

Integrating formal and informal institutions: towards a healthy community in the Pacific

Lhawang Ugyel

Abstract

The role of institutions, both formal and informal, are important for the development of a country. While existing literature tends to focus primarily on formal institutions, informal institutions play a vital role in the delivery of public services in countries where formal institutions are weak. This paper analyses the integration of formal and informal institutions, using the Bougainville Healthy Communities Program's (BHCP) delivery of public health services in the Autonomous Region of Bougainville in Papua New Guinea (PNG) as a case study. It examines how an operative framework that combines formal and informal institutions is able to determine positive outcomes. The integrations take place at various levels between government and non-government sectors, as well as between formal and informal institutions. While the findings can be applied to PNG and other, similar, countries, particularly developing and post-conflict countries, this case study is important for Bougainville itself. In the next year or two, Bougainville will have a referendum on its future status, and the need for a strong governance system at the national and community levels will be of paramount importance.

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Lhwang Ugyel

Lhwang Ugyel is a Lecturer working in Port Moresby as part of the ANU-UPNG partnership.

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1. Introduction

Most development economists believe that institutions are important for a country's development. The most common definition of institutions is by Douglass C. North (1991), he defines institutions as the humanly-devised constraints that structure political, economic and social interaction. This broad definition encompasses aspects of both formal and informal institutions as a combination of formal constraints, informal rules and their enforcement characteristics. Although few disagree that 'institutions matter', there are differences in opinion on what institutions are and which institutions matter for development (Rodriguez-Pose 2010, p. 1037). In practice, the focus is mostly on formal institutions. For instance, Peter A. Hall (1986, p. 19) describes institutions as 'the formal rules, compliance procedures, and standard operating practices' which structure the relationship between individuals in various units of the polity and economy. Despite the focus on formal institutions, the role of both formal and informal institutions is important. In countries where formal institutions are weak, informal institutions, which are often neglected in the literature, provide an important link – filling the void left by weak formal institutions and actors. The role of informal institutions in shaping formal institutions cannot be ignored, particularly for shaping socio-economic outcomes (Casson et al. 2010). While formal institutions tend to be similar or can be applied from one country to another, informal institutions are context- and geography-specific, and different institutional contexts yield different results (Rodriguez-Pose 2010). To find the perfect mix of the integration of formal and informal institutions is difficult in practice. Important questions to consider are what sort of an operative framework for institutions work in new democracies, and whether citizens respond primarily to the inscribed regulations of formal institutions or to the unwritten codes embedded in everyday social practice (Bratton 2007).

This paper explores why the integration of formal and informal institutions are important in the delivery of public services. It examines how an operative framework that combines formal and informal institutions is able to determine positive outcomes. The study is based on the successful implementation of the Bougainville Healthy Communities

Program (BHCP), an advocacy program for public health care services. BHCP mainly operates in Bougainville, which is an autonomous region of Papua New Guinea where the reach of government administration is weak. The paper argues that combinations of formal and informal institutions are necessary. Such mixes of institutions are particularly important in countries where local government plays an important role in provision of local services and infrastructure (Razin 2000), but there is also the risk that these governments are overtasked, which affects performance (Kuhlmann and Wayenberg 2016). In such cases, where national governments are weak or the local government lacks capacity and resources, there is space for informal institutions to play a greater role. It is observed that agency performance can be improved when community-based organisations and local governments work in support of one another (Krishna 2003).

BHCP started in 2014 and operates under the aegis of the Department of Health of the Autonomous Bougainville Government. PNG is an independent country located in the Pacific Islands with a population of 7.3 million people. The country consists of 22 provinces spread over 600 islands, and its population speaks close to 800 different languages. Endowed with rich natural resources, such as copper and natural gas, PNG is classified as a lower middle-income country by the World Bank, with a GDP per capita of US\$2,268 in 2014. In its 2015 report, Transparency International classified PNG as one of the most corrupt countries in the world, ranking it 139 out of 168. PNG is also among the five weakest states in the East Asia and Pacific region (Rice and Patrick 2008). Despite its rich resources, PNG has a track record of corruption and poor development, which is attributed to the culture that is strongly embedded in society (Fukuyama 2007; Pieper 2004). Attempts have been made in PNG to incorporate new policies and mechanisms to overcome some of its challenges, but these policies have largely failed as they overlooked the clashes and the ambivalence created between modern and traditional elements in PNG (Abraham & Miller 2011; Payani 2000). Within such a grim economic and political scenario of PNG lies the Autonomous Region of Bougainville, an island of 9,318 square kilometres with a population of approximately 200,000 people. Bougainville makes for an interesting place of study for two reasons. Firstly, it is a region that came out of almost a decade of deadly conflict only at the turn of the century. One of the key features of the Bougainville Peace Agreement was the creation of an autonomous government, and one of the powers available was over the provision of health care services. Over the years, the

Autonomous Government of Bougainville has taken over some functions for health provision but the Department of Health continues to face challenges. The conflict in Bougainville resulted in destruction of facilities and loss of health sector workers, which impacted health service delivery. Despite the commitment of the Department of Health, the level of political commitment to the health budget is lacking (Richards et al. 2012). This study provides insight into how conflict-ridden states can overcome hurdles of state-building and provision of basic services such as health care. Bougainville is due for a referendum of independence from PNG in June 2019, and the outcome of the referendum will have significant political and socio-economic implications for Bougainville.

