



**Health Portfolio Plan
Mid-Term Review
(2022)
Final Report**

**Human Development Monitoring
and Evaluation Services**

December 2022

Health Portfolio Plan Mid-Term Review (2022)

Final Report

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Abbreviations and Acronyms

Term	Definition
ABG	Autonomous Bougainville Government
ADB	Asian Development Bank
AHC	Australian High Commission [Port Moresby]
AIHSS	Accelerated Immunisation Health Systems Strengthening
ANC	Antenatal Care
ART	Antiretroviral Therapy
AUD	Australian Dollar
CNR	Case Notification Rate
CPHL	Central Public Health Laboratory
CSEP	Comprehensive Strategic and Economic Partnership
CSP	Clinical Support Program
CYP	Couple Years of Protection
DAC	Development Assistance Committee
DFAT	Department of Foreign Affairs and Trade [Australia]
DGH	Daru General Hospital
DHERST	Department of Higher Education, Research, Science and Technology
DHS	Demographic and Health Survey
DNPM	Department of National Planning and Monitoring
DoF	Department of Finance
DoT	Department of Treasury
DPM	Department of Personnel Management
DPLGA	Department of Provincial and Local-level Government Affairs
DR-TB/DS-TB	Drug-Resistant Tuberculosis/Drug-Sensitive Tuberculosis
EHP	Eastern Highlands Province
EOIO	End of Investment Outcome
GAVI	Gavi, The Vaccine Alliance
GBV	Gender-Based Violence
GEDSI	Gender Equality, Disability, and Social Inclusion
GoPNG	Government of Papua New Guinea
HDI	Human Development Index
HDMES	Human Development Monitoring and Evaluation Services
HHISP	Health and HIV Implementation Services Provider
HIV	Human Immunodeficiency Virus
HPP	Health Portfolio Plan
HSACC	Health Sector Aid Coordination Committee
HSIP	Health Services Improvement Program
HSS	Health Systems Strengthening
HSSDP	Health Services Sector Development Program
IO	Intermediate Outcome
KII	Key Informant Interview
LTFU	Loss to Follow-Up
M&E	Monitoring and Evaluation

MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
MDR-TB	Multidrug-Resistant Tuberculosis
MMR	Maternal Mortality Rate
MSPNG	Marie Stopes Papua New Guinea
MTR	Mid-Term Review
NCD	National Capital District
NDoH	National Department of Health
NFPTP	National Family Planning Training Program
NGO	Non-Government Organisation
NHP	National Health Plan
OECD	Organisation for Economic Co-operation and Development
OIC	Officer-in-Charge
PAF	Performance Assessment Framework
PATH	Papua New Guinea–Australia Transition to Health
PFM	Public Financial Management
PHA	Provincial Health Authority
PNG	Papua New Guinea
PNGIMR	PNG Institute of Medical Research
PPF	PNG Partnership Fund
PPTCT	Prevention of Parent to Child Transmission
PSF	Partnering for Strong Families
RDT	Rapid Diagnostic Test
RID-TB	Reducing the Impact of Drug-Resistant Tuberculosis in Western Province
RPHSDP	Rural Primary Health Services Delivery Project
SLSS	Saving Lives Spreading Smiles
SPAR	Sector Performance Annual Review
SRH	Sexual and Reproductive Health
SRHIP	Sexual and Reproductive Health Integration Project
STI	Sexually-Transmitted Infection
TB	Tuberculosis
TFR	Total Fertility Rate
TMP	Trilateral Malaria Project
U5MR	Under 5 Mortality Rate
UN	United Nations
USD	United States Dollar
VCCT	Voluntary Confidential Counselling and Testing
VFM	Value for Money
VHV	Village Health Volunteer
WBW	<i>Wok Bung Wantaim</i>
WHO	World Health Organization
WHP	Western Highlands Province

Executive Summary

Introduction

Australia's investment in health in Papua New Guinea (PNG) is broadly guided by the 5-year *Portfolio Plan: PNG Health Sector Program 2018–2023* (known as the Health Portfolio Plan or HPP). The HPP budget was set, in 2018, at AUD62.5 million per year (AUD312.5 million over 5 years).¹ The HPP serves as an umbrella for several separate agreements provided through a combination of modalities, including technical assistance and projects directly managed by contractors, co-funding with multilateral institutions, and a direct funding agreement that exclusively uses government systems.

Background

The *2017 Foreign Policy White Paper* stated that supporting a stable and prosperous PNG was one of Australia's most important foreign policy objectives. The *2017–2023 PNG Health Sector Investment Plan* of the Australian Department of Foreign Affairs and Trade (DFAT) identified 3 core priorities for Australia's assistance to the PNG health sector: (1) health security; (2) scalable interventions to improve the health of women, children, and vulnerable groups; and (3) stronger health governance, management and financing systems. The HPP refined the objectives of the Health Sector Investment Plan, contributed to the achievement of DFAT's Health for Development Strategy, and aligned with the 2021 Papua New Guinea–Australia Comprehensive Strategic and Economic Partnership (CSEP)

The Health Portfolio

The *Portfolio Plan: PNG Health Sector Program 2018–2023* has comprised 17 investments. Their start and end dates are not neatly aligned to the dates of the start and end of the HPP. Some investments are continuing projects that preceded the HPP and have endured through, or ended during, the course of the current HPP. Other programs were redesigned or adopted new management arrangements. The HPP investments contribute to different HPP Intermediate Outcomes (IOs) and End of Investment Outcomes (EOIOs).

COVID-19

The impacts of the COVID-19 pandemic on the implementation of the HPP were profound. They included diverting the time of the Australian High Commission (AHC) Health Team away from management of the HPP and its investments; diverting and consuming the time and resources of the Government of PNG (GoPNG), particularly the National Department of Health (NDoH) and Provincial Health Authorities (PHAs), towards the COVID-19 response; shifting the focus of HPP investments away from HPP priorities towards pivoting programs to account for COVID-19 programming needs, accommodating travel restrictions, staff vaccination requirements and hesitancy, staff absenteeism due to illness, access to facilities and resources, and community attitudes.

The sometimes-critical position of the review around a range of issues needs to be carefully weighed against the unprecedented demands of supporting PNG's response to the global pandemic. Successes over the past few years should be amplified against the backdrop of the pandemic response, while lack of progress in some areas should be mediated against the COVID-19 challenges.

¹ Exclusive of the ANGAU Hospital Redevelopment Project.

Key Review Questions

The 9 Key Review Questions (KRQs) of the review are outlined in the table below.

KRQ	Focus	Question
KRQ1	Relevance	To what extent does the Health Portfolio Plan align with the Government of Australia and the Government of PNG development priorities (including the new National Health Plan)?
KRQ2	Impact	To what extent is the Health Portfolio Plan making progress towards its Goals and Objective?
KRQ3	Effectiveness	To what extent is the Health Portfolio Plan making progress towards the 3 End of Investment Outcomes?
KRQ4	Efficiency	To what extent has Health Portfolio Plan progress towards the End of Investment Outcomes been delivered efficiently?
KRQ5	Model/Coherence	Does the Health Portfolio Plan have the right scope and ambition, and the right mix of partners and modalities to meet the HPP objectives?
KRQ6	Sustainability	To what extent are the positive impacts of DFAT investments likely to be sustained?
KRQ7	Gender Equality, Disability and Social Inclusion (GEDSI)	To what extent is the Health Portfolio Plan making progress towards GEDSI goals and objectives?
KRQ8	Monitoring and Evaluation (M&E)	To what extent are Health Portfolio Plan M&E arrangements fit for purpose?
KRQ9	Governance	To what extent are the Health Portfolio Plan governance arrangements fit for purpose?

Key Themes of the Review

There are 4 common themes that recur throughout the review:

1. A portfolio-level approach to managing health activities was never fully realised, meaning the whole of the portfolio is not greater than the sum of its parts.
2. A tension between the need to underpin basic service delivery, while working in a manner that aligns with and where possible strengthens GoPNG systems, as reflected in the choice of funding modalities, investment partners, and concerns about sustainability.
3. Continued challenges across GoPNG systems (e.g. finance, staffing, and supply chains) undermine progress towards achieving the portfolio's outcomes in support of PNG.
4. Health Portfolio management at the AHC.

Findings of the Review

Relevance

The Objective of the HPP strongly aligns with Government of Australia development priorities, as articulated in the *2017 Foreign Policy White Paper* and *2014 Aid Policy*². Its focus on communicable diseases aligns with Australia's interests, particularly with regard to tuberculosis (TB) in Western Province, given its close proximity to Australia.

² *Australian Aid: Promoting Prosperity, Reducing Poverty, Enhancing Stability*, DFAT, June 2014.

There is strong alignment between the HPP and the Government of PNG development priorities, as articulated in *Papua New Guinea Vision 2050*, the *PNG Development Strategic Plan 2010–2030*, and both the previous (2011–2020) and current (2021–2030) National Health Plans (NHPs).

There are priorities in the current NHP that are not a focus of the HPP, particularly the elevated focus on non-communicable diseases.

Impact

The period prior to COVID-19 saw progress in improved service delivery contributing to the first HPP Goal of improved health and well-being of PNG citizens. Unfortunately, this progress was interrupted, and in some cases reversed, in the context of COVID-19, consistent with global trends.

The HPP is contributing positively to its second Goal of contributing to the overall Australia–PNG bilateral relationship. Opportunities to further strengthen the relationship could be enhanced with improved brand management that leads to a deeper understanding among PNG government stakeholders of the scale of Australia’s support to the health sector.

Progress has been mixed towards the HPP Objective of *improved health of the citizens of Papua New Guinea in selected provinces and districts relating to TB, family planning, sexual and reproductive health, HIV, and maternal and child health*.

- **Tuberculosis:** Portfolio TB investments have made a significant contribution to increasing and maintaining a treatment success rate of over 80% in National Capital District (NCD) and Western Province.
- **Family Planning:** NDoH performance indicators show progress for family planning prior to COVID-19, with Couple Years of Protection (CYP) per 1,000 women increasing by one-third between 2016 and 2020, but then reverting to 2016 levels by 2022.³
- **Sexual and Reproductive Health (SRH), and HIV:** The overall prevalence of HIV is projected to have declined from 7.43% (2016) to 6.45% (2021), and the proportion of people receiving Antiretroviral Therapy (ART) treatment has increased from 23,875 (53%) to 38,376 (65%) between 2016 and 2021. There has been a decline, however, in the proportion of pregnant women tested between 2015 (33%) and 2020 (16%), according to UNAIDS data. The UNAIDS modelling shows the proportion of people living with HIV who know their status has remained steady between 2018 and 2021.
- **Maternal and Child Health:** National data on child and maternal health shows mixed results prior to COVID-19, and decline or stagnation since that time. While data on child and maternal mortality is either incomplete or inconclusive, HPP investments contributed to improvements in immunisation prior to COVID-19, and improvements to the quality of newborn care in investment locations.

Effectiveness

Health Security and Major Communicable Diseases

HPP investments were effective as vertically-aligned programs, achieving and maintaining a high TB treatment success rate in 2 provinces, and improved coverage of immunisations in the majority of AIHSS target provinces.⁴ The achievements in service delivery were not matched by improvements in

³ This may not include all data from Marie Stopes International, one of the largest providers of family planning services in PNG.

⁴ AIHSS target provinces are West Sepik, Western, Central; Southern Highlands, Eastern Highlands, Gulf, Madang, Morobe, Jiwaka, Autonomous Region of Bougainville, Western Highlands, and East Sepik.

the health security system. Efforts to improve the system were impacted by their disease/intervention design focus, in-country coordination challenges, and the emergency response setting during COVID-19.

Rural Primary Health Care

The HPP acknowledged the difficulties in improving primary health care because of lack of finance, inefficiencies in budget prioritisation and the health finance disbursement system, as well as issues in staff management, recruitment and retention, medical supplies procurement and distribution, facility upkeep and maintenance, and laboratory services. Investment support to NDoH, Department of Treasury (DoT), Department of National Planning and Monitoring (DNPM), and Department of Finance (DoF), has had mixed results to strengthen capacity to disburse health budgets and staff health facilities.

- **Capacity to Disburse Health Budgets:** Individual HPP investments attempted to tackle capacity to disburse health budgets in different ways. While there were certainly some positive outcomes, intractable obstacles remain. While these are no doubt largely a function of the complexity of the issues, the review posits that more can be achieved from Australia's investments by a stronger focus on central agencies (Departments of Finance and Treasury), leveraging DFAT's economic governance program, and strengthening connections between investments addressing public financial management (PFM) reform.
- **Capacity to Staff Health Facilities:** The capacity of NDoH and Department of Personnel Management (DPM) to staff health facilities is undermined by a paid staffing establishment that often does not accurately correspond to reality, and an approved staffing establishment that does not align with what is needed. The level of HPP focus and resourcing on staffing reform was less than for budget disbursement, with most support from World Health Organization (WHO) and Health Services Sector Development Program (HSSDP) technical advice. While incremental progress has been made, such as through DFAT-funded training under the Australia Awards (Short Courses and Midwifery) and HSSDP training, much more remains to be done.
- **PHA and District Capacity to Deliver Primary Health Care:** Effective primary health care requires qualified health personnel, operational funding, medical supplies and quality infrastructure being available concurrently. Different HPP investments have positively contributed to improving capacity in different ways, in different places, and at different times. The effectiveness of investments would be enhanced with a connected and coordinated approach to capacity development.

The goal of the ANGAU Hospital Redevelopment Project is for ANGAU Hospital to serve as a functional regional referral hospital. While there has been a slight increase in referrals to ANGAU Hospital, there is as yet no evidence of an improved or strengthened referral process across the province.

Integrated Family Planning, HIV, and SRH

Integration is aligned to either moving away from a fragmented model of siloed (vertical) service delivery towards an integrated (horizontal) model of primary care services delivered by state or non-state providers; or moving away from parallel support systems (for example, in program governance, financing, staffing, supplies, and information systems) to systems integrated with those of government. While some HPP investments met their service delivery targets, they had varying degrees of success in strengthening quality integrated primary care services. Progress in building community awareness of health issues and health-seeking behaviour for health care has been mixed.

- All but 2 of the HPP investments adopted a fully integrated service delivery model. In terms of integration of support systems, the results were mixed. While none of the investments achieved integration to the extent that service delivery support was funded within the government system, there was some success in integrating systems of governance, finance management, medical supplies, and information systems.
- There were missed opportunities for integration between HPP investments. These were underpinned by limited exchanges of learning between the partners at the national level, and across the different provinces where service delivery activities overlapped.
- Relationships between PHAs and programs varied. The role of PHAs, as stewards of the primary care system, was undermined by a lack of consideration for integration in investment design and different states of readiness for integration by PHAs/Provincial Health Offices, noting that some of the investments were designed prior to the PHAs being established. In the absence of a coherent, comprehensive, and collective vision for integrated primary care, and the absence of functioning processes for coordinating providers in the provinces, personal relationships often formed the basis of cooperation. The quality and duration of these varied considerably, impacting project effectiveness and sustainability.
- There is limited data to assess changes in health knowledge and care-seeking behaviour. There are, however, some indications of changes in service delivery patterns that might reflect better awareness and care-seeking behaviour.

Efficiency

Whether the portfolio is efficiently progressing towards delivery of End of Investment Outcomes cannot be determined. Data about allocation of funds across portfolio outcomes has not been compiled. Nor has data about allocation of funds between provinces. The absence of portfolio-level financial tracking and monitoring diminishes capacity to make effective resource allocation decisions, which might lead to inefficient portfolio management.

Value for Money

Portfolio investments are delivering value for money (VFM) in some areas of their operations, but more could be done to deliver value for money across the portfolio, and at the level of the portfolio. While individual investments focused on the Commonwealth Procurement Rules, cost-consciousness and encouraging competition, lack of integration and coordination across the investments is likely contributing to lost opportunities to improve VFM through synergies that might come from combining resources, or potentially achieve economies of scale.

Understanding Overhead

The portion of portfolio funds absorbed by overhead expenses, at different levels, needs to be understood to better assess efficiency. HPP investments have adopted different approaches to accounting for overhead expenses, which makes it difficult to shed light on the overall overhead cost burden of the portfolio.

Coherence

The Health Portfolio model that emerged in 2017–2018 aggregated investments under an overarching, time-bound strategy. Two key challenges in managing the portfolio were that none of the investments commenced with the HPP, and that a diverse mix of aid modalities and partners were adopted and engaged.

Scope and Ambition

The scope and ambition of the HPP, from the perspective of health priorities, are appropriate to meeting the HPP Objective. Scope and ambition are less clear from the perspective of the portfolio's geographic footprint. The intent to deliver the plan with a targeted approach to some provinces and districts was never fully realised, as the portfolio was built around existing investments with already established footprints.

Scope and ambition are also unclear from the perspective of focus. While the HPP logic places a strong emphasis on health systems strengthening, the work of several HPP investments has placed an equally strong emphasis on the delivery of essential emergency and primary health services. What therefore, is the appropriate balance between the two? This question has been generally resolved by pragmatic decisions made at the investment level, rather than with regard to the HPP.

Partners and Modalities

While the HPP envisaged a range of modalities delivered through a mix of partners, the review found a greater reliance on the project-based modality, with investments delivered primarily through non-government organisations (NGOs) (also a United Nations (UN) agency and a co-funding agreement with the Asian Development Bank (ADB)); limited ability to deliver investments directly through government financial management systems; and judicious use of technical assistance. The modalities again reinforce the service delivery versus systems strengthening tension. While the HPP is delivered primarily through project-based modalities, which are more effective as vehicles for service delivery, there has been less emphasis on adopting program-based approaches that are more appropriate to driving systems strengthening.

Technical assistance is the glue that potentially addresses the dilemma, through targeting the lack of capacity undermining program-based approaches, and reducing the over-reliance on NGO partners to deliver systems strengthening initiatives for which they are often ill-suited. While the technical assistance provided through the portfolio was welcome and appreciated by government respondents at the national and provincial levels, its value and effectiveness was sometimes diminished by lack of coordination among technical assistance providers, and their lack of coordination with other HPP investments.

Sustainability

There are mixed positions on the sustainability of the positive impacts of HPP investments. These mixed positions stem from different understandings of what constitutes sustainability; a complex relationship between sustainability and service delivery; and the enduring challenges of health systems staffing and financing.

Sustainability of Service Delivery

HPP investments supported service delivery that is integrated into the broader public health service delivery system, and service delivery provided parallel to government. Investments also used both parallel support systems (that is, where the investment relies on its own systems of governance, finance management, staffing, and medical supplies), and integrated support systems. The review concluded that, if funds were available, a number of the HPP investments have strong prospects for sustainability through local ownership, local management, and local service delivery, and others are well-positioned to make adjustments that would strengthen or enhance prospects for sustainability.

Sustaining Changes in the Health System

As a result of the portfolio's limited successes, to date, in overcoming finance bottlenecks to effective health services, the consensus among informants from the different investments, from government, and from the AHC Health Team, was that it is premature to assess whether any positive impacts of DFAT investments in the health system are likely to be sustained.

Unless and until staffing and financing bottlenecks are overcome, the sustainability of Australia's investments in health infrastructure are at risk. While the infrastructure has been constructed to a high standard, any long-term positive impact is dependent on the facilities having sufficient qualified and skilled staff, and the funding necessary for ongoing operations and maintenance.

GEDSI

The review did not explicitly consider GEDSI outcomes or results. Instead, it analysed the approaches taken to GEDSI at the portfolio level and among a sample of investments.⁵ The review concluded the HPP does not have a clear theory of change that would foster the advancement of GEDSI and does not include GEDSI-specific goals or objectives. There is no focus on outcomes for improving inclusion for people with disability or other marginalised groups. This lack of an explicit focus on GEDSI outcomes has contributed to a lack of focus on GEDSI in investment-level design and performance monitoring and reporting.

Benefits for Women or GEDSI-Transformative Approaches?

Gender equality and disability and social inclusion is about much more than access to health services for women, which has been the GEDSI focus of HPP investments. While this focus on services undoubtedly delivers positive benefits for women, it commonly fails to adopt more comprehensive approaches that intentionally or systematically advance gender equality and inclusion in a comprehensive and integrated manner. While health services for women may have improved as a result of the HPP, and some projects calibrated these for greater inclusiveness, the portfolio has not required, and the investments have not adopted, GEDSI-transformative approaches.

The GEDSI Domains

The Human Development Monitoring and Evaluation Services (HDMES) GEDSI Strategy and Toolkit recognises that the causes of gender inequality and disability and social exclusion are deep-rooted, complex, and intersectional. The GEDSI Strategy and Toolkit outlines 7 GEDSI Domains: access to services; skills and capacities; agency and voice; leadership and representation; social norms; institutional policies and practices; and safeguarding. The review found that HPP and its investments generally adopted a narrow focus on just a few GEDSI Domains. There was no focus on agency and voice; social norms; institutional policies and practices; and safeguarding. The narrow focus has significantly limited the GEDSI approaches and results of the HPP and its investments.

AHC Oversight and Management

Perhaps consistent with the limited focus on GEDSI in the HPP design and performance assessment requirements, AHC Health and Gender staff and investment staff indicated that the AHC has provided minimal guidance, mandate or oversight of GEDSI aspects of individual investments, and appears to have played no role in promoting, overseeing or monitoring GEDSI within the HPP at the portfolio level. This would seem to be a missed opportunity given the skilled resources within the AHC Health

⁵ GEDSI: Document review and interviews were conducted at the portfolio level and investment level through a sample of investments. The sample of investments included PATH, SRHIP, RID-TB, HSSDP, and the WHO Partnership.

and Gender Teams, and the AHC mandate in relation to the Gender Equality and Women's Empowerment Strategy and Gender Action Plan.

Dedicated Investment in GEDSI

There is a lack of dedicated GEDSI resourcing and activities across the portfolio. The exception is the more recent gender analysis and reporting from PATH, where there has been a more explicit and proactive focus on GEDSI (or perhaps more specifically on gender equality), and a dedicated executive-level GEDSI Lead and Team that is resourced with skilled people and a dedicated budget.

Monitoring and Evaluation

The portfolio's M&E arrangements are not fit for purpose, diminishing capacity for robust portfolio-level management. The portfolio-level Performance Assessment Framework (PAF) and M&E Framework have not been used as management tools by those with responsibilities across the portfolio. Different investments have different approaches to M&E, with varying approaches to program logic and different understandings of key M&E concepts. Ongoing monitoring and assessment of portfolio progress comes through investment-level reporting, which differs in formats and quality. Until recently, there has been a lack of demand from the AHC for a consistent approach.

Human Development Monitoring and Evaluation Services

Since 2020, HDMES has been an important plank of the portfolio's M&E arrangements. It was the consensus among AHC staff that HDMES has the potential to add value to the management of the Health Portfolio, but also the consensus that HDMES still has some way to go in realising the ambition behind its establishment. In addition to initial challenges with engagement and management, other concerns with HDMES and the HDMES model include: (i) its focus on compliance-related M&E, and lack of support to program design, M&E capacity building across investments, M&E to inform learning, and M&E to inform evidence-based decision-making; (ii) its reliance on a tasking model that diminishes opportunities for HDMES to use its resources to ask questions that might not relate to a specific task, but which might have implications across multiple investments or issues; and (iii) the absence of a HDMES quality assurance framework.

Use of M&E Data

The Health Team's use of M&E data reflects the lack of portfolio-level data and the reliance on investment-level M&E, which is most often used by the AHC for compliance and accountability purposes. It was not evident to the Review Team whether M&E data is used in a structured way to inform learning, or to inform decision-making.

Governance

The capacity of the AHC Health Team to engage with government, coordinate and manage investments, and coordinate with other development partners was impacted by the COVID-19 pandemic. While more work is needed to establish fit-for-purpose portfolio governance arrangements, the review recognises the team achieved all that was possible in the context of the COVID-19 response and its aftermath.

Government of PNG Engagement

The AHC Health Team's engagement with the Government of PNG is heavily reliant on personal relationships, which is challenging for Australian-based members of the team whose time in PNG is limited to 3 or 4 years. Engagement with GoPNG is sometimes impacted by the AHC team's internal work arrangements, and further impacted by capacity issues on the PNG side.

Internal Coordination and Management of Investments

Normal patterns of work and systems and processes for coordination and management were overwhelmed by the demands of responding to the COVID-19 pandemic. Other factors influencing internal coordination and management include the functional, investment-oriented organisational structure of the Health Team, and challenges with the PATH program, which is yet to meet expectations. There have been notable improvements in internal processes through 2022, which have improved prospects for coordination and more effective portfolio management going forward.

Coordination with Development Partners

The major mechanism for coordination between development partners and the Government of PNG is the Health Sector Aid Coordination Committee (HSACC), which brings together a large number of stakeholders and only meets twice per year. Recognising the limitations of the current mechanism, DFAT and WHO have combined, with the encouragement of NDoH, to resurrect a monthly development partners coordination meeting, which had previously lapsed. This is a positive step forward in increasing the effectiveness of coordination among development partners.

Recommendations

The central recommendation of this review is to largely maintain the present priorities and direction.

Short-Term: Remainder of the HPP

The shorter-term recommendations are largely concerned with positioning the AHC Health Team and the Health Portfolio for a future Health Portfolio Plan, establishing a solid foundation for more efficient and effective program management.

Recommendation 1 – Alignment in portfolio logic: A key principle for investment design and redesign should be clear alignment between the program logic of investments and the overall logic of the portfolio.

Recommendation 2 – Standardisation: To improve portfolio efficiency, enable comparative analysis of investments, and facilitate streamlined portfolio planning, budgeting, and reporting, standardisation of approaches and tools across investments is recommended.

Recommendation 3 – Organisational structure: The review recommends the AHC Health Team shift from a functional to a matrix structure, which combines a vertical functional structure with a cross-functional thematic structure for PFM, and GEDSI (and other identified cross-cutting themes).

Recommendation 4 – Sequencing: With the completion of the HPP corresponding with the end of several HPP investments, the process of redesign should follow a sequence that commences with HPP program logic, proceeds to development of tools and templates, and concludes with investment design.

Recommendation 5 – HDMES: In addition to compliance-oriented evaluation work, the HDMES role should encompass quality assurance of all HPP investment M&E requirements; training, mentoring and ongoing M&E support to investments; and designing and facilitating learning events for the AHC Health Team.

