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

EVALUATION REPORT

JUNE 2009



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CONTENTS

Acknowledgements	iv
Acronyms and abbreviations	iv
Executive summary	v
AusAID Response	x
Chapter 1: The study	1
Purpose	1
Approach and methodology	1
Structure of the report	2
Chapter 2: Background	3
Country context	3
Summary of AusAID support to the health sector	4
Chapter 3: Health system performance	6
Health sector financing and expenditure	6
Health service utilisation and outcomes	8
Health systems performance: overall assessment	10
Chapter 4: AusAID support to health service delivery	12
Effectiveness of AusAID contribution to health service delivery	12
AusAID’s approach to providing support to health service delivery	21
Chapter 5: Recommendations	28
Annexes	
Annex A: Terms of reference—health sector evaluation	35
Annex B: Health systems in the case study countries	42
Annex C: Selected health utilisation, outcome and impact indicators	48
Annex D: Minimising fiduciary risk when using government systems	49



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ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
AusAID	Australian Agency for International Development
DFID	Department for International Development (United Kingdom)
DHS	demographic and health survey
GDP	Gross Domestic Product
IDA	International Development Association
MDG	Millennium Development Goal
MP	Member of Parliament
NDOH	National Department of Health (Papua New Guinea)
NGO	Non-Government Organisation
ODE	Office of Development Effectiveness
ODI	Overseas Development Institute
PNG	Papua New Guinea
RAMSI	Regional Assistance Mission to Solomon Islands
SWAP	Sector wide approach
TB	tuberculosis
UN	United Nations
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

This report examines the effectiveness of the Australian Agency for International Development's (AusAID) support to improve the delivery of essential health services to the poor. The findings are based on three country case studies conducted in Papua New Guinea (PNG), Solomon Islands and Vanuatu, which examined Australian-funded activities in the health sector that were concluded within the past five years or are currently ongoing. The purpose of the study is to draw lessons about what has worked and what has not, to inform and improve AusAID's future support in the health sector.

PNG, with a population of more than 6 million, has 90 per cent of the population of the three countries, compared to 7 per cent in Solomon Islands and just 3 per cent in Vanuatu. Latest estimates place the proportion of the population living on less than US\$1 per day at 40 per cent in PNG, 23 per cent in Solomon Islands and 26 per cent in Vanuatu.

Difficult physical geography is a dominant feature in PNG, but also a major constraint in the island states of Solomon Islands and Vanuatu. It is associated in all three countries with extremely high levels of cultural and linguistic diversity. Strong communities provide support to their members and to local services, but high levels of cultural and linguistic diversity have also contributed to problems of conflict, unstable national governments, and weak institutions prone to favour local over national interests. These pressures do not operate to the same extent everywhere and at all times.

Australia is by far the largest donor in the health sector in each of the three countries studied. Over the period 1998–2008, AusAID provided more than half a billion dollars in support through its country programs—three quarters of which went to PNG. Nearly half of total Australian support was in the form of technical assistance. AusAID direct financing of health service operating costs has been a relatively small proportion of assistance in PNG and Vanuatu. In Solomon Islands, in contrast, nearly 60 per cent of support to the health sector has financed operating costs, reflecting the important role Australia played during the tensions in the early part of the decade. Capital investment in buildings and equipment accounted for approximately 20 per cent of total assistance.

Health systems performance

In Vanuatu and Solomon Islands, health facilities are accessible to and used by the majority of the population. In PNG, coverage and utilisation are significantly lower and are either flat or declining. Vanuatu and Solomon Islands appear to be on track to reach the Millennium Development Goal (MDG) for reducing under-five mortality, while estimated maternal mortality rates in Vanuatu are better than the average for upper middle income countries, and approaching it in Solomon Islands. In PNG, under-five



mortality is higher and has declined more slowly. In all three countries, the majority of childhood deaths are still due to readily preventable or treatable causes. Maternal mortality in PNG seems to be extremely high and not declining, reflecting low levels of skilled birth attendance and severe physical access problems in reaching emergency obstetric care.

Malaria incidence in all three countries is the highest outside Africa. In Solomon Islands and Vanuatu, however, incidence is now falling with Global Fund support and continued improvement is anticipated with the commencement of the Australian-supported Pacific Malaria Initiative. Health system performance in Solomon Islands and Vanuatu has been generally stronger than in PNG but improvements are uneven and vulnerable, with immunisation coverage dangerously low in Vanuatu, and progress on malaria in both countries still dependent on vertical aid programs.

Higher health spending, supported by aid, has enabled Vanuatu and Solomon Islands to provide reasonably effective health services at affordable cost and close to where the majority of their populations live. These two countries generally succeed in staffing health facilities and keeping them supplied with drugs and consumables. The high level of spending enables them to do so despite serious inequalities in the way resources are allocated, with too great a concentration on the capital cities, and on hospital-based services.

PNG spends significantly less than the other two countries on health services and unlike the other two, real per capita spending fell from 1998–2006 because of slow economic growth and declining aid. Although pockets of the populations in all three countries are not being served, the problem in PNG is of a different order of magnitude. In PNG, lack of resources and staff have forced many aid posts to close and also led to often protracted shortages of drugs and other medical supplies. Also, a significantly higher proportion of PNG's population live beyond the effective reach of health services. With the highest delivery costs for health services, and the lowest per capita budget with which to deliver them, it is not surprising that PNG achieves significantly poorer results.

Effectiveness of AusAID's contribution

The effectiveness of Australia's contribution to improved health service delivery in the three countries has been mixed. Notable successes, such as maintaining services during periods of crisis, have to be balanced against approaches that, while well intentioned, have limited the potential impact of Australian assistance. This is not to underestimate the difficult environments in which the aid program has operated; achieving results against the health MDGs is a challenge globally and particularly so in environments where partner government commitment is subject to change. The Australian aid program rightly sought to develop the way it managed and delivered aid, but lessons can be learned about the success of AusAID's support to health service delivery and the ways assistance was provided.

What AusAID supported

A supportive policy framework has long been understood to be essential for the success of all types of aid. AusAID has made positive contributions to health policy development, where the partner government has owned and led the process. An example is the support to quantify the inequalities in revenues and the costs of health service delivery between provinces in PNG. Legislation has recently been passed that will focus future growth of government health grants on the most disadvantaged provinces. However, attempts to drive policy reform in the absence of leadership commitment have been less successful.

In all three countries, poverty and gender inequality received little specific attention in sector policy. Australia has taken some steps to encourage governments to address poverty and gender-based inequalities in access to health services but efforts have not always been sustained.

Importantly, AusAID has provided assistance to maintain financing (and hence performance) of front-line health services. Provincial health grants from AusAID, for example, saved the health system in Solomon Islands from collapsing during the 1999–2003 tensions, and were arguably the single most important and effective intervention by AusAID in any of the three countries. However, a cautious approach to managing fiduciary risk overall has prevented AusAID from providing financial support to local health services on the required scale, and supporting its own, pro-poor policy advice. In both PNG and Solomon Islands, progress towards a more pro-poor allocation of health expenditure could be accelerated if donor funding were made easier for provinces to access, and allocated in favour of provinces with the largest gaps between available resources and the cost of financing basic services for all.

Effective front-line services also depend on ensuring that sufficient supplies of drugs and medical supplies reach facilities. AusAID has rightly supported this critical function in all three countries but has made limited progress in strengthening the underlying procurement and distribution systems. All three countries also face health workforce shortages and distribution problems; the limited support Australia has provided to these aspects of the health systems has had some success but this has mainly been directed towards secondary and tertiary care (and, in Vanuatu, to village health worker training). Significant challenges remain in all countries for strengthening the skilled primary care workforce.

Much of Australian support over the period was directed at improving the effectiveness and efficiency of the health systems themselves. Technical assistance was the main means of support (accounting for nearly half of the total), but AusAID also funded investments in health systems infrastructure and equipment. Important improvements have been made but, overall, the results achieved in terms of lasting improvement in the capacity of health systems have not been commensurate with the costs. Attempts to help organisations operate more effectively had limited impact on service delivery



because of deeper institutional problems. Similarly, inadequate operating budgets limited the effectiveness of other efforts to build capacity through technical assistance support and capital investment.

How AusAID provided its support

After initial difficulties, AusAID has begun to adopt a more inclusive approach to aid delivery. AusAID has rightly attempted to move to program-based approaches to tackle the challenges of health service delivery but it had difficulties changing its ways of working and managing expectations about the pace of progress possible. AusAID continued to rely heavily on its traditional, project-based approach over the period studied, which in practice resulted in rather fragmented support, spread across a broad range of individual activities. Mechanisms to effect better dialogue with partner governments and civil society about health sector policy, strategies and performance have been under-developed.

As the largest donor and a significant source of funding for health in all three countries, AusAID did not give sufficient priority to communicating future funding intentions to partner governments, ensuring that funding commitments were met, and ensuring continuity in support. In addition, AusAID's approach to fiduciary risk management over the period hindered its ability to provide a relevant response to service delivery needs in PNG and Solomon Islands. The effectiveness of technical assistance (nearly half of AusAID's funding to health) was limited by weak integration with country health plans, and a limited repertoire of approaches not sufficiently adapted to the specific requirements.