2. Methodology

BHCP was selected as a case study based on the success stories of the program narrated to the author by international advisors (from the World Health Organization and UNICEF) who were either involved with the program or heard about it during their visits to Bougainville. Based in a country where public service delivery is riddled with inefficiency, BHCP is an outlier. This study relies on a series of interviews of key people involved with the BHCP and the Department of Health of the Autonomous Bougainville Government. The research was conducted in the months of February and March 2017, and included field visits to Buka (where the Department of Health is located) and Arawa (where the BHCP main office is located). A visit to Tangari village in the Selau District of Bougainville, was also made to observe firsthand some of the impacts of the BHCP's activities. In-depth interviews with the management and staff of BHCP and officials from the Department of Health were conducted. According to Weiss (1994, p. 10), such qualitative interviewing techniques help in getting 'dense' information that is useful while describing 'how a system works or fails to work' and will enable us to 'learn about perceptions and reactions known only to those to whom they concerned'. In terms of the techniques applied in the interviews, initially a few key officials from the Department were identified based on their involvement in the BHCP. Others were later identified based on a snowballing method – they were recommended based on their potential to provide information for the study. Following a short introductory note, questions took an organic form depending on the situation and the answers provided by the respondents.

Some of the key people interviewed were: (i) Program Director, BHCP; (ii) Acting Secretary of the Department of Health; (iii) District Coordination Facilitator, Buka District; (iv) District Facilitator, Sela-Suir District; (v) Administrator, Tangari Village; and (vi) Operations Manager, BHCP. In addition, some basic information about and reports on the BHCP were obtained from World Health Organization and UNICEF staff based in PNG. The format for the interviews was mostly semi-structured, which according to Burnham et al. (2004, p. 205) is 'often the most effective way to obtain information about decision-makers and [the] decision-making process'. Interviews with elites are useful because they are often the ones who possess the most knowledge about the reform and are therefore the most reliable informants (Enticott 2004).

3. Formal and informal institutions

The shift in the discourse from government to governance has resulted in a change in the notion of the government as a single decision-making authority to include multiple actors from various institutional settings (Pahl-Wostl 2009). This process of policy making through active and cohesive discussions among policy makers is connected by a broad range of networks that connect the state to the civil society, private sector and the communities (Bevir et al. 2003; Bogason and Musso 2005; Emerson et al. 2011; Kim et al. 2005). It is in such a pluralistic setting that governance allows formal and informal institutions to influence the coordination and steering processes (Pahl-Wostl 2009). At the start of this paper we observed that the coming up with a precise meaning of institutions was difficult. In fact, Rodriguez-Pose (2010) contends that there is no agreement on a common definition. Part of the reason is because of recent developments on the topic of governance which have expanded the role of public policy beyond the sphere of the government. The line between what comprises a formal and informal institution has been blurred and the distinction can be confusing. Nevertheless, attempts to form various distinctions based on theoretical perspectives between formal and informal institutions have been offered, and Chavance (2008) points out notable scholars who have addressed aspects of these distinctions. For instance, John R Commons pointed out that the common law method led to customs and authoritative figures operating to manage conflict, which in turn led to formal and legitimised rules. Friedrich Hayek argued that the beneficial informal rules through a selection of cultural evolution eventually

transformed into legislation. Douglass North stressed the distinction of formal and informal constraints, with informal constraints underlying and supplementing formal constraints. Chavance (2008) argues that the perspectives of Hayek and North have become the two influential, although contrasting, ways to conceptualise the relation of informal and formal institutions. The followers of Hayek's line of thought give weight to the evolved informal rules, and view the deliberate formal rules as beneficial only if they correspond closely to informal ones. There are also those that have extended the new institutionalist view in terms of the interplay between formal and informal institutions based on an interaction thesis where different instances of the relations are distinguished (Chavance 2008).

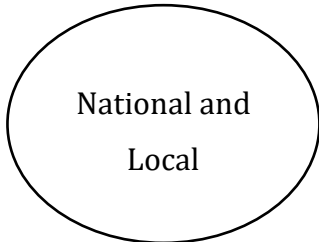
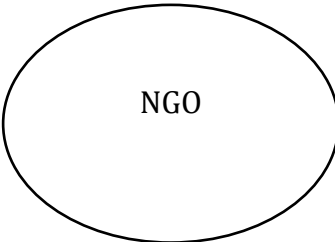


Current literature on institutions focuses mostly on formal institutions. However, both formal and informal institutions are important, especially in countries with weak state capacities. In such countries, partnerships among the various actors in policymaking, especially those that sit outside the government sector, are vital for development. Such partnerships, Brinkerhoff (2002) notes, are the most appropriate approach to development and service delivery. The partnership should be built on democratic values and principles of mutual influence, equality, and reciprocal accountability. In such countries, institutions also work effectively when they are rooted within a society and elicit voluntary compliance from most of its people (Krishna 2003). Informal institutions are 'reflexive' and actors need to know and understand what they are, and unlike formal rules they are not officially written down or enforced by legal recognition (Grzymala-Busse 2010, p. 312). These informal rules can replace, undermine, and support or strengthen formal institutions. The integration of institutions is not as simple as it is made out to be. Although both formal and informal components need to be included in any analysis, there is the possibility that different institutional relationships result in different outcomes, and the nature of the interaction is not a clearly defined relationship (Williamson and Kerekes 2011). Rodriguez-Pose (2010) also cautions that the problems of defining what adequate and efficient institutions across different types of regions will undermine any type of institution-based regional development intervention. The problems of measuring institutions and the difficulty for defining the right mix of formal and informal institutions makes establishing guidelines for institutional intervention impossible (Rodriguez-Pose 2010).

