken longer to meet these milestones and receive further tranche payments, indicating capacity limitations within the PHA.

The rate of expenditure to funds received averaged 76 per cent for all AIHSS provinces and ARoB. The PHA-led provinces of Western Highlands and Eastern Highlands have spent 70 per cent and 73 per cent respectively, slightly lower than the average rate of expenditure to funds received. The rate of expenditure to funds received is likely to be dependent on the capacity of the PHAs to spend on service delivery, including logistical issues and staff capacity from the PHAs to health facilities at district level, as well as to effectively meet the administrative and financial management requirements of the AIHSS program.

Western Highlands PHA's significantly lower receipt of available funding is likely to be due to acquittal issues – either delays in providing acquittals to the NDoH or delays in the NDoH processing acquittals once received. Once funding is received, Western Highlands PHA's expenditure rate is only marginally below other provinces.

### Key activities

The AIHSS program was designed to strengthen and support the implementation of routine childhood immunisation through improved governance, planning, operations, financial management and routine immunisation service delivery, with a focus on hard-to-reach communities. The program provided a package of routine vaccinations to children aged less than one year. AIHSS focused on the following key activities:

- Support for operational costs and planning for outreach and clinic-based immunisation activities.
- Capacity building to lead quality multi-stakeholder immunisation program.
- Financial management training and systems strengthening.
- Additional activities identified by provincial health leaders to meet local health system needs.

The scaling up of vaccine delivery through fixed facilities, mobile outreach, and overnight patrols, combined with improving community engagement, are key activities for the achievement of health outcomes under the program.

## Key outputs/achievements

Western Highlands Province was one of the two provinces assessed as having adequate financial management systems and processes in place within the PHA to manage the AIHSS funding provided directly, without the support of an ISP. Western Highlands PHA also received additional capacity building support through the PATH program.

The following table compares key antigens given for the pre-program period (2018–2019) to the program period (2020–2021) for AIHSS and non-AIHSS provinces.

### Percentage change in number of vaccinations provided before the AIHSS program start and during the program period in AIHSS and non-AIHSS provinces<sup>57</sup>

#### Penta1

| Province  | 2018–2019 | 2020–2021 | % Change |
|-----------|-----------|-----------|----------|
| AIHSS     | 182,395   | 215,823   | 18%      |
| Non-AIHSS | 134,869   | 125,741   | -7%      |

#### Penta3

| Province  | 2018–2019 | 2020–2021 | % Change |
|-----------|-----------|-----------|----------|
| AIHSS     | 118,203   | 146,366   | 24%      |
| Non-AIHSS | 112,499   | 105,118   | -7%      |

#### MR1

| Province  | 2018–2019 | 2020–2021 | % Change |
|-----------|-----------|-----------|----------|
| AIHSS     | 98,314    | 145,875   | 48%      |
| Non-AIHSS | 89,438    | 84,706    | -5%      |

Overall, the AIHSS program provinces showed increases in vaccinations during the program period, where non-AIHSS program provinces experienced a decline.

An examination of the number of children immunised for Pentavalent 1 (Penta1), Pentavalent 3 (Penta3), and Measles 1 (MR1) antigens in 2020–2021 in AIHSS provinces, compared to the 2018–2019 baselines for those provinces, shows that:

- East Sepik, Jiwaka, and Gulf<sup>58</sup> Provinces (ISP-led provinces) achieved the largest percentage increases of children immunised with these three antigens during the AIHSS program period.
- Western Highlands Province (PHA-led, using the HSIP TA) and Southern Highlands Province were among the three provinces that achieved the lowest increases in number of children immunised with Penta1, Penta3, and MR1.<sup>59</sup>

Stronger PHA PFM capacity<sup>60</sup> has not necessarily equated to the achievement of improved immunisation coverage in AIHSS provinces. Western Highlands PHA was assessed as having stronger

<sup>57</sup> Draft AIHSS Evaluation Report (submitted to DFAT 22 December 2022).

<sup>58</sup> It is important to note that Gulf Province was starting from a very low baseline and therefore a small increase in numbers of children immunised could represent a relatively large percentage increase.