Australian assistance has on occasion missed opportunities to lock in earlier achievements when developing new activities. Support to the health sector has not consistently sought to coordinate and exploit the strengths of other relevant parts of the aid program in each country or build on locally-adapted, country-led solutions.

Recommendations

To inform thinking about effective approaches in the future, the following recommendations are made and elaborated on in the main report.

1. AusAID strategy in the health sector should be shaped by deeper analysis of how sustainable improvements in services for the poor can be achieved, and reflected in understandings with government on both the uses to which AusAID will be put, and the policy and expenditure framework within which it will operate. Changing circumstances in each country need to be continually reassessed to determine implications for the strategy.
2. The strategy should recognise that government is the key to building sustainable health services in the three countries studied. It is both possible and necessary to work within government policies and institutions in each of the countries studied.

Where parts of the health system are so ineffective that alternative approaches are justified, AusAID should explicitly manage the risks associated with parallel systems.

3. AusAID should continue in its efforts to build a sector partnership with government and other development partners, working towards a full sector wide approach. This involves establishing effective institutional arrangements for dialogue and review both with government and outside, to develop wider ownership of key policies.
4. Partnership should be based on transparency with respect to planning and reporting on aid finance. This requires effort to strengthen reporting and dialogue around aid commitments, preferably as part of broader processes involving other donor partners.
5. AusAID should progress to use government systems for financial management of aid flows, backed up with the necessary attention to strengthening those systems and supporting those responsible for financial management. Where essential to safeguard Australian funds, reasonable additional controls should be applied but these should not become a barrier to implementation.
6. Support to build health systems capacity should be fully integrated, as part of a broader strategy and plan that addresses other factors critical for improving performance. AusAID should recognise explicitly the limitations of technical assistance, and give more attention to identifying the necessary and sufficient conditions for capacity to be built.
7. AusAID should ensure greater continuity and coherence between phases and types of support to protect the benefits achieved and avoid instability in the level of support provided, given the central role that AusAID plays as the main donor to the sector.
8. Further analysis of the factors influencing AusAID's ability to provide a relevant response to the health challenges in the countries studied is warranted. Translating high-level Australian political commitment into action is not straightforward in these environments, especially where this entails reduced direct control and a greater need to manage uncertainty. In-depth discussions among AusAID senior management and staff would help to develop a better understanding of the incentives and perceived constraints influencing its approach.



AUSAID RESPONSE

AusAID welcomes the findings of the ODE evaluation and accepts the recommendations. As reflected in the Director General's Blueprint and the associated Agency Business Plan 2006 -2010, AusAID is committed to improving the performance of the aid program.

Arising from the findings of the 2007 Annual Review of Development Effectiveness (tabled in March 2008), this evaluation is the first of three commissioned by AusAID focussing on Australian aid support for the delivery of services in difficult environments – the other two being on education and water supply and sanitation. The purpose of these evaluations is to extend the evidence base on support for service delivery – in this case health - and to identify lessons for the Agency to strengthen the impact of Australian aid on the lives of the poor.

The report provides a retrospective review of Australian assistance in the health sectors of Papua New Guinea, Solomon Islands and Vanuatu over the preceding decade. To a large extent it confirms the Agency's own thinking about the shortcomings of earlier interventions and supports the new directions already being taken. It confirms that new ways of working are required and provides useful insights that will support recent efforts to refine the Agency's engagement in the health sector, particularly in countries where AusAID is a major financial contributor, as well as inform broader changes that are underway in the aid program concerning aid management and delivery.

As the report concludes, Australian assistance has made important contributions to improved health outcomes in all three countries. Nevertheless, the evaluation raises a number of important issues that we welcome as support for our efforts to improve the effectiveness of Australian aid.

Improving delivery of essential health services

The evaluation acknowledges the difficulties improving health service delivery in resource poor environments where systems are weak. It also highlights the short-lived benefits from stand alone projects compared with approaches that work through and strengthen partner systems. Health reforms are complex and achieving results is a challenge faced by all donors – as the recent evaluation of World Bank support to the health sector demonstrates.

The evaluation points out that working in partner systems will only be effective if based on sound analysis of the sector, and public administration more broadly, and driven by a clear strategy for AusAID policy and programming. It is also important that AusAID's assistance reaches where it is most needed, in a form that can be used to achieve its intended purposes. In this regard, the evaluation provides a valuable reminder that systems strengthening and delivery of services are not separate ambitions working on different timeframes. AusAID welcomes the detailed and thoughtful contribution the evaluation makes to meeting this challenge.

Building sector dialogue

AusAID has made concerted efforts to develop more effective engagement at the sector level in all three countries. The evaluation endorses this approach.

Donors need to work with governments to ensure all available resources are used in the most effective and efficient manner for improving service delivery. In this regard, AusAID needs to focus policy dialogue on funding arrangements and allocations within the sector, budget development and execution at both national and sub-national levels, and alignment of central and health ministry public financial management reforms. A sound understanding of the degree of political, fiscal and administrative decentralisation will be critical. Dialogue must also consider how these arrangements will address the needs of the poor and gender disadvantage. The Pacific Partnerships for Development and country strategies provide the basis for building AusAID's engagement in policy dialogue.

The evaluation also noted that dialogue in the health sector could be strengthened by building better links with other parts of the Australian program – in particular with support for improved public administration and with assistance for civil society. These issues will be addressed in future delivery and implementation strategies.

Managing risk

The evaluation makes important observations about ways to manage financial risk that do not limit the effectiveness of our support. The global recession provides additional impetus to work with countries to improve the efficiency and effectiveness of their health spending and donor assistance. AusAID has now developed formal guidance on analysis and risk mitigation measures when using partner country expenditure systems and is in the process of building up its technical capacity in this key area. Use of partner country systems will always need to be underpinned by sound diagnostics and a clear understanding of system strengths and weaknesses. However, working outside partner systems can limit the potential impact of aid and so fiduciary and effectiveness risks need to be carefully weighed in all programming decisions.

Operating in challenging environments

One area where AusAID has some reservations regarding the evaluation's findings is in recognising the reciprocal nature of the development process with partner countries. The study was an evaluation of AusAID support in these countries. It did not explicitly assess the performance of partner Governments.

The report noted that AusAID faces particularly challenging circumstances in the three countries studied. The geographical, institutional and political environment is complex and as the largest donor to the health system in all three countries, Australia is frequently the donor of first and last resort. While recognising AusAID's role in influencing reform, responsibility also rests with partner governments. In particular,



effective engagement in the sector and alignment with government systems requires strong government leadership. In this regard AusAID acknowledges that further development of guidance on how to operate in a weak policy environment is warranted.

Conclusion

This evaluation is very welcome. It will inform planned country program reviews, the work of AusAID's Health and HIV Thematic Group and that of the Operations and Policy Support Branch. The recommendations are accepted; specific responses are provided below.

Response to individual recommendations

Recommendation 1: AusAID strategy in the health sector should be informed by deeper analysis of the opportunities and constraints for improving service delivery

AusAID agrees with this recommendation. It underlines the importance of work that is already underway to strengthen delivery and implementation strategies as part of the Pacific Partnerships for Development and updated country strategies. In response, AusAID will:

- > continue to strengthen country and sector strategy analysis, including by;
 - further developing its analysis of national and sub-national contexts;
 - rigorous analysis and diagnostics of the constraints to service delivery;
- > develop and implement a work program for better integration of public administration and health service delivery assistance; and
- > continue to build and use analytical work aimed at improving service delivery and the systems that underpin it, including the work of the recently established and AusAID funded Health Knowledge Hubs at various Australian academic institutions.

Recommendation 2: The strategy should recognise that Government is the key to building sustainable health services for the poor

AusAID agrees with this recommendation. AusAID is committed to working with country governments as partners, particularly through the Pacific Partnerships for Development. In response, AusAID will:

- > continue to strengthen the policy dialogue on service delivery at the country level;
- > work with countries on strategies to address critical gaps in recurrent funding to ensure health resources and services reach the intended beneficiaries; and
- > continue to develop guidance on working through partner government systems and on strengthening diagnostics and modalities which prepare for a sustainable transition to government systems.

Recommendation 3: AusAID should continue its efforts to build a sector partnership with Government and other development partners, working towards a full sector wide approach

AusAID agrees with this recommendation, and acknowledges that effective engagement in policy dialogue requires deployment of suitably qualified staff at key points. The agency also recognises the need for development partners to respond to country needs in a more coordinated manner. The Australian Government is committed to implementing the principles and actions associated with the Paris Declaration on Aid Effectiveness, the Accra Agenda for Action and the International Health Partnership (IHP). In response, AusAID will:

- > update and strengthen operational policy and guidance on working through sector wide approaches and build the capacity of AusAID staff to engage more effectively in sector wide and program-based approaches; and
- > formalise partnerships with WHO, UNICEF and UNFPA, in recognition of their key role and international mandate in the health sector, in order to strengthen operational coherence and harmonisation at the field level.

