PNG AID EVALUATION FORUM AT ANU DEVELOPMENT POLICY CENTRE. 30 MAY 2018.

INDEPENDENT EVALUATION OF DFAT'S MULTILATERAL PARTNERSHIPS IN THE HEALTH SECTOR OF PNG

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STRATEGIC CONTEXT: HEALTH CHALLENGES IN PNG

Some progress: eg reduction in malaria faster than in Africa.

But

Mortality rates improving yet under 5 year old mortality 56 / 1000 live births (but confidence interval 34-93). Infant mortality 43 / 1000 live births (28-67). Maternal mortality ratio 215 / 100, 000 (98 – 457).

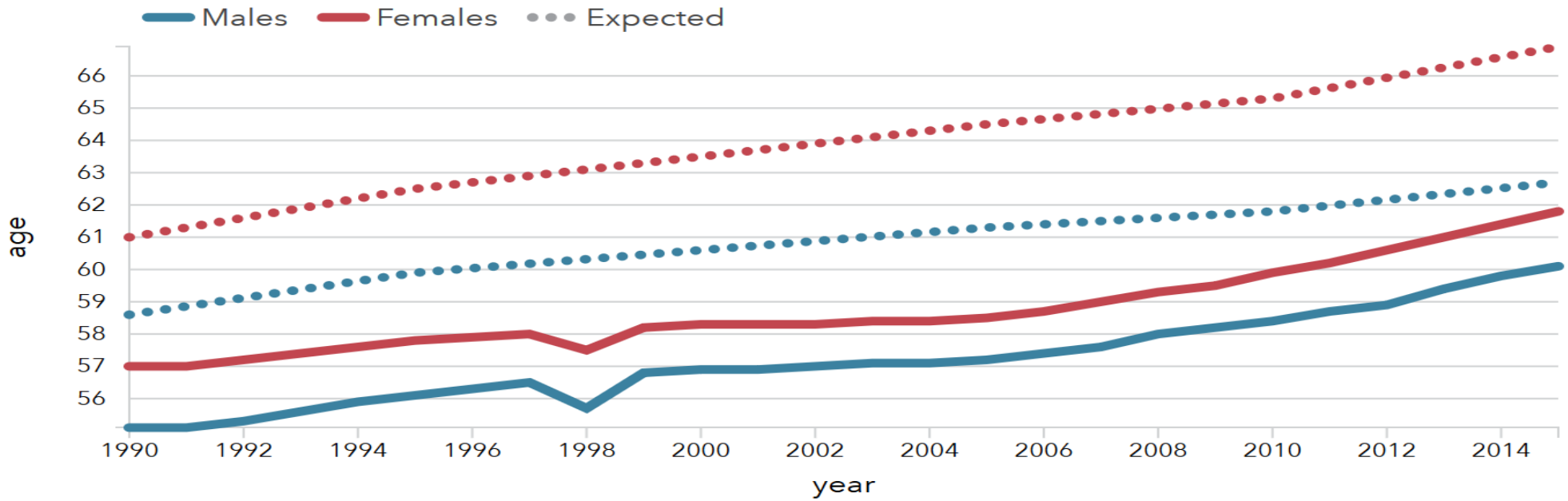
Outcomes. PNG did not achieve any of the 3 MDG health related goals.

Outputs. Diptheria, pertussis and tetanus (DPT) immunisation coverage of 72% (cf 82% LMICs; 88% PICs; 94% Australia). Glen Mola 22 May blog re POM hospital.

Future? Rapid population growth, plus "double burden" of NCDs and unfinished agenda AND declining or at least volatile public expenditure (including MDPs eg GAVI).

‘DOUBLE BURDEN’ EG LIFE EXPECTANCY IN PNG 1990 -2014, EXPECTED AND OBSERVED.

SOURCE: IHME (2017)



	Expected		Observed	
	1990	2015	1990	2015
Males	58.6	62.7	55.1	60.1
Females	61.0	66.9	57.0	61.8

STRATEGIC CONTEXT: HEALTH FINANCING IN PNG

SOURCE: WORLD BANK DATA BANK, SHOWING LATEST YEARS AVAILABLE

Criteria	Australia	Lower middle income countries globally	Pacific Island small states	Papua New Guinea
Current health expenditure as % GDP	9.4%	4.1%	5.5%	3.7%
Total health expenditure per capita in $ I PPP (includes out of pocket, insurance etc)	$Int 4491	$Int 260	$Int 291	$Int 98
Government health expenditure per capita in $I PPP	$Int 2887	$Int 81	$Int 178	$Int 70

THE STRATEGIC CONTEXT FOR THE EVALUATION

- 81.3% total health expenditure in PNG comes from GoPNG (and DPs). There are also significant public health challenges (eg communicable diseases where public expenditure is essential). So, what Government of PNG does – or doesn't do – is central to health outcomes in PNG *and the region*.