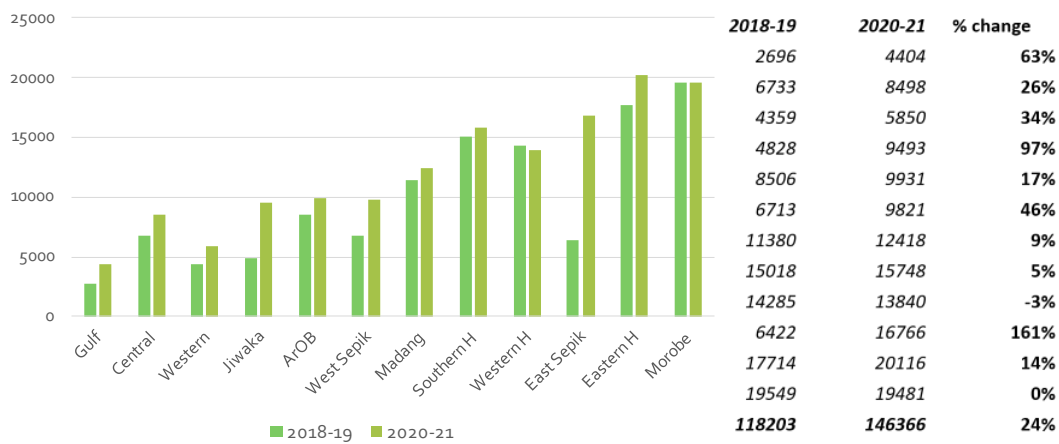
<sup>59</sup> Draft AIHSS Evaluation Report (submitted to DFAT 22 December 2022).

<sup>60</sup> Based on the EY and Deloitte PFM assessments and ISP-reported organisational capacity. For example, Oil Search Foundation, the AIHSS grantee in both Gulf and Southern Highlands Provinces, described the latter as highly organised, while Gulf PHA was at the 'other end of the spectrum'. Western Highlands is also ranked as a high-performing PHA.



PFM capacity and was contracted directly to deliver the AIHSS program, using the PHA HSIP TA, on this basis.

### Number of Pentavalent 3 doses given to children < 1 year AIHSS provinces pre-program (2018/19) and program (2020/21) periods



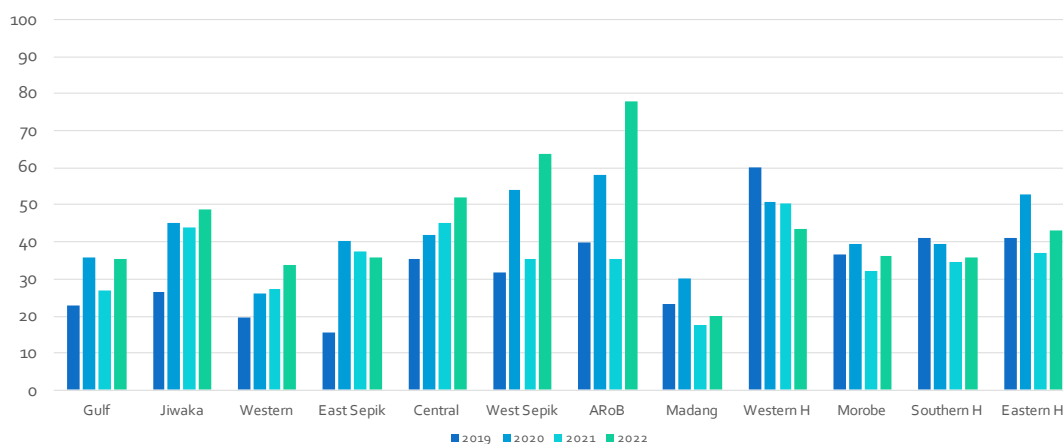
Source: AIHSS Aide Memoire, 9 March 2023.

A comparison of Pentavalent 3 in AIHSS provinces pre-program (2018–2019) and during the program (2020–2021) shows a negative change of minus three per cent for Western Highlands and a 14 per cent increase for Eastern Highlands, the two PHA-led provinces. All ISP-led provinces recorded increases in doses given during the program period, compared to the pre-program period (except for Morobe). A similar decline was also recorded for Western Highlands (minus three per cent) for Pentavalent 1.