Future DFAT Health Programming in PNG

Longer-term recommendations are concerned with the key issues that the portfolio design must address.

Recommendation 1 – Resolve the service delivery versus systems strengthening tension: A recurring tension highlighted by this review is that between service delivery initiatives by HPP investments and initiatives to strengthen the PNG health system. This tension needs to be resolved. The review recommends an explicit recognition of the necessity for Australia to support service delivery, and clear parameters around the circumstances of how and where that should happen and what should be done to maximise system-level outcomes and mitigate negative unintended consequences.

Recommendation 2 – Resolve the narrow versus expansive geographical coverage approach: The review recommends that the AHC should drive decisions about geographical coverage of investments through a portfolio lens that seeks to maximise opportunities for synergy, coordination, and a focus on cross-cutting themes.

Recommendation 3 – Tackle PFM: The review recommends an adaptive approach be taken to PFM strengthening, with all Australian-funded initiatives aligned to a singular portfolio vision that is established in collaboration with NDoH and the central agencies.

Recommendation 4 – Adopt a comprehensive GEDSI approach: The review recommends a successor to the HPP adopt a comprehensive, transformative GEDSI framework that is broad enough to enable diversity of approaches, but which incorporates sufficient commonality to harness combined impact.

Recommendation 5 – Establish a roadmap to sustainability: The review recommends the development of a portfolio roadmap that establishes a series of stages that will eventually lead to the capacity to move away from project-based modalities and deliver aid through government systems.

1. Introduction

In 2019, PNG's universal health coverage service index was 33, which was the lowest score of all lower-middle-income countries.⁶ In the same year, current health expenditure per capita (USD60) remained well below other lower-middle-income countries (USD97).⁷ Government and donor spending per capita for health peaked in 2014, but is yet to recover to the same levels following economic contraction and a decline in donor contributions. PNG Government allocations to health have remained between 6 and 9% of the total government budget to health since 2015. There is scope to increase this allocation – 15% is a target for countries in the African Union. Out-of-pocket costs (fees paid at the point of care) remain a relatively low share of current health expenditure, constituting 9–10% of total health financing between 2016 and 2020.⁸ This low share may in part reflect an under-utilisation of health services in PNG, due to financial and other barriers.

Australia's investment in health in Papua New Guinea is broadly guided by the 5-year *Portfolio Plan: PNG Health Sector Program 2018–2023* (HPP). The HPP resource framework was set, in 2018, at AUD62.5 million per year (AUD312.5 million over 5 years).⁹ At the time of its formulation, the plan recognised that 'Papua New Guinea's health and healthcare system is at a critical point'.¹⁰ Against the backdrop of high maternal and child mortality, regressing immunisation rates, high rates of multidrug-resistant tuberculosis (MDR-TB) and a 'looming wave' of non-communicable diseases, the challenge ahead for the PNG health sector was stated explicitly: 'to stabilise under a pressing fiscal crisis and seek internal efficiency gains that can address the key burdens of disease'.¹¹

The HPP serves as an umbrella for several separate agreements provided through a combination of modalities, including technical assistance and projects directly managed by contractors, co-funding with multilateral institutions, and a direct funding agreement that exclusively uses government systems. It combines continuing activities with new and redesigned initiatives. While several of the investments under the umbrella of the HPP have been reviewed and evaluated in the past, this report provides a first external review of the overall portfolio, including its management and implementation.

The review is timely for 3 reasons. First, it was undertaken during a period when the worst of the global COVID-19 pandemic had passed. After an unprecedented Australian Government response to the COVID-19 emergency in PNG, centred on support to the health system, a sense of normalcy has returned. This brings with it questions about what has been learned, about whether aid investments and approaches should be recalibrated, and about how future needs might be prioritised. Second, the review was undertaken during a period when the HPP is reaching its end point, and attention is turning to a successor plan of support to the health sector in PNG. Finally, the review took place following the release of the new PNG *National Health Plan 2021–2030*¹², providing an opportunity to ensure Australian support is aligned to and calibrated with the priorities of the Government of PNG.

⁶ *Tracking Universal Health Coverage: 2021 Global Monitoring Report*, World Health Organization and International Bank for Reconstruction and Development/The World Bank, 2021, Licence: CC BY-NC-SA 3.0 IGO.

⁷ World Bank data available at: <https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD>.

⁸ *World Health Organization Global Health Expenditure Database* (apps.who.int/nha/database).

⁹ *Portfolio Plan: PNG Health Sector Program 2018–2023*, DFAT [unpublished], 2018, p. 8 (referred to as Health Portfolio Plan). It should be noted the resource envelope changed over time, with the inclusion of the ANGAU Hospital Redevelopment Project and COVID-19 support.

¹⁰ Health Portfolio Plan, p. 24.

¹¹ Health Portfolio Plan, p. 24.

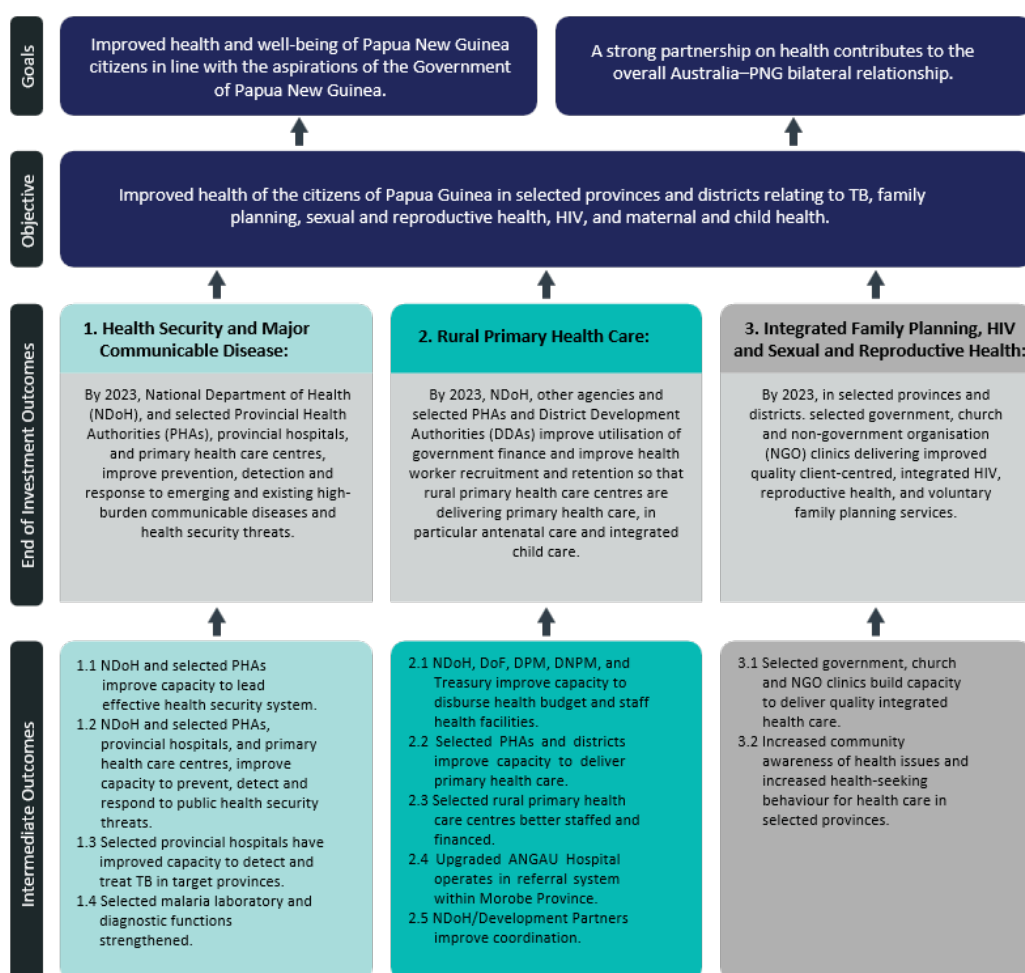
¹² *National Health Plan 2021–2030: Volume 1 Policies and Strategies*, Government of PNG, June 2021 (referred to as the National Health Plan).

1.1. Background

The 2017 Foreign Policy White Paper stated that supporting a stable and prosperous PNG was one of Australia’s most important foreign policy objectives. It recognised that it is of mutual interest to remain PNG’s preferred partner in ensuring regional security, as well as sharing Australia’s interests in building prosperity in the region.¹³

The DFAT 2017–2023 PNG Health Sector Investment Plan identified 3 core priorities for Australia’s assistance to PNG’s health sector: (1) health security; (2) scalable interventions to improve the health of women, children, and vulnerable groups; and (3) stronger health governance, management and financing systems.¹⁴ The HPP refined the objectives of the Health Sector Investment contribution to the achievement of DFAT’s Health for Development Strategy¹⁵, and aligned with the Papua New Guinea–Australia Comprehensive Strategic and Economic Partnership¹⁶, which acknowledges that developing a strong partnership on health will reap benefits for the overall PNG–Australia bilateral relationship. The program logic of the HPP is summarised in Figure 1 below.

Figure 1: HPP Program Logic



¹³ 2017 Foreign Policy White Paper, DFAT, 2017, available at: <https://www.dfat.gov.au/publications/minisite/2017-foreign-policy-white-paper/fpwhitepaper/index.html>.

¹⁴ Health Portfolio Plan, p. 24.

¹⁵ Health for Development Strategy 2015–2020, DFAT, June 2015.

¹⁶ Papua New Guinea–Australia Comprehensive Strategic and Economic Partnership, 5 August 2020.

The HPP recognised that a healthy population in PNG contributes to economic growth and development, protects against disease outbreaks, saves money, and ensures PNG’s citizens are better able to build a stronger nation for future generations. It formalised Australia’s strategy for addressing the deep financing gaps in PNG’s health sector.

1.2. The Health Portfolio

The various investments that have comprised the Health Portfolio are listed in Table 1 below.

Table 1: HPP Investments

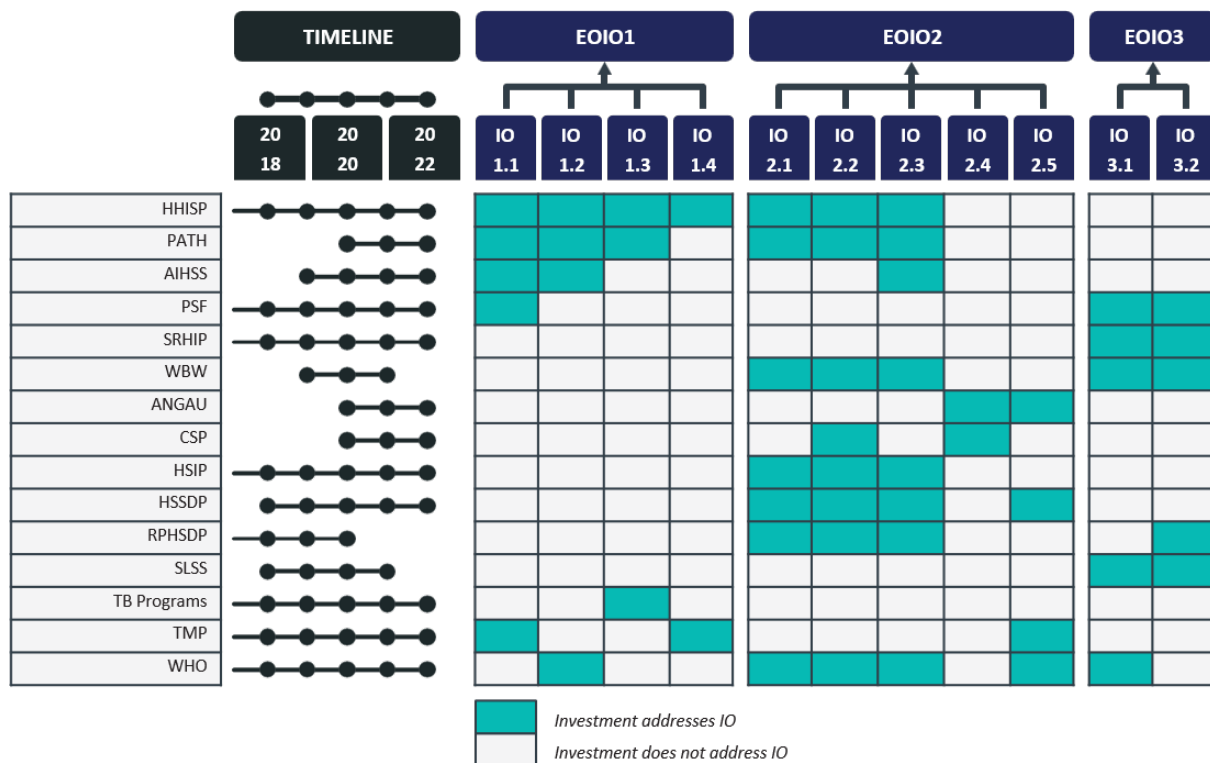
Investment	Abbreviation	HPP Start Year	HPP Finish Year
Accelerated Immunisation and Health Systems Strengthening	AIHSS	2019	–
ANGAU Hospital Redevelopment Project (A)	ANGAU	2020	–
Clinical Support Program	CSP	2020	–
Daru Accelerated Response for TB	DART	2018	–
Health and HIV Implementation Services Provider	HHISP	2018	2020
Health Services Improvement Program	HSIP	2018	–
Health Services Sector Development Program	HSSDP	2018	–
Papua New Guinea–Australia Transition to Health	PATH	2020	–
PNG Partnership Fund	PPF	2018	2020
Partnering for Strong Families	PSF	2018	2023
Reducing the Impact of Drug-Resistant TB in Western Province	RID-TB	2018	–
Rural Primary Health Services Delivery Project	RPHSDP	2018	2020
Saving Lives Spreading Smiles	SLSS	2018	2021
Sexual and Reproductive Health Integration Program	SRHIP	2018	2023
Trilateral Malaria Project	TMP	2018	2022
<i>Wok Bung Wantaim</i>	WBW	2019	2021
DFAT–WHO Bilateral Partnership	WHO-BP	2018	–

Notes: (A) Project came under Health Team management in 2020.

These investments need to be understood in different ways. First, the start and end dates of the various investments are not neatly aligned to the dates of the start and end of the HPP. Some investments, such as the Health Services Improvement Program (HSIP), are continuing investments which preceded and were inherited by the HPP. Other ongoing investments, such as Health and HIV Implementation Services Provider (HHISP), ended during the current HPP. A third group, such as the PNG–Australia Transition to Health (PATH) program, were established during the HPP. A final group are those continuing investments that were redesigned or whose management arrangements changed during this HPP. This group includes, for example, the Sexual and Reproductive Health Integration Project (SRHIP) and Partnering for Strong Families (PSF), which were investments managed under the PNG Partnership Fund (PPF) before transferring to the PATH program.

A second way to understand the portfolio investments is as contributors to different HPP Intermediate Outcomes and End of Investment Outcomes. The fragmented timing arrangements above mean that the alignment between investments and the HPP results framework is not always fully synchronised. There is, however, substantial alignment, which is summarised in Figure 2 below.

Figure 2: HPP Timeline and Results Framework Alignment



1.3. COVID-19

A review of the Health Portfolio Plan cannot claim to be balanced without accounting for the profound impact of COVID-19 on Australia’s support to health services and the health system in PNG. In terms of the implementation of the HPP, that impact can be summarised as follows:

- The focus of many in the AHC Health Team was, by necessity, diverted away from management of the HPP and its investments by the demands of the COVID-19 response. While funds under the team’s management (either directly or through line of sight to other DFAT funding streams) almost doubled over the course of several months, the staffing of the AHC Health Team increased only incrementally. Focusing on attending to the immediate priorities of Australia’s COVID-19 response in PNG, staff were simply unable to continue to focus on management, implementation and monitoring of the portfolio. The flow-on effect of that, into 2022, was a backlog of outstanding tasks that could not be attended to through 2020 and 2021.
- The Government of PNG, led by the National Control Centre with primary support from the National Department of Health and Provincial Health Authorities, was focused almost exclusively on the COVID-19 response. Even if members of the AHC Health Team could find time for engagement with GoPNG about HPP priorities and the HPP reform agenda, the different agencies of PNG government concerned with health were in no position to reciprocate.
- HPP investments, particularly those concerned with frontline services delivery, were focused on negotiating and implementing new ways of working in response to the pandemic. These included pivoting existing programs to account for COVID-19 programming needs, accommodating travel restrictions, staff vaccination requirements and hesitancy, staff absenteeism due to illness, access to facilities and resources, and community attitudes. While the different investments should be commended for the extent to which they were able to continue to deliver essential services during the pandemic, its impact on their operations and capacity to focus on program objectives cannot be overstated.

While this review, around a range of issues, often adopts a critical position on the HPP, that position needs to be carefully weighed against the unprecedented demands of supporting PNG's response to the global pandemic. There is no doubt that, if the time and physical and intellectual energy devoted to the COVID-19 response could have been directed back to the key concerns of the HPP, more progress could have been made. Where successes over the past few years can be identified, they should be amplified against the backdrop of the pandemic response. Where it is difficult to identify progress, this should be mediated against the challenges summarised above.

1.4. Review Purpose

This review had 2 primary purposes.

Understand

- Assess the progress and performance to date of the HPP in progressing towards its EOIOs, and contributing to improved health outcomes in selected provinces, through an assessment of relevance, impact, effectiveness, efficiency, sustainability, and GEDSI.
- Based on this assessment, provide concrete examples and evidence of how Australia's support has contributed to its EOIOs and PNG's National Health Plan, including GEDSI, and identify areas where the HPP is not meeting, or is at risk of not meeting its EOIOs.
- Identify what changes, if any, are needed to ensure that the HPP is on track to meet the EOIOs in its remaining period (to the end of 2023).

Inform

- Make recommendations on how HPP implementation could be enhanced in its remaining time (to the end of 2023), to meet its EOIOs and IOs efficiently and effectively; and what steps the AHC should take to prepare itself for a successor Health Portfolio Plan.
- Make recommendations on the development of a successor to the HPP, including specific recommendations related to GEDSI, as well as the ongoing implementation of current and future investments.

1.5. Key Review Questions

Based on the review's purpose, it has reported on the 9 Key Review Questions outlined in Table 2.

Table 2: HPP Mid-Term Review Questions

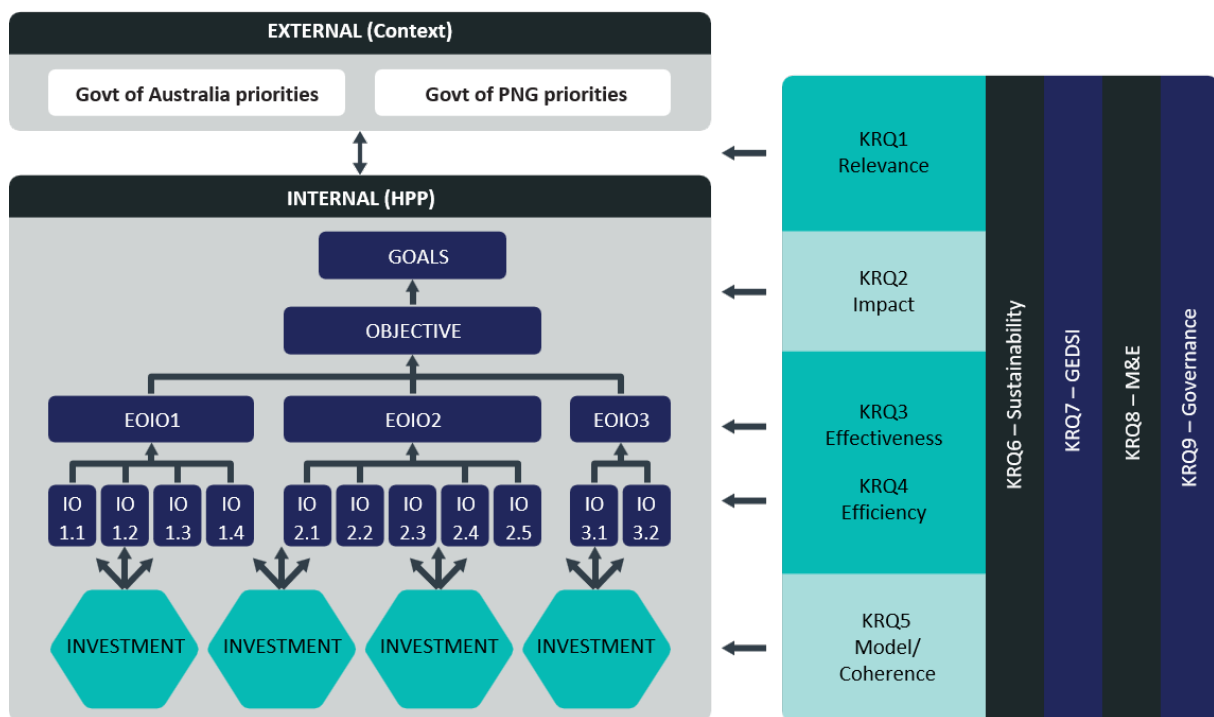
KRQ	Focus	Question
KRQ1	Relevance	To what extent does the Health Portfolio Plan align with the Government of Australia and the Government of PNG development priorities (including the new National Health Plan)?
KRQ2	Impact	To what extent is the Health Portfolio Plan making progress towards its Goals and Objective?
KRQ3	Effectiveness	To what extent is the Health Portfolio Plan making progress towards the 3 End of Investment Outcomes?
KRQ4	Efficiency	To what extent has Health Portfolio Plan progress towards the End of Investment Outcomes been delivered efficiently?
KRQ5	Model/Coherence	Does the HPP have the right scope and ambition, and the right mix of partners and modalities to meet the HPP objectives?

KRQ	Focus	Question
KRQ6	Sustainability	To what extent are the positive impacts of DFAT investments likely to be sustained?
KRQ7	GEDSI	To what extent is the Health Portfolio Plan making progress towards GEDSI goals and objectives?
KRQ8	M&E	To what extent are Health Portfolio Plan M&E arrangements fit for purpose?
KRQ9	Governance	To what extent are the Health Portfolio Plan governance arrangements fit for purpose?

1.6. Conceptual Framework for the Mid-Term Review

The KRQs, coupled with the HPP results framework and the investments, provided a conceptual model for the review (see Figure 3 below).

Figure 3: HPP Review Conceptual Model



KRQ1 is concerned with alignment between the HPP and the external context, comprising the needs of the PNG system and the priorities of both the Australian and PNG Governments. KRQ2 focuses on the higher levels of the results framework, where impact is demonstrated by the extent to which the portfolio is making progress towards contributing to its Objective and Goals. KRQ3 and KRQ4 are focused on the outcomes level of the results framework, while KRQ5 focuses on the HPP model. The remaining KRQs are cross-cutting at the different levels of the results framework. KRQ7 is highlighted in the model to emphasise the significance accorded to GEDSI in the review.

1.7. Key Themes of the Review

Any review across such a diverse portfolio with a broad range of questions will generate a raft of thoughts, ideas, and recommendations. This review has been no different. Among the many thoughts, however, are 4 common themes that recur through much of the discussion under the review questions.

The Sum of Parts

At the commencement of the review, the Review Team was asked to consider whether the whole of the portfolio was greater than the sum of its parts. The premise was that a well-functioning portfolio would potentially benefit from the synergies generated by different investments working towards shared outcomes, a shared objective, and shared goals. The review has found that a portfolio-level approach to management was not fully realised. Different investments came into the portfolio at different times through different modalities with different partners. The management systems and processes that might have corralled the investments around shared expectations and catalysed portfolio-level synergies were not developed at the commencement of the HPP, and hopes they might be developed later were then dashed by the COVID-19 response. What has resulted, rather than a well-connected portfolio approach, is a series of investments, related to but largely disconnected from each other, and often delivering encouraging results in isolation from each other. The whole is therefore not greater than the sum of its parts.

Tension between Service Delivery and Systems Strengthening

Central to the review was a fundamental tension between the imperatives of service delivery, and those of strengthening the health system. At the core of the tension is the question of immediacy. While the End of Investment Outcomes and Intermediate Outcomes that emerged from the HPP design genuflected before the aspiration to support the longer-term establishment of a more capable and robust PNG health system, this aspiration was often overwhelmed by day-to-day demands and investment-level outcomes concerned with the delivery of frontline health services. The service delivery versus systems strengthening tension played out most conspicuously in the desire to simultaneously strengthen the health security system while responding rapidly to health emergencies such as TB (and then COVID-19); and in seeking to strengthen quality integrated primary health care while delivering essential HIV, reproductive health, and family planning services. The tension was reflected in portfolio funding modalities, investment partners, and concerns about sustainability. A key concern in any successor to the HPP will be reconciling this tension.

The Finance and Staff Dilemma

The HPP noted that the 'decentralised architecture of PNG's system of government is fragmented and has a major impact on the planning, financing and delivery of rural primary health care'. In addition to other factors, fragmentation often means 'much of the finance earmarked for health does not arrive where it is needed, arrives late, or is wasted'. Exacerbating these finance challenges are those with staff, where the health payroll is 'overseen, managed and financed by the Department of Personnel Management'.¹⁷ A recurring theme of the review is that continued finance and staffing bottlenecks undermine progress towards achieving the portfolio's outcomes.

¹⁷ Health Portfolio Plan, pp. 14–15.

Management Matters

There are many definitions and understandings of management – an art, a science, a process, an activity, a discipline, a profession. Regardless of how it is understood, there is general agreement that management relates to the functions of planning, organising, directing, and controlling; and the applications of these principles in harnessing physical, financial, human, and informational resources efficiently and effectively. This review has not only highlighted that management matters, but also the need to strengthen management functions at the AHC, among investments, and at the different levels of government. It suggests that improved portfolio performance, and improved impact on the health system from investments, might have been achieved with a stronger focus on the levers of both technical management (for example, financial analysis) and non-technical management (for example, coordination and problem-based decision-making). An effective successor to the HPP should recognise the importance of balancing public health capacity, experience and expertise with capacity in efficient and effective resource management.