This paper uses the distinction between formal and informal institutions and their integration to analyse the activities and outcomes of the BHCP. Broadly, formal institutions are the universal and transferable rules and generally include constitutions, laws, charters, bylaws and regulations, as well as elements such as the rule of law, property rights, and contract and competition monitoring systems (Rodriguez-Pose 2010). In other words, they are the political constraints on government and individual behaviour enforced by legal institutions (Williamson 2009) and the organised routines of political democracy, such as regular elections for top officeholders and legal constraints on the political executive (Bratton 2007). Informal institutions, on the other hand, include a series of features of group life such as norms, traditions and social conventions, interpersonal contacts, relationships, and informal networks which are essential for generating trust (Rodriguez-Pose 2010). These norms and customs, which emerge spontaneously and outside the realm of the government, regulate socio-economic life and determine an individual's position relative to others (Casson et al. 2010; Williamson 2009). These informal institutions are the patterns of patron-client relations by which power is also exercised (Bratton 2007). In summary, formal institutions are linked to the official channels of governmental bureaucracies, whereas informal institutions are socially shared rules such as social or cultural norms (Pahl-Wostl 2009). In spite of the differences in definitions between formal and informal institutions, Casson et al. (2010) summarises that formal institutions are a crystallisation of informal ones and that both co-evolve through the operation of informal and formal social groups, from households and villages, to networks, firms, parties and governments.

Attempts have been made (for example, Krishna 2003) to provide frameworks that integrate formal and informal institutions. This paper seeks to add to the existing literature by using a framework that integrates formal and informal institutions. Figure 1 shows the framework of formal and informal institutions, to help understand the types of institutions that play a role in providing services to the people. The framework is designed to classify formal and informal institutions so that it is applicable in developing country context and assists in understanding the nature of their interactions. It uses two main classifications: the first classification is formal and informal institutions and the second is whether they belong to the government or non-government sector. Within this 2x2 matrix, four categories can be discerned. The first quadrant (Q1) is the formal

government category and includes national and local government actors. The second quadrant (Q2) is the formal non-government category and includes NGO actors. The third quadrant (Q3) is the informal government category and includes community self-government. The fourth quadrant (Q4) is the informal non-government category and includes volunteer groups. It must be pointed out that these categories, although simplistic, are useful in providing an understanding of the different categories of institutions and how these categories overlap in their actual application. As we will see later in the case of the BHCP, institutions do not fit into neat categories and instead overlap into multiple categories. This is not necessarily a bad outcome, and such overlaps are required to deliver effective services.

Figure 1: Framework for formal and informal institutions

	Government	Non-Government
Formal	Q1: Formal – Government 	Q2: Formal – Non-Government 
Informal	 Q3: Informal – Government	 Q4: Informal – Non-Government

4. Bougainville Healthy Communities Program (BHCP)

The BHCP started as an off-shoot of the successful implementation of the leprosy elimination program in Bougainville. The program was funded by the New Zealand Government in 2001, and as claimed by the Acting Secretary of the Department of Health, Bougainville eliminated leprosy within a span of four years. Following the success of the

leprosy program, a new project proposal was submitted to the New Zealand Aid Programme to promote health awareness. The first tranche of the BHCP was approved in 2005 as an NGO program but integrated into the Department of Health. The Department approached the current Program Director of the BHCP, who had worked with the leprosy elimination program, to be the program manager for the BHCP. According to the Program Director, the Program aimed to support the 'needs of the people of Bougainville', and started with a training program on health issues to a group of volunteers to promote health awareness and educate people in basic health care. The program's management team then realised that the trained volunteers did not have the support of the community and their leaders, making it difficult for the program to achieve its objectives. They decided to train community leaders, who would then manage the Program at the community level by supporting the volunteers. In 2006, the Program was rolled out in three of the total 13 districts in Bougainville (Buka, Suir and Keita), with a small team which included the program manager and three district facilitators. The first set of activities of the BHCP started with training activities for the facilitators, political leaders and community leaders. Initially, the district facilitators were trained, followed by the leaders and the volunteers they selected. The Department then started to target other villages and expanded the training to include themes such as gender equality, in addition to health and leadership.

BHCP is based on the Autonomous Government of Bougainville's Constitution, which is the operating manual for the government. Section 51 of the Constitution on strengthening traditional leadership allows for the BHCP to operate within the government system. Furthermore, the BHCP is also integrated into the Bougainville Constitution through Section 16(35) which provides for partnerships in the provision of health services which act as the bridge between health centres and communities. Sections 13 and 24 provide a platform for empowerment of traditional leadership and self-reliance. The Autonomous Government of Bougainville and its departments are structured in a similar manner to the provincial administrations of other parts of PNG. However, unlike other provinces, Bougainville does not have district development authorities that work at the district levels. In its place, Bougainville has the community government (previously the Council