- But numerous gaps and constraints (capacity possibly more than $) means GoPNG still needs specific international support (TA but also sometimes actual *implementation*).

- Demonstrably in Australia's interests to have effective, efficient, engaged multilateral partners supporting GoPNG priorities so DFAT decision to engage with MDPs makes sense. Why?
- (i) scale of the health challenges requires multilateral effort
- (ii) DFAT cannot / should not do everything
- (iii) Australia is a shareholder in all 6 multilateral agencies and wants to see them working well.

THE EVALUATION ITSELF

Agencies	Amount paid 2011-2017, in current $A Source: DFAT
Asian Development Bank	$73,769,800*
World Health Organisation	$16,937,547^
UNFPA	$10,000,000
UNICEF	$8,891,317
World Bank	$2,301,336
TOTAL	**$111,900,000**

APPROACH AND METHODOLOGY: SOME KEY ISSUES

- What is it ? A program? A portfolio? A project ? Original DFAT approval (FMA 9 / Section 23 is therefore key). Series of projects cf "program" and disconnect from the strategy.
- Emphasis on *documentary evidence* that provides a "line of sight" between inputs and outputs / outcomes.
- Numerous confounding factors: health outcomes affected by factors outside health sector; changes in economic growth and X rate in PNG; other DPs (GAVI and UNFPA).
- Several factors are (rightly) beyond direct span of control of agencies at least in medium term Eg NDOH capacity; provincial resource allocation etc.

THE EVALUATION CRITERIA OF EFFECTIVENESS, EFFICIENCY, EQUITY, SUSTAINABILITY ETC ARE LINKED:

THE STORY OF THE BUBULETA COMMUNITY HEALTH POST AND THE GURNEY COMMUNITY HEALTH CENTRE IN MILNE BAY

Effective ? **Yes.**

- Increased the number (consultation rooms etc) and type of services (eg birthing and 24 hour care).

- Well built (but incinerator, toilets, emergency bed).

- Good physical access (near main roads) and social access (clean, attractive).

- Community engagement and support.

HEALTH POST: THEN AND NOW

HOWEVER, SIGNIFICANT AND SUSTAINED DRUG SHORTAGES AFFECT ALL CRITERIA….

- Effectiveness: Misoprostol (key for maternal, postpartum bleeding) and Flucloxacillin (antibiotic, including for pneumonia) not available.
- Efficiency: Expensive centres and staff simply not able to do their essential job at all. Also likely to mean some patients bypass the CHP / CHC and go to the more expensive hospital.
- Equity: Rural clinics tend to serve poorer, rural, and female (maternal plus their children) needs. Drug stock-outs means either no care, or issuing prescriptions that then involves direct out of pocket expenditures.
- Sustainability: Drug supplies were already not sustainable after the first month.
- M & E : the M&E system is not capable of triggering a key health system response.

OBVIOUS IMPROVEMENTS BUT DRUGS SUPPLY A FUNDAMENTAL AND WIDESPREAD PROBLEM

EFFECTIVENESS:
QUALITY OF OVERALL ENGAGEMENT. EVIDENCE OF CHANGE AND "RESULTS''

- A threshold issues at the outset: "additionality" or substitution (fungibility)
- Malaria and **GFATM / WHO:** "Unprecedented" decline in malaria (11.1% to 0.9%) in 5 years to 2014; faster than Africa and lower than Asia Pacific region, largely due to GFATM supported bed nets (Hetzel et al 2017) plus WHO TA (NDOH).
- **ADB rural clinics RPHSDP:** Expanded the *potential* for increased / improved rural services (eg 24 hour access); community engagement; within budget.
- **WHO and MDRTB:** Daru "vertical" but also a potential platform.
- **World Bank analytics and policy dialogue:** 2011 Health Human Resources Review still continues to shape policies and investment in NDOH but also DFAT (eg in-country training, and actual numbers that would be affordable). World Bank *Below the glass floor*

EFFECTIVENESS (CONT'D)

- **UNICEF:** Early Essential Newborn Care program: clear line of sight between policy, training (and testing for competence) and reduction in newborn deaths.

  Credible operational research and innovative approaches to essential newborn care after stagnant trends for 10 years

  Key role in supporting the nutrition policy and good initiatives on institutional structures for nutrition by engaging 5 sectors (documentary evidence?).

- **UNFPA:** NDOH welcome UNFPA financing and support of $ 1 million per year average on FP commodities and delivery to the provinces as stop gap (Mt Hagen). The *potential* of a DHS for generating evidence about MMR, equity etc.