A comparison of measles vaccines for children less than one year of age in AIHSS provinces pre-program and during the program saw an overall average increase of 48 per cent across the 12 provinces. The percentage change in Western Highlands was 13 per cent, and in Eastern Highlands 23per cent.<sup>61</sup> Immunisation coverage data shows that most AIHSS provinces are maintaining 2021 activity levels in 2022, but some provinces are greatly exceeding them; e.g. AROB, and West Sepik.

<sup>61</sup> Draft AIHSS Evaluation Report (submitted to DFAT 22 December 2022).

## Progress towards End Of Project outcome: 80 per cent coverage of Pentavalent 3



Source: NHIS data accessed February 2023

3/13/2023

Source: AIHSS Workshop Presentation, 13 March 2023.

### Key issues/challenges

Lead grantees, Western Highlands and Eastern Highlands PHAs, have both demonstrated the financial and organisational capacity to access AIHSS funding directly through the HSIP TA mechanism, but they have struggled with various aspects of AIHSS program implementation.<sup>62</sup> Western Highlands Province did not commence the AIHSS program until Quarter 1, 2021, coinciding with the impacts of COVID-19 on health systems across PNG, with Eastern Highlands Province commencing one quarter earlier. The PHA-led provinces did not have the opportunity to establish the program prior to the disruption of COVID-19. It was thus more difficult to achieve the improvements that were evident in the ISP-led provinces, where AIHSS was commenced prior to the impacts of the pandemic.

The impacts of the COVID pandemic have substantially set back the AIHSS program at multiple levels. COVID-19 impacted on immunisation activity, in particular in 2021 when community concerns over the safety of COVID-19 vaccines were at their height.

Many PHA stakeholders considered that a longer period was needed to bed down the positive impacts achieved by the AIHSS and noted that without ongoing program funding or alternative sources of support, it is likely that the outreach and mobile clinics supported by the program would either cease or be significantly scaled down.<sup>63</sup>

The management of AIHSS project funds by Western Highlands PHA (and Eastern Highlands PHA) was an additional load for PHAs. HSIP TA mechanisms within PHAs have been impacted by compliance and capacity issues that slow down the accessing of funds and the implementation of program activities. A further issue in ISP-led provinces is that PHAs may not gain access to information on expenditure, progress, or outcomes. In addition, the extent to which ISPs worked collaboratively with PHAs varied across partner organisations. The required capacity building activities and enhancement

<sup>62</sup> Draft AIHSS Evaluation Report (submitted to DFAT 22 December 2022).

<sup>63</sup> Draft AIHSS Evaluation Report (submitted to DFAT 22 December 2022).

that was required within ISP contracts was not clearly monitored or measured, nor was a clear PFM capacity building strategy articulated.

## Summary and recommendations

The AIHSS review concluded that:

*'Lead grantees Western Highlands and Eastern Highlands PHAs have both demonstrated the financial and organisational capacity to access AIHSS funding directly through the HSIP TA mechanism, but they have struggled with various aspects of AIHSS program implementation.'*<sup>64</sup>

Program implementation using the resources of the PHA, already operating with up to 50 per cent vacancy rates in funded positions, was found to be an impediment to achievement of program outcomes. In PHA- and ISP-led provinces, all program implementation is carried out by PHA staff. Western Highlands PHA has been able to expend funds once received at a rate of 70 per cent, compared to the average of 76 per cent for all provinces. Greater efficiencies and improved outcomes could have been achieved with more support for program implementation and management.

The efficiency of the HSIP TA mechanism in delivering funds to PHA-led provinces in a timely way has been hampered by three issues:

1. The ability to spend 75 per cent of program funds to enable access to the next tranche of funding, including gaining the required approvals for expenditure.
2. The capacity of PHAs and service providers to acquit for all program expenditure, particularly where service providers are in remote areas and operate within the informal economy.
3. The capacity of the NDoH HSIP TA team to process all acquittals and approve the release of the next tranche of funding.

The impact of COVID-19 on Western Highlands PHA's ability to commence this program once the impacts of the pandemic were being felt across PNG needs to be considered in assessing the effectiveness and efficiency of the HSIP TA mechanism in providing the funding required to Western Highlands PHA for the AIHSS program.