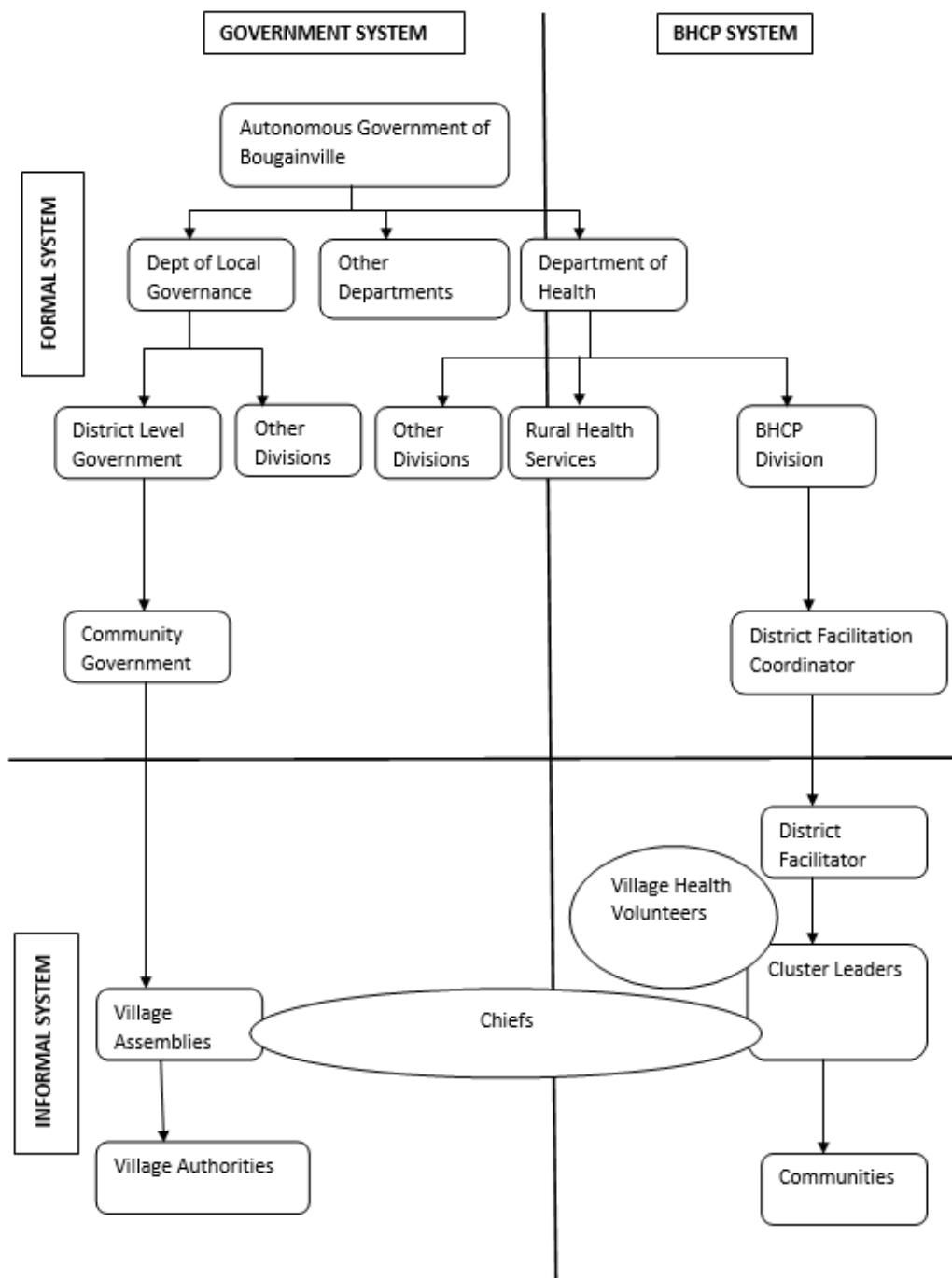
of Elders) that is comprised of leaders from the village assemblies.¹ Based on the definition of formal institutions where structures are legally organised, the government departments and the community government form the formal system in Bougainville. The informal system in Bougainville includes village assemblies supported by village authorities. These structures do not have any legal legitimacy and are based on traditions and norms, interpersonal relationships, and networks, and continue to have more salience than the state. Figure 2 shows the structure of the BHCP including how it is part of the existing government and community system in Bougainville. It maps the BHCP onto Figure 1 and is divided into four main quadrants. The government and the non-governmental systems form the horizontal quadrants, and formal and informal systems of the BHCP form the vertical quadrants. Figure 2 also shows the relationship – that cuts across quadrants – among the various institutions and actors in the management and implementation of the BHCP’s activities.

Currently, the BHCP functions as a non-governmental program, however this distinction from a governmental program is not clear cut as it operates under the Department of Health. However, the BHCP does have its own office and manages its own funds – independently of the government. The office is based in Arawa, whereas the Bougainville government is based in Buka, and the BHCP office has 40 staff members working under the Program. The program manager and the two district facilitation coordinators are paid by the department. Under the district coordination facilitators are the district facilitators. Generally, there is one facilitator for each of the 13 districts of Bougainville, but the larger districts have more than one. In total, there are 19 district facilitators, all paid directly through the Program, and not the Department, and this budget comes from the New Zealand Aid Programme. The district facilitators operate at the informal level and liaise directly with the leaders and chiefs of the villages. Each village also has one to two village health volunteers, who are the point of contact for district facilitators. The village health volunteers and district facilitators play an important role as a link connecting people to

1. The Council of Elders was replaced by community government by the Bougainville Community Government Act 2016. Based on the Act, the first community government elections were held in June 2017. The Act seeks to ‘provide for a system of community government to replace the Council of Elders as a level of formal government below the level of the Autonomous Bougainville Government (Part 1, Section 3 of the Bougainville Community Government Act 2016).

the formal health system. At the community level, the village health volunteers and the chiefs are responsible for mobilising and providing support. People who need to use health services are referred to health facilities such as the district clinics. Depending on the severity of the illness, patients can be either referred to the hospital – which is under the jurisdiction of the National Department of Health or go through the Bougainville Government’s system.