1.8. Structure of the Review Report

Section 2 of the report comments on the overall scope of the review, describes the way the work was undertaken and identifies some of the limitations. Section 3 discusses the key findings, using the different lenses established by the KRQs. Section 4 draws on the insights from section 3, and outlines review recommendations, focusing on both the remaining months of the current HPP, and considerations for the arrangements that might follow it. Further information, where appropriate, is provided in the Annexes.

2. Scope, Methodology and Limitations of the Review

2.1. Scope and Boundaries

The scope of the review is clearly set out in the Terms of Reference. The review was guided by the evaluation criteria of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC)¹⁸, and by DFAT Monitoring and Evaluation Standards¹⁹.

The review focuses on Australia's health support to PNG over the life of the HPP, from commencement in mid-2018 to the end of 2022. It considers the implementation and management of Australia's health investments; the work of DFAT staff, including internal and external stakeholder engagement; and policy dialogue with PNG counterparts. It also considers the broader context of COVID-19 with regard to the impact and relevance of the HPP; assesses the achievements, challenges, and lessons learned; advises whether the HPP is fit for its purpose; and considers how effectively the HPP M&E system is used for decision-making.

The review includes a particular focus on GEDSI. This encompassed the application of the HDMES GEDSI Toolkit across the HPP²⁰, an evaluation (using the toolkit) of a sample of specific identified HPP investments, and recommendations about how GEDSI can be strengthened during the remaining period of the HPP, and in a future DFAT health program in PNG.

The review is not an in-depth assessment of the individual DFAT health investments which, over time, have comprised the Health Portfolio. It is a review of a portfolio of investments which, in combination, and in potential interaction and synergy with each other, contribute to the achievement of portfolio-level Intermediate Outcomes, End of Investment Outcomes, Objective and Goals. While the review, at times, highlights the contribution and achievements of different investments, or the challenges they have addressed or overcome, it is important to note these individual investments are not the focus of the review.

2.2. Methodology

The review adopted a mixed-method parallel design, where quantitative and qualitative data were collected and assessed concurrently. The approach was adopted in response to the time constraints of the review, and the fact different team members worked on distinct parts of the review at different times and in different locations.

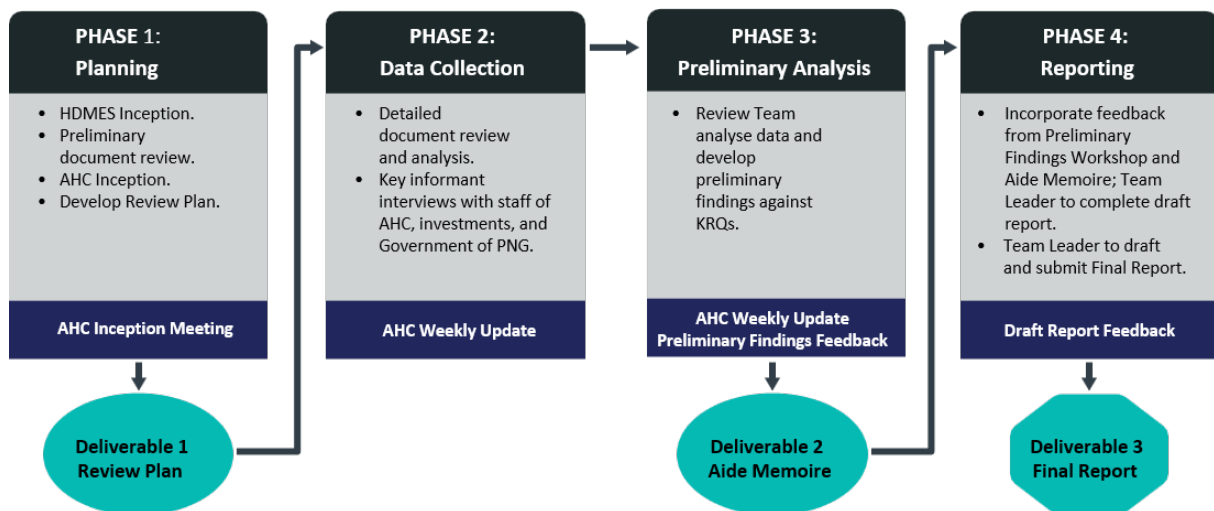
The different stages and deliverables of the review are outlined in Figure 4 below.

¹⁸ *Better Criteria for Better Evaluation: Revised Evaluation Criteria, Definitions and Principles for Use*, Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) Network on Development Evaluation, December 2019, available at: <https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf> (referred to as Better Criteria for Better Evaluation).

¹⁹ *DFAT Design and Monitoring, Evaluation and Learning Standards*, DFAT, September 2023, available at: <https://www.dfat.gov.au/about-us/publications/dfat-design-monitoring-evaluation-learning-standards>.

²⁰ *GEDSI Toolkit*, HDMES, 2021.

Figure 4: HPP Review Phases



The evaluation methods comprised key informant interviews (KIIs) and document review analysis:

- 76 stakeholders from DFAT, national and subnational government, and the HPP investments were interviewed. Annex 2 provides the full list of stakeholders consulted.
- Over 600 documents were included in the document register for the review. These included Government of Australia and Government of PNG policies and guides, and the designs, plans, budgets, reports and evaluations of the different HPP investments.

Initial findings were presented to the AHC Health Team in early September 2022. An Aide Memoire was presented in late September 2022. Tentative review findings were tested and iteratively developed through ongoing consultations with the Health Team during the course of the evaluation.

2.3. Limitations

The following limitations were experienced:

- The Key Review Questions were broad and covered a wide range of issues across a large portfolio of investments. By necessity, the review was reliant on existing evaluations and other documentation about individual investments. The quality of these varied.
- The variable quality of investment documentation was often coupled with a dearth of reliable or consistent secondary or complementary documentation. The data limitations that characterise the PNG health sector also limited the review. In short, data was often incomplete, out of date, or contradictory.

3. Key Findings of the Mid-Term Review

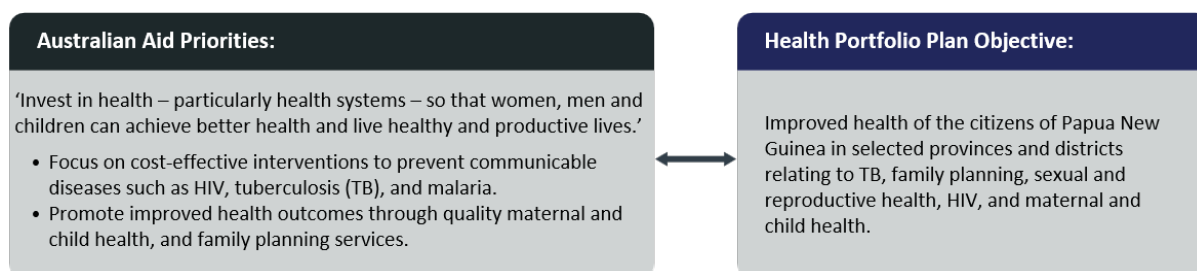
3.1. Key Review Question 1: Relevance

To what extent does the Health Portfolio Plan align with the Government of Australia and the Government of PNG development priorities (including the new National Health Plan)?²¹

Government of Australia Development Priorities

The Objective of the HPP strongly aligns with Government of Australia development priorities. A starting point for understanding those priorities is the *2017 Foreign Policy White Paper*, which succinctly notes that ‘supporting a stable and prosperous Papua New Guinea is one of our most important foreign policy objectives’.²² The purpose of the Australian Government’s aid program, since 2014, has been ‘to promote Australia’s national interests by contributing to sustainable economic growth and poverty reduction’. A priority was that Australia ‘will invest in health—particularly health systems – so that women, men and children can achieve better health and live healthy and productive lives’.²³ The aid policy highlighted Australia’s focus on cost-effective interventions to prevent communicable diseases such as HIV, TB and malaria, and promoting improved health outcomes through quality maternal and child health and family planning services. These priorities align with the HPP (see Figure 5 below).

Figure 5: Australian Development Priorities and the HPP



The portfolio’s focus on communicable disease, particularly TB, and the focus of TB investments in Western Province, with its close proximity to Australia, demonstrates clear alignment between the plan and Australia's national interest.

Government of Papua New Guinea Development Priorities

There is strong alignment between the HPP and Government of PNG development priorities. At the highest level, PNG’s development priorities are outlined in the aspirational Vision 2050, which seeks to build a ‘smart, wise, healthy and happy society’.²⁴ The vision is delivered through the *Papua New Guinea Development Strategic Plan 2010–2030*²⁵, and implemented through 5-year Medium-Term Development Plans. PNG’s National Health Plan is aligned to each of the Vision 2050, Development Strategic Plan and Medium-Term Development Plans, and articulates PNG’s development priorities in

²¹ Relevance (DAC criteria): ‘The extent to which the intervention objectives and design respond to beneficiaries’, global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.’ Better Criteria for Better Evaluation, p. 7.

²² *2017 Foreign Policy White Paper*, DFAT, p. 100.

²³ *Australian Aid: Promoting Prosperity, Reducing Poverty, Enhancing Stability*, June 2014, pp. 1 & 21, available at: <https://www.dfat.gov.au/sites/default/files/australian-aid-development-policy.pdf>.

²⁴ *Papua New Guinea Vision 2050*, Government of PNG, November 2009 (referred to as Vision 2050).

²⁵ *Papua New Guinea Development Strategic Plan, 2021–2030*, DNPM, March 2010.

the health sector. The NHP in place at the start of the HPP finished in 2020, with a new NHP commencing in 2021. The question of the relevance of the HPP to PNG government priorities therefore requires examination of how the HPP aligned with the NHP 2011–2020, and how it aligns to the current NHP 2021–2030. The alignment is summarised in Figure 6 below:

Figure 6: Alignment between National Health Plans and the HPP

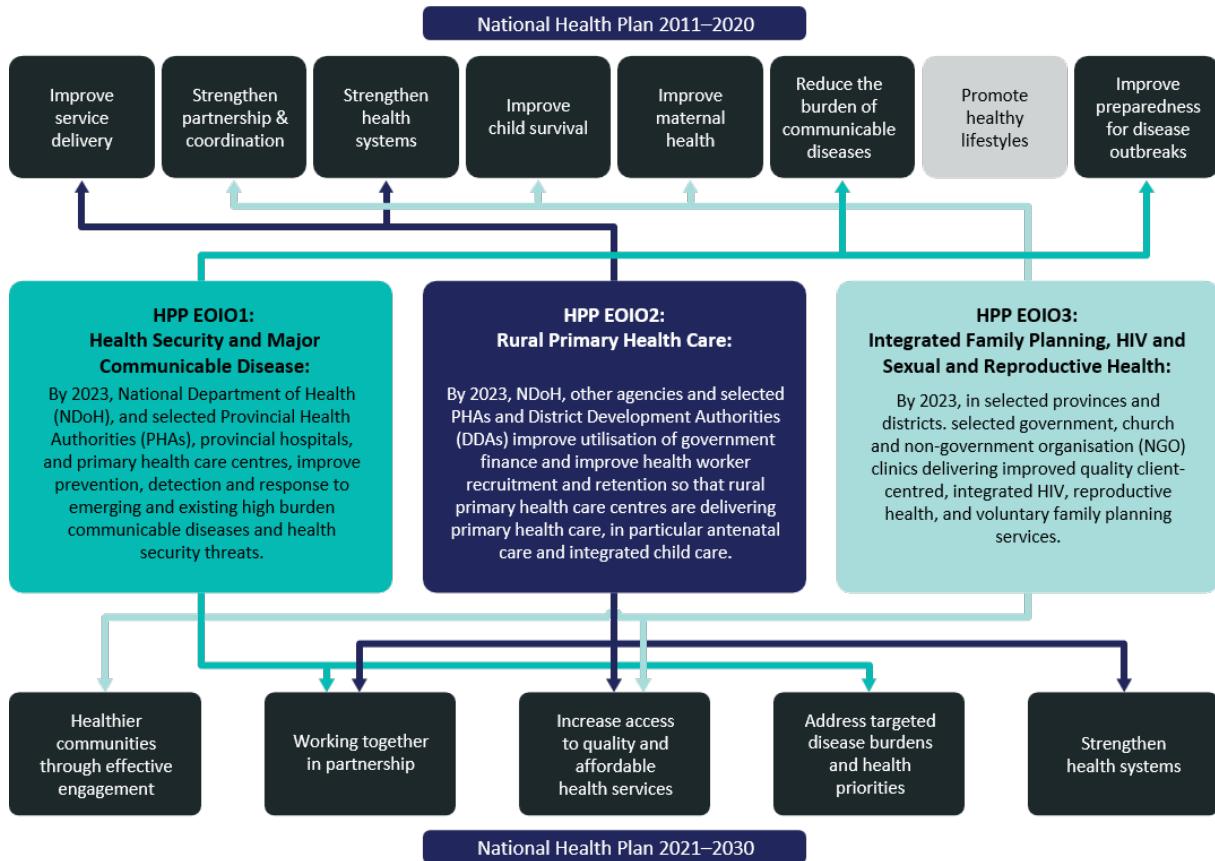


Figure 6 demonstrates how the HPP End of Investment Outcomes align with both the ‘back to basics’ NHP 2011–2020 and the ‘leaving no-one behind’ NHP 2021–2030. The NHP in place at the commencement of the HPP aligned with the HPP in all but the ‘promote healthy lifestyles’ key result area. The more recent NHP is more thematically consolidated, with each of the 5 key result areas aligning with the HPP.

HPP Gaps

There are priorities in the current NHP that are not a focus of the HPP. While the discussion above has highlighted where the HPP intersects with Australia’s and Papua New Guinea’s development priorities, what also needs to be considered are those development priorities that are not a focus of the HPP framework. The contextual outline in the HPP highlighted a raft of health challenges for PNG, underpinned by a ‘double burden of disease’ comprising ‘continuing high communicable disease along with an increased burden of non-communicable disease’.²⁶ The focus of the HPP, in EOIO1, is on the communicable diseases side of the double burden. This reflects the stronger focus of the NHP 2011–2020 on communicable diseases. The more recent NHP 2021–2030, while maintaining

²⁶ Health Portfolio Plan, p. 16.

a focus on communicable diseases, elevates the focus on non-communicable diseases, highlighting lifestyle-related diseases and cancers that are not a focus of the HPP.

If Australia was to consider supporting this stronger focus on non-communicable diseases through a successor to the current HPP, several issues would need to be taken into consideration:

- Resolving the value for money dilemma between balancing the need to sustain focus on communicable diseases for the isolated and vulnerable, who are at risk of TB, HIV, malaria and childhood preventable diseases, against investing in non-communicable disease management and prevention for those who are often from higher income and more socially-mobile groups.
- Australia has finite resources and must, by necessity, be selective in determining which of the priorities of the NHP it is willing and able to support.
- Australia must determine, with reference to its own institutions and partnerships, where it is best positioned to add value.
- To both avoid duplication of effort and to enhance or augment other initiatives, Australia's support should account for the support being provided by other development partners.
- Australia's national interest, at least in the short- to medium-term, is likely best served through continued focus on communicable diseases, alongside maternal and child health.

3.2. Key Review Question 2: Impact

To what extent is the Health Portfolio Plan making progress towards its Goals and Objective?

Impact is concerned with the extent to which the portfolio has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects.²⁷ It relates to effects of the portfolio that are longer-term or broader in scope than those relating to effectiveness, which is concerned with end of investment outcomes, and is the focus of Key Review Question 3, in the next section. KRQ2 is therefore not so much concerned with measuring impact, as this is a longer-term endeavour, but on assessing whether the portfolio is contributing to outcomes that might eventually achieve the positive effects articulated in the Goals and Objective.

Progress towards Goal 1: Improved Health and Well-being of PNG Citizens

The period prior to COVID-19 saw some progress in increasing services related to the goal of improved health and well-being of PNG citizens. Unfortunately, the progress made in improving service delivery was interrupted, or reversed in some cases, in the context of COVID-19, consistent with global trends.

The first Goal of the HPP is the *improved health and well-being of Papua New Guinea citizens in line with the aspirations of the Government of Papua New Guinea*. Those aspirations are outlined in the first pillar of Vision 2050. PNG seeks to improve its Human Development Index (HDI) ranking to 50 from 148 among the United Nations member countries; to improve access to services and basic infrastructure; and to improve life expectancy of Papua New Guineans from 57.9 to 77 years of age.²⁸

²⁷ Better Criteria for Better Evaluation, p. 11.

²⁸ Vision 2050, p. 5.

In terms of program logic, or a results chain, the proxies adopted to assess progress towards the goal, in accordance with the HPP Monitoring and Evaluation Framework, are Couple Years of Protection²⁹, and maternal and child mortality. CYP in PNG increased by one-third between 2016 and 2020, in part due to contributions from HPP investments (which are discussed below under Progress towards Objective). Good progress was made towards the HPP target of doubling the CYP by 2030 (from 102 to 200). Unfortunately, these gains were lost in 2021. There is limited reliable, high-quality data on child and maternal mortality and mixed evidence on the coverage of key interventions that contribute to reducing child and maternal mortality both before and after COVID-19 (as discussed below). On balance, however, the limited available data does not indicate significant gains towards the HPP M&E Framework targets of achieving an Under-5 Mortality Rate (U5MR) of 25 per 1,000 live births and Maternal Mortality Rate (MMR) of 70 per 100,000 live births.

Progress towards Goal 2: Contribution to the Australia–PNG Bilateral Relationship

The HPP is contributing positively to the Australia–PNG bilateral relationship, but opportunities could be enhanced with improved brand management.

The second Goal of the HPP is that a *strong partnership on health contributes to the overall Australia–PNG bilateral relationship*. The 2021 HPP Annual Report noted that ‘data for indicators on Goal 2 ... is not available’, making ‘it difficult to use these measures to assess progress’.³⁰ The HPP M&E Framework seeks data indicating Comprehensive Strategic and Economic Partnership Pillars are mentioned in joint national or regional initiatives, or in cooperation on health between Australia and PNG. A brief survey of PNG mass media indicates some success in this regard, with articles positively referencing both the CSEP Pillars and the priority commitments of the CSEP Action Plan (see Annex 4).

On the GoPNG side, there was an appreciation among review informants that Australia’s support to the PNG health sector was comprehensive and demonstrated the strength of an enduring Australia–PNG relationship. At the same time, however, Australia is potentially missing opportunities to further build the strength of the partnership, because the scale of its support is often not fully understood. A senior NDoH officer highlighted this point when stating that: ‘Australia has many tentacles [in its support to health in PNG], and we don’t always know where they are’.³¹ While a large program such as PATH is unequivocally associated with Australian aid, others are not. The Health Services Sector Development Program, for example, is almost universally regarded as ‘the ADB program’, despite the greater Australian financial contribution.

The lack of understanding of the scale of support under HPP indicates that brand management could be strengthened. While there is a strong perception among GoPNG stakeholders of the value of the Australian brand (‘supporting PNG when it needs it most’, ‘supporting PNG as a friend’, ‘helping us with grants, not loans’), improved brand awareness could further reinforce this perception. Central to achieving that is improved transparency about what programs are funded (or co-funded) by

²⁹ CYP is the estimated protection provided by family planning methods during a 1-year period. For further details, see: [https://www.usaid.gov/global-health/health-areas/family-planning/couple-years-protection-cyp#:~:text=Couple%20Years%20of%20Protection%20\(CYP\)%20is%20the%20estimated%20protection,to%20clients%20during%20that%20period](https://www.usaid.gov/global-health/health-areas/family-planning/couple-years-protection-cyp#:~:text=Couple%20Years%20of%20Protection%20(CYP)%20is%20the%20estimated%20protection,to%20clients%20during%20that%20period)

³⁰ *Health Portfolio Annual Report: January to December 2021*, HDMES, 2022, p. 11.

³¹ It is important to note this was stated without any obvious negative connotation. It was simply a statement that Government of PNG stakeholders do not always know where Australian support is directed.

Australia. This could be driven by the AHC Health Team, as flag-bearers for the Australian brand, being more visible throughout the different levels of NDoH.

Finally, it is important to note the inclusion of the Australia–PNG bilateral relationship goal in the HPP program logic was significant from an internal management perspective. Former AHC staff noted the importance of shifting the AHC team’s understanding of Australia’s relationship with PNG away from donor-recipient, and towards partnership based on mutual economic and strategic interests. In this respect, Goal 2 was a mechanism to ensure the AHC team remained cognisant that the Health Portfolio contributed to enhancing the relationship between the 2 countries. From an internal management perspective, the inclusion of the goal was successful. Current AHC staff consistently stressed the importance of the HPP in contributing to the Australia–PNG relationship, with long-serving staff clearly distinguishing the contemporary CSEP approach from the former donor-recipient approach.

Progress towards Objective

The HPP Objective *is improved health of the citizens of Papua New Guinea in selected provinces and districts relating to TB, family planning, sexual and reproductive health, HIV, and maternal and child health*. The rationale underpinning the Objective was that it ‘will contribute to the Goal by being a subset of the health improvements envisaged in the Goal, both in terms of a more limited geographical coverage and smaller set of health outcomes’.³² While the HPP M&E Framework draws the limited geographical scope and smaller set of health outcomes together by noting indicators are only to be monitored in the provinces and districts where HPP-funded investments operate, the geographical scope of the portfolio is not defined. Different HPP investments focus on different provinces. Progress towards the Objective is therefore assessed here in terms of outcomes, rather than geography.³³

Tuberculosis

Portfolio TB investments have made a significant contribution to increasing and maintaining a treatment success rate of over 80% in NCD and Western Province (in 2020). In Western Province, efforts to improve treatment have focused on Daru. The largest gains were achieved at the commencement of Australian Government support to the TB program in Western Province, with treatment success rates increasing in Daru between 2013 and 2016 for Drug-Sensitive-TB (65.4% to 84.5%) and Drug-Resistant-TB (50% to 88.1%), reaching over 85% prior to COVID-19. These treatment success rates are high compared to both international and national standards, with a national treatment success rate of 78%, ranging from 54% in Hela to 95% in Gulf.³⁴ COVID-19 resulted, in some instances, in a slight decline in quality of care, with delayed recognition and management of bacteriological treatment failure in some key patients. In Daru, loss to follow-up (LTFU), which is important for both individual patient outcomes and preventing resistance amplification, remains low, although it is slightly better (lower) for Drug-Sensitive-TB compared to Drug-Resistant-TB, which has a longer treatment regime with a higher toxicity.³⁵

³² Health Portfolio Plan, p. 34.

³³ It should be noted, however, that some HPP investments, particularly those concerned with TB, had a clearly defined and narrow geographical focus.

³⁴ *Sector Performance Annual Review 2020*, NDoH, August 2021 (referred to as SPAR 2020).

³⁵ *TB Treatment Outcomes in Daru BMU*, Burnet Institute, 2022.

Family Planning

NDoH performance indicators show positive progress for family planning prior to COVID-19, although there remains a high level of unmet need. There was nationwide progress with regard to CYP per 1,000 women³⁶ between 2016 and 2020. CYP increased by one-third, from 102 to 136 years per 1,000 women aged 15–44 years.³⁷ The change was consistent with the trend prior to the HPP, when the Modern Contraceptive Prevalence Rate (mCPR) among married women increased from 24% to 31% between 2006 and 2016–2018.³⁸ The HPP Partnering for Strong Families investment contributed to this continued progress between 2018 and 2020³⁹, particularly during 2018–2019, when 13 PSF-supported provinces reported increases in CYP, and 5 of those achieved PNG’s largest CYP improvements.⁴⁰ The increase in a number of provinces was not sustained following the transition to the second phase of PSF in 2020, when reduced funding from a no-cost extension saw the closure of several service delivery teams. With the onset of the COVID-19 pandemic, CYP declined nationally to 100 in 2021 and 96 in 2022 (to October).

There is limited data on whether these gains in CYP prior to 2020 addressed existing inequities. There is no disaggregated data available on increases in CYP by age and marital status, with significant unmet need for modern contraceptives among married women in the poorest quintile (31%) and sexually-active unmarried women (65%), particularly in rural areas (70%).⁴¹ Research published by the PNG Institute for Medical Research, based on data from 4 rural areas, suggests that unmet need for modern contraceptives (35% among married women) is higher than the unmet need suggested by the Demographic and Health Survey (DHS) (26% for married women).⁴²

Sexual and Reproductive Health, and HIV

According to UNAIDS, PNG is one of 38 countries in which the number of new HIV infections has increased since 2015 (from 3,400 in 2016 to 3,800 in 2021),⁴³ although the overall prevalence is projected to have declined from 7.43% (2016) to 6.45% (2021).⁴⁴ NDoH measures progress with regard to HIV confirmed prevalence in pregnancy among women aged 15–24 years, with data showing a consistent positivity rate around 1% for women presenting at antenatal care (ANC) across the country between 2016–2020. This needs to be considered against other trends. For example, between 2019 and 2020, there was an increase in the positivity rate from 0.93% to 1.00% and, critically, a 30% decrease in the number being tested, from 28,548 to 19,927.⁴⁵

³⁶ CYP measures the number of years protection provided by all modern methods (sterilisation, injectable Depo-Provera, oral contraceptive pill, intra-uterine devices, and implants) in 1 year (SPAR 2020). It is considered a proxy for contraceptive prevalence, which can only be measured through a household survey.

³⁷ For details, see Table A1 in Annex 1 (SPAR 2020). The SPAR notes that there was a change in measurement in CYP in 2020; although the impact of this on the trend analysis is unknown. The 2021 SPAR data was not available at the time of writing.

³⁸ *Papua New Guinea Demographic and Health Survey 2016–18*, PNG National Statistical Office, 2019, available at: <https://www.dhsprogram.com/pubs/pdf/FR364/FR364.pdf> (referred to as PNG DHS 2016–18).

³⁹ These years were selected for this analysis as the program commenced in mid-2017. The first phase ended in March 2020, with a no-cost extension to June 2020. The PSF evaluation found the no-cost extension had a significant impact on program activity. See *Partnering for Strong Families (PSF) Evaluation*, HDMES, June 2022 (referred to as PSF Evaluation).

⁴⁰ Review Team analysis based on SPAR 2020 data.

⁴¹ PNG DHS 2016–18.

⁴² ‘Measuring unmet need for contraception among women in rural areas of Papua New Guinea’, *Sex Reprod. Health Matters*, Vol 28(2), B.N. Pham, M. Whittaker, A.D. Okely, & W. Pomat, December 2020, DOI: 10.1080/26410397.2020.1848004. PMID: 33308048; PMCID: PMC7888066.