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<sup>64</sup> Draft AIHSS Evaluation Report (submitted to DFAT 22 December 2022).

## Annex 9: DFA Program Monitoring and Evaluation Framework

**Goal: To improve access to rural health services, particularly in disadvantaged districts, through providing targeted funding and improving the implementation, reporting and governance of the TA at the national and provincial levels.**

### Strategic Objective 1: To increase access for the poor to effective health services

| Indicator   | Data source                | Frequency            | Management   |
|---|----------------------------|----------------------|--|
| Increased% of rural clinics open and functioning.                         | NHIS, NDoH                 | Annual Sector Review | Corporate services staff conduct analysis of the HSIP TA expenditure report to extrude development impact of HSIP TA. Analysis contributes to ASR. |
| Increased % of health facilities with running water to the delivery room. | NHIS, NDoH                 | Annual Sector Review | Corporate services staff conduct analysis of the HSIP TA expenditure report to extrude development impact of HSIP TA. Analysis contributes to ASR. |
| Increased % health centres with functioning radio/telephone.              | NHIS, NDoH<br>Indicator 26 | Annual Sector Review | Corporate services staff conduct analysis of the HSIP TA expenditure report to extrude development impact of HSIP TA. Analysis contributes to ASR. |

### Outcome 1.1. HSIP TA access funding increases access to health services and improved service delivery for rural populations

| Indicator  | Data source                   | Frequency            | Management   |
|--|-------------------------------|----------------------|--|
| Outpatient visits per person per year by province.                                     | NHIS, NDoH<br>Indicator 21    | Annual Sector Review | Corporate services staff analyse increased number of people accessing HSIP TA funded health facilities by district (not facility). |
| Increased number of people accessing health facilities in HSIP TA districts/provinces. | NHIS, NDoH and HSIP TA report | Annual Sector Review | Corporate services staff analyse increased number of people accessing HSIP TA funded health facilities by district (not facility). |

### Outcome 1.2. Health services are improved in the least developed districts

| Indicator  | Data source                                   | Frequency            | Management  |
|--|---|----------------------|---|
| Rehabilitation of facilities and housing in districts (no. and expenditure) and disability activities. | National inventory of health facilities, NDoH | Annual Sector Review | Report to HSFC and DP Summit.   |
| Outpatient visits per person per year by province and in disadvantaged districts by gender.            | NHIS, NDoH and HSIP TA report                 | Annual Sector Review | Corporate services staff analyse increased number of people accessing HSIP TA health facilities in poorer districts and gender-disadvantaged districts. |

| Indicator   | Data source                | Frequency                 | Management   |
|---|----------------------------|---------------------------|--|
| Increased number of people accessing health facilities in disadvantaged districts and provinces (poverty and gender). | NHIS, NDoH and IASR report | Annual Sector Review      | Corporate Services staff analyse increased number of people accessing HSIP TA health facilities in poorer districts and gender-disadvantaged districts.          |
| HSI and GDDI improve in poor districts receiving HSIP TA funds.   | UNDP HDI report            | End of program evaluation | <ul style="list-style-type: none"> <li>End of program evaluation team looks for trends in change in HDI.</li> <li>MTR team consults with communities.</li> </ul> |

### Strategic Objective 2: To increase the absorptive capacity of the health sector to achieve GoPNG commitment to the National Health Plan