EFFECTIVENESS:
EVIDENCE ABOUT RELATIONSHIP MANAGEMENT WITH GoPNG and OTHER PARTNERS

- "One UN" approach has advantages and disadvantages. WHO etc collaboration (disentangle individual organisation contribution?)
- World Bank – and WHO – both have strong convening power re Ministers and other stakeholders, as well as agenda setting authority
- ADB and World Bank have complementary approaches to each other (World Bank focus on national level, and revenue, whereas ADB focuses on sub-national and expenditure).
- Complementary? WHO helped prepare financing request to GFATM but then GFATM funding exceeded NDOH capacities: fraud and repayments.
- Structure vs personalities: WHO co-location in NDOH a "masterstroke" for continuous engagement but ……

EFFECTIVENESS…. "FAILURES" TOO

- Immunisation
  - Little progress and often deterioration in coverage rates despite its fundamental importance to public health; "legitimacy " and confidence in the health system; and as a precondition / marker for health security.
  - Partly explained by decentralisation issues. But still raises fundamental questions about MDPs and Gavi ?
- Under-nutrition. 4th highest prevalence in the world
- Public financing. Multiple failures despite commodity boom.
- Engagement strategies with PNG

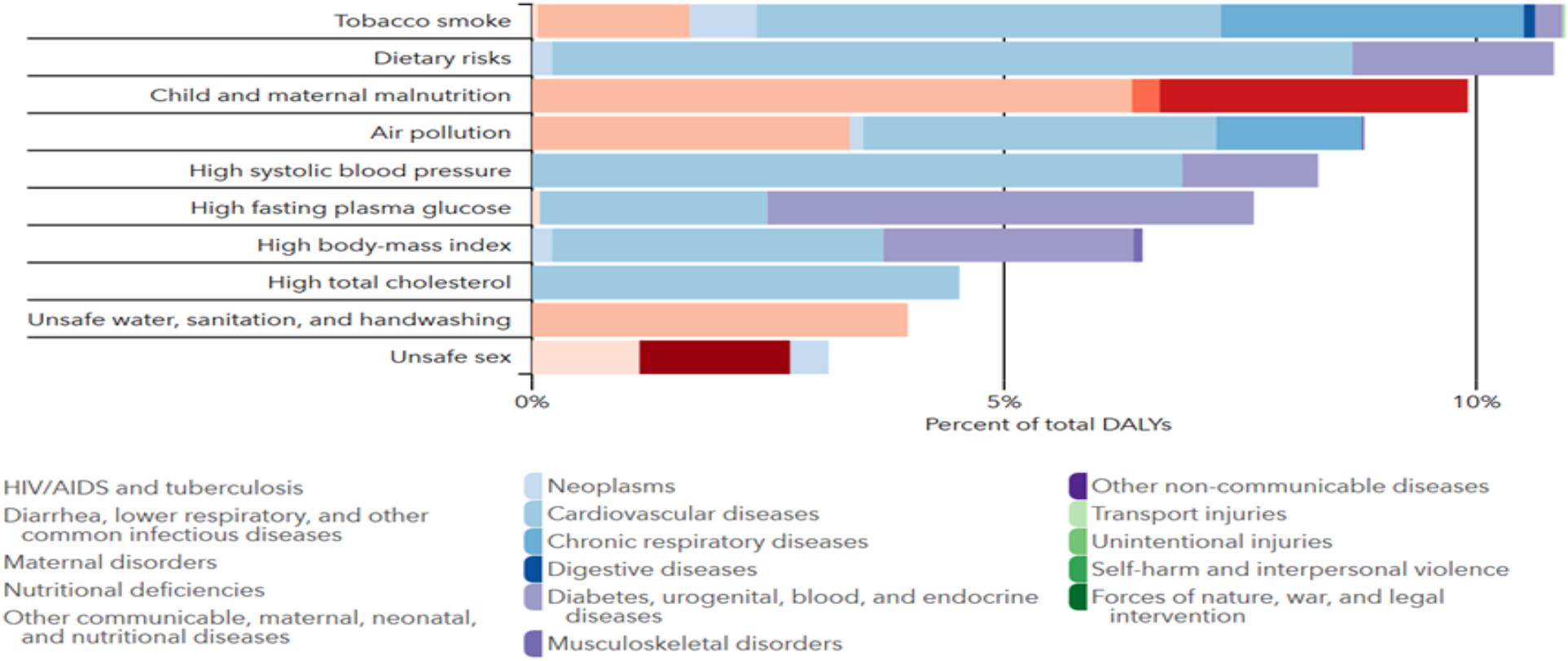
GFATM overwhelmed GoPNG systems: NDOH had to refund $ and implications for the relationship GFATM / GoPNG. PR issues (direct and indirect financial and efficiency costs).

EFFECTIVENESS: FOCUSED ON THE RIGHT AREAS?

- "Right areas" in terms of burden of disease
  - Maternal mortality, MDRTB, HIV. But do the DFAT direct grants align at a strategic level and also at a program level eg maternal health?
  - And tobacco (single largest cause of DALYs) and NCDs?
  - And undernutrition (PNG 4th highest country in the world for stunting) but received *relatively* minor focus and PNG a member joins SUN in April 2016.
- "Right areas" in terms of HSS
  - ADB HSS in rural areas, not a vertical approach.
  - Future ADB loan involves sizeable concessional financing if policy triggers – including financing bottlenecks – are met first.
- Pro-poor ?
  - Good evidence all MDPs interested and focused on sub-national development and also women.