Recommendation 4: Partnership should be based on transparency with respect to planning and reporting on aid finance

While AusAID does not accept that there has been a consistent lack of transparency in the past, it agrees that a more systematic effort to provide predictability of financing is warranted. In response, AusAID will:

- > continue to establish multi-year partnerships with UN agencies and Partnerships for Development with national governments in the Pacific in order to improve predictability of health financing;
- > establish a best practice system for provision of multi-year information on aid flows to partner countries;
- > continue its efforts to make greater use of partner government expenditure systems and ensure aid expenditure is recorded on-budget;
- > through membership of the High Level Taskforce on Innovative International Financing for Health Systems, continue its efforts to ensure international development financing is aligned with result-focused plans and strategies developed and owned by national authorities; and
- > continue to support the International Health Partnership process that the Government committed to last year, which promotes working with all development partners in a more coordinated manner to develop effective national health plans and budgets.



Recommendation 5: AusAID should progress to use Government systems for financial management of aid flows

AusAID agrees with this recommendation and welcomes the evaluation's recognition of the challenges of doing this where systems are weak. In response:

- > AusAID has established a work program for analysis and use of country systems, to enable the Agency to better address opportunities and risks in using partner systems and to better target technical and capacity building support to strengthen partner systems; and
- > future decisions regarding the use of partner government systems, including partial use, will explicitly consider the potential risks and distortions that may arise from using parallel systems and outline a plan for the eventual transition to the use of government systems.

Recommendation 6: Support to build health systems capacity should be fully integrated, as part of a broader strategy and plan that addresses other factors critical for improving performance

AusAID agrees with this recommendation. Funding technical assistance without a commensurate focus on addressing any shortfalls in funding for service delivery can undermine the efforts of AusAID and partner governments to improve services. In response, AusAID will:

- > continue its efforts to ensure capacity building programs are well designed and integrated within programmatic approaches; and
- > develop guidance on integrating technical cooperation and capacity building objectives into broader sectoral strategies and the dialogue on priorities and budget.

Recommendation 7: AusAID should ensure greater continuity and coherence between phases and types of support

AusAID agrees with this recommendation and will use country program strategies and the Pacific Partnerships for Development to take this forward. AusAID's planned actions in relation to the provision of information on multi-year aid flows will help partner governments plan ahead and minimise the risk of abrupt discontinuities in support for critical programs.

Recommendation 8: Further analysis of the factors influencing AusAID's ability to provide a relevant response to the health challenges in the countries studied is warranted

The evaluation acknowledges the reform processes that are underway within AusAID. Many of the factors identified in the evaluation are not unique to the health sector and AusAID is already conducting analysis of the sort proposed as part of its wider efforts to update its approach to aid delivery and management. Work is underway to develop an Operational Policy and Management Framework, which will address working in partner systems, choice of appropriate aid modalities, minimum requirements for accountability under different aid modalities and clear guidance on how AusAID will manage risk in these contexts.

CHAPTER 1: THE STUDY

Purpose

This report examines the results of a study conducted on the effectiveness of AusAID's contribution to improving the delivery of essential health services for the poor on a sustainable basis. The terms of reference are reproduced at Annex A. The purpose of the study was to draw lessons about what has worked and what has not to inform the development of improved approaches. The study is one of three evaluations of Australian assistance to the delivery of basic services commissioned by AusAID's Office of Development Effectiveness (ODE) in 2008–09; the other two examine the education and water supply and sanitation sectors.

Approach and methodology

The report is based on three country case studies conducted in PNG, Solomon Islands and Vanuatu. It covers the Australian-funded interventions in the health sectors that have concluded within the last five years or are currently ongoing. For this study, health sector refers to promotive, preventive and curative health services provided or financed by government or by non-government sources. The team only considered those aspects of the HIV epidemic that lie within the policy and regulatory responsibilities of health ministries.

The study took an explicit systems perspective, recognising that an improvement in health policy, for example, may be equally or more important than a direct but transitory intervention targeted at the poor. This meant first reviewing how the health systems have operated in each country; that is, the inputs (e.g., funding), processes (e.g., national plan implementation), systems (e.g., governance arrangements), the services delivered and outcomes achieved (e.g., increased utilisation and coverage and reduced inequity) and ultimately the health outcomes of the poor (e.g., improved survival and reduced morbidity). From this, the team identified the factors enabling and inhibiting performance, both within the health systems themselves and more broadly within the social, political and economic environments. The team's main evaluation task was to ask whether the choices about where and how to spend Australian aid were reasonable given the information and the circumstances at the time, or whether different choices would have been likely to produce improved outcomes.

The methodology of the study involved:

- > a literature review and analysis of available data;
- > visits to each case study country, for between two and three weeks, to conduct interviews with key informants (this was supplemented in PNG with an email survey)—in addition, part of the team visited Fiji, where regional health programs are managed;



- > field visits in each case study country to a sample of health facilities and consultations with managers, medical staff and a limited number of patients and community representatives; and
- > debriefs with government partners and AusAID in each country, and with AusAID staff in Canberra.

Structure of the report

Chapter 2 presents background information on each country to help the reader understand the subsequent discussion of performance. It provides a brief review of the broader country contexts and a summary of Australia's support to the health sector. Chapter 3 discusses the performance of the health systems in the three countries in recent years. Chapter 4 considers the contribution of Australian aid to that performance. Chapter 5 makes recommendations, based on the study's findings.



CHAPTER 2: BACKGROUND

Country context

The three countries studied represent very challenging environments. All three are often described as ‘fragile’ states, but simplistic labels can be misleading. Although Solomon Islands rank 62 out of 75 International Development Association (IDA) eligible countries in the World Bank resource allocation index (down with the Democratic Republic of the Congo and Angola and reflecting its dependence on the Regional Assistance Mission to Solomon Islands (RAMSI) to keep the peace), PNG and Vanuatu rank 43 and 45—scores that put them with the bulk of mainstream aid recipients.¹

With a population of more than six million, PNG has 90 per cent of the population of the three countries compared to 7 per cent in Solomon Islands and just 3 per cent in Vanuatu. Latest estimates place the proportion of the population living on less than US\$1 per day at 40 per cent in PNG, 23 per cent in Solomon Islands and 26 per cent in Vanuatu.²

Difficult physical geography is a dominant feature in PNG, but also a major constraint in the island states of Solomon Islands and Vanuatu. It is associated in all three countries with extremely high levels of cultural and linguistic diversity. Two of the countries have suffered from conflict and insecurity due to ethnic tensions and local rivalries. In Solomon Islands, the current peace depends on the RAMSI. The history of communal violence in PNG remains a further constraint to delivering services.

Although all three countries are parliamentary democracies, the sense of nation is underdeveloped amongst many citizens, whose allegiance to local family and clan groups can be much stronger. In these countries, the challenge is not to re-establish state institutions and processes—as is commonly the case when talking about state fragility—but to create them or to allow them to emerge in situations where they have never existed in an effective form.

Gender relations in Melanesia are generally characterised by a clear division of labour. Women are in many ways the primary producers of wealth, but men tend to dominate decision making in nearly all public arenas. The Pacific subregion, excluding Australia and New Zealand, ranks second last in the world in terms of the proportion of female Members of Parliament (MPs). In 2006 Solomon Islands had no women MPs, PNG had one out of 108 MPs, and Vanuatu two out of 52. Violence against women is endemic in the region and has high social, economic and health costs.

¹ 2007 IDA resource allocation index. It ranks countries on indicators of economic management, structural policies, social inclusion, and public sector management and institutions.

² Tracking Development and Governance in the Pacific, AusAID, August 2008.



National politics has been associated with unstable coalition governments,³ and pressure on politicians and officials to deliver jobs and resources to members of the same community or language group ('wantok'). The highly devolved system of government in PNG means implementation of national health policies and plans depends on the willing cooperation and capacity of provincial governments. Provinces have devolved responsibility for health, and a large degree of autonomy over how resources are used.

Churches and traditional chiefs remain powerful forces in all countries studied. In PNG, churches deliver around half of all health services. In Vanuatu and Solomon Islands, there are impressive examples of community engagement in health and development. In PNG, also, there are excellent examples of activity by civil society organisations, although these generally represent an adaptation to weak government services rather than a contribution to government response and accountability. Overall, civil society organisations appeared strongest in Vanuatu where a number of well-organised Non-Government Organisations (NGOs) are collaborating on encouraging and supporting civil society voice and greater government accountability.

Summary of AusAID support to the health sector

Australia is by far the largest donor in the health sector in each of the three countries studied. During the period 1998–2008, AusAID provided some \$530 million in support through its country programs (Table 2.1). Vanuatu and Solomon Islands—and to a much lesser extent PNG—also received assistance through regional AusAID health programs and regional organisations receiving Australian Government support during the period.⁴

TABLE 2.1: AUSTRALIAN AID^a TO THE HEALTH SECTOR, 1998–2008

	A\$ million	%
Papua New Guinea	412	78
Solomon Islands	91	17
Vanuatu	27	5
Total	530	

a Country programs excluding regional aid.
Source: AusAID data

³ Vanuatu had 16 changes in government in the 13 years before the 2004 elections.

⁴ In Vanuatu health sector, the team estimates a further 30 per cent of support (approximate) was provided through regional programs.

Australian support to the health sector has been wide-ranging. In all three countries, Australia has provided significant assistance to improve health sector planning and management (including budgeting), as well as support for national policy development and primary health care implementation at provincial and local levels. In PNG and Solomon Islands, considerable support has been provided to assist in the procurement and distribution of essential drugs and medical supplies.