| Indicator   | Data source  | Frequency   | Management   |
|---|--|---|--|
| Signed Joint Financing Agreements with the DPs specifying commitment (amount of funds) by May each year (including 10% for program management). | Minutes of governance committees<br>Budget papers for NDoH and provinces                     | May each year<br>Published budget papers show DP funds for health | <ul style="list-style-type: none"> <li>DPs and NDoH attend governance committee meetings.</li> <li>Corporate Services planning staff undertake analysis of AIP documents on uptake of HSIP TA targeted funds.</li> <li>Financial Management Branch reports to Finance Committee annually on analysed expenditure.</li> </ul> |
| HSIP TA options reflected and costed in provincial AIPs.  | Provincial AIP   | Annual  | <ul style="list-style-type: none"> <li>DPs and NDoH attend governance committee meetings.</li> <li>Corporate Services planning staff undertake analysis of AIP documents on uptake of HSIP TA targeted funds.</li> <li>Financial Management Branch reports to Finance Committee annually on analysed expenditure.</li> </ul> |
| Number of health facilities receiving HSIP TA funds through provincial AIPs by province.  | Provincial AIPs, HSIP TA expenditure reports by PGAS (national) and provincial spread sheets | Annual  | <ul style="list-style-type: none"> <li>DPs and NDoH attend governance committee meetings</li> <li>Corporate Services planning staff undertake analysis of AIP documents uptake of HSIP TA targeted funds</li> <li>Financial Management Branch reports to Finance Committee annually on analysed expenditure.</li> </ul>      |
| Annual expenditures by province of HSIP TA funds from April to March differentiated by targeted and non-targeted components.                    | HSIP TA expenditure reports and bank reconciliations   | Annual  | <ul style="list-style-type: none"> <li>DPs and NDoH attend governance committee meetings.</li> <li>Corporate Services planning staff undertake analysis of AIP documents on uptake of HSIP TA targeted funds.</li> <li>Financial Management Branch reports to Finance Committee annually on analysed expenditure.</li> </ul> |

**Outcome 2.1. Increased predictability of donor funding to the sub-national level**

| Indicator  | Data source   | Frequency | Management                            |
|--|---|-----------|---------------------------------------|
| DPs commit to funds amount in May each year.             | Minutes of DP summit  | Annual    | DP commitment presented to DP summit. |
| Biannual National Health Conference funded.              | Proceedings and recommendations of the National Health Conference | Biannual  | –                                     |
| Reduced number of Applications for Change Forms in NDoH. | FMB (need baseline 2011)  | Annual    | Report to DP Summit through HSFC.     |

**Outcome 2.2. Staff at facility level are better trained to plan, budget, acquit, and report**

| Indicator  | Data source                                       | Frequency       | Management   |
|--|---|-----------------|--|
| Number of health facility Officers-in-Charge and District Health Coordinators trained in management by district, province, and gender. | HSIP TA report                                    | Annual          | Simple analysis documents the impact of finance and management training for health facility staff and DHC.   |
| Number of health facilities with activities (options) in AIP.  | AIPs and HSIP TA Expenditure Report               | Annual          | Simple analysis documents the impact of finance and management training for health facility staff and DHC.   |
| Increased operational funds from HFG to facilities as a result of management training.   | Health sub-committee reports from site monitoring | At least annual | Reports to HSFC on expenditure provide data to NEFC to analyse any trends between HSIP TA expended with % HFG unspent. NDoH planners coordinate with Treasury. |

**Outcome 2.3. HSIP TA complements Health Functions Grants and improves the reliability of cash flow**

| Indicator                        | Data source            | Frequency | Management   |
|----------------------------------|------------------------|-----------|--|
| HSIP TA funds spent by province. | HSIP TA review reports | Quarterly | Reports to HSFC on expenditure provide data to NEFC to analyse any trends between HSIP TA expended with % HFG unspent. NDoH planners coordinate with Treasury. |
| % unspent HFG by province.       | PER series             | Annual    | Reports to HSFC on expenditure provide data to NEFC to analyse any trends between HSIP TA expended with % HFG unspent. NDoH planners coordinate with Treasury. |

| Indicator   | Data source  | Frequency                       | Management   |
|---|--|---------------------------------|--|
| Qualitative and quantitative data on health expenditure, including HSIP. TA from t <sup>he</sup> 2nd Quarter review to provinces. | NDoH regional planners attend Treasury Quarterly Reviews to ask questions about HSIP TA expenditure and data reporting, and report | August each year report to HSFC | Reports to HSFC on expenditure provide data to NEFC to analyse any trends between HSIP TA expended with % HFG unspent. NDoH planners coordinate with Treasury. |