ARE WE FOCUSING ON THE "RIGHT THINGS"?

TOBACCO AND NUTRITION > 30% CAUSES OF DALYS IN PNG, AND HIGH RISK FACTORS FOR NCDS. SOURCE INSTITUTE OF HEALTH METRICS AND EVALUATION (IHME) (2017)

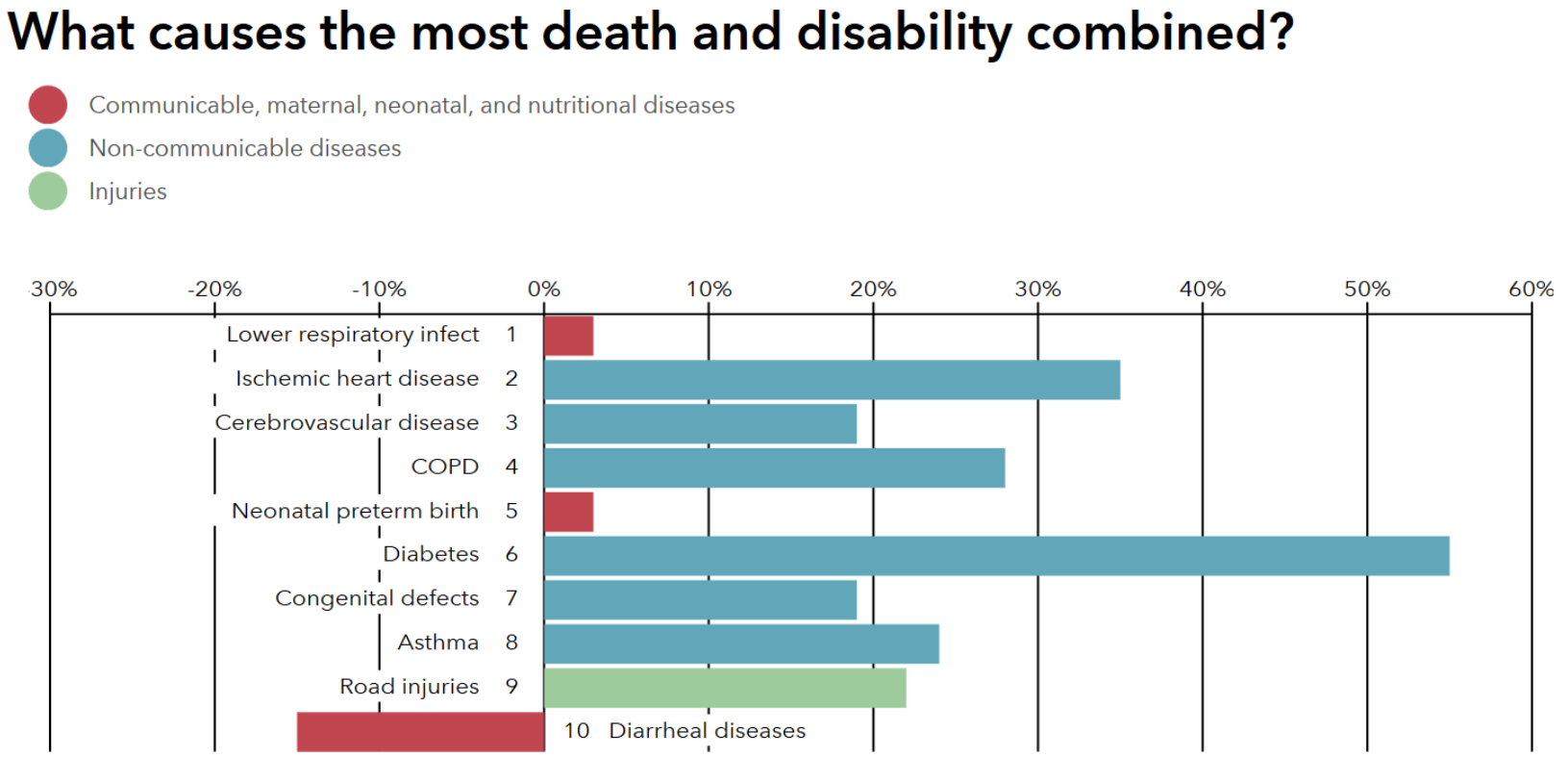


Top 10 causes of DALYs with key risk factors, 2015

Source: IHME 2017

FOCUS ON THE RIGHT THINGS? THE RISE OF NCDS.