Technical assistance has accounted for nearly half of total support—including training, research and analysis and advisory support. The provision of international staff in advisory and line positions in government health organisations has been a strong feature of this assistance. Approximately 20 per cent of total support was for investment in infrastructure (buildings and equipment).

Direct financing by AusAID of the operating costs for health service delivery has varied across the three countries. In PNG and Vanuatu, this was a relatively minor part of the total assistance provided—around 25 per cent of total assistance in PNG⁵ and less than 10 per cent in Vanuatu. In contrast, nearly 60 per cent of support to Solomon Islands over the period was provided for health service operating costs, reflecting the important role Australia played during the conflict and tensions in the early part of the decade.

AusAID's approach to delivering support evolved over the period studied. Attempts have been made in each country to move from a predominantly project-based model of engagement to a program-based approach (Box 2.1). The PNG country program has led the way, with the initiation of a sector-wide approach (SWAP) in the early 2000s. In Solomon Islands, a sector-wide program has just started, while in Vanuatu preparatory steps are underway, focusing a more coherent approach to health sector financing.

BOX 2.1: PROGRAM-BASED APPROACHES

Program-based approaches, including what are known as SWAPs, deliver aid based on the principles of co-ordinated support for a locally owned program of development, such as a national development strategy or a sector program. In principle, they provide a stronger basis for engaging in policy dialogue and progressing principles of partner ownership and alignment, donor harmonisation and results management. Program-based approaches share the following features:

1. leadership by the host country or organisation;
2. a single comprehensive program and budget;
3. a formalised process for donor co-ordination, and harmonisation of donor procedures for reporting, budgeting, financial management and procurement; and
4. greater use of local systems for program design and implementation, financial management, monitoring and evaluation.

⁵ This estimate excludes Australia's contributions to the Global Fund and Global Alliance for Vaccines and Immunizations (GAVI)—organisations that are also active in PNG in delivering services.



CHAPTER 3: HEALTH SYSTEM PERFORMANCE

This chapter begins with a brief analysis of health expenditure and financing in each country. It then examines what has been delivered and achieved in the health sector and it concludes with an overall assessment of how well the health systems of PNG, Solomon Islands and Vanuatu have performed. Annex B provides a more detailed outline of the health systems in each country and the main system constraints affecting operations.

Health sector financing and expenditure

Table 3.1 presents data on health expenditure by country. Per capita health spending in Vanuatu is significantly higher than in PNG and Solomon Islands, thanks to a high and rapidly growing per capita income based on tourism and high aid per capita, reflecting small country biases in aid allocations.⁶

Solomon Islands suffered a sharp decline in government spending during the 1999–2003 tensions, which was compensated for by higher AusAID spending. This decline was followed by a burst of rapid economic growth based on massive aid flows and unsustainable logging. Country data suggest that health spending has grown strongly since 2004, but with exploitable timber nearly exhausted, the country now faces the prospect of a return to economic stagnation.

PNG spends significantly less on health services than Solomon Islands and Vanuatu and, unlike the other two countries, real per capita health spending has until very recently been on a declining trend.⁷ PNG's ability to pay for improved health services has been handicapped by erratic but declining aid to the sector and low economic growth from 1998 to 2005. There has been a recovery since 2006 with the boom in commodity prices, but the more favourable economic circumstances have yet to translate into higher spending.⁸ This is partly because the Government has allocated the additional resources available to capital spending, which takes longer to plan than recurrent expenditure, and is also more prone to political and interest group pressures on how it is allocated. The looming recession suggests that windfall gains will not be sustained.⁹

6 This growth, however, has been associated with the alienation of land and a big increase in inequality, with little benefit accruing to the vast majority of the population which does not participate in the formal economy.

7 The downward trend in real spending per head in National Department of Health (NDOH) data differs from estimates by the World Health Organization (WHO). The NDOH data is preferred because it records public expenditure financed from aid. WHO data may reflect donor payments rather than public expenditure, and includes spending outside the government health plan. WHO aid data in all three countries appears inconsistent in coverage.

8 2009 provincial health function grants and 2008 District Service Improvement Grants may increase spending.

9 According to the Asian Development Bank (ADB), recent price falls could result in a 25 per cent reduction in mining and oil and agricultural export income in 2009 (ADB: Navigating the Global Storm, October 2008).

The public sector (including donors) dominates health sector financing in all three countries, but especially in Solomon Islands, which has one of the lowest shares of private health financing of any country in the world. Even in PNG, government is the largest source of finance for the churches that deliver around 50 per cent of health services. The formal private sector is quite small in all three countries, and the non-government contribution consists mainly of NGO and church financing, and out-of-pocket costs born by patients.

TABLE 3.1: HEALTH EXPENDITURE

	PNG		Solomon Islands			Vanuatu	
	2001	2005	2000	2004	2006	2005	2008 (budget)
Public plus development partner expenditure (% of Gross Domestic Product (GDP))	3.2	3.1	4.7	5.6	6.2	2.8	..
Private expenditure (% of GDP)	0.6	0.6	0.4	0.3	0.3	1.5	..
Government real spend per head (2006 AUD)	28.0	25.3	42.9	17.7	30.2	43.2	84
Donor real spend per head (2006 AUD)	11.6	9.6	8.2	32.1	32.0	23.3	51
Private health per head (2006 AUD)	7.3	6.6	3.5	3.0	3.1	30.5	..
Total spending per head (2006 AUD)	46.9	41.5	54.6	52.8	65.2	97.0	>135

Sources: PNG: public and donor expenditure data from NDOH planning and admin division. Expenditure in Kina was converted to 2006 prices and then to AUD using an average 2006 exchange rate. Solomon Islands: expenditure data comes from the WHO, but the 2006 figure has been adjusted for under-reporting of aid. Vanuatu: 2005 data is from the WHO's, World Health Statistics, adjusted to AUD, and to include Australian aid not reported.

In PNG, aid accounted for 42 per cent of public sector health spending in 2002, but has been less than one third of the total since 2003. In Solomon Islands, published figures on aid are incomplete but in recent years aid has accounted for significantly more than half of public health expenditure. In Vanuatu, 2008 budget analysis suggests that aid finances around 38 per cent of government health spending. In all countries, AusAID accounts for more than half of aid spending. In spite of a declining share as a result of the entry of the Global Fund in the region since 2003, AusAID continues to be the lead donor and often the donor of 'last resort' in all three countries.

All points of health care in the three countries charge user fees for all except essential public health services (e.g., childhood immunisation), with at least some revenue being used to improve services or facilities at the local level.¹⁰ Routine charges in government facilities in PNG are markedly higher than in the other two countries and are higher still at church facilities (which may be a monopoly provider at the district level). Rates may be doubled for patients attending from outside the facility's catchment area and double again for injuries resulting from fighting (including, remarkably, victims of

¹⁰ In the case of Solomon Islands, all user fees are in principle required to be surrendered to the Treasury.



domestic violence). Transport costs for reaching a facility are also very high in some parts of PNG. These are significant disincentives for poor community members or for victims of violence to use health services.

In Solomon Islands, outpatient charges are very modest compared with PNG and may be deferred or waived in cases of real individual hardship. In Vanuatu, health workers generally make provision for payment 'in kind' or for deferral of payment where the family is unable to afford the designated charge.

Health service utilisation and outcomes

This section examines the achievements in each country using a selection of key indicators. The data presented are from the most recent or best available sources. As far as possible, data were validated through in-country discussions with health sector experts. Annex C includes a full discussion of sources and data limitations.

Access and utilisation of health services in the three countries compare favourably with other low income countries (but access in PNG is lower than in Solomon Islands and Vanuatu). Clinic utilisation improved in Solomon Islands following the end of the tensions in 2003, but appears not to have increased in any country in the last three years; indeed, in PNG, clinic utilisation has been static or declining for the past six years. Remote communities are especially disadvantaged. The difficulty and high cost of transport pose major problems for those responsible for providing services, and for those trying to access services.

	PNG		Solomon Islands		Vanuatu	
Annual per capita outpatient contacts	1.53 (2002)	1.43 (2007)	1.2 to 1.8 (2002–03)	2.0 to 2.5 (2007)	—	>2 (2007)

Immunisation coverage is dangerously low and not showing sustained improvement. Only Solomon Islands reports reasonable coverage, but the team has some scepticism about the reported rates, which would be difficult to achieve using the intermittent, facility-based immunisation services observed in all facilities visited by the team.

	PNG		Solomon Islands		Vanuatu	
% of 1 year olds fully immunised against measles (MDG)	53 (2002)	53 (2007)	84–95 (2004)	87 (2005)	48 (2003)	37 (2007)
% of 1 year olds who received a third dose of DTP vaccine	68 (2003)	68 (2007)	73–93 (2004)	88 (2005)	—	58 (2007)

Note: Vanuatu data for 2007 are provisional.

The United Nations Children’s Fund (UNICEF) regards Vanuatu as ‘on track’ to achieve the child mortality MDG. Solomon Islands and PNG are reported as making ‘insufficient progress’, although data from the 2007 Demographic Health Survey (DHS) suggest that Solomon Islands may now be ‘on track’.

	PNG		Solomon Islands		Vanuatu	
Under 5 mortality rate per 1,000 live births (MDG)	100 (2001)	64 (2005)	88 (2000)	37 (2003–07)	48 (2000)	36 (2006)

Contraceptive usage among women of reproductive age is low in all three countries, albeit improving in PNG.