⁴³ *In Danger: UNAIDS Global AIDS Update 2022*, Joint United Nations Programme on HIV/AIDS, 2022, Licence: CC BY-NC-SA 3.0 IGO.

⁴⁴ *AIDSinfo*, UNAIDS, UNICEF & WHO, available at: <https://aidsinfo.unaids.org/>.

⁴⁵ SPAR 2020.

UN modelling projects an increase in the number and proportion of HIV-positive people receiving ART treatment from 23,875 (53%) to 38,376 (65%) between 2016 and 2021.⁴⁶ PNG modelling also showed an increase in the proportion of HIV-positive pregnant women receiving treatment for HIV between 2016 (38%) and 2019 (82%), although a decrease in 2020 (64%).⁴⁷ Given the static coverage of ANC between 2016 and 2020, it is plausible that HIV-positive women are less likely to be identified during pregnancy, and plausible that the high vertical transmission rate will also remain largely unchanged, with 35–36% of children born to women living with HIV acquiring the condition.⁴⁸

While DFAT invested significant funding in this area through SRHIP and PSF, collectively AUD53.925 million between 2017 and 2022, positive population outcomes are yet to be fully realised.

Maternal and Child Health

National data on child and maternal health show mixed results prior to COVID-19, and decline or stagnation since that time. Coverage of child and maternal health interventions supported by HPP investments, which would be expected to contribute to declining mortality rates,⁴⁹ show mixed results prior to COVID-19, and decline or stagnation since that time. Coverage of childhood immunisations, in select provinces, outreach clinics, and CYP (discussed above), increased nationally between 2016 and 2020 before declining in 2021 (17% decline for third dose pentavalent, 16% decline for outreach, and 26% decline for CYP).⁵⁰ Coverage of other interventions targeted by HPP investments, including ANC visits and births delivered in facilities, showed stagnation at the national level between 2016 and 2019, with a decline in coverage between 2020 and 2021 (6% for ANC, and 8% for births in facilities). The decline in coverage, against the backdrop of COVID-19, is consistent with global trends, with 67% of countries in the Western Pacific region reporting declines between 5% and 25% in use of both primary care and immunisation services in 2021.⁵¹ Data between January and October 2022 suggests mixed performance across all of these interventions. None have yet surpassed coverage from 2016 or 2019 levels, except childhood outreach clinics.⁵²

Declining Mortality

Estimates generated from the most recent Demographic and Health Survey indicate that maternal and child mortality rates declined in the 10 years prior to the HPP.⁵³ Between the 2006 and 2016–18 DHS, it is estimated the MMR reduced from 773 to 171 per 100,000, although local research, conducted between 2008 and 2014 at facilities and/or community settings, have estimated a MMR between 68 and 900 per 100,000 live births.⁵⁴ The 2 DHS from 2006 and 2016–18 also indicate that the U5MR reduced from 75 to 49 deaths per 1,000 births for the 5 years preceding the survey.⁵⁵ No

⁴⁶ *AIDSinfo*, UNAIDS, UNICEF & WHO, available at: <https://aidsinfo.unaids.org/>.

⁴⁷ SPAR 2020.

⁴⁸ *AIDSinfo*, UNAIDS, UNICEF & WHO, available at: <https://aidsinfo.unaids.org/>.

⁴⁹ For example, Marie Stopes PNG projected that CYP increases over the course of the program resulted in reductions in unintended pregnancies (205,279), maternal deaths (253), and unsafe abortions (22,443). See PSF Evaluation.

⁵⁰ For details, see Table A1 in Annex 1.

⁵¹ *Third Round of the Global Pulse Survey on Continuity of Essential Health Services during the COVID-19 Pandemic: November–December 2021*, WHO, February 2022, available at: https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2022.1. Countries completed the third round of the survey between November and December 2021, and were asked to report on the situation in the previous 3 months.

⁵² Review Team analysis based on data in the National Health Information System and SPAR 2020.

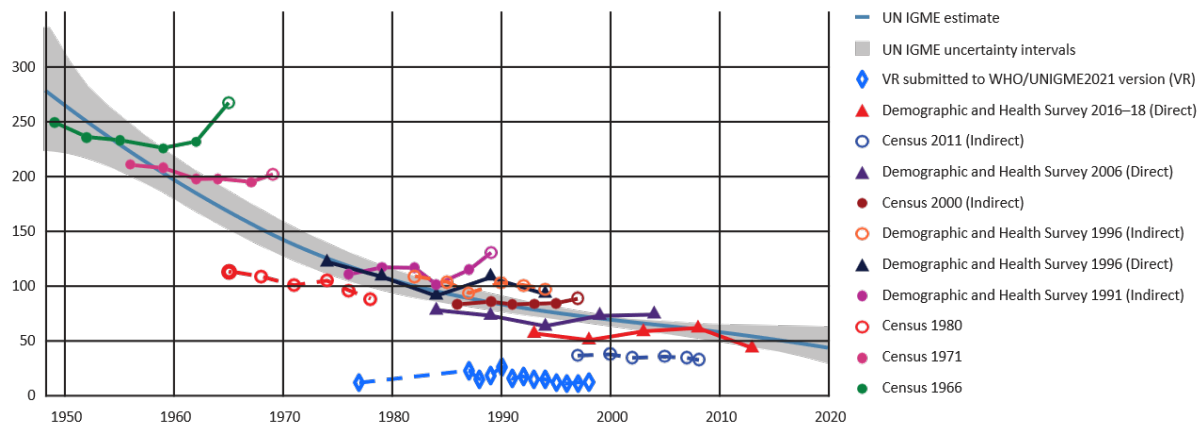
⁵³ Data from the DHS conducted in 2006–2007 was used as the baseline for child and maternal mortality in the HPP results matrix. This evaluation has used the data from PNG DHS 2016–18, which coincided with the commencement of the HPP, as the baseline to measure the impact of the HPP.

⁵⁴ 'Maternal and newborn health indicators in Papua New Guinea – 2008–2018', *Sex Reprod. Health Matters*, Vol 27(1), G. Robbers, J.P. Vogel, G. Mola, J. Bolgna & C.S.E. Homer, December 2019,,1686199, DOI: 10.1080/26410397.2019.1686199. PMID: 31790637; PMCID: PMC7888046.

⁵⁵ PNG DHS 2016–18.

national household survey data is available to verify this and assess whether these trends have continued. Modelling from the UN Inter-agency Group for Child Mortality Estimation, which is largely based on the DHS data, predicts that this trend continued until 2020 (U5MR of 44), as shown in Figure 7 below. Some positive trends in outcome indicators tracked on an annual basis support this modelling, showing a decline in the number of children who are moderately or severely underweight and the incidence of diarrhoeal diseases⁵⁶, as well as a small decline in the case fatality rate for children aged under 5 years at provincial hospitals (7.5% in 2011, 7.3% in 2016, and 5.4% in 2021), although the quality of the data is unknown.⁵⁷

Figure 7: Estimates of Under-5 Mortality Rates



Source: UN Inter-agency Group for Child Mortality Estimation⁵⁸

It is important to note that concerns have been raised about the quality of the DHS mortality estimates, and the accuracy of the mortality trends mentioned above. Total Fertility Rate (TFR) and prevention of childhood communicable disease, which are regarded as important in reducing maternal and child mortality, did not decline between the 2 most recent DHSs. Between the DHS in 2006 and 2016–18, there was minimal change in the TFR (4.2 and 4.4) and a 30% decline in the proportion of fully-immunised children aged 12–23 months.⁵⁹ Recent research by the PNG Institute of Medical Research estimates the child mortality rate was higher than suggested by the most recent DHS. The research estimated an U5MR of 93 (using direct estimates based on birth and death records) and 105 (using indirect estimates based on maternal birth history) between 2014 and 2017⁶⁰, based on data collected in 4 provinces, with the large range reflecting the uncertainty of the estimates.⁶¹

⁵⁶ SPAR 2020.

⁵⁷ *Child Morbidity and Mortality: 12th Annual Report, 2021*, NDoH & Paediatric Society of PNG, available at: <https://pngpaediatricsociety.org/wp-content/uploads/2022/07/2021-Annual-Child-Morbidity-and-Mortality-Report.pdf>. It should be noted that hospital admissions for children under 5 years of age also increased over this time period at a rate higher than the population growth rate (which may be due to improved care-seeking and referral practices), meaning the improved management of childhood conditions at hospitals may not yet lead to a decline in the overall U5MR.

⁵⁸ See: <https://childmortality.org/data/Papua%20New%20Guinea>.

⁵⁹ PNG DHS 2016–18. See also: ‘Estimating Child Mortality at the Sub-national Level in Papua New Guinea: Evidence from the Integrated Health and Demographic Surveillance System’, *Front Public Health*, Vol 27(9), B.N. Pham, R.B. Emori, T. Ha, A.M. Parrish, & A.D. Okely, January 2022, DOI: 10.3389/fpubh.2021.723252. PMID: 35155330; PMCID: PMC8830799.

⁶⁰ Pham et al., January 2022.

⁶¹ Eastern Highlands Province (EHP), Central, Hela, and Madang Provinces. The U5MR varied from 39/42 in Central Province to 147/159 in EHP for the direct/indirect estimates.

Immunisation

Data indicates HPP investments contributed to improved immunisation coverage in target provinces. The third dose of pentavalent vaccine among children under 1 year of age, for example, increased, on average, 38% in HPP investment-supported Accelerated Immunisation Health Systems Strengthening (AIHSS) provinces (versus 24% in GAVI-supported AIHSS provinces, and minus 13% in non-AIHSS provinces), between 2018–2019 and 2020–2021.⁶² Due to COVID-19, all HPP-investment-supported AIHSS provinces experienced a decline in coverage of the third dose of pentavalent vaccine between 2020 and 2021 (average 17% decline).⁶³

Newborn Care

National coverage of births in facilities did not increase. While there was no project baseline, the Saving Lives Spreading Smiles (SLSS) investment estimated that the proportion of at-risk newborns delivered in health facilities in selected provinces, who received skin-to-skin contact, was 52% to 84% (N=19,022) in 2020.⁶⁴ Similarly, the investment estimated that between 22% and 62% of low birth weight newborns (N=4,798) delivered in facilities in select provinces received kangaroo care.⁶⁵

3.3. Key Review Question 3: Effectiveness

To what extent is the Health Portfolio Plan making progress towards the 3 End of Investment Outcomes?

Progress towards EOI01: Health Security and Major Communicable Diseases

HPP investments were effective as vertically-aligned programs, achieving and maintaining a high TB treatment success rate in 2 provinces, and improved coverage of immunisations prior to COVID. The achievements in service delivery were not matched by improvements in the health security system.

NDoH, PHA, Provincial Hospital and Primary Care Capacity to Lead an Effective Health Security System, and Prevent, Detect and Respond to Public Health Security Threats

- *To what extent has the capacity of NDoH and selected PHAs to lead an effective health security system improved due to HPP investments?*
- *To what extent has the capacity of NDoH, and selected PHAs, provincial hospitals and primary health care centres to prevent, detect and respond to public health security threats improved due to HPP investments?*

Given the overlap between the 2 review sub-questions, these are addressed together here. HPP investments contributing to capacity to lead an effective health security system, and to prevent, detect and respond to health security threats, are summarised in Table 3 below.

⁶² SPAR 2020; PHA Performance Report 2021, NDoH, July 2022.

⁶³ PHA Performance Report 2021.

⁶⁴ Saving Lives, Spreading Smiles Review, HDMES, July 2021. For low birth weight newborns, between 22% and 55% could have received kangaroo care; and for newborns with asphyxia, between 23% and 60% could have been resuscitated.

⁶⁵ Saving Lives, Spreading Smiles Review.

Table 3: Summary of HPP Health Security Investments

Investment	Year	Provinces	Diseases	Outcome Areas	Strategy
Trilateral Malaria Project	2016	National (Phase 1 and 2); West Sepik PHA (Phase 2)	Malaria	Detect (Phase 1 and 2); prevent, respond (Phase 2)	Capacity development
RID-TB (Burnet) and Stop TB/ DART TB (WVI)	2011, 2014–2025 ⁶⁶	Western Province (RID-TB, Stop TB), NCD (some exchange through RID-TB)	TB, with a focus on MDR/DR-TB	Prevent, detect and respond	Direct service delivery and capacity development
DFAT–WHO Bilateral Partnership	2018–2022	National	General and TB, with a focus on MDR/DR-TB	Detect and respond	Technical assistance and training
AIHSS	2020–2022	ARoB, East Sepik, Madang, Morobe, Jiwaka, Western, Western Highlands	Communicable diseases prevented through childhood immunisations ⁶⁷	Prevent (vaccination)	Direct service delivery and capacity development
HSIP (COVID-19 Funds)	2021–2022	All 22 provinces	COVID-19	Prevent (vaccination capacity)	Financing only

HPP investments have been successful in terms of TB treatment success rates and immunisation coverage. In challenging contexts, these successes are noteworthy. In considering how the different investments sought to move beyond service delivery and develop capacity to lead an effective health security system, and to prevent, detect and respond to public security threats, 3 interrelated themes emerge. First, the design and implementation of the investments were not conducive to system strengthening. Second, the dual focus of the investments on health security and Australia’s national interest may have undermined efforts to strengthen capacity. Finally, imperatives associated with delivering essential services (generally in an emergency response setting) often competed with those associated with systems strengthening. Each of these themes influence the effectiveness of the portfolio moving towards achievement of EOIO1.

Investment Design

The portfolio’s health security-related investments were designed, implemented and monitored as discrete programs at different times and according to different timeframes. With the exception of the DFAT–WHO Bilateral Partnership, they were designed through a vertical disease/intervention paradigm. A number of the investments were a direct response to a public health emergency (TB, COVID-19, and childhood disease outbreaks). The disease/intervention paradigm had 3 effects:

1. Three out of 5 investment designs were emergency response measures rather than designs based on a comprehensive assessment of health security risks and capacities. While respondents noted that efforts were made to encourage the Government of PNG to undertake a Joint

⁶⁶ Australian Government funding for TB in Western Province began in 2011. Stop TB/DART (through World Vision International/WVI) began in 2011. RID-TB (through Burnet Institute) commenced in 2014.

⁶⁷ Diphtheria, tetanus, pertussis, hepatitis B, haemophilus influenzae type B, polio, streptococcus pneumoniae, and tuberculosis.

External Evaluation of its capacities according to the International Health Regulations, other national assessments were not undertaken to inform program design.

2. Given the emergency response, there was no overarching strategy for how the investments would collectively strengthen the health security system. At best, as was the case with AIHSS, there was limited definition of specific strategies to strengthen the health security system in the program design. In the case of the TB and COVID-19 investments, which were rapidly established to respond to health security emergencies, there was minimal investment design, with systems strengthening initiatives an afterthought. At the time, the imperative of a rapid response to save lives was understandably and justifiably regarded as a higher priority than health system strengthening.
3. There was limited formal exchange and/or learning across investments to address gaps and maximise synergies in HPP efforts to strengthen the health security system, either during or after implementation. Where elements of the health security system have been strengthened within a disease-specific program, such as malaria microscopy, there has been little consideration of transferability to other diseases and/or other geographical areas within or between provinces. This is consistent with the slight decline in PNG's score on the Global Health Security Index between 2019 and 2021.⁶⁸

Coordination Challenges

The lack of an overarching strategy for health security system strengthening often results in investments focusing on a single disease, working to resolve issues in silos, and working without an explicit assessment and prioritisation of needs across the system. At provincial hospitals, for example, laboratory capacity is often identified as a core health security system issue. The Trilateral Malaria Project (TMP) responded by strengthening laboratory services at the Central Public Health Laboratory (CPHL) and some provincial hospitals for malaria diagnostics, as well as other vector-borne and viral infections. At the same time, however, CPHL has limited capacity to perform genetic testing for multiple drug-resistant TB, limited capacity to store TB samples, and has been hamstrung by infrastructure challenges (for example, among many issues, a collapsed roof).

Dual Focus Undermines Capacity Strengthening

Respondents highlighted the dual focus of health security investments. On one hand, the investments are concerned with strengthening the PNG health security system. On the other, they promote Australia's interests, including the need to control MDR-TB on Australia's border, the interest in partnering with China in an area of mutual interest (Trilateral Malaria Project), and the interest in ensuring Australia was publicly seen and acknowledged to be a valued partner in responding to the COVID-19 emergency. The pursuit of these priorities impacted the effectiveness of in-country efforts to strengthen the health security system. Respondents highlighted, for example, that the TMP provides low value for money for the health outcomes it produces⁶⁹; that the model for the detection and treatment of TB in Daru could not be maintained or replicated in Western Province or other PNG provinces without significant external assistance; and that there was very limited monitoring of the COVID-19 funds provided to PHAs, in part due to staff workloads during the pandemic response.

⁶⁸ See *Global Health Security Index 2021: Country Score Justifications and References, Papua New Guinea*, available at: <https://www.ghsindex.org/wp-content/uploads/2021/12/Papua-New-Guinea.pdf>. See also: <https://www.ghsindex.org/country/papua-new-guinea/>

⁶⁹ It is worth noting that the malaria program does not align with the HPP Objective, which specifically refers to TB, family planning, sexual and reproductive health, HIV, and maternal and child health.

Systems Strengthening and Service Delivery Imperatives

Systems strengthening is a longer-term endeavour concerned with improving human resources capacity, institutions, governance, operational processes, and the linkages between each of these. The portfolio investments concerned with health security were not conceived with these longer-term endeavours in mind. Rather, except for the DFAT–WHO Bilateral Partnership, they were conceived in response to health security emergencies requiring immediate action. As a result, health security system strengthening, and initiatives to improve systemic capacity to prevent, detect and respond to public security threats, have often been de-prioritised when weighed against more immediate service delivery imperatives.

In primary care, for example, both AIHSS and the TB program were confronted by financial management and human resources constraints at the PHA-level, which impacted their capacity to address urgent service delivery needs. HSIP confronted similar challenges at the national level in seeking to support the PHA COVID-19 response. In each of these instances, the investment-level response was to substitute capacity or streamline governance requirements to achieve necessary coverage and treatment outcomes. With regard to the TB program, for example, interview respondents from AHC, the PHAs, and the NGOs involved, recognised this approach was necessary, given the PHAs in NCD and Western Province were not established or fully operational. With regard to AIHSS, while the intent was to partner directly with PHAs, only 2 (Western and Eastern Highlands) were assessed to have sufficient financial management capacity.

Detection and Treatment of TB at Provincial Hospitals in Target Provinces

- *To what extent has the capacity of selected provincial hospitals to detect and treat TB in target provinces improved due to HPP investments?*

Consistent with the 2018 review of DFAT investments in TB⁷⁰, data reviewed for this evaluation has found the projects were effective at increasing and maintaining the detection and treatment of TB. It also found, however, the changes are project-dependent and do not stem from improved capacity at Daru General Hospital, or the health system more broadly. Moreover, they have not yet translated into a decline in case notifications in either province, given that there has been no change in the underlying determinants. For these reasons, a long-term view is needed of prevention, detection and treatment of TB, and the strengthening of systems necessary to achieve this.

Detecting TB

NCD and Western Province, where portfolio investments have been focused, continued to record the highest Case Notification Rates (CNRs) in the country, as of 2020.⁷¹ Prior to COVID-19, case notification rates increased in NCD and marginally in Western Province between 2016 and 2019, and may in part reflect improved routine detection capacity, including by capacity to provide laboratory diagnosis of DS-TB and DR-TB. Recent data shows there was an approximately 20% decline in case detection in Daru across 2020–2021 in the context of COVID-19.⁷² This decline reflects both demand- and supply-side constraints, with minimal case finding (detection) activities taking place in the province in 2020 and 2021.⁷³ There is also some evidence of a decline in the quality of detection at Daru during COVID-19, with reports of late detection for a cluster of patients with pre-XDR TB.⁷⁴

⁷⁰ *TB Prevention and Control in PNG: Report of the Review of Contribution of DFAT Investments 2011–2018*, DFAT Specialist Health Services, March 2019 (referred to as TB Prevention and Control in PNG).

⁷¹ In 2020, the CNR per 100,000, was 1,199 in NCD and 547 in Western Province, compared to 533 in West New Britain and 470 each in Morobe and Madang (SPAR 2020).

⁷² *RID-TB IIB: Six monthly report, Jul–Dec 2021*, Burnet Institute, 2022.

⁷³ *RID-TB IIB: Six monthly report, Jul–Dec 2021*, Burnet Institute, 2022.

⁷⁴ *TB Treatment Outcomes in Daru BMU*, Burnet Institute, September 2022.

Interview respondents expressed a need to improve the investment's case finding activities, which were initiated again in 2022, including through the training of Treatment Supporters to conduct case finding outside of Daru.⁷⁵

Treating TB

As outlined in the impact-level discussion about TB earlier in this report, portfolio TB investments have made a significant contribution to increasing and maintaining treatment success rates over 80% in NCD and Western Province (in 2020). The treatment success rates are high compared to both international and national standards, demonstrating the investment's service delivery effectiveness.⁷⁶

Capacity to Detect and Treat TB

Portfolio investment success in detecting and treating TB (service delivery) is not replicated in terms of improved capacity to detect and treat TB (systems strengthening). The RID-TB and Stop TB programs aim to 'identify health system bottlenecks for TB, and design and support the implementation of systems solutions'. The Burnet Institute describes its approach as 'field implementation support', where 'experienced staff support program implementation and in conjunction build capacity of local staff'.⁷⁷ Some gains have been made in Daru, including improving clinical knowledge, skills, and processes within the hospital. These gains are reflected in a declining death rate for DR-TB prior to COVID-19 and the declining length of stay at Daru General Hospital.⁷⁸

Outweighing the gains, however, are a range of external and systemic factors that highlight the limitations of a systems strengthening approach reliant on building the capacity of staff. These factors reflect the limitations highlighted above in terms of the lack of progress in improving capacity to lead an effective health security system. They include:

- Human resource challenges associated with living in Daru (poor facilities and staff housing), with travel restrictions during COVID-19, and PHA staffing.
- Lack of a strategic plan to shift away from emergency response programming; to consider the need for decentralising and strengthening the capacity of services at other levels (such as district hospitals and upper-level primary facilities), which are more proximate to much of the population in the province; and to consider exit and sustainability strategies, in light of lacklustre improvements in the underlying social determinants and population mobility.⁷⁹
- Limited capacity of the PHA to assume responsibility for program initiatives.

Malaria Laboratory and Diagnostic Functions

- *To what extent have the selected malaria laboratory and diagnostic functions been strengthened due to HPP investments?*

A key objective of the TMP over Phases 1 and 2 was to 'increase the quality of malaria diagnosis in the Papua New Guinea health services'. This has only been achieved to a limited extent, due to the sole focus of TMP on microscopy, but preference for using rapid diagnostic tests (RDTs) in the field. The 2018 Mid-Term Review of Phase 1 noted that there were indications of the early effectiveness of the investment at improving microscopy capacity for malaria diagnosis: 136 microscopists

⁷⁵ *Strengthening Community Response to Stop TB in Western Province: Jan–Jun report, 2021*, World Vision International, 2021.

⁷⁶ SPAR 2020.

⁷⁷ *RID-TB IIB: Six monthly report, Jul–Dec 2021*, Burnet Institute, 2022, page 17.

⁷⁸ TB Prevention and Control in PNG.

⁷⁹ TB Prevention and Control in PNG.

participated in the WHO External Competence Assessment for Malaria Microscopists across Phase 1 and 2; 17 microscopists were accredited at Level 1 and 37 at Level 2. While the proportion of reported malaria cases diagnostically confirmed through microscopy or RDT increased from approximately 65% to 93% between 2017 and 2021,⁸⁰ the contribution of microscopy to this increase is minimal, as microscopy only accounted for approximately 3% of confirmed cases for malaria in 2021. The TMP 2021 Annual Report acknowledges the use of microscopy as 'low', although believes it is underreported. Limiting factors include the fact that trained microscopists are located at only 20 of 73 functioning laboratories across the country (27.4% coverage),⁸¹ and there is limited provision of necessary microscopy supplies.

Both Phase 1 and Phase 2 of the TMP placed emphasis on strengthening the national capacity of CPHL and PNG Institute of Medical Research (PNGIMR), with this objective forming a more explicit part of the design in Phase 2, yet this has been disease or virus-specific. The project has funded staff salaries in both the CPHL and PNGIMR; provided financial and coordination support for the procurement of necessary laboratory consumables at CPHL; and supported strategic initiatives such as a malaria blood slide-bank at CPHL and a Molecular Hub to monitor vector-borne pathogens and anti-malarial drug resistance markers at PNGIMR. TMP support is predominantly focused on malaria, but also included COVID-19, dengue, and other arboviruses. As this is newly emerging work, its outcome is unclear at this point, although it is likely to result in the strengthening of the capacity for microscopic diagnosis and surveillance for malaria.

Progress towards EO102: Rural Primary Health Care

Efforts have had mixed results to strengthen capacity to disburse health budgets and staff health facilities through the support of HPP.

Effective, efficient and sustainable primary health care ultimately depends on 4 input factors – sufficient operational funding, a sufficient number of appropriately trained and qualified health personnel, adequate medical supplies, and adequate quality infrastructure.⁸² The HPP Intermediate Outcomes focus on 2 of these: funding and health personnel. A recurring theme of the review is that health systems strengthening initiatives are often hamstrung by concerns about these 2 inputs. While total health spending per capita in PNG increased slightly between 2016 and 2019 (from USD60 to USD65 per capita), this was largely due to an increase in aid (from 18% to 32% of total health spending). PNG government expenditure declined as a share of total health spending (from 72% to 58%), while the share of the budget allocated to health also declined (from 8% to 6%).⁸³ The number of health workers per 10,000 people increased slightly between 2000 and 2010 (4.89 to 4.95), but then declined between 2010 and 2019 (from 4.95 to 4.53).⁸⁴ Between 2018 and 2019, prior to the COVID-19 pandemic, the total number of nurses in PNG reportedly declined from 4,673 to 3,975.⁸⁵

The challenges in health financing and staffing were recognised in the HPP, which noted that 'improving primary health care is difficult because of the inefficiencies in the health financing

⁸⁰ *6-Monthly Report: Jan–June Report 2022*, Trilateral Malaria and Health Security Phase 2, 2022; *Annual Report January–December 2021*, Australia–China–Papua New Guinea Trilateral Collaboration on Malaria and Health Security, 2022. Note that the confirmation rate between January and June 2022 further increased to 94.5%.