### Strategic Objective 3: To improve the performance and governance of the HSIP TA

| Indicator  | Data source   | Frequency | Management  |
|--|---|-----------|---|
| Unqualified audit for HSIP TA.   | AGO-HSPC  | Annual    | Continuous improvement in PFM process.  |
| Number of unqualified audits for subsidiary TAs by province.                           | HSPC committees   | Annual    | Risk assessment of PHAs completed in 2020.  |
| Manual updated and revised to include HSIP TA strategies and better reflect GoPNG PFM. | HSPC/HSFC   | Annual    | Expenditure report and development impact report sent to DPs, DNPM, Department of Treasury, Department of Finance, Department of Provincial and Local-level Government Affairs, NEFC, and Corporate Services. |
| Annual report on impact of HSIP TA.  | <ul style="list-style-type: none"> <li>HSIP TA expenditure report and analysis of development impact</li> <li>Expenditure by province of untargeted elements</li> <li>Expenditure by province of targeted elements</li> <li>Major expenditure of disadvantaged district funds</li> <li>Report from Human Resources on Divine Word University</li> </ul> | Annual    | Collation of data from FMB, Monitoring Division, IASR, and monitoring visits. Consider inclusion in NDoH annual report.   |

| Indicator  | Data source   | Frequency  | Management   |
|--|---|--|--|
|  | management training   |  |  |
| HSIP TA performance included in PER.   | Annual PER, NEFC  | Annual   | Ensure HSIP TA data is transmitted to NEFC Deputy Secretary reports to DP Summit (November). |
| Health sub-committee meets regularly.  | Quarterly   | Quarterly with regular site visits to monitor HSIP TA districts' impacts | Deputy Secretary   |
| NDoH Audit Committee meets regularly.  | Annual Committee minutes  | Monthly  | Secretary  |
| National and provincial stakeholders briefed on updated HSIP TA Manual of Procedures and operational start dates and expectations. | Annual Health Conference Provincial Health Advisers forum (February 2013) | By end 2013  | Secretary<br>Deputy Secretary  |

### Outcome 3.1. Improved management and coordination of HSIP TA

| Indicator   | Data source                             | Frequency         | Management  |
|---|---|-------------------|---|
| Number of provinces with updated Provincial HSIP TA Manual of Procedures.   | Report to HSFC                          | May 2013          | HSIP TA consultant updates and revises manuals to reflect re-designed HSIP TA, including distribution and orientation to health facility level (communications strategy). |
| Secretary's instruction provided to provinces and NDoH outlining HSIP TA priorities prior to budget and planning. | HSPC/HSFC minutes                       | By July each year | HSIP TA consultant updates and revises manuals to reflect re-designed HSIP TA, including distribution and orientation to health facility level (communications strategy). |
| Number of acquittals outstanding (by province) and recommendations for resourcing if required.                    | Finance Committee (Strategic Oversight) | Quarterly         | Secretary   |
| Number of fraud cases notified reduced.   | Finance Committee minutes               | Quarterly         | HSIP TA FMSB (compliance function).   |



| Indicator   | Data source                   | Frequency  | Management                          |
|---|-------------------------------|--|-------------------------------------|
| Number of meetings with Provincial and Local Level Service Monitoring Authority health sub-committee. | Minutes of meeting            | Quarterly  | HSIP TA FMSB (compliance function). |
| Costs of the HSIP TA (running) supported by DPs reflected in AIP.                                     | NDoH AIP                      | Annual and reflected in budget as line item (donor source) | Deputy Secretary                    |
| NDoH targeted HSIP TA activities do not exceed 10% annually.  | Quarterly reviews to Treasury | Copy of quarterly review NDoH provided to HSFC             | Corporate Services Branch           |
| NDoH activities in line with core activities identified.  | –                             | –  | Corporate Services Branch           |
| Development, improved analysis, narrative and printing of the Annual Sector Review supported.         | ASR report                    | Annual   | IASR group                          |

### Outcome 3.2. Better information on expenditure and development impact to GoPNG and development partners

| Indicator  | Data source  | Frequency             | Management                          |
|--|--|-----------------------|-------------------------------------|
| Development impact communicated to DPs.          | HSIP TA Development impact report from regular monitoring visits to provinces sent to Deputy Secretary | Each monitoring visit | Deputy Secretary Corporate Services |
| Increased HSIP TA spending on targeted elements. | HSIP TA expenditure provided to HSFC   | Quarterly             | Corporate Services through FMB      |
| Little change in unspent HFG.                    | PER trends   | Annual                | Monitor PER                         |