Figure 2: Structure of the BHCP within the overall system of governance



5. BHCP and its outputs

An evaluation of the BHCP was commissioned by the New Zealand Ministry of Foreign Affairs and Trade in 2012. The evaluation concluded that the BHCP is an 'excellent example of a well-planned and well-executed public health and community development model... implemented within the enormous constraints and challenges of a post-conflict setting' (Whelan 2012, p. 5). The evaluators found positive health outcomes, with lower numbers of people suffering from malaria, TB and pneumonia, and communities showing improvements in health practices, such as cleaner villages, and better hand washing habits and sanitary conditions. The successful implementation of the BHCP during its initial years resulted in an increase in the funds and a wider coverage of the Program.

The second tranche of BHCP started in 2014. The BHCP Office has expanded to a total of 40 staff members: 19 working in management and administration in the Head Office, and 21 in the field (that is, the 19 district facilitators and two district facilitators coordinators). Niel Toura, the Program's Operations Manager, reported that as of February 2017 BHCP covered 739 villages under 12 districts. Out of the 13 districts and 817 villages in Bougainville, the BHCP covers an impressive 80 percent. Seven of those villages have been identified as model villages, which means that they are doing well in terms of the Program and in areas of finance and governance. At the policy coordination level, the Department of Health provides technical support to the BHCP and guides it as much, or as little, as possible. While the BHCP Office coordinates directly with their main donor, the New Zealand Aid Programme, the Department liaises with other donors who support other activities not included in the BHCP but which complement the overall objectives, such as Australia's Department of Foreign Affairs and Trade, the World Health Organization, and UNICEF. The direct funding and technical support from the New Zealand Aid Programme to the BHCP Office was specially created so that they retained their independence, and at the same time also integrated with the Department to an extent.

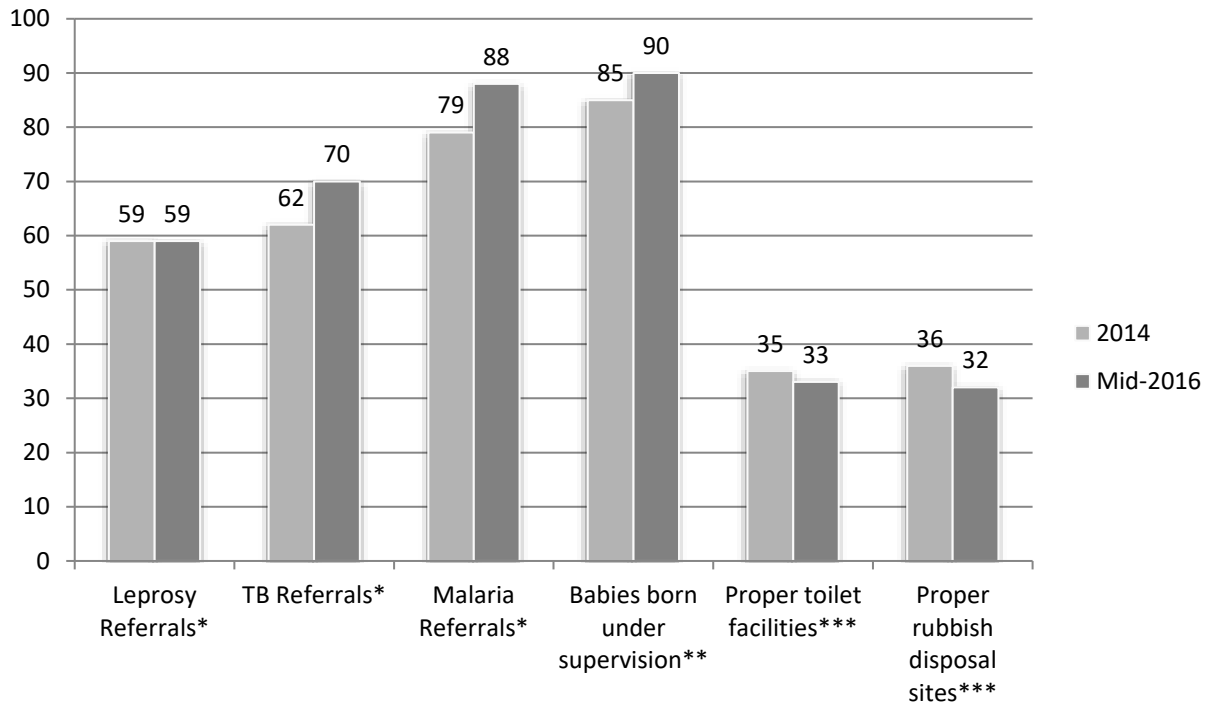
The BHCP operates through district facilitators who train the chiefs who in turn train communities and encourage them to take ownership of the activities. The training activities are mostly advocacy in nature, with the purpose of providing information to people, and are not forced on them. Training activities are aimed at two different target

groups, depending on the needs of the people and community: a basic training program includes information on primary health care issues, and an advanced training program includes information on complex health issues such as lifestyle diseases. To reinforce the message and ensure wider coverage the district facilitators visit villages and provide information on topics such as the preventive healthcare and the benefits of proper healthcare and sanitation. They also help to identify and refer patients suffering from diseases such as tuberculosis (TB). The district facilitators mostly liaise with chiefs and village health volunteers, and it is therefore important for them to maintain good relationships with the chiefs. The District Facilitator for Sela-Suir District mentioned that it helps that district facilitators are perceived as 'non-government officials', so that they can more easily build trust and confidence in their relationships with chiefs. Most villages have two village health volunteers. These volunteers, who are currently not paid a salary, support the district facilitators and the chiefs in their respective villages. District facilitators try to visit villages twice a week for monitoring and evaluation of program activities. The information collected during these visits are sent to the main office. Once a month, the entire team meets with the Department. The district coordination facilitators supervise the district facilitators, and whenever possible also try to visit the districts. According to the District Coordination Facilitator of Buka District, during the monthly meetings, district coordination facilitators play an important role in collecting data and forms with information and assist the district facilitators in making sure that the reports are up-to-date. The forms submitted by the district facilitators is a community development checklist, which was developed locally and has now become an important tool for the Program. The collected data are analysed and shared with the community so that the people have an idea of the outputs and outcomes of the Program. The Program Director highlighted that the BHCP management realises the importance of taking a holistic approach through a 'traditional way of doing things' in order to promote advocacy. Such an approach is integral to human development and for ensuring good governance at the community level. The programs on leadership training where human resource management and financial management components are taught were some of the strategies to overcome challenges presented by some of the traditional leaders.