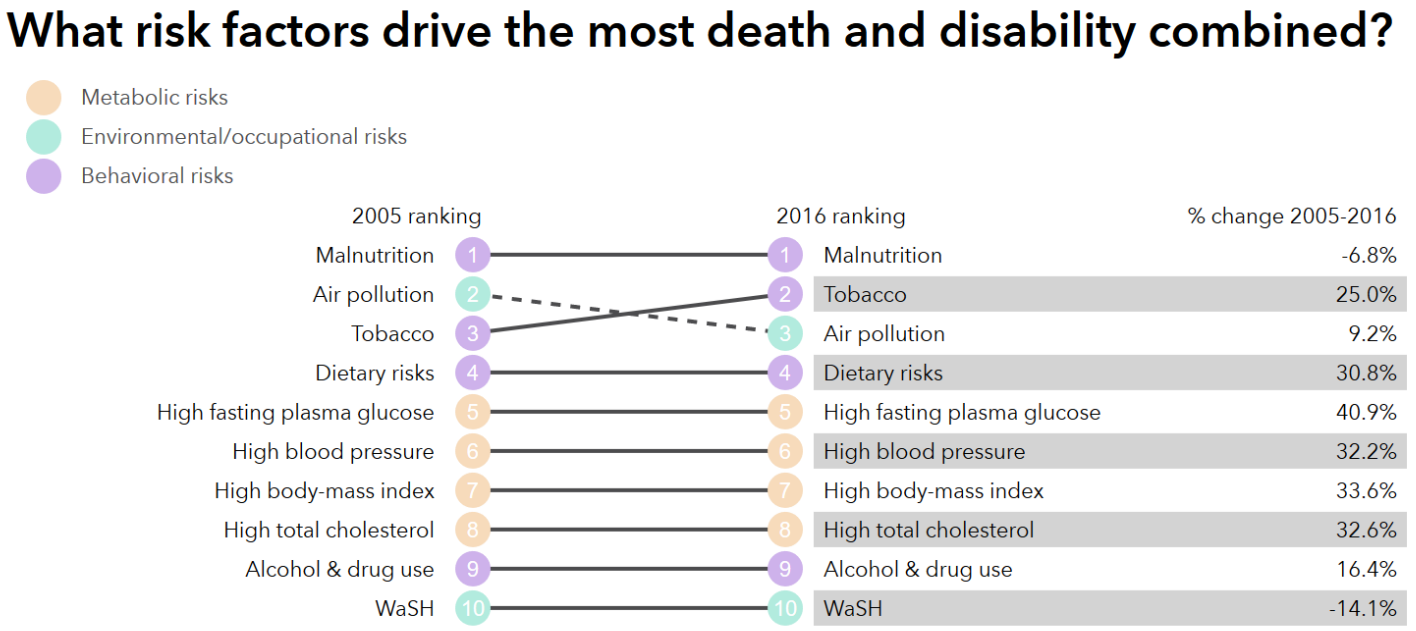
SOURCE: IHME (2017)



Top 10 causes of disability-adjusted life years (DALYs) in 2016 and percent change, 2005-2016, all ages, number

RISK FACTORS ARE INCREASINGLY NCD RELATED

SOURCE: IHME (2017)



Top 10 risks contributing to DALYs in 2016 and percent change, 2005-2016, all ages, number

EFFICIENCY, INCLUDING VALUE FOR MONEY

- Effectiveness of governance and planning arrangements
  - Drug stock outs a major source of inefficiency and under-utilisation.
  - UNFPA and NDOH underestimated costs of DHS: delays and costs.
  - ADB's RPHSDP originally underestimated difficulties of land acquisition (despite a long history in PNG) which led to delays. But then did navigate the political economy environment well.
- Engaging with each other and reducing transaction costs
  - Do collaborate but are there joint reviews?
- DFAT's own engagement with partners

EFFICIENCY (CONT'D)

- Partners' own M&E as part of their planning, and to what extent were risks reported to DFAT
  - ADB mid term review provided detailed and candid reporting of land acquisition problems and implications this had for overall efficiency (eg para 56 of ADB mid term review)
  - Less evidence of mid term reviews among other MDPs
  - UNFPA delays in highlighting the problems being incurred with the Demographic and Health Survey. (Complicated as UNFPA the funding agent to NSO)

GENDER AND EQUITY

- Women as "users" and patients. But also women as a significant proportion of the formal and informal health workforce. No women in Parliamentary discussions about health.
- Particular direct focus by UNFPA and UNICEF on RMNCH, and broader system wide support from WHO, ADB and World Bank .
- But surprisingly little disaggregated gender data that we have seen to date either in the requests for funding or the reporting. A successful DHS would be key to gender disaggregated data.
- ADB has a good scorecard on gender within its programs eg % women on village health councils eg Appendix 8 of the MTR is a good model. But data on training men about GBV etc ? But other organisations ?