**Outcome 3.3. Better compliance with PFM at NDoH and provinces**

| <b>Indicator</b>   | <b>Data source</b>   | <b>Frequency</b> | <b>Management</b>  |
|--|--|------------------|--|
| HSIP TA untargeted element phased out by 2016.                                       | Secretary's instructions   | Annual           | Secretary's instruction to NDoH and provinces.   |
| Audit reports, TA balance and available activity reports, trends in health outcomes. | End of re-design period collates data, incorporates MTR data from NHP evaluation | 2016             | Re-design assesses the appropriateness of provincial budget support in selected provinces. |

## Annex 10: DFAT funding into HSIP TA; quantum and amendments 2012–2022

### Direct Funding Agreement (No. 68768) on the Health Service Improvement Program Trust Account Funding

| Year        | Receipts (PGK) | Closing balance (PGK)   | Cumulative DFAT funding (PGK) | Comments   |
|-------------|----------------|---|-------------------------------|--|
| 31 Oct 2013 | –              | –   | –                             | DFA signed between AusAID on behalf of GoA and NDoH on behalf of GoPNG.  |
| 2014        | 28,010,570     | –   | 28,010,570                    | Three tranches of the funding for the Direct Funding Agreement provided in the three quarters totalling up to PGK28 million.   |
| 2015        | 8,879,744      | –   | 36,890,314                    | Final tranche payment for 2014 paid in 2015.   |
| 2016        | –              | 17,166,461<br>Comprising: <ul style="list-style-type: none"> <li>4,997,144 (committed for two projects – (i) disadvantaged districts; and (ii) provincial building and maintenance)</li> <li>12,169,317 (uncommitted funds).</li> </ul> | –                             | <ul style="list-style-type: none"> <li>DFAT funding remain frozen.</li> <li>Balance remaining when frozen. PGK4.9 million pre-committed to activities; PGK2,529,234 (disadvantaged districts), PGK2,467,910 (building and maintenance).</li> <li>Available for reprogramming – PGK12,169,317.</li> </ul> |

#### Amendment 1

17 October 2017. No cost extension to 31 October 2018. Amendment revised value from **AUD 48,730,000** to **AUD 16,535,628,91**.

| Year | Receipts (PGK)                          | Closing balance (PGK)  | Cumulative DFAT funding (PGK) | Comments   |
|------|---|--|-------------------------------|--|
| 2017 | No additional funds transferred by DFAT | 16,977,605<br>Comprising: <ul style="list-style-type: none"> <li>4,997,144 (pre-committed funds)</li> <li>188,856 (expenditure)</li> <li>11,980,461 (remaining reprogrammed funds).</li> </ul> | –                             | Total DFAT funds remaining from the DFA included the pre-committed funds from 2014, on which there was no movement (PGK4,977,144), and expenditure of PGK188,856 from the PGK12,168,317 that was available for reprogramming. Which brought the total remaining funds by the end of 2017 to PGK16,977,605. |

#### Amendment 2

29 October 2018. Extended to 30 June 2020. Purpose: Utilise balance of AUD 6,913,280.35 in account.

| Year | Receipts (PGK)                          | Closing balance (PGK)   | Cumulative DFAT funding (PGK) | Comments   |
|------|---|---|-------------------------------|--|
| 2018 | No additional funds transferred by DFAT | <b>15,823,570</b><br>Comprising: <ul style="list-style-type: none"> <li>517,001 (expenditure)</li> <li>4,977,144 (pre-committed funds)</li> <li>11,463,460 (reprogrammed funding).</li> </ul>               | –                             | Amendment of Agreement No. 68768 to extend the funding period by a year to October 2018.<br>From the Reprogrammed funds, PGK517,001 used. No movement on the pre-committed funding and the remaining balance to be reprogrammed was PGK11,463,460. |
| 2019 | No additional funds transferred by DFAT | <b>11,685,411</b><br>Comprising: <ul style="list-style-type: none"> <li>4,138,159 (expenditure)</li> <li>5,000,398 (pre-committed funds)</li> <li>6,685,013 (remainder of reprogrammed funding).</li> </ul> | –                             | No new Input of funding in 2019. Expenditure for 2019 was PGK4,138,159 from the reprogrammed funding component, bringing that total down to PGK6,685,013 remaining, while pre-committed funding remaining in account was PGK6,685,013.             |