⁸¹ *6-Monthly Report: January–June 2022*, Trilateral Malaria and Health Security Phase 2, 2022.

⁸² *Line of Sight: How Improved Information, Transparency, and Accountability Would Promote the Adequate Resourcing of Health Facilities Across Papua New Guinea*, A.I. Cairns & J. Wolff, ADB, June 2019, p. 26 (referred to as Line of Sight).

⁸³ Global Health Expenditure Database, WHO, available at: <https://apps.who.int/nha/database/Select/Indicators/en>.

⁸⁴ *2022 Update, Global Health Workforce Statistics*, World Health Organization, available at:

<https://www.who.int/data/gho/data/themes/topics/health-workforce> (referred to as Global Health Workforce Statistics).

⁸⁵ Global Health Workforce Statistics.

disbursement system, issues in staff recruitment and retention, [and] facility upkeep and maintenance’. Importantly, it also noted that ‘the influential stakeholders and actors on these issues are often outside NDoH’, including the Departments of Finance, Treasury, National Planning and Monitoring, and Personnel Management.⁸⁶ The HPP’s second outcome, formulated in response to these challenges was concerned with *NDoH, other agencies and selected PHAs and District Development Authorities improving utilisation of government finance and improving health worker recruitment and retention.*

Capacity to Disburse Health Budgets

- *To what extent have NDoH, Department of Finance, Department of Treasury, and selected PHAs improved their capacity to disburse health budgets?*

Capacity to disburse health budgets is a multi-layered problem. Cairns and Wolff suggest it should be framed in terms of ‘enabling’, or ‘ensuring that the right funding and/or in-kind support is available at the right place at the right time’.⁸⁷ It is a problem that can be viewed from the top down, where Department of Treasury warrants lead to revenue flow from the Department of Finance to Provincial Health Authorities (through health function and hospital grants), and eventually to health facilities. It can also be viewed from the bottom up, where cost of service and budget information needs to flow from facilities to PHAs, and eventually the Department of Treasury. Achieving the ‘right funding at the right place at the right time’ is not the responsibility of one agency. It is an inter-agency effort that requires different capacities (institutions, systems, processes and people) *within* NDoH, the Departments of Treasury and Finance, and the PHAs; and it requires different capacities for interaction and engagement *between* them, synchronising intra-agency and inter-agency coordination.

Individual HPP investments have attempted to tackle the capacity to disburse health budgets in different ways, as highlighted by the selection of activities and outputs in Table 4 below:

Table 4: HPP Investment Support to Budget Disbursement Capacity

HPP Investment	Support to Capacity Development	Agency of Focus
AIHSS	<ul style="list-style-type: none"> • Immunisation Support Providers support the improvement of financial management and accountability. Examples include: <ul style="list-style-type: none"> ▪ Gulf PHA: Supported to establish costings for outreach patrols and immunisation activities against the health functional grant allocations. ▪ West Sepik PHA: Supported to prepare activity-budgets. ▪ ABG: 42 health centres trained on financial procedures and the procedural requirements to have funding requests approved. • Opened dedicated bank accounts for PHAs with Immunisation Support Providers being joint signatories to mitigate risks to operations. 	PHAs
HSSDP	<ul style="list-style-type: none"> • Produced PFM modules for PHAs, health sector agencies, and stakeholders, to guide them in improving compliance with central agency and legislative requirements. • Trained Corporate Services staff in all PHAs about PNG’s budget process, alignment requirements, and methods of budgeting. • Supported establishment of a Technical Working Group for developing health service costings for Level 1 to Level 4 facilities. 	PHAs NDoH DoT

⁸⁶ Health Portfolio Plan, p. 43.

⁸⁷ Line of Sight, p. 41.

HPP Investment	Support to Capacity Development	Agency of Focus
HSIP	<ul style="list-style-type: none"> Procedural PFM training to ensure appropriate oversight of the sector-wide approach mechanism and fiduciary obligations. 	NDoH DoF DoT
PATH	<ul style="list-style-type: none"> Provincial Facilitators support PHAs to align with financial instructions, guidelines and circulars, the DoF Finance Management Manual, the draft Audit Manual, the Audit Act, quarterly reporting requirements, and budget formulation requirements. Independent PFM reviews conducted by Ernst and Young and Deloitte of EHP PHA and WHP PHA. Corrective Action Plan developed to specifically address PFM weaknesses/gaps in both PHAs to ensure readiness to establish and oversee subsidiary HSIP Trust Accounts and the receipt of AIHSS grant funding. 	PHAs
WBW	<ul style="list-style-type: none"> Targeted financial management strengthening across Gulf, Southern Highlands, and Hela PHAs, which included establishment of Finance Sub-committees and procurement policies. Trialed facility-based budgeting in Hela, in partnership with churches, district health managers, and officers-in-charge (OICs). 	PHAs
WHO	<ul style="list-style-type: none"> Supported establishment of the Inter-agency Financing and Budget Committee for COVID-19, chaired by NDoH with DoT, DoF, and DNPM to strengthen the whole-of-government approach to financing the pandemic. Provided inputs into NEFC/NDoH Provincial Health Authority regional workshops. 	NDoH DoT DoF PHAs NEFC

Source: HPP Investment Progress Reports

The different activities and capacity development initiatives referenced in the table above represent substantial effort and use of resources across 6 of the portfolio's investments. In a number of instances, they have contributed to positive outcomes. The support provided by *Wok Bung Wantaim*, for example, has led to the establishment of working and functioning Finance Committees, Disciplinary Committees, stronger Board oversight of PHA budget and expenditure issues, and the establishment of several internal policies and procedural requirements to further strengthen and tighten the financial frameworks being used by the supported PHAs to disburse public funds.

Despite the effort and the resources, seemingly intractable obstacles remain. There is a persuasive argument that the continued obstacles result from the scale of the problem. The central premise of this argument is that PNG's PFM challenges are far more complex than can be resolved through the technical assistance provided in the selected activities of several HPP investments. There is, however, an equally valid argument, which acknowledges the complexity of the PFM challenges, but posits that more can be achieved from Australia's investments. The review supports this second argument.

- Despite the HPP Intermediate Outcome referring to support to NDoH, DoF, DoT, and PHAs, there is a lack of balance in implementation. This has resulted in a skewing of support towards PHAs. This is valid and understandable for at least 3 reasons. First, PHAs are the most accessible agency for the investments whose work is concentrated at the subnational level (AIHSS, PATH, SRHIP, and WBW). Second, PHA problems and capacity issues are most readily understood, and support to them can be more simply designed and delivered, especially by organisations whose core competencies are often not associated with PFM. Finally, Health Team staff at the AHC and investment levels often have strong relationships within the health sector, but limited relationships and engagement with the non-health agencies that are so critical to more effective disbursement of funds.

- HPP engagement with DFAT’s economic governance work is currently not substantive. AHC and government respondents agreed that addressing longstanding PFM challenges requires greater engagement with the central agencies. While the AHC Health Team acknowledged there is some interaction with the AHC Economic Governance Team, it does not extend to the joint programming or action that might lead to improved budget disbursement in health.
- HPP investments are not connected with each other around PFM. While there is some PFM-related engagement between PATH and both AIHSS and HSIP, it is generally the case that HPP investments are working towards their own PFM priorities. There is presently no HPP vision for PFM, or more specifically budget disbursement, and no coordinated approach that might synchronise engagement with NDoH, support to PHAs, and an aligned package of capacity development initiatives that move beyond only achieving the different outcomes of individual investments.

Capacity to Staff Health Facilities

- *To what extent have NDoH and Department of Personnel Management improved their capacity to staff health facilities?*

Underpinning the capacity of NDoH and DPM to staff health facilities are 2 problems. The first is that the staffing establishment (number and type of positions in a facility or organisation) funded through DPM often does not accurately correspond to reality. Throughout the system there are ghost officers, unattached officers, and officers acting in positions (sometimes multiple positions). Achieving the government’s goal of ‘one position, one person, one pay’ requires a cleansing of the health sector payroll that will essentially establish an accurate baseline position. A second problem is that the approved staffing establishment is not necessarily the one needed. Ideally, staff requirements should be mapped against needs, in terms of population numbers, the disease burden of different districts and provinces, the anticipated outputs from education and training programs, and the demographic profile of the (aging) health workforce.

While a number of HPP investments tackled budget disbursements, the same level of focus and resourcing was not directed to addressing the capacity to staff health facilities. Apart from initiatives by different investments to fund essential positions, most support has come from WHO and HSSDP technical advice (see Table 5 below).

Table 5: HPP Investment Support to Health Facility Staffing Capacity

HPP Investment	Support to Capacity Development	Agency of Focus
HSSDP	<ul style="list-style-type: none"> • Supported NDoH restructuring for decentralised system. • Proposed senior management structure, approved by DPM. • Function and Organisation Review was completed and awaiting Senior Executive Management endorsement. 	NDoH DPM
WHO	<ul style="list-style-type: none"> • Human Resources for Health information system set up in 2018. • Human Resources for Health Strategic Plan 2021–2030 developed and finalised. • Supported health workforce education, including collaboration with Department of Higher Education, Research, Science and Technology (DHERST) to understand health-related enrolments and graduates for 2010–2018 from the available reports and databases maintained by the training institutions and DHERST. 	NDoH

Source: HPP Investment Progress Reports

In several respects, HPP capacity to influence the resolution of the staffing problems referred to above mirrors the issues in budget disbursement. Staffing health facilities requires considerable engagement with and support from a central agency – in this case, DPM. In the same way the AHC Health Team and HPP investment staff do not have strong relationships with the Departments of Finance and Treasury for budget disbursement, they do not have strong relationships within DPM. Engagement with DFAT’s economic governance program is currently not substantive, and connections and interaction between the HPP investments (in this case only HSSDP and WHO) around staffing issues are weak.

PHA and District Capacity to Deliver Primary Health Care

- *To what extent have selected PHAs and districts improved their capacity to deliver primary health care as a result of HPP?*

The capacity to deliver primary health care rests at the core of PNG’s National Health Plan and the HPP. Different HPP investments, in different ways, have positively contributed to improving this capacity. In some places, investments have provided essential training to frontline health workers and health system administrators and managers. They have constructed health infrastructure. They have improved capacity to plan, budget, and manage funds. A selection of these positive contributions are highlighted in Table 6 below:

Table 6: Selected Contribution of Investments to Capacity to Deliver Primary Health Care

HPP Investment	Support to Capacity Development
AIHSS	<ul style="list-style-type: none"> • Strengthened M&E and reporting capacity through UNICEF and WHO training. • Strengthened PHA financial management capacity, particularly acquittal of funds. • Improved capacity of PHAs to plan and supervise routine immunisations.
HSSDP	<ul style="list-style-type: none"> • Strengthened capacity of midwives, nurses and community health workers to provide Emergency Obstetric Care or Primary Mother and Baby Care. • Strengthened management capacity of PHA line managers across 10 provinces. • Strengthened capacity of Provincial Health Information Officers.
PATH	<ul style="list-style-type: none"> • Strengthened health sector governance and financial management capacity of 12 senior executives of Western Highlands PHA. • Strengthened financial management and procurement capacity, in the context of HSIP, in Morobe, East New Britain, and Autonomous Region of Bougainville.
PSF	<ul style="list-style-type: none"> • Strengthened the capacity of health workers throughout PNG to provide long-acting reversible contraception through the National Family Planning Training Program (NFPTP).
SRHIP	<ul style="list-style-type: none"> • Strengthened capability of frontline health workers and selected PHA personnel to diagnose, treat, refer and report HIV, SRH and associated sequelae within an integrated primary care setting. • Strengthened project management and leadership capability of core primary health personnel to oversee health service process, finances, and staff.
WBW	<ul style="list-style-type: none"> • Strengthened health financing partnerships, leading to District Development Authorities allocating an estimated PGK7 million to health service development in Hela and approximately PGK1 million in Southern Highlands (between 2019 and 2021). • Strengthened financial management capacity of health facilities in Hela, using facility-based budgeting approaches.

Source: HPP Investment Progress Reports

In and of themselves, each of the activities and outputs summarised above has made a positive contribution to improving capacity to deliver primary health care. As the later discussion about

sustainability of service delivery demonstrates, the models adopted by the different investments often have strong prospects for institutionalisation and sustainability (subject, of course, to the funding and staffing bottlenecks outlined above being resolved).

Central to the question of increasing the portfolio's effectiveness to further improve capacity to deliver primary health care is the issue of concurrence of critical inputs. An appropriate number of sufficiently trained and qualified health personnel, sufficient operational funding, adequate medical supplies, and adequate quality infrastructure, each must be available at the right place at the right time.⁸⁸ The HPP, through different investments, supports 3 of these 4 inputs (medical supplies being the exception) in some places at different times. As Cairns and Wolff demonstrate, even at a (relatively high) probability of 80% for each input factor being available at any point in time, the resulting combined probability that all 4 inputs are available concurrently is approximately only 40%.⁸⁹ Their analysis clearly demonstrates the importance of adopting a connected approach to capacity development initiatives. At the portfolio level, this requires, at the very least, appropriate coordination and information sharing synchronised around a mutually-understood vision.

ANGAU Hospital Referrals

- *How has the upgraded ANGAU Hospital improved referrals in Morobe Province?*

While there has been a slight increase in referrals to ANGAU Hospital, there is no evidence of an improved or strengthened referral process across the province.

The goal of the ANGAU Hospital Redevelopment Project is for ANGAU Hospital to serve as a 'functional regional referral hospital'. Data indicates that referrals to the hospital have increased from 2,544 in 2018 to 3,238 in 2021.⁹⁰ This represents an annual average 6.8% increase, exceeding the increase from population growth of 2.5%.⁹¹ The key driver of growth, according to review respondents, was the attraction of the new 'first class' infrastructure provided through Australian support. Program documents and interview respondents indicate, however, the challenge remains for the investment, including its Clinical Support Program (CSP), to support improvements to the coordination of care, and clinical diagnosis, management and referral processes throughout the provincial health system.

Primary Care Disconnected

There is no evidence the increase in referrals is reflective of improved diagnostic and referral capacity of primary care. The number of 'urgent care cases' self-presenting at ANGAU Hospital have more than doubled – from 31,472 in 2018 to 89,869 in 2021.⁹² This suggests that the hospital, rather than primary care, is inefficiently functioning as the first entry point to the health system. This is supported by data from the *Sector Performance Annual Review 2020*, which shows that the annual average number of outpatient visits per person in Morobe has been consistent between 2016 and 2020 (0.85), and below the national average (1.08).⁹³ Some respondents noted that while primary care infrastructure in the province has improved (through HSSDP), human resources capacity,

⁸⁸ Line of Sight, p. 26.

⁸⁹ Line of Sight, p. 26. If probability of an input being available is reduced to 50%, concurrent probability is reduced to 6.25%.

⁹⁰ ANGAU Annual Report, April 2022, ANGAU Hospital Redevelopment Project 2021, Johnstaff International Development (JID), 2022.

⁹¹ *Provincial Estimates of Key Population Groups 2018–2022*, C. McMurray & E. Lavu, PNG National Research Institute, March 2020, available at: https://pngnri.org/images/Publications/Provincial_estimates_of_key_population_groups_2018-2022_Other_publications_.pdf.

⁹² ANGAU Annual Report, April 2022.

⁹³ SPAR 2020.

financing and commodities supply have not. Other respondents noted that, with a number of new urban and rural primary care facilities soon to be opened, the over-reliance on ANGAU Hospital as the point of entry should be addressed.

Progress towards EOIO3: Integrated Family Planning, HIV and SRH

While some HPP investments met their service delivery targets, they had varying degrees of success in strengthening quality integrated primary care services. Progress in building community awareness of health issues and health-seeking behaviour for health care has been mixed.

Integrated HIV, Reproductive Health and Family Planning Services

- *In targeted provinces, how have integrated HIV, reproductive health and family planning services improved?*

EOIO3 refers to *selected provinces and districts, selected government, church and non-government organisation (NGO) clinics delivering improved quality client-centred, integrated HIV, reproductive health, and voluntary family planning services.* The assessment of impact earlier in this report has already established that HPP investment service delivery activities had varying degrees of success in contributing to improved health outcomes. Significantly, however, EOIO3 does not refer to the delivery of services. It specifically refers to *integrated* services. This assessment of effectiveness therefore focuses on the delivery of integrated services.

In investment program documentation, and in the absence of a working definition in the HPP, integration is aligned to one of 2 closely-related concepts:

1. Moving away from a fragmented model of siloed (*vertical*) service delivery towards an integrated (*horizontal*) model of primary care services delivered by state or non-state providers.
2. Moving away from *parallel* delivery support systems (for example, in program governance, financing, staffing, supplies, and information systems) funded by external assistance to systems that are integrated with those of government.

How the different portfolio investments supporting EOIO3 have reflected integration in program design, implementation and monitoring is not consistent. Only one HPP investment (SRHIP) defined integration (as institutional, service, project and sector integration). Across the portfolio, different approaches were adopted, which combined the 2 concepts in different ways. These are summarised in Table 7 below.

Table 7: Degree of Integration of PSF, SRHIP and SLSS

Investment	Silo vs Integrated Primary Care Services	Parallel vs Integrated Delivery Support Systems
PSF	<p>Silo:</p> <ul style="list-style-type: none"> • MSPNG-owned and led outreach. • MSPNG Community-Based Mobilisers disconnected from Village Health Volunteer (VHV) model. • Ad hoc integrated outreach with other non-HPP partners. <p>Integrated:</p> <ul style="list-style-type: none"> • Long-acting reversible contraceptives provided by facility staff in public 	<p>Parallel:</p> <ul style="list-style-type: none"> • All delivery support systems owned and managed by MSPNG. <p>Partial integration:</p> <ul style="list-style-type: none"> • Governance, finance, supervision staff and information systems owned and managed by MSPNG. • Medical supplies provided by NDoH/PHA. <p>Integrated:</p>

Investment	Silo vs Integrated Primary Care Services	Parallel vs Integrated Delivery Support Systems
	<p>(primary and hospital) facilities through NFPTP.</p> <ul style="list-style-type: none"> SSM Outreach and Clinic working within PHA facilities ecosystem. Works with VHV network. 	<ul style="list-style-type: none"> Governance, finance, medical supplies and information systems aligned to government system.
SRHIP	<p>Partially Integrated:</p> <ul style="list-style-type: none"> HIV services integrated into primary healthcare facilities and outreach Do not offer modern contraceptives (because of Catholic belief system); draft family planning referral policy yet to be approved by Diocese leadership. 	<p>Integrated:</p> <ul style="list-style-type: none"> Governance, finance, medical supplies and information systems aligned to government system.
SLSS	<p>Integrated:</p> <ul style="list-style-type: none"> Trialled with VHVs to support referrals of mothers to facilities for maternal and child health. <p>Integrated:</p> <ul style="list-style-type: none"> Strengthening of maternal and newborn care at public (primary and hospital) facilities through introduction of active management of third stage labour, kangaroo care, and other interventions. 	<p>Partial Integration:</p> <ul style="list-style-type: none"> UNICEF-funded incentives. <p>Integrated:</p> <ul style="list-style-type: none"> Pre-service training integrated into national curricula, and measures introduced into NHIS.

Source: Review Team interpretation of program evaluations

The table demonstrates that all but one approach to service delivery adopted an integrated service delivery model. In terms of support systems, the results were mixed. While none of the investments achieved integration to the extent that support was funded within the government system, there was some success in integrating systems of governance, finance, medical supplies and information systems.

Missed Inter-Investment Integration Opportunities

There were missed opportunities to model primary health care integration between HPP investments and limited efforts to understand the potential costs and benefits of doing so for the health system as a whole. PSF and SRHIP, for example, could have partnered in relation to referrals for modern contraceptives and SRH, HIV testing for young people, and prevention of parent to child transmission (PPTCT). Similarly, SLSS and PSF could have partnered in relation to referrals for modern contraceptives for post-partum women, or aligned messages in relation to family planning. All of the investments could have collaborated on outreach and community engagement programs, the cost of which is considerable in the PNG context. Underpinning the missed integration opportunities were limited formal learning exchanges offered by DFAT and/or PATH between the partners at the national level, and across the different provinces where their service delivery activities overlapped.

Alignment with PHAs

Relationships between PHAs and programs varied. The role of PHAs as stewards of the primary care system was undermined by demand and supply-side factors. On the demand side, there was a lack of consideration for integration in investment design. On the supply side, PHAs were at different stages

of their evolution under the decentralised institutional arrangements. A select few (in Milne Bay, Western Highlands, and Eastern Highlands Provinces) had functioned for several years. Others were still coming to terms with their structure, the roles they would play, and the systems and processes through which they would play those roles.

Multiple investments working in different ways increased demands on PHAs for formal and informal cooperation around service agreements, continued funding, nominations for health worker training and volunteers, and supervision of trained health workers. The PHAs, in turn, sought from each of the investments information about budgets, services and work plans. While PHA partnership committees were mandated to address these issues of multiple partners, with few exceptions (for example, Hela PHA), they often struggled to be effective. In the absence of a coherent, comprehensive, and collective vision for integrated primary care, and the absence of functioning processes for coordinating providers in the provinces, personal relationships often formed the basis of cooperation. The quality and duration of these varied considerably, impacting project effectiveness and sustainability.

Assumptions about Absorptive Capacity

The different investments, as they evolved over time, often sought to couple their service delivery activities with initiatives focused on strengthening or aligning with government systems. Such initiatives, often stemming from requests for rapid redesigns, were either not preceded by an assessment of PHA capacity, or not aligned to assessments which had been conducted. The result, reflected in investment strategies and workplans, was often unrealistic assumptions that PHAs could assume responsibility for financing or managing different areas of activity. Both SLSS and PSF, for example, allocated program funds for PHAs to assume supervision of trainees and supplies. The PHAs, however, are yet to assume these functions.

In other areas of their work, because of pressure to deliver services, the investments made assumptions that government had insufficient capacity, and explicitly sought to uncouple their activities from government systems. While some investments relied on government medical stores, for example, others bypassed them and operated independent supply chains. They employed additional staff to deliver services. While it engaged with government to seek opportunities for integration, one part of PSF used separate reporting and information systems for a number of its activities, with mixed reports on the extent of reporting to PHAs.

Community Awareness of Health Issues and Health-Seeking Behaviour

- *To what extent has community awareness of health issues and health-seeking behaviour for health care increased?*

In the absence of household surveys or other information gathering, there is limited data to assess changes in health knowledge and care-seeking behaviour. There are, however, some indications of changes in service delivery patterns. MSPNG (PSF) adapted its community awareness strategy in Phase 2 from traditional information, education and communication materials towards integration of social media, where it reportedly reached 640,000 people in 2021. The organisation points to changes in the family planning method mix, with increases in permanent and long-acting reversible contraception, as evidence that its community awareness approach (which includes social media, community-based mobilisers, outreach and improved family planning counselling services) changed healthcare-seeking behaviour and decision-making. This position was supported in the SLSS evaluation, which also pointed to changes in demand for modern contraceptives arising from Village Health Volunteers.

Stagnation with regard to Voluntary Confidential Counselling and Testing (VCCT) and facility-based births suggests limited change in health knowledge and care-seeking behaviour for those services. Exploration of this issue as part of the SLSS evaluation was limited as it was only based on interviews with women who live near facilities, and mostly focused on the use of the hypothermia alert bracelet and kangaroo care. Women interviewed did report receiving messages from VHVs regarding the importance of delivering in facilities, together with a range of other messages regarding pre- and post-natal care. Whether many had already intended to give birth in facilities was unclear. With static supervised deliveries, efforts to raise awareness of the importance of facility-based deliveries should thus target women in hard-to-reach communities, strongly supplemented with strategies to improve access to care. This mirrors the evaluation finding with regard to barriers to seeking HIV care, which found it did not effectively cater to the needs of vulnerable and marginalised groups.

3.4. Key Review Question 4: Efficiency

To what extent has Health Portfolio Plan progress towards the End of Investment Outcomes been delivered efficiently?

Proportion of Use of HPP Resources towards End of Investment Outcomes

Whether the portfolio is efficiently progressing towards delivery of EOIOs cannot be determined.

Fundamental to an understanding of whether the portfolio is efficiently making progress towards the End of Plan Outcomes is an understanding of the allocation of resources across the portfolio. How have available funds been divided among the 3 End of Investment Outcomes? How have they been further divided among the 11 Intermediate Outcomes? In light of the widely-held but incorrect perception that Australia provides health support to only a small number of provinces in PNG, how have HPP resources been allocated among provinces? How are the funds divided by outcome across the separate provinces? Responses to these questions would enable Health Team decision-makers to better understand the performance of different provinces (and perhaps then the drivers of performance and underperformance), and to better understand the performance of different investments.

Responses to the questions above would ultimately lead to a more nuanced understanding of impact and effectiveness. They would drive the evidence-based decision-making that constitutes one of the 8 principles of DFAT's VFM framework. Evidence-based decision-making involves, according to the framework, 'systematic, structured and rational approaches to decision-making, framed around logical arguments informed by accurate analysis'.⁹⁴ In terms of efficient resource allocation decisions, this requires consistent monitoring and tracking of funds allocation.

Unfortunately, the data that would enable this to happen is not available. Data about allocation of funds across the EOIOs and IOs has not been compiled. Nor has data about allocation of funds between provinces. There are a number of explanations for this:

- Setting up a framework for portfolio-level financial reporting, by outcome and by province, was not prioritised at the establishment of the portfolio.
- Responding to emergency health needs (for example, the polio outbreak and COVID-19) necessarily absorbed the management attention that is essential to design and implement systemic portfolio-level tracking and monitoring tools.
- Investment-level reporting is not aligned with the HPP. The portfolio was fragmented at its outset, with existing health investments brought under the HPP umbrella. These investments

⁹⁴ See: <https://www.dfat.gov.au/aid/who-we-work-with/value-for-money-principles/Pages/value-for-money-principles>.

already had established ways of working, including reporting, and it is unclear whether any attempt was made to align them with the HPP. Investments that have been established during the HPP have not been required to align with the reporting needs of the portfolio, which were never articulated.