The half-yearly summary report of the BHCP collates the information submitted by the district facilitators and provides insightful information on the status of the Program's

activities (ABG DOH 2016). There are various indicators that reflect the success of the BHCP. Firstly, a large number of village health volunteers (VHVs) and local community leaders have been trained between 2014 and mid-2016. A total of 2579 VHVs have been trained in various aspects of the healthy community concept. There have been 662 participants trained in advanced community health development training. The BHCP has also covered training programs in governance and leadership. A total of 2145 participants attended the basic leadership and governance training, and another 47 the advanced leadership and governance training. Another indicator of success, and one that ensured that the BHCP effectively implemented its activities, is the strengthening of organisational structures at the village and community levels. The number of village authorities has increased and there are now 80 of them in Bougainville. The number of “healthy communities”, that is, communities covered by the BHCP, has also increased substantially from 18 to 63 communities within the two-year period. There has, however, been a decrease in the number of village treasuries from 62 in 2014 to 44 in 2016. The best indicator of BHCP’s effectiveness is in its objective of promoting health awareness and educating people in basic health care. Figure 3 shows the increase in referrals since 2014, particularly in TB, malaria and the number of births. However, an area that the Program needs to focus on is sanitation. Since 2014, the Program has not been able to increase the number of families with access to proper toilets and waste disposal. This is because, during these years, the BHCP focused on advocacy rather than treatment measures. There is now a concerted effort to move towards prevention measures, particularly with the WASH program supported through the UNICEF.

Figure 3: Outcomes of the BHCP



Proportion (in percent) against total suspects made by Village Health Volunteers; **proportion (in percent) of babies born; *proportion (in percent) of families*

Source: ABG DOH 2016

An issue that concerns the long-term plans of the BHCP is sustainability. The New Zealand Aid Programme plans to end support to the program in 2018. The Program Director pointed out that since the beginning of the Program in 2009 the intention has been for the Program to be integrated into the Department and have a skeletal staff to help in its coordination. As such, the integration of the Program into the Department is not a major issue. Currently eight of the staff members are paid by the Department, and their payments can continue in the future without donor support. The major challenge for the Program will be the integration of the district facilitators, who are currently paid directly through the BHCP. If their positions are to be continued once Program support ends, the cost of their salaries will have to be borne by the Government. The Acting Secretary noted that for the Department to pay their salaries will overburden the budget, which continues to face shortages due to PNG's financial issues. In addition, the Autonomous Bougainville Government has other priorities, and the training programs require substantial funds. As a remedial measure, the Government will continue to seek other partners and donors to support aspects of the current Program. In the long-term, however, communities and people are encouraged to take ownership and sustain the activities of the Program. To

ensure sustainability of the activities beyond the Program, volunteerism is being encouraged. The Program Director stated that 'where there is faith, where there is church, people seem to listen' and 'people are happy to do volunteer work'. The Program is also trying to change peoples' mindsets by not depending on handouts from donors. Communities are asked to use local resources, including human resources. To this end, the BHCP has attempted to build capacity by training community leaders. By setting up village treasuries, the Program has highlighted the importance of exploring avenues to raise funds and support public health initiatives.

Another issue that BHCP faces at a broader level is the rural to urban migration trend that afflicts Bougainville as well as other provinces in PNG. Many educated people leave their villages to work in other parts of PNG, usually urban areas. These groups of people often include the village health volunteers and educated leaders, as they are capable and are likely to get jobs in other parts of PNG. To mitigate this issue, the BHCP helps train new people, particularly those who are likely to remain in the villages. Furthermore, not all local leaders support the Program, and a handful of them are reluctant to participate in its activities. Such people, as pointed out by the Administrator of Tangari Village, are still stuck to notions of 'traditional beliefs and culture' and their prominent roles within such a context. Therefore, rather than coercing the communities to implement Program activities, the BHCP management moved on to other villages. Based on the success of those communities taking part in the BHCP, other villages see the benefits of the Program and then they also request support from the BHCP. Villages that perform well are identified as model villages and exchange visits are arranged for them with those who need help. Even other areas, such as Manus (where the Program Director visited) see the benefit of the BHCP and are looking towards implementing similar programs. Given the partnership quality of the BHCP arrangement, the Bougainville Health Partnerships legislation, passed in 2017, formalises the Autonomous Bougainville Government's Department of Health as an entity to forge partnerships with a wide range of institutions.