MONITORING AND EVALUATION

- **Key background and context**

  DFAT 2011-2015 PNG strategy says *"M&E and reporting of results is critical to the success of the aid program. However, to date it has been the weakest part of the health portfolio"*

  "Poor quality monitoring & evaluation affects AusAID's ability to tell a coherent story, hold PNG to account, and maintain public goodwill for the aid program in PNG". Do not want to create parallel systems but ……

- **Timely reporting and strategic insight into effectiveness of DFAT grants?**

  M & E reports from most MDPs are often input focused, not timely, not fit for purpose, appear to be used by MDPs for reporting not "managing for results" even for DFAT funds. DFAT ability to follow up? Rural visits ?

MONITORING AND EVALUATION

- **How could DFAT better monitor and evaluate the programs of the 6 organisations?**

DFAT 2011 -2015 strategy refers to "*more cross-program field monitoring visits (managed through a whole-of-program monitoring plan), and developing an internal operational research agenda to understand and address incentives and barriers to improved service delivery*".

And 2016-2020 strategy says "*We will validate the cumulative effect and broader significance of investment achievements at a sectoral level through impact evaluations.*"

What happened?

Weak real time M&E a strategic blindspot (affecting effectiveness, VFM, and **lesson-learning / program correction).** We recommend at least 5% all programs allocated to **real time M&E**

FINDINGS AND RECOMMENDATIONS TO DFAT

1. **Multilateral partners are essential partners for GoPNG - and DFAT.**

- Their programs are generally well aligned to GoPNG strategic priorities.
- But, MDPs also have multiple levels of engagement with PNG eg: analytical work and policy; technical assistance; concessional financing; and actual implementation, including at provincial levels i.e. they are not marginal.
- They can - and should - do things Australia cannot do by itself at all those levels.
- They provide generally low fiduciary risk. But value for money also requires them to have "impact" and there are more questions there.
- The reality of resource constraints in AHC and DFAT: both numbers and technical expertise
- Australia is also a direct shareholder in each of those organisations. In Australia's national interest to also have those MDPs working effectively and efficiently, especially in PNG.

Therefore ***Depending on what DFAT really wants to achieve including how much risk / willingness to proactively manage, DFAT should selectively partner with these agencies.***

FINDINGS AND RECOMMENDATIONS

2. There are risks in working with MDPs and these need to be managed more proactively and explicitly. Risks include

- Displacing GoPNG's own financial effort. "emergency" funding vs simply accommodating substitution and fungibility. ***DFAT should support policy based lending with explicit PFM triggers that support HSS (eg ADB)***

- DFAT budget allocations to MDPs may not fully reflect DFAT's own strategic priorities OR the performance of the MDPs in PNG. "Partnering" versus "contracting". An aggregation of projects rather than a portfolio of investments. ***Establish an overarching, proactive, performance framework that is broadly linked to DFAT budget allocations. Consider alternative performance based partnering arrangements and financing eg with an element of contestability and use of incentives***

- The role of managing for results? MDP's own M&E systems and / or those reporting on DFAT grants may be skewed towards inputs (eg "numbers trained" rather than "competencies gained"), more than outcomes and outputs. More purposive evaluations and evidence drives programming decisions. ***DFAT should negotiate with MDP that they allocate at least 5% of each DFAT grant to M&E including purposive evaluations***.

FINDINGS AND RECOMMENDATIONS

3. **Relationship management is always important …..and it takes time and expertise**

- Appears to be differing expectations between DFAT and MDPs about what needs to be reported, when, and for what purpose. ***DFAT negotiates, in advance of finalising a grant, its M&E requirements while recognising the need to avoid parallel reporting systems and additional transaction costs.***

- There are unexploited opportunities for strategic leverage and coherence. ***PNG health staff at Post:***
  - ***liaise with the economic governance team within the AHC about budget flow and PFM issues, especially during key times in the GoPNG planning and budget cycle.***
  - ***AHC health team more directly inform DFAT Canberra and then Australian Executive Directors eg in Manila and New York, Washington DC and Geneva about the performance of MDP operations in PNG.***

- DFAT budget volatility perhaps inevitable, but if poorly communicated it undermines trust and confidence in the largest bilateral partner. ***DFAT line managers to be accountable for providing advice promptly.***

- Technical expertise is required to participate in complex policy dialogue. "Do no harm"'. ***DFAT staff need access to genuine expertise, especially at critical decision points such as negotiating agreements with MDPs. M&E competencies are an especially valuable investment.***

FINDINGS AND RECOMMENDATIONS

4.Sustainability: building capacity and systems.

- There are fundamental structural issues ($, human resources, 'leadership' and accountability) that constrain sustainability. We all need to be realistic.
- There are some good examples that compensate for the problem (40 year design of health posts) but this is still a second best response.
- Capacity building is more than "training". Involves supervision and incentives.