### Amendment 3

4 April 2020. Extended to June 2022. Value: AUD 23 million. Funding for COVID-19 and AIHSS.

| Year | Receipts (PGK)             | Closing balance (PGK)   | Cumulative DFAT funding (PGK) | Comments   |
|------|----------------------------|---|-------------------------------|--|
| 2020 | New Receipts<br>28,427,615 | <b>14,821,205</b><br>Comprising: <ul style="list-style-type: none"> <li>28,427,615 (new receipts)</li> <li>11,685,411 (reprogrammed funding)</li> <li>20,294,676 (expenditure)</li> <li>4,977,144 (pre-committed funds).</li> </ul> | 40,133,026                    | Exchange of Letters for Amendment 3 of Agreement 68768 dated 14 April 2020 to extend agreement to 30 June 2022. The total amount remaining in the account was PGK11.685 million and that was to be repurposed to go to PHAs immediately for the implementation of the COVID 19 Emergency Response. This amount would be replaced with the additional amount that will be given. Receipts in 2020 included:<br>PGK21,452,845 (29 Apr 2020) for COVID 19 Response, PGK3,468,122 (11 Jun 2020) additional COVID-19 Funds, PGK3,626,646 (11 Jun 2020) AIHSS for WHPPHA.<br>Expenditure for 2020 saw up to PGK14,821,205 was sent to PHA subsidiary accounts for use. |

**Amendment 4**

16 April 2021. No change to end date. Value: **AUD20.15 million** (AUD15 million for COVID 19 preparedness; AUD5.15 million for COVID 19 vaccine roll-out).

**Amendment 5**

7 June 2021. No change to end date. Value: **AUD661,000**.

| Year | Receipts (PGK)  | Closing balance (PGK)  | Cumulative DFAT funding (PGK) | Comments  |
|------|---|--|-------------------------------|---|
| 2021 | 76,941,979<br><br>Break up:<br>13,922,587<br>(23 Apr 2021)<br>40,738, 634<br>(26 May 2021)<br>1,740,298<br>(21 Jun 2021)<br>19,577,841<br>(20 Sep 2021) | <b>48,883,977</b><br><br>Comprising:<br><ul style="list-style-type: none"> <li>• 76,941,979 (total receipts)</li> <li>• x (total expenditure)</li> <li>• 4,977,144 (pre-committed funds).</li> </ul> | 116,092,387                   | Exchange of Letters in April 2021 for an added AUD20,150,000 for the agreed extended period until June 2022. This funding would be for the COVID 19 response and AIHSS.<br><br>COVID 19 Vaccination Funding and the NCD TB PHA support also provided. Two amendments to Minute for 2021, one for COVID and the other for the TB funding.<br><br>A summary of 2021 payments include PGK13,922,587 (COVID 19 vaccine roll-out), PGK40, 738,634 (COVID 19 response and health systems strengthening), PGK1,740,286 (NCD TB Support), PGK19,577,841 (additional COVID-19 vaccine roll-out). |

**Amendment 6**

9 June 2022. Extended to 30 Oct 2023. Value: **AUD7,875,628** for COVID 19 response, COVID 19 vaccination and health system strengthening at national and provincial levels.

| Year | Receipts (PGK) | Closing balance (PGK)  | Cumulative DFAT funding (PGK) | Comments  |
|------|----------------|--|-------------------------------|---|
| 2022 | 18,657,555     | 48,883,977<br><br>Comprising:<br><ul style="list-style-type: none"> <li>• 76,101,950 (2022 appropriation)</li> <li>• 24,084,453 (expenditure)</li> <li>• 3,133,520 (committed funds)</li> <li>• 4,977,144 (pre-committed funds)</li> </ul> | 134,659,941                   | Received on 11 July 2022 for the Vaccine Task Force Micro-Plan. |