6. Integration of formal and informal institutions

At a time when PNG, and particularly Bougainville, faces multiple political and socio-economic challenges, the relative success story of BHCP is a silver lining. BHCP's success can be attributed to many factors, including the integration of formal and informal institutions in the delivery of public health services. The success of formal institutions depends on the ability to map them onto informal rules, although finding the 'right mix' of institutions and predicting the subsequent impact on development is difficult and varies across countries (Williamson 2009, p. 383). This "right mix" of institutions is visible in the case of BHCP's successful outcome. The Acting Secretary attributed the success of the program to the people, the government system and the communities themselves:

I believe people are very motivated... Secondly, the people are convinced that the Health Department as a part of the government system is fully supporting it... Third, the communities feel that they have been empowered, they have been recognised as a traditional system of government... And then we have a Program that is much more organised so that people can actually deliver right down to the village level.

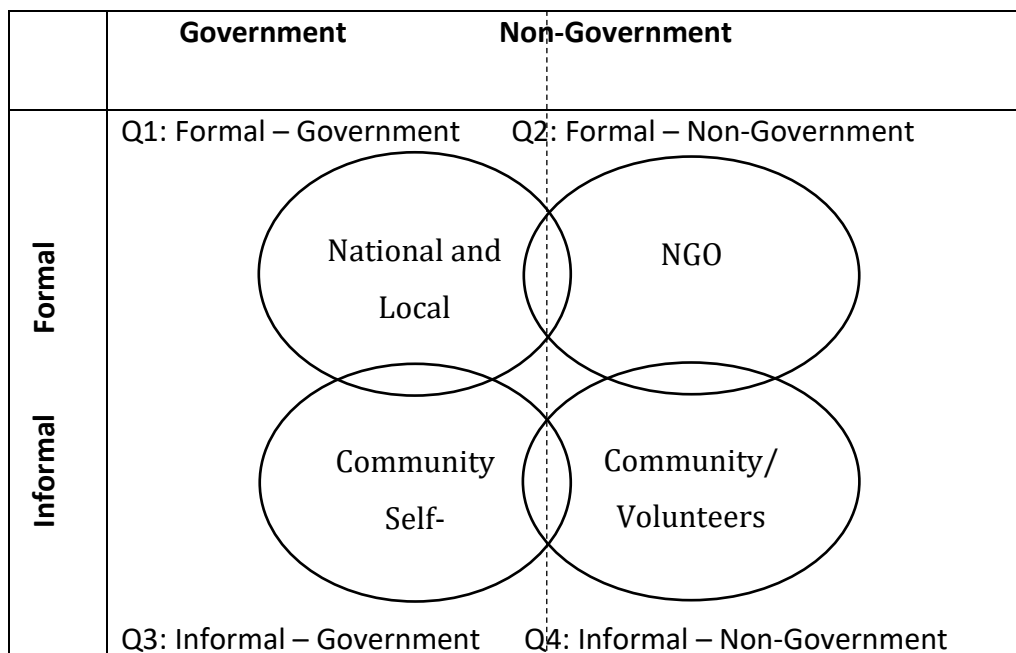
Similarly, the Program Director also stated that:

[The] BHCP is integrating at different levels: at the policy making level, and at the community level, where integration is taking place at the VA [Village Authority] level. So the ownership is at the village level.

Figure 4 shows the integrations that are taking place at various levels. One of the important relationships that works well in the case of BHCP is between Q1 (formal – government) and Q2 (formal – non-government). There is a shared understanding of their own capacity and the strength of the other partner. As an organisation, the management of the BHCP has been included under the Department. However, they operate independently in the implementation of its funds and activities. This allows the BHCP to be objective and more focused on the Program, in addition to enjoying the support and connections of the government. In general, Krishna (2003) notes that local government stability and performance are improved when community-based

organisations provide access and information to citizens, and each partner can help enhance the utility and effectiveness of the other partner. The other important relationship indicated in Figure 4 is between Q1 (formal – government) and Q3 (informal – government) that reflects the integration of formal and informal government systems in Bougainville. The traditional leaders (chiefs and senior members of the communities form the village assemblies) form the community government, which is included within the government’s formal system. Not only is a link between the community and the government established, but a link with the traditional values and cultural system is integrated into this relationship. Normally, formal institutions function well in established democracies where the rule of law guides political actors, whereas in emergent democracies these conditions do not hold or are weak (Bratton 2007). Under such conditions, the influence of formal institutions is weakened, as political actors align themselves with more familiar relationships and routines. However, in the case of BHCP, the integration of Q1 and Q3 are strengthened as they have legitimacy from the formal system, such as the constitution and other government laws and acts, as well as legitimacy from the traditional system, where, as chiefs and senior members of clans and tribes, they have informal legitimacy.

Figure 4: Framework for formal and informal institutions – BHCP



Within the non-government and informal institutions, various integrations take place. The relationship between Q2 (formal – government) and Q3 (informal – government) in

the BHCP is the role of the district facilitators and the village health volunteers. And the relationship between Q3 (informal – government) and Q4 (informal – non-government) are the chiefs, village health volunteers, and the community. It is in these spaces where volunteers and the community take ownership and ensure sustainability of the programs and activities that affect them. The relationships within informal institutions also relies less on the Government and reduces the burden on its limited budget. Informal institutions usually play an important role in developing countries and can shape the formal institutions, especially when formal institutions fail (Casson et al. 2010). Developing nations are different from advanced countries in that they face both greater challenges and more constraints, and this may require appropriate institutions (Rodrik 2008). Unfortunately, most development policy today is based on the models of the developed world, however the social dynamics of developed countries fundamentally differ from those of developing countries (North et al. 2007). This is mainly because of limitations of formal institutions – either due to lack of financial capacity or human resources. Informal institutions may emerge from repeated interactions and may have an important impact on institutional outcomes (Farrell and Heritier 2003). Such informal institutionalisation is likely to have the following impacts: firstly, informal institutions may modify or even supersede formal procedures; and secondly, substantive issues may be instrumentalised to establish informal institutional gains. Despite these findings, the role of formal institutions, primarily within the context of the government, must not be ignored or diminished. However, when it comes to providing healthcare services, the relationships among the various actors also have some challenges, which we know of from the BHCP's experiences. The key challenge is the role of Q2, that is, the NGO in the case of BHCP. If the funds stop, and which is likely to be the case soon for BHCP, the current positive outcomes will be affected. In such instances, Q1, that is, the Government must step up to provide the support or mobilise funds, particularly to the groups in Q3 and Q4.