	PNG		Solomon Islands		Vanuatu	
% of married women of reproductive age using any modern form of contraception (MDG)	26 (1999)	36 (1997–2005)	—	27 (2003–07)	—	37 (2007)

Maternal mortality is of grave concern in PNG (although with some caution around interpretation of the most recent DHS data). Higher mortality is related to a far lower percentage of births taking place in a facility or with skilled birth attendance. Factors contributing to higher maternal mortality in PNG include lower availability of functioning health services, higher average transport and user-fee costs of access, and poorly-functioning referral pathways between community-based health care and secondary or tertiary facilities for women in need of emergency obstetric care.

Given access-related and other challenges, maternal mortality rates in Solomon Islands and Vanuatu reflect comparatively good performance by service delivery systems, relative to countries at similar stages of socioeconomic development.¹¹

	PNG		Solomon Islands		Vanuatu	
% of births with skilled birth attendance (MDG)	—	41 (1997–2005)	—	85 (1997–2005)	—	79 (2007)
Maternal mortality ratio per 100,000 live births (MDG)	370 (...)	733 (...)	140 (2000–06)	118 (2006–07)	130 (2000)	68 (2000–06)

Note: (...) = indeterminate reference period.

¹¹ Solomon Islands is a low-income country, Vanuatu is a lower-middle income, but their maternal mortality rate is closer to the upper middle income country average of 91 per 100 000; the average maternal mortality rate in lower middle income countries is 180 per 100 000 (*Maternal Mortality in 2005*—WHO 2007).

Malaria incidence in Solomon Islands and Vanuatu is the highest in the world outside Africa. Malaria surveillance data in PNG are not considered reliable, but transmission is also reported to be high and steady.¹² Nevertheless, with Global Fund assistance, all three countries are making progress with distribution of long-lasting insecticide treated bed nets and early case detection and treatment, with malaria incidence falling fastest—as expected—in areas that have achieved good bed net coverage.

	PNG		Solomon Islands		Vanuatu	
Annual incidence of malaria per 1000 population	245 (2003)	243 ^a (2007)	200 (2003)	128 (2007)	74 (2003)	23 (2007)

Note a: Range 101.3–409.5.

The **HIV** epidemic is generalised in PNG—estimated overall prevalence was 1.6 per cent among 15 to 49 year olds in 2007. Unprotected intercourse with multiple partners is the main mode of transmission. Infection is increasing most rapidly among young women and also in rural areas. Current forecasts are for prevalence to reach 5.7 per cent by 2012, representing almost 200 000 people living with HIV in PNG. While Solomon Islands and Vanuatu have reported a cumulative total of only 11 and 5 cases of HIV infection, respectively, both countries have a high and increasing incidence of chlamydia and other sexually transmissible infections, which represent an important risk factor for acquiring HIV.

The **tuberculosis** (TB) incidence rate in PNG is estimated to be 250 cases per 100 000—one of the highest in the region, and only moderately associated with the HIV epidemic (HIV prevalence among adults with TB is four per cent). Multi-drug resistant TB has been reported.

Non-communicable diseases are on the verge of rapidly escalating in Vanuatu and Solomon Islands. Diabetic vascular disease is already the most common reason for surgical ward admission in provincial hospitals in Vanuatu, and one of the most common in Honiara.

Health systems performance: overall assessment

Higher spending has enabled Vanuatu and Solomon Islands to provide reasonably effective health services at an affordable cost and close to where the majority of the population lives. These countries generally succeed in staffing health facilities and keeping them supplied with drugs and consumables. The high level of spending enables them to do this despite serious inequalities in the way resources are allocated, with too great a concentration on the capital cities, and high spending on hospital-based services. There are concerns to be addressed, particularly poor immunisation

¹² WHO, *World Malaria Report*, 2008.

coverage and insufficient training of nurses in Vanuatu, and relatively low levels of outreach in Solomon Islands with the likely consequence of inadequate service for remote communities. The imminent decline of the logging industry means that Solomon Islands will face difficult choices on how to prioritise health spending given diminishing resources and increasing demand for tertiary care.

Although pockets of the population in all three countries are not being served, the problem in PNG is of a different order of magnitude, with lack of resources and of staff having forced the closure of many aid posts, and with a significantly higher proportion of the population beyond the effective reach of health services. However, the performance of the health system in PNG needs to be assessed in the context of lower and declining real per capita spending, and a far more difficult set of service delivery challenges. With the highest delivery costs for services, and the lowest per capita budget with which to deliver them, it is not surprising that PNG achieves significantly poorer results. A recurring problem of drug stock-outs has also been a major factor limiting service utilisation, and should have been addressed far earlier, although action is finally being taken. Some useful foundations for progress seem to have been put in place, with improvements in management structures and in the allocation of grants for provincial health services. These and others issues are discussed further in the next chapter.



CHAPTER 4: AUSAID SUPPORT TO HEALTH SERVICE DELIVERY

This chapter considers two basic questions:

- > How effective was AusAID's contribution to improving health service delivery for the poor?
- > Was the way AusAID provided assistance appropriate in the light of the challenges faced?

Effectiveness of AusAID contribution to health service delivery

Over the period reviewed, Australian support in all three countries shared the same, principal objective: namely to improve, on a sustainable basis, health services delivered to the poor. The team assessed effectiveness in terms of AusAID's contribution to:

1. developing policy;
2. getting adequate resources to where they are needed; and
3. increasing the capacity of health systems to use resources effectively to achieve the priority objectives.

1. Health sector policy development

AusAID support to policy development has been successful where government owns and leads the process. A supportive policy framework has long been understood to be essential for the success of all types of aid, and AusAID has supported partner governments in developing health policy and plans in all three countries. However, developing and implementing sound policies is especially difficult in the challenging environments of the countries studied.

Some success was achieved where government exercised leadership and oversight. In the 2002–05 period, for example, the development of the PNG national health plan, and subsequently the medium-term expenditure framework, appear to have coincided with a period of relatively effective leadership in the health sector, and there was at that time a degree of ownership and commitment to implementation of the plans produced. In a reversal characteristic of fragile environments, commitment then weakened. The subsequent development and approval of the proposals by the National Economic and Fiscal Commission for equalisation grants—designed to enable all PNG provinces to deliver equivalent services—was similarly built on strong national leadership of the organisation, supported by good quality Australian technical assistance (Box 4.1).

BOX 4.1: NATIONAL ECONOMIC AND FISCAL COMMISSION, PNG

In PNG, AusAID has provided long-term technical assistance to the National Economic and Fiscal Commission. The Commission has quantified the severe inequalities between provinces due to big differences in the cost of delivering equivalent services and big inequalities in the revenues available to provinces. Government has recently passed legislation that will focus the growth of conditional health grants on the most disadvantaged provinces. The aim is to eventually reach a situation where each province can finance at least basic health services for all.

However, attempts to drive policy reform in the absence of leadership commitment have been less successful. AusAID’s efforts to promote a SWAP to engagement in the health sector stalled in Vanuatu in 2005 and struggled initially in Solomon Islands—in both cases because of a lack of government ownership. The independent monitoring review group in PNG has visited twice yearly since November 2006 and produced long reports, but these reviews did not achieve sufficient government ownership of their analysis, and few of the many recommendations have been implemented.

In all three countries, AusAID is now trying to make progress in a consultative way. In PNG, for example, the National Department is working with donor partners to develop joint policy responses to issues of particular difficulty, using a recently established high level steering group and associated working groups. In the other two countries, centrally placed policy advisers are working with senior management in the health ministries to develop policy frameworks and programs.

Poverty and gender inequality have received little attention in sector policy. There is a lack of data to analyse the extent or causes of unequal access to services in all three countries. Performance indicators are not disaggregated by sex or by any other socio-economic characteristic, meaning that the extent of inequality and the success of any responses to address it cannot be monitored.¹³ In all three countries, better information is needed on the size and location of populations not currently well served, to inform policies and approaches to address the issue.

In PNG, the principal challenges of reaching poorer populations—especially those residing in remote highland and island districts—relate to costs and logistic difficulties on the supply side, and high out-of-pocket costs on the demand side (especially the cost of transport for reaching a facility). Other factors are also important and need locally adapted solutions: tensions between rival communities; cultural attitudes to health services; gender discrimination; and the need to find innovative ways to deliver health interventions in places where trained staff may be unwilling to live. Overcoming these barriers requires local level planning and locally appropriate solutions.

¹³ Lack of sex disaggregation in national performance frameworks is not unusual, e.g., indicators sets used in Ghana, Bangladesh and Nepal all lack sex disaggregation. It is important to ensure that disaggregated data are collected to permit periodic review of inequality issues. Ghana collects some sex-disaggregated data, reported in some sources; Nepal is piloting data disaggregation by sex and socioeconomic characteristics.



Cost and access barriers are generally lower in Solomon Islands and Vanuatu than in PNG, but still, both countries have isolated pockets of population that may be eight hours or more from a health facility, and receive only infrequent visits by a health worker. Reaching those with poorer access requires increased resources for primary and preventive care outreach.