Therefore:

DFAT should design a portfolio that explicitly considers the balance between immediate and often emergency needs with a medium to long term commitment to structural reform through PFM etc

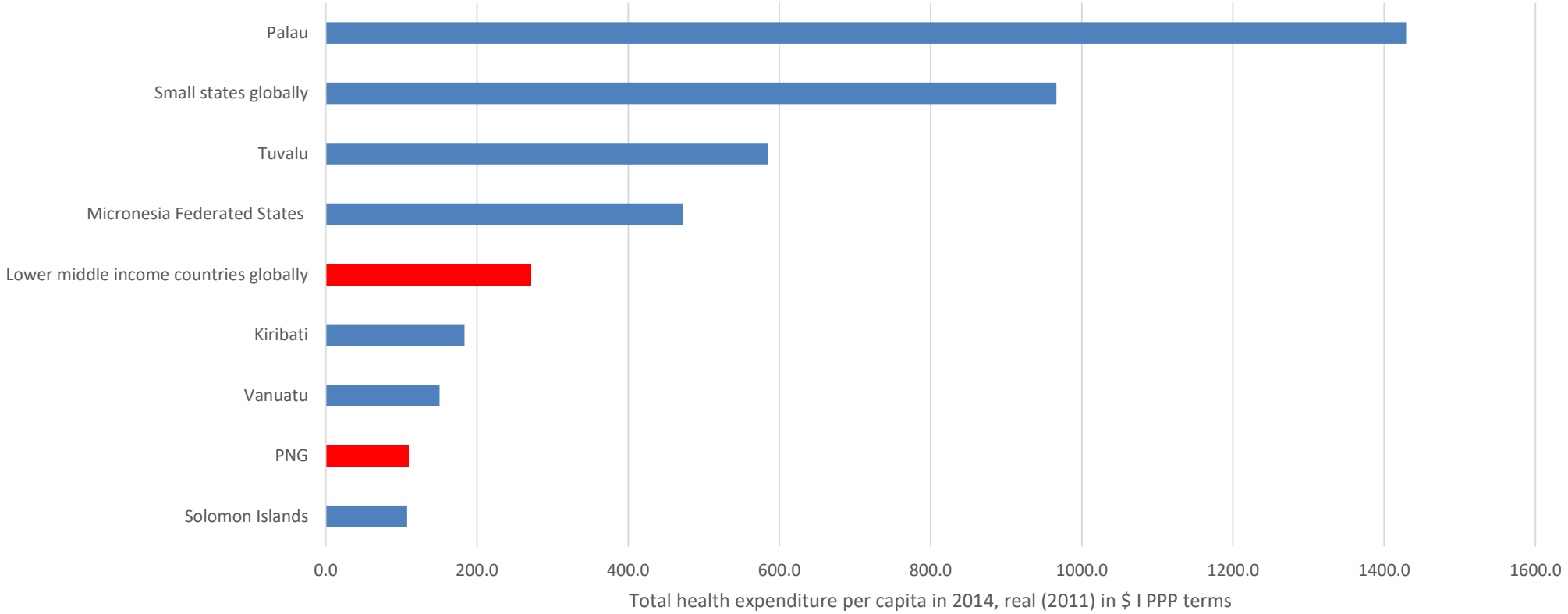
SPECIAL MENTION: HEALTH SECURITY

- Clearly a priority for Australian Government.
- Is not so clear health security is a priority for GoPNG or even among MDPs (eg strong for WHO at a global level). MDPs own comparative advantage / mandate?
- Health security is not a vertical program, it depends upon health systems.
- And therefore some disturbing findings from this evaluation
  - MDRTB in Daru but also no isolation ward in Mt Hagen > patients at home;
  - "No condoms" for last 2 years > HIV incidence increasing ?
  - Vaccination rates stagnant or falling (pentavalent 77% in 2006 but 53% in 2010)
  - Persistent stock outs in rural areas and appears to be no early solution
  - Perceptions about drug quality imports