In the absence of financial allocations data, the review is unable to comment on the efficiency of the allocation of portfolio resources towards achieving outcomes. What can be concluded, however, is that the absence of portfolio-level financial tracking and monitoring diminishes capacity to make effective resource allocation decisions, which might lead to inefficient portfolio management. A successor to the HPP should prioritise, at its outset, the development of appropriate financial monitoring, reporting, and decision-making tools.

Value for Money

Portfolio investments are delivering value for money in some areas of their operations, but more could be done to deliver value for money across the portfolio, and at the level of the portfolio.

When asked to respond to questions about what they are doing to promote VFM, investments generally focused on the Commonwealth Procurement Rules, and 2 of DFAT's VFM principles: cost-consciousness and encouraging competition. Respondents highlighted, for example, how they follow the procurement rules, seek preferential pricing from regular suppliers (such as discounted room rates at hotels or hotel groups), seek and select from multiple quotations for high-value purchases, and regularly review their preferred supplier lists.

While they are worthy of note, cost-consciousness and competition actions are the 'low-hanging fruit' of VFM initiatives. There was little evidence that investments are taking a more strategic or comprehensive approach to VFM. DFAT's VFM principal 4 (proportionality) notes that VFM requires 'organisational systems are proportional to the capacity and need to manage results and/or deliver better outcomes and be calibrated to maximise efficiency'. There were isolated examples of investments consulting with other investments to avoid duplication. HSSDP, for example, had loosely engaged with PATH to avoid duplication of effort in supporting PHA capacity development in provinces where both are engaged. Beyond this, the review found little evidence that investments are developing, implementing or revising business processes, policies and systems with an eye to reducing transaction costs or delivering outcomes more efficiently.

Lost Opportunities for Synergy

At the portfolio level, lack of integration and coordination across investments is likely contributing to lost opportunities to improve VFM through synergy. In terms of frontline service delivery, for example, AIHSS, PSF, and SRHIP, support or conduct rural health patrols. The patrols sometimes overlap in provinces and districts, are resource-intensive, and challenge the absorptive capacity of PHAs and health facility infrastructure and staff. Despite these factors, the implementing organisations generally adopt their own ways of working, coordinate to varying degrees with PHAs, and rarely, if ever, coordinate with each other. Opportunities to combine resources, synchronise approaches, and potentially achieve economies of scale, have not been considered by the investments, or the PATH program that manages them.

Understanding Overhead

The portion of portfolio funds absorbed by overhead expenses, at different levels, needs to be understood to better assess efficiency.

The delivery of almost any aid investment requires that a portion of the investment funds received by the investment be dedicated to expenses that enable program delivery to take place. Sometimes these are the fixed and variable core expenses of the organisation delivering the investment.⁹⁵ Other times they are *administrative and management expenses* specific to the investment. The efficiency goal is to generally maximise the proportion of funds used for program delivery, and to achieve an optimal minimum of the proportion of funds allocated to these overhead expenses.

In the case of the Health Portfolio, overhead is often applied at 2 levels. The first, for a selection of investments, is at the level of the managing contractor (currently PATH, previously PPF and HHISP), which charges expenses and a management fee for performing grant management functions. The second is at the level of each portfolio project and program. The organisations implementing the investments usually charge a portion of their core costs to the investment, sometimes in the form of a management fee, and charge ongoing program management or operating costs. In accounting, there is no universal approach to the apportionment of overhead, and so it is unsurprising that organisations adopt different approaches to how they account for expenses such as the cost of association with or support from overseas-based headquarters, executive and senior management salaries (whose time might be split across multiple programs), and core operating costs.

The challenge of understanding the overhead component of investment (and portfolio) efficiency is highlighted in Table 8 below. Of 12 HPP investments in 2021, only 6 have a dedicated ‘management fee’ or ‘overhead’ reporting line in their finance reports. Of these, 3 report on ‘operational costs’ and a further 3 on ‘program management and administration costs’. ‘Project support’ is reported by another of the investments, which does not report a management fee or overhead. The ‘management fee’ or ‘overhead’, where it was reported, ranged between 7% and 13% of total investment expenditure.

Table 8: Overhead-Related Expense Reporting of HPP Investments, 2021

Investment	Management Fee/Overhead	Operational Costs	Program Management & Administration	Project Support
PATH	X	X	–	–
PSF	X	–	X	–
SRHIP	X	–	X	–
ANGAU	X	X	–	–
RID-TB	X	X	–	–
RPHSDP	X	–	–	–
WHO	–	–	–	X

Source: Review Team analysis from Investment Progress Reports

⁹⁵ Including, for example, rent for headquarters, vehicles, utilities, and a portion of the costs of key organisational personnel.

Unfortunately, the reported expenses shed little light on the overall overhead burden of the portfolio. First, there is a lack of detail in the investment reports. Second, different approaches have been taken to overhead apportionment. Some investments have reported ‘indirect support costs’ or ‘overhead costs and management fees’ in the finance sections of their annual reports. What is included and not included in these expense categories is determined by the different reporting organisations, whose motivations are generally to report lower overheads against higher program delivery costs. The result, confirmed by the investments, is that overhead expenses are sometimes embedded in and reported under other expense categories such as ‘direct staffing costs’, ‘indirect staffing costs’, and other cost categories.

Better understanding of overhead at the portfolio level requires 2 things. First, it requires a consistent approach to overhead apportionment. What must be included as overhead, and what can be excluded from overhead, should be clearly articulated by DFAT and understood by the investments. Second, that consistent approach needs to be incorporated into investment financial reporting, with program delivery expenses clearly distinguishable from overhead expenses and management fees. Underpinning each of these should be more robust grants management from PATH, which oversees grants in each of the 3 EOIO areas.

3.5. Key Review Question 5: Coherence

Does the HPP have the right scope and ambition, the right mix of partners and modalities to meet the HPP Objective?

The coherence of the HPP model as a factor in contributing to meeting the HPP Objective needs to be considered from several perspectives – scope, ambition, partners, and modalities. A starting point, however, is the question of why adopt a portfolio approach.

The Portfolio Model

When a team was assembled in 2017 to consider the future of Australia’s support to the health sector in PNG, several issues dominated the discussions. The long-running HHISP program had been through several iterations and was, as one participant observed, ‘coming to the end of its natural life’. There was a belief that Australia’s health investments, while generally ‘doing good things’, had drifted, were fragmented, and were ‘not joined up’. The budget for health sector aid had been reduced, as had the size of the Health Team. The TB problem, particularly in Western Province, was becoming more concerning, and driving AHC to focus increasingly on health security.

The portfolio model was a response to these issues. A portfolio is ‘an aggregate grouping of discrete projects or programs linked by an overarching, time-bound strategy’.⁹⁶ It should ideally be distinguished from what might be considered a ‘basket’ or ‘catalogue’ of investments, which have a common source of funding but no overarching strategy. The portfolio approach, which spoke to a high-level narrative transcending the different Australian investments, emerged from the planning discussions, not only as a response to the fragmented program, but as an internal planning tool which was hoped would lead to more effective and efficient resource allocation decisions.

The challenges in building the portfolio were substantial. Central among these was that it was not a process of establishing new investments from scratch and then aligning them to the desired portfolio outcomes. In fact, none of the investments commenced with the HPP. As outlined in section 1.2, some investments were long-running programs that preceded and were inherited by the HPP, while

⁹⁶ ‘Monitoring and learning for country-level portfolio decision-making and adaptation,’ *Overseas Development Institute Briefing Notes*, A.L. Buffardi, P. Mason, C. Hutchings & S. Sharp, May 2019, p. 2.

others were there at the beginning of the HPP but scheduled to end during its life. A second challenge stemmed from the diverse mix of aid modalities, with different management approaches required to ensure coherence of the portfolio. These challenges serve as key themes in the sections below.

Scope and Ambition

The scope and ambition of the HPP can be assessed from 3 perspectives. The first concerns health priorities, where the scope and ambition of the portfolio are appropriate to meeting the HPP Objective. The discussion in section 3.1 demonstrated the relevance of the HPP to the development priorities of both Australia and PNG. In supporting health security, rural primary health care, and integrated family planning, HIV, and sexual and reproductive health, the 3 HPP outcome areas are not only aligned to the HPP Objective, and serve Australia's interests, but provide a solid foundation for Australia to support the health priorities of PNG, as articulated in the National Health Plan.

The second perspective on scope and ambition concerns the geographic footprint of the portfolio. The HPP stated 'DFAT will deliver this Plan with a targeted approach to some Provinces and Districts'. The targets would be provinces and districts 'demonstrating commitment on health, making progress which yields useful lessons, and where innovations can be tested'.⁹⁷ Given the circumstances under which the portfolio was built, as a mix of new and old investments, this targeted approach was never fully realised. The 'selected districts and provinces' referred to in the objective were often determined at the investment level rather than the portfolio. As a result, by coincidence more than design, there is significant overlap of portfolio investments in some provinces, and little overlap in others. The issue of geographical scope was raised by GoPNG stakeholders. The perception, driven by the location of PATH program focal points, is that Australia provides support in only a very limited number of provinces. The reality is that aid to health through the different portfolio investments has been provided across 21 of PNG's provinces plus Autonomous Region of Bougainville. This raises important questions. Would the portfolio be more effective with a focused geographical scope, where all investments work in the same provinces? Would it be more effective by focusing on all provinces? In the absence of portfolio-level monitoring and evaluation data that is disaggregated by province (or district), it is not possible for the review to provide an evidence-based response to these questions.

A final perspective regarding the scope and ambition of the portfolio relates to its focus. The HPP logic places a strong emphasis on health systems strengthening. Table 9 below, for example, highlights the systems strengthening emphasis of HPP Intermediate Outcomes. The work of several HPP investments, however, placed an equally strong emphasis on the delivery of essential primary health services, which arguably relate to the Objective of the HPP, but have a tenuous link to its End of Investment and Intermediate Outcomes.

⁹⁷ Health Portfolio Plan, p. 33.

Table 9: Health Systems Strengthening (HSS) Focus of HPP Intermediate Outcomes

IO	HSS Focus	Intermediate Outcome (with emphasis added for HSS)
1.1	X	NDoH and selected PHAs improve capacity to lead effective health security system.
1.2	X	NDoH, and selected PHAs, provincial hospitals and primary health care centres improve capacity to prevent, detect and respond to public health security threats.
1.3	X	Selected provincial hospitals have improved capacity to detect and treat TB in target provinces.
1.4	X	Selected malaria laboratory and diagnostic functions strengthened .
2.1	X	NDoH, DoF, DPM, DNPM and Treasury improve capacity to disburse health budget and staff health facilities.
2.2	X	Selected PHAs and districts improve capacity to deliver primary health care.
2.3	X	Selected rural primary health care centres better staffed and financed .
2.4	X	Upgraded ANGAU Hospital operates in referral system within Morobe Province.
2.5	X	NDoH/development partners improve coordination .
3.1	X	Selected government, church and NGO clinics build capacity to deliver quality integrated health care.
3.2	–	Increased community awareness of health issues and increased health-seeking behaviour for health care in selected provinces.

This report has already highlighted the portfolio's systems strengthening versus service delivery tension through an effectiveness lens. In terms of HPP scope and ambition, the tension has never been fully resolved. Investments are, in several programs, delivering services and have indicators in their results frameworks that measure their effectiveness in doing so. As discussed in section 3.2 and section 3.3, these service delivery initiatives are directly contributing to the health and well-being of PNG citizens (HPP Goal) in relation to TB, family planning, sexual and reproductive health, HIV, and maternal and child health (Objective). They are addressing needs and filling gaps that GoPNG health officials acknowledge could not be met with the government's existing capacity and resources. At the same time, however, while the success of these investments is being measured by service delivery outcomes, they are aligned to portfolio outcomes focused on systems strengthening, the demands of which are often at odds with service delivery priorities.

The result of the tension is confusion about scope and ambition. Should the scope of the HPP include both systems strengthening and service delivery? If so, what is the appropriate balance between the 2? While the portfolio, by implementation if not design, has responded to the first question in the affirmative, the question of balance has been generally resolved by pragmatic decisions made by the organisations delivering the investments, rather than with regard to the HPP.

Partners and Modalities

The HPP design envisaged ‘a consolidation around [the] three [end of investment] outcomes with a much smaller number of larger scale investments’.⁹⁸ It proposed working ‘with a mix of partners and project modalities’ to deliver the HPP.⁹⁹ Proposed partners were UN agencies, international financial institutions, non-government organisations, and managing contractors. Modalities cited include standalone technical assistance and capacity building through both programs and individual advisers, grant funding for health services delivery, co-financing with multilateral development banks, analytical work, policy development, and policy engagement. The HPP also states that ‘investments directly through government financial management systems are unlikely ... because of insufficient safeguards in public financial management’.¹⁰⁰

The intentions of the HPP were largely reflected in the range of partners and modalities that comprise the portfolio investments. Program-based modalities are those, such as sector budget support and pooled funds, that tend to work with and through government systems. Project-based modalities, on the other hand, are those with their own specific objectives, which often establish parallel implementation structures to achieve those objectives, and where donor control of resources is high. Technical assistance generally refers to the personnel involved in the implementation of technical cooperation, which is concerned with actions aimed at strengthening individual and organisational capacity. The relationships between HPP modalities, partner types, specific investments, and HPP End of Investment Outcomes, are summarised in Table 10 below.

Table 10: HPP Modalities and Partners

Modality	Partner	Investments	EOIO
Program-based	Government	HSIP	1
Technical assistance	MDB	HSSDP	2
	MC	PATH	1, 2
	UN Agency	WHO	1, 2
Project-based (through Managing Contractor)	MC	ANGAU	2
	NGO/PHA	AIHSS	1
	NGO	TMP	1
	NGO	PSF	3
	UN Agency	SLSS	3
	NGO	SRHIP	1
	NGO	TB (RID-TB/DART)	1
Project-based co-funding	MDB	HSSDP	2

Notes: MC: Managing Contractor; MDB: Multilateral Development Bank; NGO: Non-Government Organisation

The table demonstrates the portfolio’s reliance on the project-based modality, where investments are delivered primarily through NGOs (also a UN agency and a co-funding agreement with ADB); it reflects the reluctance expressed in the HPP to deliver investments directly through government financial management systems; and it highlights the portfolio’s limited use of technical assistance.

⁹⁸ Health Portfolio Plan, p. 37.

⁹⁹ Health Portfolio Plan, p. 37.

¹⁰⁰ Health Portfolio Plan, p. 37.

There is a considerable body of literature on the relative merits of different aid modalities. The general consensus from the literature is that ‘aid that explicitly avoids state systems may have an adverse impact on future system-strengthening efforts’¹⁰¹, but also that aid delivered through program-based approaches requires a degree of PFM and governance capacity to be effective.¹⁰² The literature sheds light on the fundamental partners-modality dilemma in the HPP. Driven by concerns about capacity and governance, there is reluctance to deliver aid through the program-based mechanisms that best lend themselves to the systems strengthening orientation of the HPP’s Intermediate and End of Investment Outcomes. As a consequence, the HPP is delivered primarily through project-based modalities, which are less effective in driving systems strengthening, and implemented by NGO partners, whose core competencies often align better with service delivery priorities.

Technical assistance is the glue that potentially addresses the dilemma. On the one hand, it can target the lack of capacity undermining program-based approaches. On the other it can reduce the over-reliance on NGO partners to deliver systems strengthening initiatives for which they are often ill-suited. Technical assistance in the HPP is provided through 3 investments –HSSDP, PATH, and the DFAT–WHO Bilateral Partnership. While the technical assistance provided through these programs was welcome and appreciated by government respondents at the national and provincial levels, its value and effectiveness could be enhanced through establishing a long-term portfolio-level vision of where technical assistance personnel fit into the systems strengthening agenda. This should involve:

- Linking technical assistance to locally-driven reform processes, and embedding technical assistance in local structures as quickly as possible. This involves investing more effort in developing the capacity of NDoH to manage technical assistance, rather than be driven by it.
- Identifying the kinds of knowledge and techniques that will be politically and technically feasible in the PNG context and aligning consultant capacity and experience with the identified knowledge and techniques.
- Achieving an appropriate balance between long-term and short-term technical assistance, recognising that consultants need time to learn about local conditions, build relationships, and eventually transfer skills; and that frequent short-term inputs may place unreasonable demands on over-burdened local counterparts.

The key concerns with existing portfolio technical assistance investments are their lack of coordination with each other, and their lack of coordination with other HPP investments. At present, HSSDP, PATH, and WHO technical assistance advisers rarely, sometimes never, engage with each other, missing opportunities to share learning, address common problems, streamline engagement with government counterparts, and potentially coordinate approaches. In the case of PATH, there is a lack of engagement and coordination between its technical assistance initiatives and the other investments it manages.

¹⁰¹ ‘Adapting aid delivery modalities and technical assistance,’ in *Supporting Statebuilding in Situations of Conflict and Fragility: Policy Guidance*, OECD Publishing, 2011, p. 82.

¹⁰² See, for example, *Better Aid Modalities: Are We Risking Real Results? Literature Review*, H. Tilley & H. Tavakoli, Overseas Development Institute, July 2012.

3.6. Key Review Question 6: Sustainability

To what extent are the positive impacts of DFAT investments likely to be sustained?

There are mixed positions on the sustainability of the positive impacts of HPP investments. These mixed positions stem from different understandings of what constitutes sustainability; a complex relationship between sustainability and service delivery; and the enduring challenges of health systems staffing and financing.

Approach to Sustainability

Different stakeholders (from investments, government, and AHC) have different perspectives on sustainability. At one extreme was the perspective that at some undefined point in the future, the PNG government (including national and subnational levels of government) should be able to fully fund, staff and support the health system needs of the country. A second perspective was that current Australian investments in the health sector in PNG should ultimately be absorbed into the PNG health system, in terms of both systems capacity and funding, thus enabling Australian support to concentrate on other pre-existing or emerging health needs. A final perspective on sustainability was that while PNG systems might eventually be capable of managing the issues in health that Australia has invested in, support would still be required to fund them. This final perspective was one that foresees a shift away from project-based modalities, towards more program or sector-based approaches.

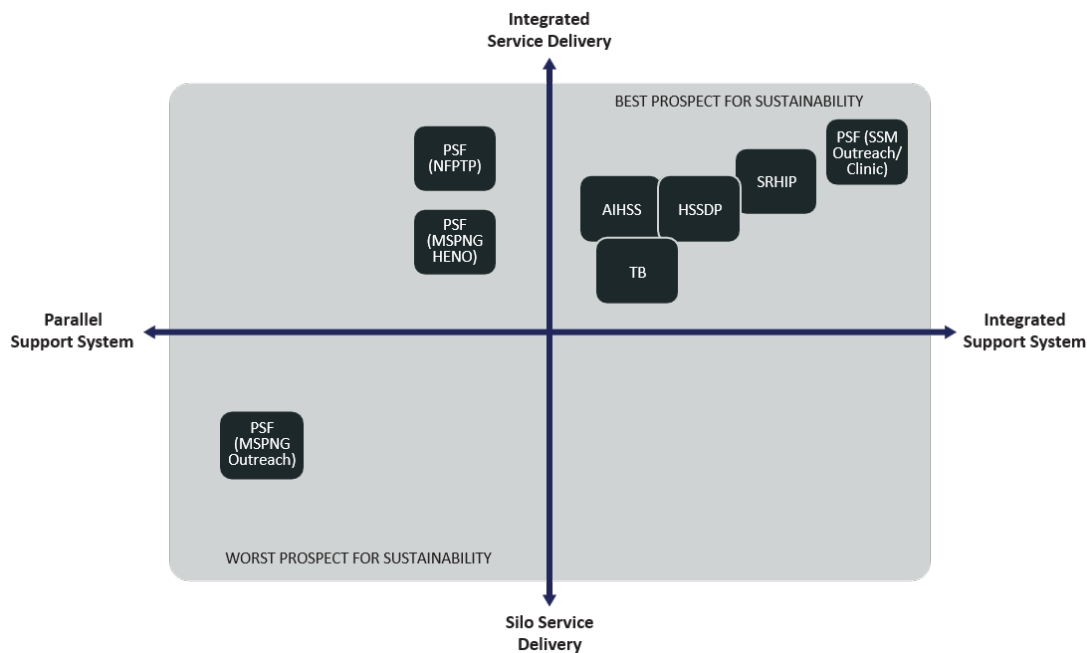
The fact different stakeholders have different perspectives on sustainability raises some important issues. The first, which is essentially a question for PNG to answer, is what a sustainable PNG health system looks like. Is it a system where the state fully provides for the basic health needs of its citizens? Or is it a system where the resources of the state are supplemented by the resources of the private sector and other non-state actors such as the churches and NGOs? The second issue points to Australia's support to the health sector in PNG. Is there an end point for Australia's support? If so, when? If not (and this is more likely the case into the foreseeable future), what does a path to sustainability look like? Does Australia, over time, reduce the absolute value of its support? Does it maintain existing levels of support, but shift away from funding essential services to a focus on strengthening the health system? Or supporting infrastructure? Or supporting emerging needs?

Sustainability of Service Delivery

HPP investments supported service delivery that is integrated into the broader public health service delivery system, and service delivery provided through a silo model. As previously noted, the service delivery initiatives, regardless of approach, have often been quite effective. In situations where an investment has supported a silo model of service delivery, the popular view among stakeholders is that the positive impacts stemming from the delivery of the service will not be maintained beyond the life of the investment. Conversely, where the investment has integrated with the public system, the popular view is that the positive impacts might be maintained beyond the life of the investment. Both views tend to simplify a complex situation.

The Sustainability – Service Delivery Matrix in Figure 8 below demonstrates the interplay between integrated service delivery, siloed service delivery, parallel support systems (that is, where the investment relies on its own systems of governance, finance management, staffing, and medical supplies), and integrated support systems (where the investment has integrated with public systems of governance, finance management, staffing, and medical supplies). The matrix excludes the availability of funds from government as a sustainability criteria.

Figure 8: Sustainability – Service Delivery Matrix



The matrix demonstrates, if and when funds are available, that prospects for sustainability are strongest when integrated service delivery is adopted in an integrated support system (top right quadrant). They are at their worst when siloed service delivery is adopted in a parallel support system (bottom left quadrant), where the provider functions using its own governance, finance management, staffing, and medical supplies systems and processes. It is encouraging, based on the matrix, that if funds were available, a number of the HPP investments have strong prospects for sustainability through local ownership, local management, and local service delivery, and others are well-positioned to make adjustments that would strengthen or enhance prospects for sustainability.

Sustaining Changes in the Health System

While portfolio investments have supported service delivery, the report has already highlighted how the HPP logic places a strong emphasis on health systems strengthening. The HPP states that ‘each new investment will be designed explicitly with the intention of ... supporting the Government to overcome bottlenecks to effective health services, or supporting quality and scale up of proven interventions that are working’.¹⁰³ The assessment of effectiveness above addressed the portfolio’s limited successes, to date, in overcoming the bottlenecks to effective health services, particularly those relating to the adequate staffing and financing of the system. The consensus among informants from the different investments, from government, and from the AHC Health Team, was that it is premature to assess whether any positive impacts of DFAT investments are likely to be sustained.

Unless and until these staffing and financing bottlenecks are overcome, the sustainability of Australia’s investments in health infrastructure are also at risk. Australia’s investments in the ANGAU Hospital Redevelopment and the HSSDP program (managed by ADB) are substantial. Their benefits are highly visible, providing points of access to people, and potentially enabling improved quality of care. While reports generally indicate the infrastructure has been constructed to a high standard, any long-term positive impact is dependent on the facilities having sufficient qualified and skilled staff, and the funding necessary for ongoing operations and maintenance.

¹⁰³ Health Portfolio Plan, p. 37.

3.7. Key Review Question 7: GEDSI

To what extent is the Health Portfolio Plan making progress towards GEDSI goals and objectives?

The review sub-questions for GEDSI were concerned with the extent to which the HPP *had adopted approaches or implemented strategies* that would contribute to each of the 7 HDMES GEDSI Domains. The review did not explicitly consider GEDSI outcomes or results. Instead, it analysed the approaches taken to GEDSI at the HPP and investment levels to identify strengths, gaps, learning, and recommendations for improvement going forward.¹⁰⁴

GEDSI Focus in HPP Design, PAF and M&E Framework

The Australian Government's *Gender Equality and Women's Empowerment Strategy* and the AHC *Gender Action Plan (GAP II) 2018–2022*¹⁰⁵, provide a broad framework and commitments against which the HPP was designed and within which it loosely sits. The Gender Strategy seeks to enhance women's voice in decision-making, leadership, and peace-building; promote women's economic empowerment; and end violence against women and girls.

While some HPP investments focus on aspects of these commitments, such as gender-based violence (GBV), the HPP does not have a clear theory of change that would foster the advancement of GEDSI and does not include GEDSI-specific goals or objectives. Within the HPP Performance Assessment Framework and M&E Framework¹⁰⁶, only 3 of the 13 End of Program Outcome Indicators relate to improvements for women. These are all focused on the delivery of services, such as attended births or access to SRH and ANC, rather than promoting and measuring more comprehensive or transformative changes to gender equality and inclusion. None of the 11 HPP Intermediate Outcomes have an explicit focus on women or advancing gender equality and inclusion. The HPP has no focus on outcomes for improving inclusion for people with disability or other marginalised groups. It does not have an overarching GEDSI (or even gender equality) framework that could inform and promote a cohesive, comprehensive or deep coverage or approaches to advancing GEDSI.

This lack of an explicit focus on GEDSI outcomes in the HPP design, and within its performance assessment requirements and accountabilities, has contributed to a lack of focus in investment design and performance monitoring and reporting at the investment level and the portfolio level. GEDSI-related reporting at the HPP level and for the investments reviewed is generally weak and perfunctory. In other words, the current HPP design and its performance requirements have relatively low GEDSI expectations, were not designed to explicitly promote GEDSI practice, and therefore have not required good GEDSI practice or performance information from the investment partners.

¹⁰⁴ The review focused on a sample of HPP investments: PATH, SRHIP, RID-TB, HSSDP, and the WHO Partnership.