Australia has taken some steps to encourage government to address poverty and gender-based inequalities in access to health services. In PNG and Solomon Islands, AusAID highlighted the need to improve the distribution of spending in favour of remote provinces with higher costs and a bigger concentration of poor and disadvantaged communities. In Solomon Islands, AusAID used a formula with poverty weighting to allocate provincial grants during the tensions, but the formula fell into disuse when the Government assumed responsibility for the grants, and there remains some evidence of increased inequality in the distribution of funding. In PNG, with no growth in real per capita spending during most of the period studied, resources were lacking to address barriers to access. There are prospects for a more pro-poor distribution of spending in the future (Box 4.1) although demand side barriers will remain, in particular for women in cases where facilities impose high charges on those seeking care following episodes of violence (including gender-based violence).

Projects to address inequality faced problems in sustaining their benefits. In all three countries, provincial level technical assistance projects helped develop local level service planning and brought with them resources to support outreach activities to remoter communities. But in general when the projects finished, so did the resources that had facilitated outreach activities. In PNG, for example, the focus on gender constraints that featured quite strongly in the Women's and Children's Health Project, had begun to address the issue of violence against women through education and training materials and case management guidelines. However, this was not sustained after the project closed.

2. Getting adequate resources to where they are needed

AusAID has provided important assistance to maintain financing (and performance) of front-line health services. In all three countries, AusAID recognised that sustainably improving services for the poor required an increased share of available funding to be spent at province level and below.

In PNG, the donor pooled fund—the means by which donors were to help finance increased operational spending by the provinces—was successfully used to leverage additional government resources for health spending. Access to the pooled fund was made conditional on provinces allocating at least six per cent of their own budgets to health services. After an initial dip in 2002 (a year of negative economic growth), both central and local governments responded positively and increased allocations to provincial health spending.

In Solomon Islands, direct AusAID support to provincial health grants during the tensions of 1999–2003 ensured that the collapse in government revenue was not accompanied by a collapse in health services. It covered some salaries as well as operating budgets, and was fundamental to keeping staff and basic management and institutional structures in place and functioning. There are many examples around the world during similar periods of instability of health facilities falling into disrepair and disuse, patients and staff deserting the system, and large-scale misappropriation of resources occurring. AusAID deserves a significant share of the credit for helping to ensure that this did not happen to a significant extent in Solomon Islands. Indeed, the rapid recovery in health services following the tensions would not have been possible without timely direct Australian assistance. AusAID withdrew from direct funding of provinces as soon as domestic revenues recovered and enabled the Government to resume responsibility for funding local health services.

But conservative financial management has limited AusAID’s capacity to support pro-poor policy advice with financial aid. A cautious approach to managing fiduciary risk has prevented AusAID from providing financial support to local health services on the required scale, in spite of helping to develop health plans and expenditure programs in PNG and Solomon Islands that recognised the need for increased spending at province level and below.

In PNG, the 2004–06 medium-term expenditure framework—produced with AusAID technical assistance—explicitly called for increased spending on operational budgets at province level and below. In practice, however, spending by AusAID and other pooled fund donors has fallen far short of planned levels in the provinces. Donor funding proved very difficult to utilise because of the demanding financial management procedures put in place to minimise fiduciary risks. The shortfall in aid meant that per capita spending in the provinces did not increase in real terms during 2001–06, making it difficult for the provinces to expand services. Instead of providing increased support for operating costs, AusAID spending continued to be dominated by technical assistance and investment in buildings and equipment, categories of spending that the framework said should be reduced.

In Solomon Islands, the 2008 program document for the SWAP envisages shifting resources to province level and below. But the document was produced by a consultant and there appears to be little government ownership of the objective, and still less of the proposed means for achieving it, including introduction of user fees in what has been a predominantly free system. AusAID finances more than 30 per cent of government health spending but is not at present financing the provinces because of concerns about fiduciary risk. It is thus poorly placed to advocate higher government spending in the provinces when it is unable to ‘put its money where its mouth is’. In both PNG and Solomon Islands, progress towards a more pro-poor allocation of health spending could be accelerated if donor trust account funding were made easier for provinces to access, and allocated in favour of provinces with the largest gaps between available resources and the cost of financing at least basic services for all.



These problems of low disbursement are not unique to AusAID supported trust accounts. In Bangladesh and Nepal, pooled funds based on World Bank procedures have also faced severe disbursement difficulties, and Overseas Development Institute (ODI) research suggests that pooled fund arrangements using parallel procedures are characterised by a range of serious problems.¹⁴ Although these problems are common, they nevertheless have to be solved if Australian aid is to be fully effective in addressing poverty in a sustainable way. Funds disbursed using government procedures generally achieve higher disbursement rates, as has been the case with government budget funding in the three countries.

Partner government financial management systems also need reform. In Vanuatu, provincial health managers often receive funds far short of the amounts expected, reflecting inefficiencies in the way government budgets are managed and delegated. The process for approving even small amounts of money is highly centralised, problems in acquitting funds lead to delayed releases, and resources are frequently reallocated within the MOH. In PNG and Solomon Islands, government public expenditure management at national and local level is being strengthened with AusAID technical assistance.

Drugs and medical supplies: enormous challenges and limited progress. Effective front-line health services also depend on sufficient supplies of drugs and medical supplies reaching the facilities. AusAID has rightly supported this critical function in all three countries but has made limited progress addressing the underlying challenges affecting procurement and distribution systems.

PNG has faced long-running problems in the procurement and distribution of drugs, with stock-outs of several months' duration, including of many essential items needed for delivering adequate primary and preventive care. Many problems stemmed from inefficiency and corruption in the NDOH, compounded by an institutionally complex delivery system. AusAID attempted to help government reform and strengthen the drug procurement and distribution system with project support (technical advisers and investment in stores and management systems). With the benefit of hindsight, this support was largely irrelevant. Progress in overcoming the complex web of constraints on effective procurement and distribution proved impossible without the PNG Government first tackling the heart of the problem—corruption.

At the same time as this reform effort, AusAID used a parallel system to maintain at least minimally adequate drug supplies in PNG, by supplying drug kits. However, this only met part of the need, and stopped in 2007 when the NDOH indicated it was prepared to resume responsibility. A recurrence of serious drug stock-outs occurred,

¹⁴ Zainab Kizilbash Agha and Tim Williamson (2008), ODI briefing paper 36, 'Common funds for sector support, building blocks or stumbling blocks?' For Bangladesh, see Bangladesh Health, Nutrition and Population Sector Program, Mid Term Review, Main Consolidated Report, Key Findings, Conclusions and Recommendations, 31 March 2008. For Nepal, see Review of Nepal Health Sector Program: A Background Document For The Mid-Term Review, Mick Foster, John Quinley, Raghav Regmi and Binjwala Shrestha, Final Report, November 2007.

however, when the Department failed to procure on time. The team does not know if more could have been done to support a smooth transfer of responsibility, but the risk of significant loss of life might have argued for a cautious approach, particularly as it was known that no progress had been achieved in the overall reform of the Medical Supply Branch. Very recently, the Department has begun to tackle corruption and engage seriously with donor partners to address the problems in a comprehensive way.

In Solomon Islands and Vanuatu, Australian support by-passed government systems. In Solomon Islands, AusAID is responsible for supplying most drugs through the SWAP trust account, while the JICA has procured a significant proportion of the drugs in Vanuatu. There are weaknesses in drug supply and management systems, but both countries have had more success in getting drugs and supplies to the point of service delivery, with stock-outs generally of shorter duration than in PNG and more amenable to back-up arrangements with neighbouring facilities. However, both countries depend on financial and technical assistance for maintaining drug supplies, with no early exit in sight.

Support to overcome health workforce constraints has had mixed success. Health workforce shortages in PNG, Solomon Islands and Vanuatu are largely the result of insufficient training needed to replace each country's ageing nursing and primary care workforce.¹⁵ Weak coordination between central agencies and among donors has meant the problem has fallen through the cracks. AusAID provided support to improve workforce planning but this effort was not matched by consistent support for the nurse training institutions which provide basic (pre-service) training.

Medical training is a mixed picture. Solomon Islands and Vanuatu are too small to sustain a medical school and rely on training provided at the University of PNG Medical School and the Fiji School of Medicine (and more recently in Cuba). Vanuatu remains dependent on aid-funded expatriate clinical and pharmacy specialists. PNG is able to train enough doctors for its own needs, including surgical and paediatric specialists (although obstetrics and gynaecology, anaesthesia and rural medicine remain areas of need); this is a significant success achieved with AusAID assistance. Consistent AusAID support to the PNG and Fiji schools of medicine has produced sustainable improvements and both schools are now moving onto core funding arrangements.

In all three countries, an excessive share of the health workforce is located in the capital. In Solomon Islands, 58 per cent of the medical work force is concentrated in Honiara's National Referral Hospital. Attracting staff to work in remote locations is a major problem, especially in PNG many facilities are closed for lack of staff. Addressing this requires national attention to boosting training and improving incentives (including provision and maintenance of staff housing), plus locally specific solutions to bring services closer to the population. Solomon Islands also have limitations around

¹⁵ Nursing retirements in Vanuatu outstrip training by a ratio of more than 2:1.



facility maintenance and staff housing, although the situation is not as critical as in PNG. In Vanuatu there are few doctors outside Port Vila.