In addition to the integration of formal and informal institutions in the delivery of public health services, generous and sustained donor support from the BHCP is important. The commitment made by the New Zealand Aid Programme, the major donor, helped to sustain the Program, as well as in reaching out to almost all districts in Bougainville. Well-coordinated donor support by the Program management and the Department of Health,

along with other donors such as the Australian Department of Foreign Affairs and Trade, World Health Organization and UNICEF, supplemented the funds and the efforts of the BHCP. In addition, the BHCP also received support from the churches and other NGOs such as Volunteer Service Abroad and World Vision. The method of donor coordination and management of funds was unique to the BHCP, in that the money from the New Zealand Aid Programme was managed directly by the BHCP's main office, and funds from other donors were managed by the Department. In addition, the BHCP had great independence and flexibility in managing the funds. The New Zealand Aid Programme was responsible for providing funds and technical support. Generally, aid seeks to offset the disadvantages of lack of resources and capacity, and allow developing countries to learn from reforms that have worked in other countries (Rodrik 2008). There are instances, however, where international best practices are adopted that do not fit into the domestic environment, and this problem can be particularly pronounced in states with weak capacity and limited resources (Schnell 2015). With the BHCP, there was a strong sense of good management and ownership of the Program, and local knowledge was also incorporated into its activities.

The BHCP had good leaders and a committed group of people working towards a common goal. The New Zealand Aid Programme evaluation report also points out that the impressive village leaderships and their commitment resulted in a positive outcome for the BHCP. In particular, it pointed out that the system of chiefs that predominantly operates in Bougainville drives changes in the village (Whelan 2012). The same report claimed that impacts were greater in those communities where leaders were supportive, local governance strong, and communities well-organised. Furthermore, communities that partnered well with other actors in public health issues benefited (Whelan 2012). Unlike a market setting based on a dyadic relationship (where partners come together to seek gains in productivity from one another), in a network setting partners come together in a 'facilitated environment where a governance structure is often overlaid in partner organisations' (Isett and Provan 2005, pp. 150-151). The collaboration between the Government Department and the NGO was based on mutual respect and trust between the two key people involved, the Program Director and the Acting Secretary. Normally, in successful programs such as the BHCP, cooperative interactions are executed through structures of 'interagency collaboration' (O'Toole 1997, p. 46), which recognises the

importance of formal and informal rules and protocols, institutional design, and other structural dimensions to on-going collaboration (Emerson et al. 2012). The integration between formal actors in the BHCP, such as the district coordination facilitators coordinators and the district facilitators, and informal actors such as community leaders and village health volunteers, were in-built into the program. At the implementation level, the district facilitators, chiefs and village health volunteers played a key role in seeing through the Program activities. These interactions can be defined as ideal partnerships where diverse actors act based on cooperation towards mutually agreed objectives pursued through a shared understanding, and encompasses a careful balance between synergy and respective autonomy and an equal participation in decision making (Brinkerhoff 2002).

7. Conclusion

Formal and informal institutions are generally seen to operate independently, and formal institutions are often given preference by donors. The formal and informal institution distinction only exists for analytical purposes and in reality, exist as hybrid regimes. Rather than ask if institutions matter, the more critical question to ask is ‘what matters more: formality or informality?’ (Bratton 2007, p. 98). This question is important, particularly in countries where formal institutions can be weak. Building on democratic values, such as participation and empowerment, partnerships among diverse actors is the appropriate approach to sustainable development and service delivery (Brinkerhoff 2002). Since the notion of government as a single decision-making authority has widened to include multiple actors, the divide between formal and informal institutions and actors begins to blur. This integration is important as they often complement and supplement each other. The overlap between formal and informal institutions is sometimes necessary in order to generate positive outcomes. This study was an example of such an overlap – a Program based on a framework that integrated formal and informal institutions. The framework used classifications that highlighted the roles of multiple actors within the governance process. Although a simple framework, it was useful in providing an understanding of the different categories of institutions and the nature of their overlaps (in the case of BHCP).

The experience of the BHCP revealed how formal and informal institutions integrate to deliver positive outcomes. The integrations took place at various levels, between the government and non-government sectors and between formal and informal institutions. Such forms of integration are important in places such as the Autonomous Region of Bougainville, where national governments are weak either due to the lack of capacity or resources or other issues. Some of the pre-conditions for such forms of integration are local leadership, community involvement, and support from the international community, particularly donors. The BHCP was fortunate to have good leaders with the best interests of the community at heart during its inception, as well as donors who were willing to fund it but let the people manage the Program themselves, and communities that were willing to actively participate in Program activities. However, these strengths could prove to be its biggest challenge too. At some point the current managers and leaders that spearhead the Program will retire or move on to other positions. International donor support is also likely to diminish or stop soon. The integration of formal and informal institutions may face a new set of challenges. Within the next year, Bougainville will be faced with another challenge when its people vote in a referendum for its independence. Irrespective of the outcome of the referendum, Bougainville will need strong governance systems, both at the national and community levels.

8. References

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