¹⁰⁵ *Gender Equality and Women's Empowerment Strategy*, DFAT, February 2016; *Gender Action Plan (GAP II) 2018–2022*, Australian High Commission Papua New Guinea.

¹⁰⁶ The PAF and M&E Framework are discussed in section 3.8 on M&E.

Benefits for Women or GEDSI-Transformative Approaches?

Gender equality and disability and social inclusion is about much more than access to health services for women. Within the HPP, there is an important distinction to be made between investments that focus on services that specifically pertain to and benefit women, such as the provision of GBV services or SRH services, and programs that also adopt GEDSI-transformative approaches. Investments that focus on services that specifically pertain to and benefit women undoubtedly deliver positive benefits for women in a linear manner. Unfortunately, however, they also commonly fail to adopt more comprehensive approaches that intentionally or systematically advance gender equality and inclusion in a comprehensive and integrated manner. Such approaches include, for example, analysing and addressing deeply-entrenched barriers to equality or inclusion, addressing harmful social norms, enhancing agency and decision-making, and strengthening enabling institutional policies or practices.

The focus on service provision (either explicitly for women's health issues or as an incidental benefit to both men and women) is the predominant focus and approach of the HPP and its investments. As a result of HPP investments, more women have accessed health services specifically for a health need (such as family planning/SRH, ANC, or having an attended birth), and this is undoubtedly positive. These services, however, could be part of a more transformative GEDSI approach if they also responded holistically to the barriers that exclude and exacerbate or fail to address inequalities and exclusion. These more transformative approaches could include changing the attitudes of health workers (male and female) that may continue to hinder access for women or people with disability, or analysing and addressing harmful cultural and family beliefs, attitudes and practices that may inhibit women from accessing new services safely. Put simply, while health services for women may have improved as a result of the HPP, and some projects calibrated these for greater inclusiveness, the portfolio has not required, and the investments have not adopted, GEDSI-transformative approaches.

Portfolio as Opportunity

Analysing issues and articulating theories of change that identify the stakeholders, barriers and enablers that could contribute to more transformative GEDSI change is a complex process. It often requires significant investment in a broad range of activities that, in the absence of higher expectations by the AHC and accountabilities within the HPP, may not be prioritised by investment partners. Looking forward, a portfolio-level design with a well-analysed GEDSI theory of change, and explicit GEDSI outcomes and performance indicators, provides a powerful opportunity to shape investment designs to achieve better GEDSI results.

AHC Oversight and Management

Perhaps consistent with the limited focus on GEDSI in the HPP design and performance assessment requirements, AHC Health Team and investment staff indicated that the AHC has provided minimal guidance, mandate or oversight of GEDSI aspects of investments, and appears to play no role in promoting, overseeing or monitoring GEDSI within the HPP at the portfolio level. Beyond the limited and often perfunctory gender and disability inclusion reporting required in investment reports, the AHC has not appeared to place any higher expectations or accountability requirements on investments for more nuanced, complex or robust GEDSI analysis and reporting. This would seem to be a missed opportunity given the skilled resources within the AHC Gender Team, and the AHC mandate in relation to the *Gender Equality and Women's Empowerment Strategy* and Gender Action Plan.

Targeted or Mainstreamed Approaches

The *Gender Equality and Women's Empowerment Strategy* and Gender Action Plan call for a twin-track approach that combines targeted and mainstreamed activities to promote gender equality. As noted above, the HPP EOIOs and investments that provide health services specifically pertaining to women, have adopted a targeted approach, albeit with a narrow and limited focus on service provision. Data reported by investments demonstrates that this approach has led to positive benefits in terms of service provision for women. Where expectations of improvements to GEDSI have been mainstreamed (for example, throughout the HPP Intermediate Outcomes and in investments such as the RID-TB program and HSSDP), the focus and investment becomes diluted or even invisible. This leads to a lack of accountability and a primary focus on 'hard' outputs such as construction, with a lack of investment in the more comprehensive approaches that could promote more transformative GEDSI change.

With the exception of SRHIP within the sample of investments reviewed, thorough and contextually-specific analysis of barriers to GEDSI was limited. As noted above, GEDSI was generally not well incorporated into designs, theories of change, M&E plans, or performance reporting, especially among those investments that preceded the HPP. Focus on broader disability and social inclusion was even more limited or entirely absent. This dilution or blindness within designs, theories of change, and performance monitoring, is a common risk with 'mainstreaming'.

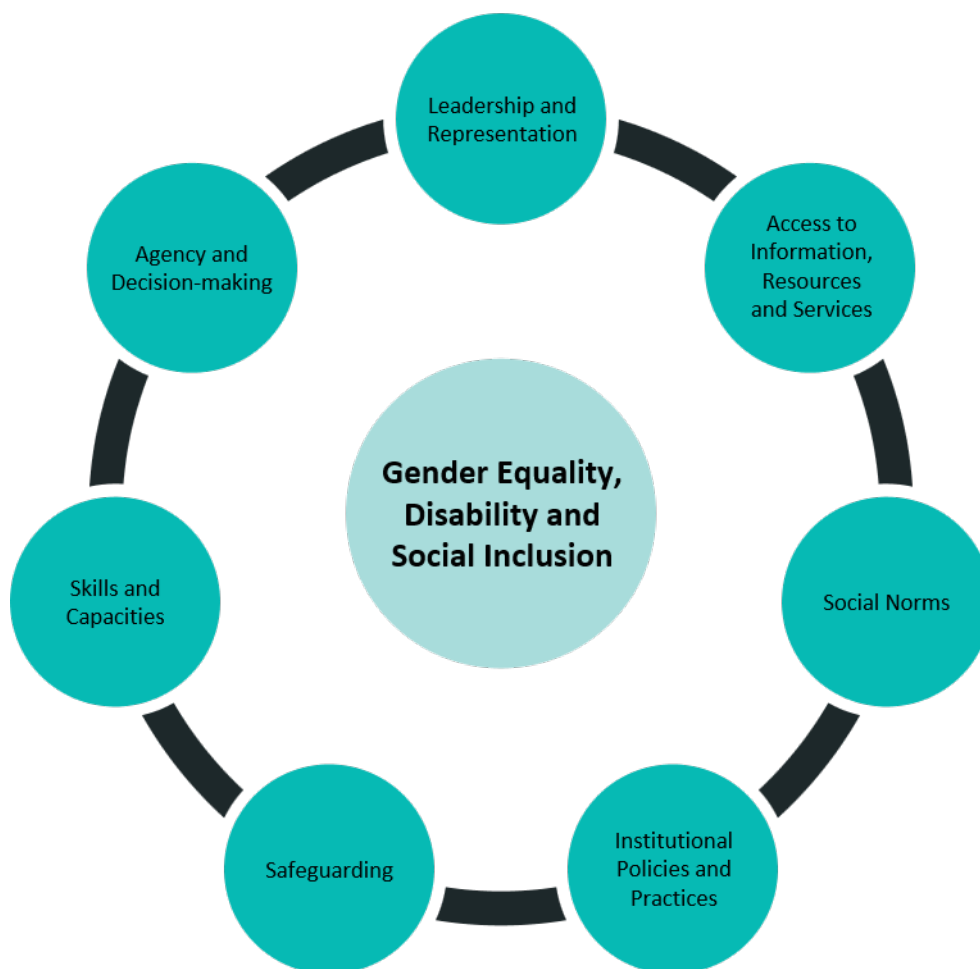
Dedicated Investment in GEDSI

There is a lack of dedicated GEDSI resourcing and activities across the portfolio. The exception is the more recent gender analysis and reporting from PATH, where 2 approaches have provided a critical point of difference, resulting in a significantly increased and improved GEDSI focus. First, there has been a more explicit and proactive focus on GEDSI (or perhaps more specifically on gender equality), resulting in 'targeted' design and outcomes with Women in Leadership as an Intermediate Outcome. Second, there is a dedicated executive-level GEDSI Lead and Team that is resourced with skilled people and a dedicated budget. It is yet to be determined whether this investment will result in improved GEDSI outputs and outcomes of the investments managed by PATH, although the targeted approach to Women in Leadership creates direct performance accountabilities in this regard.

The GEDSI Domains

The HDMES GEDSI Strategy and Toolkit recognises that the causes of gender inequality and disability and social exclusion are deep-rooted, complex, and intersectional; and that efforts to address inequality need to consider various levels and spheres of empowerment and change. The GEDSI Strategy and Toolkit outlines 7 GEDSI Domains: access to services; skills and capacities; agency and voice; leadership and representation; social norms; institutional policies and practices; and safeguarding (see Figure 9 below).

Figure 9: GEDSI Model



Source: Lucas and Thomson, 2019

Not all domains will be equal, relevant or possible within every investment. Where they are to effectively go beyond a narrow focus (for example, on providing access to health services for women), however, they should analyse and address other relevant domains such as social norms, skills and capacities, agency and voice, and safeguarding. When these additional domains are considered and integrated, an investment has the potential to address in a more holistic and comprehensive manner other barriers or enablers to more equitable and inclusive access to those health services and will begin to take a more GEDSI-transformative approach.

Review of designs and reporting at the HPP portfolio and investment levels, and interviews with gender staff from the AHC and the investments, indicated the HPP and its investments generally adopted a narrow focus on just a few GEDSI Domains, and did not adopt a comprehensive or transformative approach to GEDSI. The HPP and sampled investments generally had a predominant focus on approaches that have increased access to health services. Some investments also included a focus on increasing skills and capacities – for example, through health worker and counsellor training and leadership and representation of women. The domains that were generally absent from the HPP and sampled investments were agency and voice; social norms; institutional policies and practices; and safeguarding. As noted above, it is the absence of an integrated approach and focus on these other areas that has significantly limited the GEDSI approaches and results of the HPP and its investments.

3.8. Key Review Question 8: Monitoring and Evaluation

To what extent are Health Portfolio Plan M&E arrangements fit for purpose? (These include the HPP Performance Assessment Framework and M&E Framework, and investment-level M&E.)

Portfolio Plan M&E Arrangements

The portfolio's M&E arrangements are not fit for purpose, diminishing capacity for robust portfolio-level management.

HPP Performance Assessment Framework and M&E Framework

A portfolio-level Performance Assessment Framework and M&E Framework both exist. These were drafted in 2019, but never widely socialised. The PAF document remains as a 'marked-up' document, rather than a final version. Responses by the AHC Health Team to the documents ranged from 'I have not seen them', to 'I've looked at them, but don't use them', to 'I didn't realise they were finished'. Whatever their status, it is clear the documents have not been used as management tools by those with responsibilities across the portfolio.

Investment-Level M&E

Different investments, naturally, have different approaches to M&E. There are varying approaches to program logic (theory of change), with some investments having no program logic at all, and varying approaches to results frameworks. Different organisations apply different understandings of key M&E concepts such as activity, output, and outcome. What one organisation reports as an activity, another reports as an output. Reports across the portfolio frequently portray outputs as outcomes. This inconsistent application of concepts ultimately diminishes M&E quality, compromising the potential of M&E to contribute to learning and more informed decision-making.

In the absence of a widely socialised and used portfolio PAF and M&E Framework, ongoing monitoring and assessment of portfolio progress comes through investment-level reporting. Stemming from the variation in frameworks highlighted above, reporting from different portfolio investments applies different formats and varies considerably in quality. While there is a degree of similarity in format from the reports provided by investments managed by PATH (and its predecessors), reports generally conform to the standards of the different organisations managing the investments. Some organisations, particularly the NGO partners, have dedicated M&E staff or departments, and are able to produce informative and comprehensive reports that provide a useful snapshot of performance against targets at a particular point in time. Other organisations have provided reports that lack a sufficient level of detail to enable an understanding of progress.

Underpinning the concerns with investment-level M&E is a lack of demand from the AHC for a consistent approach and quality reporting from the different programs. At a minimum, investments should be required to have a program logic, an M&E and Learning Plan that meets DFAT standards, and should be reporting progress against outcomes in a way that also meets DFAT standards.

Human Development Monitoring and Evaluation Service

Since 2020, HDMES has been an important part of the portfolio's M&E arrangements. In the PNG context, where data and evidence often play a perfunctory role in decision-making, the HDMES remains a laudable and ambitious undertaking. The service has conducted several investment evaluations, drafted portfolio-level annual reports, and supported and trained the AHC Health Team. It was the consensus among AHC staff that HDMES has the potential to add value to the management of the Health Portfolio. Staff pointed to specific evaluations as evidence of the value of HDMES and highlighted that M&E training had been particularly useful. The service was not only

seen as an additional resource for AHC staff, but one which provided different perspectives on investment performance.

It was also the consensus among AHC staff that HDMES still has some way to go in realising the ambition behind its establishment. They attributed this to several factors, including the full HDMES team not being based in PNG, and therefore not able to consistently engage with stakeholders; less than optimal engagement by AHC staff with HDMES¹⁰⁷; and HDMES management challenges. Beyond these issues are other concerns, discussed below, with HDMES and the HDMES model.

Compliance Focus

The focus of HDMES work has so far been primarily compliance-related M&E – annual reports, and end of investment evaluations. What is notably absent is support to program design and program logic, M&E capacity building across investments (including data collection methods and tools), M&E to inform learning, and M&E to inform evidence-based decision-making. HDMES reports are generally considered to be the end point of a process. Ideally, they should be the mid-point of a process that starts with program design and ongoing support, and ends with a dialogue that generates learning and leads to data-driven or evidence-based decision-making.

Tasking Model

The AHC–HDMES relationship is based on a tasking model, where a discrete piece of evaluation work is identified, a terms of reference formulated, a team assembled and contracted, and the work undertaken and submitted. The model has 2 problems. First, it is reliant on mutual accountability, particularly regarding timelines and the exchange of information between AHC and HDMES that ensures expectations are clearly understood at the outset. Second, it has a narrow focus in terms of the allocation of HDMES resources. Staff and consultants are engaged with a task focus. Missing from that is the discretionary space for HDMES to use the resources at its disposal to ask questions that might not relate to a specific task, but which might have implications or interest across multiple investments or issues.

The result of the sole reliance on a tasking model is that HDMES outputs often lack a contextual or nuanced understanding of the public policy and political-economy issues underpinning the evaluation, leading to the frequent criticism that HDMES evaluations are either ‘missing important details’ or ‘telling us what we already know’. The alternative to the tasking model, already being discussed by the AHC, is a more expansive ‘engagement-based’ model, where space is created for HDMES to build an understanding of the context that joins the dots between different investments (and their subsequent evaluations).

Inadequate Quality Assurance

HDMES functions without an adequate quality assurance framework. The program has a task-based rather than process-oriented foundation. This is manifested in a number of ways, including ad hoc sourcing of the external consultants engaged to work on evaluations; time-based rather than output or deliverable-based contracting of consultants; ad hoc onboarding of consultants; ad hoc monitoring of project progress; and an inconsistent approach to key M&E concepts such as impact, effectiveness, efficiency, coherence, and sustainability. There is no clarity around or shared meaning of these concepts within the program, nor with external consultants. The result of the lack of quality assurance is that evaluations are conducted by consultants with different understandings of what is expected of them, follow different processes to get to the point of report submission, and potentially

¹⁰⁷ This was a problem exacerbated at the height of the COVID-19 pandemic, when the attention of AHC staff was directed towards addressing emergency needs.

present to stakeholders various understandings of what constitutes impact, or effectiveness, or efficiency. The cumulative effect is the frequent disappointment of AHC with evaluation outputs.

Use of M&E Data

The Health Team's use of M&E data reflects the lack of portfolio-level data and the reliance on investment-level M&E. In summary, as was highlighted above in reference to HDMES, M&E data is most often used by the AHC for compliance and accountability purposes. Members of the team noted that M&E data is often sought when compiling Investment Monitoring Reports, when responding to ad hoc information requests, and when decisions are made around investment extensions. It was not evident to the Review Team whether M&E data is used in a structured way to inform learning, or to inform decision-making.

3.9. Key Review Question 9: Governance

To what extent are Health Portfolio Plan governance arrangements fit for purpose? (This includes mechanisms for GoPNG engagement, governance and management of investments, and donor coordination.)

This section begins by returning to the impact of COVID-19, raised in the introduction to this report. A balanced consideration of Health Portfolio governance arrangements must take account of the global pandemic, and its impact on the capacity of the AHC Health Team to engage with government, to coordinate and management investments, and to coordinate with other development partners. While one element of the conclusion to the governance assessment is that more is needed to establish portfolio governance arrangements that are fit for purpose, the other element is that the team achieved all that was possible in the context of the COVID-19 response and its aftermath.

Government of PNG Engagement

The AHC Health Team's engagement with the Government of PNG is defined by 4 themes. First, engagement is largely driven by the strength of personal relationships. Given the importance of relationships in the PNG setting, including their significance in public policy settings, this is not a criticism. Those members of the team with stronger and enduring personal relationships are often able to capitalise on them in more frequently accessing and engaging with GoPNG counterparts. Second, building strong and enduring personal relationships is challenging for Australian-based members of the team, whose time in PNG is limited to 3 or 4 years. The challenge has been exacerbated by the COVID-19 pandemic, which heavily restricted interaction, and skewed engagement towards the unprecedented demands of the COVID-19 response. Third, engagement with GoPNG is sometimes impacted by the AHC team's internal work arrangements, with staff observing their time is often heavily absorbed by attending to internal issues, preventing them from spending time with counterparts. Finally, effective GoPNG engagement is a two-way street requiring appropriate reciprocal capacity on the PNG side. Government of PNG informants noted that capacity is not always evident, impacting the quality of engagement.

Internal Coordination and Management of Investments

When asked how you manage Health Portfolio investments amid responding to a global pandemic, a long-serving member of the AHC Health Team responded: 'You don't'. It was a telling observation, which encapsulated the monumental challenge faced by the Health Team towards the end of the first quarter of 2020. What might have been normal patterns of work, and systems and processes for coordination and management, were quickly overwhelmed, and only began to recover approximately

2 years later. While the impact of COVID-19 on internal coordination and management of investments was profound, it is important to acknowledge other factors have also been influential.

- The functional, investment-oriented organisational structure of the Health Team, while conducive to specialisation around the particular needs of different investments, is not an optimal arrangement for portfolio-level management. Opportunities for coordination across the portfolio, particularly around cross-cutting issues such as PFM reform or GEDSI, are often lost. Exacerbating the structural challenges are those with lack of financial data and M&E, highlighted in earlier sections of this report.
- The PATH program, which should play a critical role in the effective day-to-day management of investments, has not yet met expectations. Respondents highlighted PATH's challenges in filling senior management positions, in developing and implementing a transition to health strategy, and in responding to opportunities for synergies across the portfolio investments it manages, as drivers of its failure to realise its potential.

AHC Health Team staff highlighted improvements in internal processes, which have been evident in 2022. There was widespread appreciation that recent initiatives to bring the team together around issues such as risk management, finance, and overall portfolio progress, have improved prospects for coordination and more effective portfolio management going forward.

Coordination with Development Partners

The major mechanism for coordination between development partners and the Government of PNG is the Health Sector Aid Coordination Committee. The committee meets twice per year, bringing together NDoH, the central agencies, and development partners. It is an unwieldy structure with a large number of stakeholders, ultimately leading to information exchange, but no strategic decision-making. The outcomes are disappointing for government and development partners alike – government walks away with little visibility over what support is being provided to the health sector, and where it is being provided; development partners walk away with little clarity about delivering upon their workplans and ensuring their budgets are allocated and spent. In the aftermath, different development partners make additional demands on the time of NDoH, placing further pressure on its already limited capacity for engagement. It is a situation that has impacted the efficiency the HPP and escalates risk.

Recognising the limitations of these arrangements, DFAT and WHO have combined, with the encouragement of NDoH, to resurrect a monthly development partners coordination meeting, which had previously lapsed. The meeting brings together core donors to the health sector on a monthly basis and is open to other development organisations working in the sector every alternate month. The meeting provides an opportunity for development partners to engage with each other prior to engaging with NDoH. The purpose is not to make joint decisions without government. Rather, it is to ensure the different stakeholders know and understand what each other are doing before sitting down with government. This is a positive step forward in increasing the effectiveness of coordination among development partners.

4. Recommendations

The central recommendation of this review is to maintain the present priorities and direction. It is a recommendation that accounts for the following review findings:

- The HPP remains relevant, and HPP investments have contributed to its Objective and Goals.
- The COVID-19 pandemic negatively impacted both the outcomes anticipated by the Health Portfolio Plan and its management and implementation. Time was lost.
- Stronger portfolio management systems and processes might have led to improved portfolio outcomes, or at least a better understanding of portfolio outcomes.

The recommendations below support the central recommendation. They are concerned with sharpening the focus of the HPP, tightening its management, and positioning for continued support to the improvement of health outcomes in PNG.

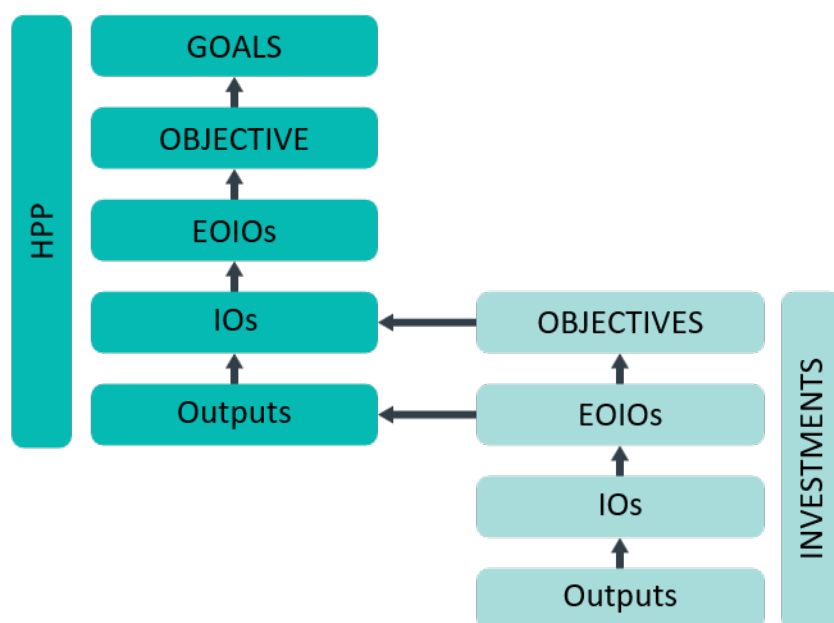
4.1. Short-Term: Remainder of the HPP

The following recommendations are concerned with positioning the AHC Health Team and the Health Portfolio for a future Health Portfolio Plan. These shorter-term recommendations are largely concerned with establishing a solid foundation for more efficient and effective program management into the future. They recognise the limited timeframe, focusing on changes and adjustments to systems and processes that should ultimately not only improve productivity at the AHC, but also establish a more relevant, effective and efficient portfolio.

Recommendation 1: Alignment in Portfolio Logic

There is wide variance in the extent to which portfolio investments align with the program logic of the HPP. Poor alignment potentially diminishes portfolio relevance, effectiveness, and efficiency; and it exacerbates the challenges associated with portfolio-level aggregation of results and reporting. A key principle for investment design and redesign should be clear alignment between the program logic of portfolio investments and the overall logic of the HPP, as in Figure 10 below.

Figure 10: Aligned Portfolio and Program Logic Model



Alignment is achieved through aligning the objective level of the investments with the intermediate outcome level of the portfolio, and the outcomes of the investments with the outputs of the portfolio. The model recognises that multiple investments will contribute to a HPP Intermediate Outcome, and establishes a clear line of accountability between the investments and the portfolio.

Recommendation 2: Standardisation

The review has highlighted how health investments came under the HPP umbrella in different ways. A consequence of that was that investments which preceded the HPP already had their own established ways of working. These included approaches to planning, budgeting and reporting. To improve portfolio efficiency, enable comparative analysis of investments, and facilitate streamlined portfolio planning, budgeting and reporting, standardisation of approaches and tools is recommended. In some instances, this process should ideally be led by PATH, which is responsible for several investments that predate the HPP. In other instances, it should be led by HDMES.

Design Logic

All future HPP investments should use and be guided by DFAT standards, and guidance and practice notes. This should include as a minimum:

- A theory of change/program logic that stems from and is aligned to the HPP logic, as per Recommendation 1 above.
- An M&E plan that adopts portfolio understanding of key M&E concepts.
- A results framework with indicators at the different levels of the program logic.
- A GEDSI plan that adopts the 7 GEDSI Domains as an analysis, design and reporting framework, and which clearly accounts for and distinguishes between gender, disability, and social inclusion.

Budgeting and Financial Reporting Tools

The formats currently adopted by investments for budgets and financial reports vary in terms of budget lines and level of detail. None of the investments operating across multiple provinces have disaggregated their budgets or reports by province. Approaches and tools should include, as a minimum standard, the following:

- Consistency between budget lines and reporting lines, so investments can accurately report spend against budget.
- An agreed set of budgeting and reporting categories and lines, with a clear portfolio-level guidance note providing commentary on the items that should be included in each line.
- Disaggregation of all investment budget and reporting categories and lines by province.

Value for Money: Overhead

Investments should be given clear guidance about budgeting for and reporting overhead-related expenses. Overhead as a broad category could be divided into 3 sub-categories – management fees for offshore support, local core costs, and local program management and administration costs – with instructions about what should be included (and excluded) in each.