3. Increasing the capacity of health systems to deliver services

In addition to supporting service delivery, much of Australian support over the period studied went to increase the effectiveness and efficiency of the health systems themselves. Technical assistance was the main means of achieving this objective, but AusAID also funded investments in health systems infrastructure and equipment to enhance capacity. **While there have been some successes, the results achieved in terms of increased capacity of the health systems studied have not been commensurate with the costs.**

On infrastructure, AusAID contributed to a number of positive developments. In all three countries, AusAID invested in the development of high frequency (HF) radio networks, linking health facilities with each other and with provincial health offices. In PNG, the HF network is robust, mature, largely maintained and an important tool used for communication on both clinical matters and for supervision and administrative support. In Solomon Islands, the radio network is also highly valued but has yet to achieve its potential, being used mainly for emergency clinical and supply problems.

The team also found examples where providing technical assistance succeeded in building capacity. In Vanuatu, AusAID funding of an international NGO to provide training and oversight of village health workers has made an important contribution to service delivery for the poor. It is able to do so because high government spending, supplemented by affordable community and user contributions, has ensured reasonable availability of necessary complementary inputs.¹⁶ The recent transition of Vanuatu's Village Health Worker Program to MOH management is seen as a positive step towards increasing ownership and reducing parallel accountability. Sustaining these benefits, however, will require the Ministry to address problems around the predictability and transparency of funding for provincial health services.

In Solomon Islands, practical improvements to operational planning and management of provincial health services are still evident in places, while practices such as more effective bed management and infection control in provincial hospitals are still being applied. However, these gains are fragile and by no means across the board. An earlier review in 2007,¹⁷ for example, noted that around 50 per cent of health clinics could not provide adequate sterilisation. In the absence of appropriate, ongoing training for senior staff, the gains in provincial health service management will be eroded by staff turnover.

¹⁶ The approach to cost recovery does not seem to have excluded the poor, mainly because of strong systems of mutual support within communities. However, there may be problems in remote and disadvantaged communities where it is costly to supply and supervise the aid post, and where cash income is hard to obtain.

¹⁷ MOH Institutional Strengthening Project (HISP): Independent Completion Report, June 2007.

The more general experience, however, has been of efforts to build capability that have struggled to leave lasting impact. A number of factors have contributed to this.

Too much time and effort was devoted to organisational reforms and planning in the central ministry that did not address deeper institutional problems and had little impact on service delivery. This in part reflected the preferences of the governments in all three countries.¹⁸ In Solomon Islands and Vanuatu, stakeholders in the ministries of health argue that both health sector management systems and capacity need to be strengthened before greater authority over service delivery can be delegated to provinces. In PNG, the problem is more that the NDOH struggles to exercise authority over provincial health services. No doubt, elements of the reorganisations and corporate planning exercises have been useful, but insufficient attention has been paid to the institutions and incentives required for implementation at the operational level—be it province or district and subdistrict. This contrasts with the bottom-up approach successfully taken in other countries, for example, Ghana, where health sector reform started with strengthening health management at district level and regional (provincial) level, which, in turn, formed the basis for reforms at the centre.

Insufficient analysis of the nature of the capacity problem and the scope for addressing it. Many of the problems limiting the effectiveness of health sector organisations relate to the policy and institutional environment within which they operate (including constraints that lie outside the health sector) and are rooted in the complex cultural, political and institutional environments of the three countries. A significant proportion of AusAID support for capacity building in each country has focused on trying to improve operations within the confines of existing policies and institutions, without explicit analysis or policy discussions on alternatives.

Although governments decide on policies and institutional arrangements, AusAID can legitimately encourage reforms to benefit the poor, and is indeed responsible for negotiating the aid it will provide based on an informed assessment of where it can be effective in the prevailing environment, and where it can achieve little without more fundamental reform. The team's impression is that this approach to developing and appraising aid proposals was not generally applied to technical assistance. In Solomon Islands, for example, significant levels of technical assistance to the National Referral Hospital could not address fundamental issues of affordability and sustainability in the absence of government policies on how best to control the ever-increasing demand for more expensive forms of tertiary care. The current policy adviser has started to engage the Ministry in discussions of priorities in the context of a more transparent health sector budget.

¹⁸ Vanuatu's MOH has reorganised three times during the last decade.



Where government leads policy change, technical assistance can be highly effective. The most prominent example is in PNG where, with AusAID support, recent legislation has the potential to improve the allocation of health budgets and re-establish the NDOH's influence in the provinces and districts. Although early days, this represents a real opportunity for the NDOH and development partners to work together to strengthen local health services. The painstaking processes behind these changes demonstrate what is possible, though they also emphasise the need for time, opportunity and skilful government leadership to find politically feasible solutions.

Technical assistance and capital investment are not substitutes for operating budgets; inadequate operating resources limit capacity building. Higher levels of per capita spending in Solomon Islands and Vanuatu have enabled technical assistance for improved health service planning and delivery to be more effective. In PNG, the ability of the system to make productive use of AusAID's substantial technical assistance and investment has been constrained by inadequate operating budgets. In PNG, AusAID activities that did not transfer real resources for operating costs or staff were somewhat irrelevant and unable to achieve sustainable benefit. Vertical programs in areas such as immunisation were able to achieve brief spurts of improved progress, but they were not sustained. The Women's and Children's Health Project supported a comprehensive approach to training down to front-line aid posts, long enough for practices to be institutionalised. But the Independent Completion Report found little evidence of any impact on service delivery; lack of sufficient drugs, staff and operating budgets were the binding constraints.

Getting money and drugs to front-line service providers does not solve the institutional and incentives problems of how to improve service delivery, but adequate resources provide an environment in which other forms of action stand a better chance of success. In PNG, the impact of technical assistance could have been greater if efforts to improve the planning, budgeting, management and supervision of services had been accompanied by resources to finance increased output.

Parallel systems are not effective means of building local capacity. The pooled fund in PNG is a case in point. It has its own secretariat and has staff across the health sector involved in accounting functions that, in the government system, would be undertaken instead by provincial and district treasury staff. It does not build any capacity, achieving modest risk reduction with regard to Australian funds at the expense of diverting attention from the much larger sums going through the government system and although it will support operating expenses it is unlikely to leave anything durable behind.

This experience is not limited to the AusAID country programs. Australian support for the health sector aspects of the response to HIV, for example, has largely been channelled through other institutions (e.g., the Global Fund and the Clinton Foundation). Although the United Nations (UN) estimates that 38 per cent of those



eligible in PNG are now receiving antiretroviral therapy, distribution is by way of parallel mechanisms and the systems of care and support through which they are delivered often sit outside the main health care settings. Support to the HIV response has contributed to further fragmentation in the health sector, with little evidence of strengthening broader health service delivery systems.

AusAID's approach to providing support to health service delivery

This section of the report considers how appropriate AusAID's approach was based on experience in each country studied, in three specific areas:

1. how AusAID adapted to new ways of working associated with the move towards more program-based approaches;
2. how AusAID provided its development assistance; and
3. how much AusAID's approach was informed by learning as implementation progressed.

1. How AusAID adapted to new ways of working

After initial difficulties, AusAID has begun to adopt a more inclusive approach to program approaches. AusAID has been right in attempting to adopt program-based approaches to tackle the challenges of health service delivery. But it has had difficulty implementing the necessary changes to ways of working and managing expectations about the pace of progress possible.

The development of both the PNG and Solomon Islands health SWAPs followed a traditional, project-style approach, with an AusAID-led design and appraisal process. Initial support for the design of the SWAP in PNG used a team dominated by Australian staff, with only one representative from the NDOH (no other development partners were involved). The NDOH rejected initial proposals because they did not support the Government's ambition to manage external donor support, nor address concerns relating to support for delivery of services in rural areas. What was finally offered and accepted was a package comprising the pooled fund trust account based on separate accountability systems and the Capacity Building Service Centre, a purely bilateral project. An earlier review¹⁹ commented that there was little sign of movement away from a donor-driven approach based on project thinking.

More recently, AusAID has begun to use a more inclusive process with government to work up proposals in Vanuatu and Solomon Islands, and to work closely with government and development partners in PNG (through a steering committee). The team believe this will lead to be better results than a project-based approach, driven by donors. However, it needs to be recognised that apparent progress in reaching

¹⁹ AusAID, 2006, Health Services Support Program: Independent Completion Report, May.



policy understandings and building capacity to implement them is fragile and subject to reversal. In these difficult environments, experience demonstrates that programs require continual reaffirmation, explanation, review and adaptation in light of events.

A fragmented approach in practice has reduced the focus on strategic priorities, such as poverty. In spite of recognising the importance of a more coherent, integrated program of assistance, Australian aid to the health sector over the period in practice remained rather fragmented and lacked a clear overall strategy. In the PNG and Vanuatu health sectors, AusAID simultaneously supported 10 or more separate aid activities and projects for most of the period. This understates the actual spread, because many of the larger programs have had a number of loosely related components within them. Similarly, AusAID has supported capital investment in the health sector by way of a number of different initiatives which have sat outside of a national plan, creating an ad hoc approach that has at times resulted in problems.