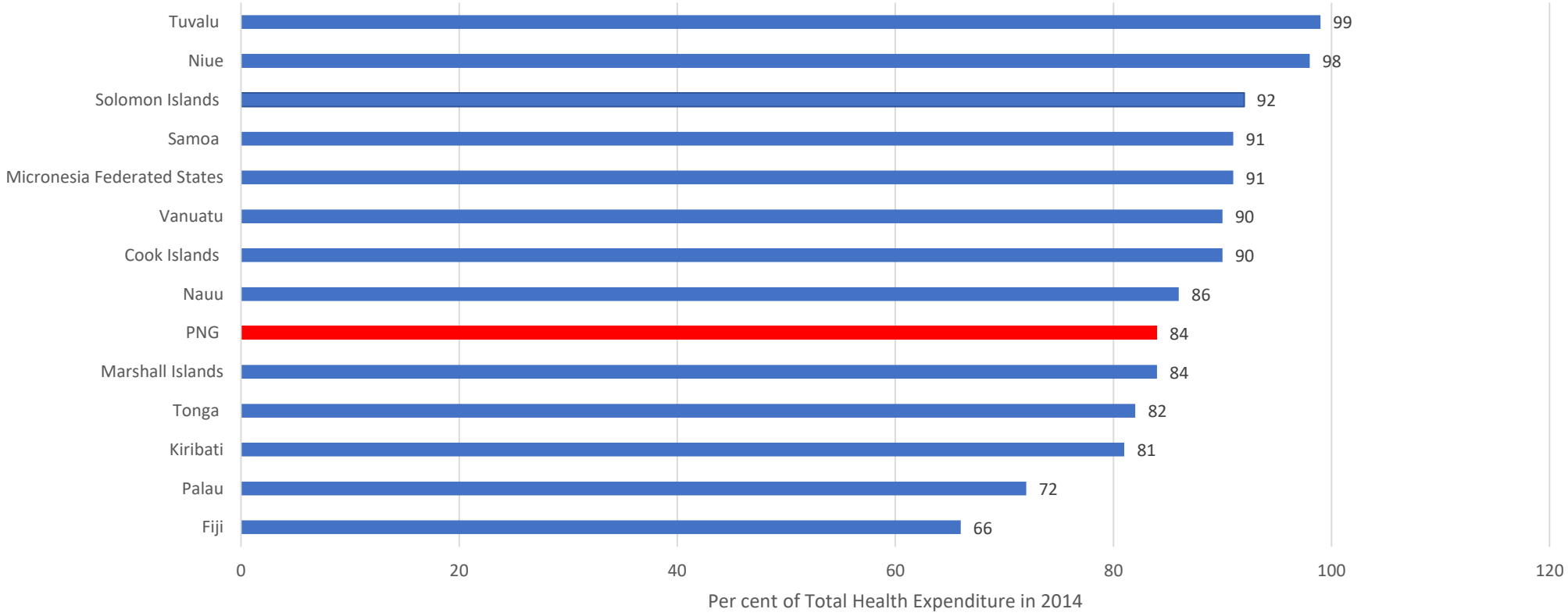
Recommendation: That DFAT uses its deep country knowledge and insights, including from the MDPs, to help inform the priority setting and policy dialogue about health security in PNG. Be realistic. And focus on the endemic diseases not just the exotic

REAL HEALTH EXPENDITURE PER CAPITA IS LOW

SOURCE: WORLD DEVELOPMENT INDICATORS 2017



GOVERNMENT SHARE OF TOTAL HEALTH EXPENDITURE IS HIGH IN RELATIVE TERMS



UNICEF

Recommendations:

- Invest in developing a stronger relationship with UNICEF as a partner that is essential to DFAT's goal of improved health outcomes for children
- Allocate some (5%) of the investment to M&E and make funding contingent on timely and fit for purpose reporting

Key findings at the strategic level:

- UNICEF EENC training and provision of essential equipment has contributed to enhanced capacity among service providers and has resulted in less deaths amongst newborns than would otherwise have occurred
- UNICEF's efforts around nutrition have resulted in positive, multisectoral policy level developments but there remains a significant way to go before nutrition is seen as a priority issue at the sub-national level
- UNICEF has supported refrigeration for vaccines at the provincial level, but immunisation rates are low and stagnant. Childhood immunisation is core to UNCIEF's mandate and stronger efforts (in collaboration with the national and provincial governments as well as other development partners) should be prioritised

Key findings at operational level:

- Information contained in the UNICEF program reporting is difficult to interpret meaningfully and not able to communicate what appears to be a highly effective EENC program with support for the Hypothermia Alert Device. This highlights both weak reporting capacity at UNICEF and missed opportunities for follow up investigation from DFAT

	Positive	Negative
Effectiveness	• Evidence of impact of EENC training in Mt Hagen and Alkena. • Evidence of behaviour change around three elements of the EENC program in four provinces (ie. Increased use of Kangaroo care, early initiation of breast feeding and successful resuscitation) • Hypothermia Alert Device an example of an effective innovation that will save lives • Successful in getting multi-sectoral acknowledgement of nutrition as a key development challenge	• Whilst nutrition has been discussed at the policy level there is a lack of evidence of it being prioritised in implementation • One of UNICEF's three focus areas is immunisation – whilst there is evidence of UNICEF supported refrigeration for cold chain storage of vaccines, the immunisation rates in the country are low and stagnant
Efficiency	• Responsive to provincial level request for supplementation – nutrition, EENC equipment • Good collaboration with WHO and NDOH to set policies and roll out training in EENC to the sub-national level	
Sustainability	• Assessment of training participants at the conclusion of EENC training and a requirement that they pass or re-sit the training and assessment. Good way to embed understanding. • Culturally appropriate IEC materials for EENC distributed to the provincial level	
Equity and gender		• No gender disaggregated data in progress reports
M&E	• Scientific rigour applied to assessment of Hypothermia Alert Device (RCT, peer review of evaluation)	• Activity level reporting for EENC program that is cumulative across reporting periods, lacking baselines and difficult to assess • No financial reporting included in progress reports
Provincial	• EENC in Bouganville, Western Highlands Province and Eastern Highlands Province	