Monitoring and Evaluation Formats and Standards

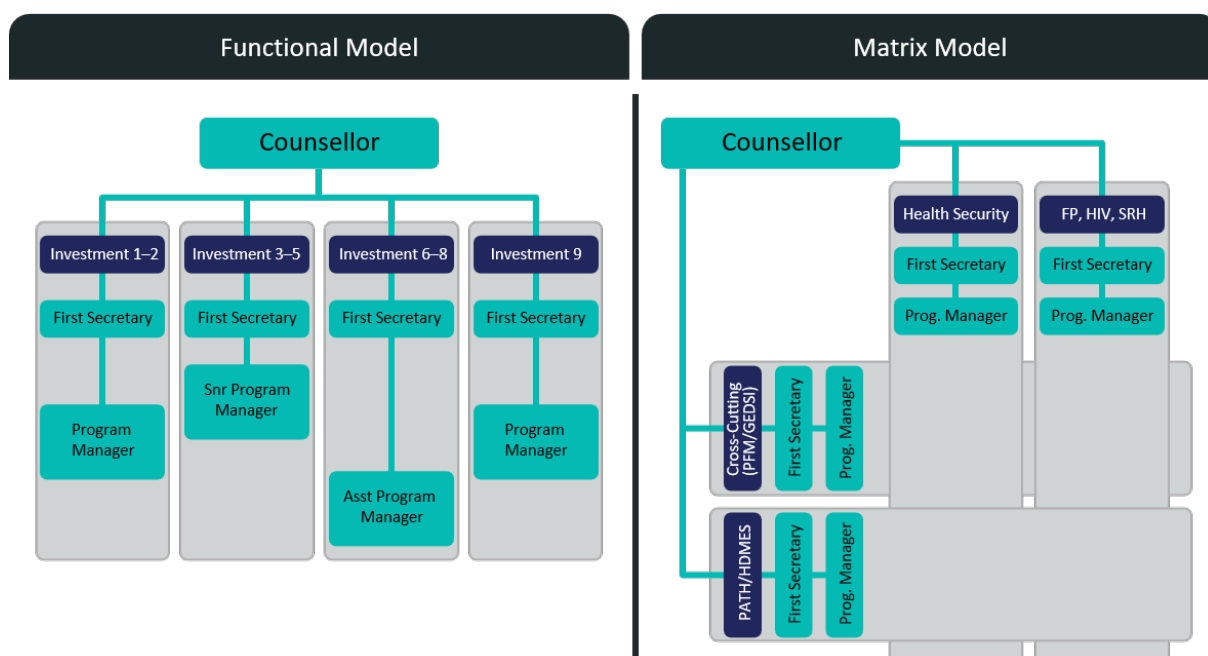
The overall structure for results frameworks and progress reports should be uniform across the portfolio, with a standardised understanding of how and when to report activities, outputs and outcomes. The process of establishing uniformity and socialising concepts should be led by HDMES and should be aligned across PATH and non-PATH investments.

Recommendation 3: Organisational Structure

During review consultations, AHC Health Team members, at all levels, highlighted the substantial demands on the team in managing a complex portfolio with a substantial budget. While adjustments to ways of working are unlikely to reduce workload pressures on the team, they potentially provide a greater sense of control in dealing with the complexity of the portfolio.

The AHC Health Team currently works according to a functional structure, where different teams assume responsibility for different portfolio investments. While such a structure has advantages in terms of specialisation and operational clarity, its disadvantages include the lack of coordination and tendency to reinforce the organisational silos that characterise current portfolio management.¹⁰⁸ The review recommends a shift towards a matrix structure, which combines the vertical functional structure around the themes of health security (EOIO1) and sexual and reproductive health (EOIO3), with a cross-functional thematic structure for PFM (and other identified cross-cutting themes) and cross-program investments of PATH and HDMES (see Figure 11 below).

Figure 11: AHC Health Team Functional versus Matrix Structure



The matrix structure comprises overlapping teams which, if not managed judiciously, potentially leads to lack of clarity. This risk is outweighed, however, by advantages in knowledge sharing and communication, and alignment across functions. This risk can be mitigated through establishing a strong sub-committee structure or routine meeting structure at the different points of portfolio intersection. The key advantage of the matrix structure in the portfolio is that it would strengthen the focus on cross-cutting areas of need – systems strengthening (particularly PFM), GEDSI, and coordination. A related advantage is that it strengthens visibility over PATH as the managing contractor responsible for several HPP investments, and therefore with the potential to facilitate integration and coordination across those investments.

¹⁰⁸ *Organization Structures: Theory and Design, Analysis and Prescription*, H. Baligh, Springer, 2006.

Recommendation 4: Sequencing

The Health Portfolio currently sits at an opportune juncture. The current phases of several programs have ended, with 1-year extensions granted to deal with COVID-19-induced backlog of outstanding designs and redesigns. The HPP ends in 2023, and the current phase of PATH in 2025. While the program cycle creates work pressures around evaluations and design, it also creates an opportunity to move into a new HPP with more strongly-aligned investments.

Critical to capitalising on this opportunity is the sequencing of activities. The following sequencing principles are recommended:

- The design of the HPP logic should be finalised prior to finalising any investment design. The program logic of the investments can then be tied to the portfolio, as per Recommendation 1.
- During the process of HPP design, the different tools and templates required to enable standardisation of approaches should be developed, as per Recommendation 3.
- Investments should be designed (and redesigned) using the new tools and templates, with quality assurance of that process provided by HDMES (see below).

Recommendation 5: HDMES

A strong and effective HDMES provides a mechanism that enables HPP M&E to move beyond compliance-related activities, and relieve a workflow pressure point for the AHC Health Team. In addition to the evaluation work, which has been its core business, it is recommended the role of HDMES should encompass the following:

- Quality assurance of all investment M&E requirements of the HPP, from investment design (program logic, and theory of change) through to completion. This would include serving as a first point of reference for investment progress reports, ensuring appropriate standards are met.
- Providing training, mentoring and ongoing support to investments to ensure sufficient capacity to meet requirements. A key element of this would be HDMES leading a HPP monitoring, evaluation and learning community of practice.
- Designing and facilitating learning events for the AHC Health Team, which are aligned to the HPP pillars of work and cross-cutting themes.

There are 2 necessary prerequisites to realise this more expansive focus. First, HDMES needs space and resourcing for independent deliberation – that is, a movement away from an exclusive reliance on top-down tasking to an arrangement where HDMES exercises a degree of discretion in pursuing a research and learning agenda (for example, exploring cross-cutting themes not specifically related to a single investment). Second, expectations around processes and timing between the AHC and HDMES should be jointly agreed upon. The current back-and-forth arrangements for the design of terms of reference, selection of consultants and acceptance of reports are inefficient. These prerequisites require, of course, that HDMES consistently performs to a standard where it meets AHC expectations.

4.2. Future DFAT Health Programming in PNG

While the shorter-term recommendations above are concerned with positioning for a future Health Portfolio Plan, the recommendations below are concerned with the key issues that the portfolio design must address.

Recommendation 1: Resolve the Service Delivery versus Systems Strengthening Tension

A recurring tension highlighted by this review is that between service delivery initiatives by HPP investments and initiatives to strengthen the PNG health system. It is a tension that was established in the HPP design, with a Goal and Objective lending themselves to service delivery and outcomes aligned to systems strengthening. As the Health Portfolio Plan has been implemented, the tension has manifested itself in different ways:

- Between immediate needs to respond to health emergencies, including TB and COVID-19; and a longer-term motivation to strengthen the system's capacity to better cope with future emergencies.
- Between the desire to deliver essential family planning, sexual and reproductive health and HIV services; and imperatives to integrate those services into the health system.
- Between program-based modalities that favour systems strengthening; and project-based modalities that are more commonly associated with service delivery.
- Among partners whose core competencies are more service delivery-oriented seeking ways to strengthen the health system.

Underpinning the tension is a thinly-veiled assumption, encapsulated in the HPP program logic, that supporting systems strengthening represents better use of Australian aid dollars; and a more conspicuous understanding that funding the provision of services is essential to save lives (and in the case of TB, to protect Australia's borders).

The service delivery versus systems strengthening tension needs to be on the agenda at the commencement of discussions about a HPP successor, and a firm position established. It is recommended there is an explicit recognition of the necessity for Australia to support service delivery, and clear parameters around the circumstances how and where that should happen.

Recommendation 2: Resolve the Narrow versus Expansive Geographical Coverage Approach

A criticism of the HPP raised by some government informants was that it has a narrow geographical focus. AHC staff countered that the portfolio has a presence in 18 provinces. While the criticism of a narrow focus, based on the presence of PATH focal points, is perhaps unfair, the argument in favour of an expansive presence is perhaps also unfair, given the HPP's minimal footprint in a number of provinces. The debate raises questions about the optimal geographical coverage of the portfolio's investments, and how they should be distributed. The arguments in favour of establishing broad geographical coverage include that it is more equitable, that it enhances the strength of the Australia–PNG bilateral relationship, that it avoids creating unrealistic 'aid-driven' outcomes in selected provinces, and that it recognises PHAs have limited absorptive capacity to manage a large influx of development assistance. The arguments in favour of a narrow coverage include that it capitalises on potential synergies across programs, achieves economies of scale, frames what is possible in a well-resourced system, and allows a focus on areas of particular need or opportunity.

Apart from the identification of PATH priority provinces, decisions about the locations of different portfolio investments were often made by the investments, based on both past activities and perceptions about future opportunities and preferences. The review recommends that, rather than leave these decisions to the investments, the AHC should drive decisions about coverage through a portfolio lens, that seeks to maximise opportunities for synergy, coordination, and a focus on cross-cutting themes.

Recommendation 3: Tackle PFM

The current HPP recognises the significance of finance bottlenecks as a key constraint to improving health outcomes in PNG. As discussed in section 3.3 above, several investments have dedicated resources to addressing elements of the bottlenecks. The review recommends a more concerted effort to address finance constraints in a future HPP. Future support should include the following dimensions:

- PFM bottlenecks must be recognised as a cross-cutting issue that impacts service delivery and systems strengthening initiatives across all investments.
- PFM must be recognised as a specialised field of support, and one that not all organisations have the capacity to address.
- PFM incorporates central agencies outside the health sector, and these agencies need to be actively engaged in programming that seeks to address finance bottlenecks.

Current portfolio initiatives concerned with PFM reform have adopted a piecemeal investment-by-investment approach. The review recommends an adaptive approach be taken to PFM reform, with all Australian-funded initiatives aligned to a singular PFM reform vision that is established in collaboration with NDoH and the central agencies.

Recommendation 4: Adopt a Comprehensive GEDSI Approach

The GEDSI assessment above concluded that, while the current portfolio is delivering positive changes to health services that will benefit women, these do not amount to transformative, systemic, or measurable social change. The absence of a portfolio-level GEDSI framework, which would encompass a GEDSI theory of change, supporting the program logic of multiple investments (from design through to measurement and reporting), means that GEDSI elements across the HPP are limited, with almost no focus on disability and social inclusion. GEDSI activities within individual investments are not consolidated under the umbrella of the HPP, diminishing the potential of the portfolio to advance a comprehensive agenda or demonstrate GEDSI results.

The review recommends a successor to the HPP adopt an overarching framework that is broad enough to enable diversity of approaches, but which incorporates sufficient commonality to harness combined impact. This recommended approach can be broken down into 3 elements:

1. A theory of change should be developed that reflects all known drivers and barriers to GEDSI change, with performance assessment requirements outlined in an M&E plan that includes explicit GEDSI indicators and accountabilities.
2. HPP investments should adopt a more comprehensive and potentially transformative approach to GEDSI, rather than the narrow or siloed approach focused on specific dimensions of women's health. This could be facilitated through the adoption of the 7 GEDSI Domains as an analysis, design, and reporting framework.

3. AHC should increase its oversight and expectations of investments and partners relating to GEDSI analysis, integration into designs and theories of change, and performance assessment requirements and accountabilities.

Recommendation 5: Establish a Roadmap to Sustainability

A viable PNG health system, which realises the development priorities of PNG governments, is a generational aspiration. It won't be realised through the current HPP, or the next one. A successor HPP represents a step on a longer journey towards sustainability (or viability). Part of that journey must involve a graduated shift from project-based modalities, driven by donor systems, towards program-based modalities, working with and through government systems.

At present, given capacity deficits in governance, management and systems, embrace of program-based modalities across the portfolio is not viable. The review recommends the development of a portfolio roadmap that establishes a series of stages that will eventually lead to the capacity to deliver aid through government systems. Critical to that roadmap is an understanding of the mix of modalities required at the different stages, and a recognition the shift towards delivery through government systems will not follow the same linear path for different government partners in different places (national and provincial).

Annexes

Annex 1 – Health Indicators

Table A1: Data on Key Indicators in PNG Measuring Progress towards HPP Objective

Indicator (HPP Objectives)	2016	2017	2018	2019	2020	2021	2022	HPP Investments
Malaria prevalence per 1,000	108	109	118	112	108	141	99	TMP
TB prevalence (100,000) based on WHO estimated incidence	432	432	432	432	432	n/a	n/a	RID-TB, Stop TB
Pregnant women with HIV treated with ART (proxy for indicator for entire population)	38%	53%	68%	82%	64%	n/a	n/a	PSF, SRHIP
CYP protection	102	124	126	135	136	100	96	PSF, SLSS

Source: SPAR 2020; Note: 2022, based on January to October.

Table A2: Additional Maternal and Child (MCH) Mortality Data Measuring Progress towards HPP Objective

Indicators (Other Key MCH Interventions)	2016	2017	2018	2019	2020	2021	2022	HPP Investments
1 ANC visit	51%	49%	47%	51%	48%	45%	47%	SLSS, PSF, AIHSS
Birth in facilities	36%	34%	32%	36%	36%	33%	31%	SLSS
LBW babies	7%	7%	8%	7%	7%	7%	7%	SLSS
Measles immunisation (9–11th month dose)	35%	32%	33%	34%	46%	n/a	n/a	AIHSS, PSF
Pentavalent immunisation (3rd dose)	42%	39%	41%	42%	47%	39%	41%	AIHSS, PSF
Incidence of diarrhoeal disease in children	241	205	207	182	178	141	118	N/A
Childhood pneumonia admission CFR	2.0%	2.4%	1.9%	2.1%	2.2%	2.6%	2.1	N/A
Childhood outreach	28	28	31	31	37	31	32	PSF, AIHSS
Children moderately or severely underweight	22%	21%	20%	21%	17%	24.6	18.3	PSF, AIHSS
TB treatment success rate	74%	72%	74%	76%	78%	n/a	n/a	RID-TB, Stop TB

Source: SPAR 2020; Note: Includes other indicators related to reducing maternal and child mortality, from 2016 to 2020, with assessment of contribution of HPP investments directly targeting those interventions.

Table A3: Progress towards Indicators and Targets under EOIO1

Indicator	2016	2017	2018	2019	2020	2021	Target
Percentage of outbreaks assessed within 48 hours (1,4)	80%	67%	54%	N/A ¹⁰⁹	N/A	–	100%
Number of people receiving TB treatment in accordance with national guidelines in NCD and Western Province (3)	–	–	–	–	–	–	W: 1900 NCD: 7,100
Treatment success rate for DS-TB in NCD and Western Province (1)	W: 80% NCD: 76%	W: 63% NCD: 14%	W: 83% NCD: 77%	W: 79% NCD: 94%	W: 81% NCD: 88%	–	85%
Percentage of malaria cases confirmed by microscopy or RDT (2)	No base-line	Approx 66%	Approx 85%	85%	93.3%	91.9%	Not set
Percentage of malaria cases treated in accordance with national guidelines (5)	No base-line	–	–	–	–	–	Not set

Source: (1) SPAR 2020; (2) Trilateral Malaria Project Annual Reports; (3) RID-TB project reports; (4) Data no longer being reported as part of the SPAR given poor data quality; (5) Data not yet available.

Table A4: Progress towards Indicators and Targets under Outcome 3

Targets in project provinces only	2016	2017	2018	2019	2020	2021	Target
Number of family planning services provided (1)	50,178	–	42,669 (MSI target 30,000) 142%	56,873 (MSI target not specified)	17,125 (MSI target 27,575) 62%	31,248 (target 25,390) 123%	Not set
Number of people treated for STIs and HIV including PPTCT (1)	9,992	–	–	16,367	7,481	3,657	Not set
Number of pregnant women attending at least 1 ANC(1)	3,675	–	–	5,595 or 6,949	3,047	1,920	12,605 (Phase 1 only)
Number of children immunised (1)	7,381	–	–	10,429	4,731	2,506	22,325
Number of people tested for HIV (VCCT) (2, 3), CCHS & Anglicare PNG (APNG)	–	18,184 (4)	21,297 (CCHS 15,927 & APNG 5,371)	18,583	11,448 (4, 5)	3,873 (CCHS only)	46,071 (CCHS 42,674, APNG 3,397)

Source: (1) PSF annual and 6-monthly reports, inconsistent figures are noted; (2) SRHIP annual reports; (3) the SRHIP evaluation noted that testing targets changed over time for the program, with the original 2021 target being 93,696; (4) Assumption based on data reported for Jul–Dec; (5) includes both VCCT and PICT.

¹⁰⁹ Timeliness of reporting was below 60%, so data for 2019 and 2020 was not reported as part of the SPAR 2020.

Annex 2 – Review Key Informant Interviews

AHC – Current

Name	Position
Dianne Barclay	AHC Minister Counsellor
Dr Lara Andrews	AHC Counsellor, Health
Anna Gilchrist	AHC First Secretary – Health, PSF, AIHSS
Elise Newton	AHC First Secretary – Health, JID/ANGAU, HSIP TA, RPHSDP/HSSDP
Celina Smith	AHC First Secretary – Health, TB, TMP, SRHIP
Catherine Herron	AHC First Secretary – Health, WHO, HDMES
Jason Court	AHC First Secretary – Health, PATH, HDMES
Robyn Liu	PATH, GEDSI
Dianne Dagam	AHC Senior Program Manager – Health, PATH
Daisy Rowaro	AHC Senior Program Manager – Health, PSF
Gertrude Ndreland	AHC Program Manager – Health, WHO
Ali Kevin	AHC Program Manager – Health, HSIP TA, RPHSDP/HSSDP
Ore Topurua	AHC Program Manager – Health, JID/ANGAU
Anna Naemon	AHC Program Manager – Health, TMP
Cathy Stoesel	AHC Assistant Program Manager – Health, SRHIP
Gaye Moore	AHC First Secretary – Program Strategy and Gender
Kate Butcher	GEDSI Adviser
Camilla Angoro	AHC, Program Manager, Gender

AHC – Former

Name	Position
Catherina Habbon	Former AHC Program Manager, TB
Will Robinson	Former AHC Health Counsellor (2017–2020)
Jacque Herbert	Former AHC First Secretary (2017–2020), PSF
Andrew Dollimore	Former AHC First Secretary (2017–2018), SRHIP, HSIP, TMP
Emmeline Cammack	Former AHC (2019–2022), SRHIP, TMP, Daru TB)
Nikki Wright	GEDSI

National Department of Health

Name	Position
Elva Lionel	NDoH Deputy Secretary – National Health Policy and Corporate Services
Navy Mulou	NDoH – Health Economics Unit; Technical Adviser
Goa Tao	NDoH Deputy Secretary – NDoH Compliance and Medical Standards
Lina Wam	Human Resource Division
Leo Makita	Malaria Control Coordinator

Provincial Health Authorities

Name	Position
Dr Nick Wuatai	CEO – Western Province PHA
Dr Miriam Boga	Director Curative Health Services – Western Province PHA
Dr Steven Yennie	CEO – NCD PHA
Amos Lano	Director Public Health – NCD PHA

Name	Position
Mr Pascoe Kase	Adviser – NCD PHA
Dr Trevor Kelebi	Director Public Health – West Sepik PHA

Department of National Planning and Monitoring, Social Sector, Public Investment Program

Name	Position
Rose Koyama	First Assistant Secretary

Department of Treasury

Name	Position
Larry Asigau	Assistant Secretary – Budget Coordination and Analysis Division
Ellison Darby	Senior Budget Officer – Budget Coordination and Analysis Division
Lumbe Silau	Assistant Secretary – Financial Management Division

Department of Finance

Name	Position
Chris Waiya	Assistant Secretary – Cash Management Division

PATH Program

Name	Position
Luke Elich	Program Delivery Adviser
Stella Rumbam	Program Delivery Lead
Matthew Moylan	Essential Services Lead and Frontline Health Outcomes Team Lead
Cornell Mirciov	Grants and Operations Manager
Stella Jimmy	Health Security Lead
Ayesha Lutschini	GEDSI and Safeguarding Lead
Maryanne Kehalie	Senior Program Manager – Health
Zerah Lauwo	HSIP
Sybilla Tulem	HSIP
Kelwyn Brown	Western Province – COVID-19 Provincial Adviser

Catholic Church Health Services

Name	Position
Graham Apian	Program Manager
Maureen Wesley	Program Officer

World Vision International

Name	Position
Heather McLeod	Country Director
Clement Chipolow	Head of Operations
Agnes Tal	Monitoring and Evaluation
Anita Victor	Team Leader, Health

Burnet Institute

Name	Position
Dr Kudakwashi Chani	Country Director
Philipp Ducros	Infectious Diseases Physician, TB
Dr Khai Huang	Infectious Diseases Physician, RID-TB
April Holmes	GEDSI Team
Melanie Wratten	GEDSI Team

HSSDP

Name	Position
Dorothy Keyser	GEDSI Officer

SLSS

Name	Position
Paula Kongua	UNICEF Program Officer

WHO

Name	Position
Dr Sevil Huseynova	Country Representative
Anna Maalsen	Universal Health Coverage, Health Systems, MCH and NCDs Team Lead
Dr Anup Gurup	Communicable Diseases Team Lead
Eric Salenger	Technical Officer Pharmaceuticals
Dr Madline Salva	Medical Officer – MCH
Dr Abdur Rashid	Malaria Program
Dr Narantuya Jadambaa	TB and Leprosy
Masamitsu Takamatsu	Immunisation
Mollent Akinyi Okech	Technical Officer Human Resources for Health Systems
Jessica Yaipupu	Technical Officer Gender and Women's Health

Marie Stopes PNG

Name	Position
Andrew Kirima	Service Delivery Director
Eva Hall	Regional Operations Manager – Cambodia, PNG, Timor-Leste

JID

Name	Position
Anthony Patridge	Director – Program, Quality and Operations

Oil Search Foundation (OSF)

Name	Position
John Piel	Strategic Finance Adviser, PHAs (Hela, Southern Highlands, Gulf), NDoH and Central Agencies

Annex 3 – DFAT Monitoring and Evaluation Standards

Introduction

No.	Element	Reference in Report
6.1	A background to the evaluation summarises: the total value of the investment; the number of years of the investment; the stage of investment implementation; key outcomes of the investment; and the key issues identified in the Terms of Reference	Executive Summary and 1. Introduction sections
6.2	A summary of the methods employed is provided	2.2 Methodology
6.3	Key limitations of the methods are described, and any relevant guidance provided to enable appropriate interpretation of the findings	2.3 Limitations
6.4	The executive summary provides all the necessary information to enable primary users to make good quality decisions	Executive Summary

Findings and Analysis

No.	Element	Reference in Report
6.5	The evaluation report clearly addresses all questions in the Terms of Reference	3. Key Findings of the Mid-Term Review
6.6	The relative importance of the issues communicated is clear to the reader	3. Key Findings of the Mid-Term Review
6.7	There is a good balance between operational and strategic issues	3. Key Findings of the Mid-Term Review
6.8	The report clearly explains the extent to which the evidence supports the conclusions and judgements made	3. Key Findings of the Mid-Term Review
6.9	Alternative points of view are presented and considered where appropriate	3. Key Findings of the Mid-Term Review
6.10	Complicated and complex aspects of issues are adequately explored and not oversimplified	3. Key Findings of the Mid-Term Review
6.11	The role of context and emergent risks to investment performance are analysed	3. Key Findings of the Mid-Term Review
6.12	The text uses appropriate methods/language to convince the reader of the findings and conclusions	3. Key Findings of the Mid-Term Review
6.13	There is an adequate exploration of the factors that have influenced the issues identified and conclusions drawn	3. Key Findings of the Mid-Term Review
6.14	The implications of key findings are fully explored	3. Key Findings of the Mid-Term Review
6.15	The overall position of the author is clear, and their professional judgements are unambiguous	3. Key Findings of the Mid-Term Review

Conclusions and Recommendations

No.	Element	Reference in Report
6.16	The conclusions and recommendations logically flow from the presentation of findings and any associated analyses	4. Recommendations
6.17	Individuals have been allocated responsibility for responding to recommendations	N/A
6.18	Where there are significant cost implications of recommendations, these have been estimated (financial, human and materials costs)	N/A
6.19	The recommendations are feasible	4. Recommendations
6.20	The circumstances under which any important lessons are transferable are described	4. Recommendations
6.21	The final evaluation report is published within the timeframes outlined in the DFAT Aid Evaluation Policy	4. Recommendations

Annex 4 – CSEP References in PNG Mass Media

CSEP Pillar	CSEP Action Plan	Mass Media Reference
5	CSEP Commitment #20	Australia's Respect for PNG, <i>Post-Courier</i> , 18 March 2021 (https://postcourier.com.pg/australias-respect-for-png/)
5	CSEP Commitment #20	Australia Donates PPE to Health Department, <i>Post-Courier</i> , 30 April 2020 (https://postcourier.com.pg/australia-donates-ppe-to-health-department)
5	CSEP Commitment #49	Australia to Aid PNG with Health Facilities, <i>Post-Courier</i> , 17 April 2020 (https://postcourier.com.pg/australia-to-aid-png-with-health-facilities)
5	CSEP Commitment #49	Australia–PNG Extend Partnership for Anti-venoms, <i>The National</i> , 20 September (https://www.thenational.com.pg/australia-png-extend-partnership-for-anti-venoms)
5	CSEP Commitment #45	Australia Provides Funding for HIV Response in Papua New Guinea, <i>Post-Courier</i> , 12 October 2021 (https://postcourier.com.pg/australia-provides-funding-for-hiv-response-in-papua-new-guinea)
2, 5	CSEP Commitment #49	Over 50 Health Professionals Complete Training on Vaccine Roll-out, <i>The National</i> , 25 October 2021 (https://www.thenational.com.pg/over-50-health-professionals-complete-training-on-vaccine-roll-out)
2, 5	CSEP Commitment #49	Online Paediatrics Workshop for Health Workers, <i>Post-Courier</i> , 26 November 2021 (https://postcourier.com.pg/online-pediatrics-workshop-for-health-workers)
5	CSEP Commitment #45	Australia Gives K852.4m, <i>Post-Courier</i> , 2 December 2021 (https://postcourier.com.pg/australia-gives-k852-4m)
5	CSEP Commitment #49	Nurse Serves with Passion in Remote Health Centre in ENB, <i>Post-Courier</i> , 29 July 2022 (https://postcourier.com.pg/nurse-serves-with-passion-in-remote-health-centre-in-enb)