In part, this reflects the dominance of Australia as the largest donor, and therefore inevitably the ‘donor of last resort’ to whom countries will go for necessary support that may be unattractive to others. It is entirely reasonable for Australia to play this role, provided that the activities form part of an overall health sector plan. But even in situations where government has developed a reasonable plan for the sector, often with AusAID technical support, AusAID has not limited bilateral support to filling financing gaps within it. Instead it has supported proposals reflecting supply-led pressures on AusAID to address current policy concerns, to continue support for long-running programs such as supply of clinicians and visiting surgical teams, and to respond to calls for regional initiatives. Many of the less poverty-relevant activities that have been supported are outside the planning and budget framework adopted by government.

Regional programs have played a prominent role in Vanuatu and to a lesser extent in Solomon Islands. While these offer economies of scale in small country settings where some interventions might be otherwise unaffordable, a clear match with national priorities is essential. Despite efforts to ensure regional programs fit with national health strategies and respond to requests from regional groups like the Pacific Health Ministers’ meeting, it appears that a number of regional projects have contributed to fragmentation—not least because they have to accommodate the priorities of a number of different countries and a number of different stakeholders.

All three countries have some arrangement for government and health sector donors to meet, but none of them have an effective forum for policy dialogue. A key feature of SWAPs is that government and development partners discuss policy and performance in the sector. For government, the SWAP provides an opportunity for an effective Ministry to persuade donors to increase their support for the government health plan. For donors, agreeing to confine support to government programs provides a voice in the design of the policy and strategy, and participation in joint reviews of performance. In PNG, the annual health conference and twice yearly donor meeting proved too

infrequent and too unwieldy to be effective forums for meaningful discussion.

Operations and finance committees met more regularly, but were chaired at too low a level and did not address major policy concerns. In response, a high-level steering committee chaired by the health secretary was recently established, with a limited agenda focusing on four areas of major policy concern, and supported by working groups tasked with generating proposals for consideration by the steering committee.

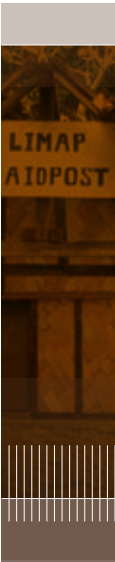
It is difficult to assess whether more use of high-level dialogue to influence health policy and planning would have yielded better results. The team found few examples of overt Australian efforts to engage government in discussions of health policy issues (which is not to say that this did not occur in earlier years). It is unclear, for example, whether more might have been done to press for vigorous action on drug procurement and distribution in PNG. Where issues are central to health sector performance, as in this case, the team’s judgement is that it would have been worth using every available avenue to persuade government, including by working in concert with other donors.

AusAID’s engagement with non-state actors has been relatively narrow in scope. These actors play important roles in the health sector, covering health service provision, health promotion, and support for civil society voice and accountability, but their significance varies considerably between the three countries studied. With the notable exception of the churches in PNG, relatively few non-government actors are engaged in the routine delivery of health services. A large number of NGOs are active in health promotion and home care, with particular emphasis on HIV, in part due to the availability of significant external funding. A wide variety of civil society organisations, not usually specific to health, are active in supporting civil society in exercising voice. AusAID’s support to the health sector has had limited engagement with non-state actors. The exception to this has been long-running assistance for the work of Save the Children Australia (SCA) in Vanuatu, which provides support to village health workers and building government capacity, more recently under contract to the MOH. In all three countries, there is scope to strengthen the relationship between government and non-state actors and government capacity to provide policy guidance and oversight (Box 4.2).

BOX 4.2: WORKING WITH NON-STATE HEALTH SERVICE PROVIDERS

In many post-conflict countries, international and national NGOs deliver the majority of health services, often under specific performance-linked contracts with government or with donor agencies. This is not the case in the study countries—the Government in each is likely to remain the lead provider of services, though there may be scope for more use of public private partnerships.

The situation of faith-based organisations—the churches—in PNG is quite different. Church health services are an integral part of that country’s national health system. They are already highly subsidised by the PNG Government and a related legal act is under development. However, the partnership could be further developed by building mutual accountability between the NDOH and the Churches Medical Council based on agreed, shared key outcomes and indicators in return for predictable funding and support. Support is needed to strengthen the Churches’ Medical Secretariat so it can monitor the performance of its members, ensure quality of care and negotiate contracts with Government and different church partners.



There is also a strong case for donors to use their influence to open up policy space for government to discuss with civil society organisations that can play a constructive role in policy advocacy and strengthening accountability, as means to build ownership that can survive changes in government. A particular role, for example, would be to stimulate more rigorous debate on the poverty and gender focus of the health system. There is also potential value in regular consultation forums where government and non-government service providers can exchange experiences.

2. The way AusAID provided its development assistance

As the largest health donor in all three countries, there have been a number of problems in the way AusAID has managed its health funding. Governments in all three countries cannot determine what health services they can afford to provide in the long term without knowing the future profile of Australian support. In Solomon Islands, for example, the imminent demise of commercial logging means a severe and probably prolonged contraction in government revenues. If health aid from Australia continues at current levels, then government may need to plan for a contraction in health spending, whereas, a doubling of aid sustained for the next decade would give some modest scope for expansion.

Given the importance of Australian aid, there is scope to improve how it is managed.

- > AusAID has not routinely communicated future financing intentions to government, and there have been problems in the completeness and the timeliness of the reporting on actual expenditure that AusAID provides to government.
- > AusAID has given insufficient priority to ensuring that committed funds get spent on time. Failure to spend at intended levels in PNG, for example, should have prompted more vigorous action to review what more could have been done to ease disbursement.
- > All three countries have experienced some abrupt discontinuities in support for important programs. For example, funding for Solomon Islands fell by 30 per cent in 2007–08 due to the delayed start of the SWAP. The gap between the end of AusAID support to the vector-borne diseases project in Vanuatu and the start of Global Fund assistance was associated with a doubling of malaria incidence.

A cautious approach to managing fiduciary risk has prevented AusAID from providing financial support to local health services on the required scale. AusAID has a responsibility to ensure Australian taxpayers' money is not misused but risks vary, depending on the system being considered. With rural health services, for example, experience suggests the main risks are weak accounting and relatively minor fiddling of expenses; there are significantly fewer opportunities for large-scale corruption with these services compared with major national procurement contracts.

AusAID's ability to provide a 'relevant' response to the health issues it helped identify has been constrained in PNG and Solomon Islands by the Agency's approach to fiduciary risk management. This approach has prevented AusAID from providing flexible financial support to precisely those parts of the system identified as deserving the highest priority. In Solomon Islands, the decision to withdraw from provincial-level funding has limited AusAID's leverage in encouraging greater government health funding for provinces. In PNG, the controls placed on the pooled fund for provinces and below have been so onerous that a significant proportion of the available funds have not been spent. Alternative approaches to risk management could have made the funds more accessible for legitimate health services (Box 5.2), without necessarily increasing fiduciary risk. Instead, the accounting requirements attached to the pooled fund in PNG had the effect of rewarding spending in national and provincial headquarters, where it can be most easily accounted for.

AusAID has relied heavily on technical assistance, which in turn has not been sufficiently diverse or integrated. Technical advisers (international and local) account for a significant proportion of the assistance provided. Individual advisers have worked with one or more counterparts to transfer their skills. There is a great deal of international literature and research that points out the limitations and low success rate of the counter-parting model. There are some examples of positive impacts being achieved, but the approach is expensive, and has a high risk that the adviser will not be an effective trainer, the counterparts will not be willing or able to learn, or will not stay in the job. Even more important, the model assumes that performance is limited by human skills, when the real challenges may relate to deeper problems of institutional and personal incentives. The management of these advisers has also emphasised results against quantitative monitoring frameworks, which in turn has encouraged a natural tendency to do rather than provide advice that may not be acted on.

Technical assistance has also largely been implemented through parallel approaches, usually through an Australian Managing Contractor. In the case of PNG's Capacity Building Service Centre, the project has had its own board and management structure and its own annual planning process, completely separate from the annual planning and budgeting process for the rest of the health sector. This has institutionalised ineffective integration between the assistance and the overall strategy for sector development, despite the best efforts of those involved, and has created a supply-driven approach, with the Government poorly placed to discuss alternative ways of spending available funds.

The leading role of the Australian Managing Contractor has itself carried the risk of a lack of diversity in approach. Again, the Capacity Building Service Centre is a case in point, with its largely supplied Australian and national technical advisers. There is little evidence of a coherent approach to identifying capacity building needs and opportunities and to managing the provision of an appropriate mix of interventions to address them.



Some of the more successful technical assistance the team observed involved introducing new ways of doing business, often at local level (for example, local service planning processes introduced with adviser support and still in use). Sufficient ownership can have lasting benefit, maybe not evenly across the country, but in areas where local leadership is responsive. It needs support for long enough to be institutionalised. In Solomon Islands, an approach based on individual advisers who stayed for only one year on average contributed to a number of initiatives that were started but not brought to a conclusion (e.g., manuals produced but never printed, disseminated or supported).

In all three countries, AusAID has rightly provided support explicitly to augment national capacity, but there may be more cost-effective ways to achieve this. A final observation of the team in this regard relates to the direct provision of capacity, which has featured to some extent in all three countries (for example, supplying medical specialists to Port Vila’s referral hospital). Some of these programs are long standing, with the justification for the relatively high-costs resting partly on the role of foreign staff in mentoring those who may eventually succeed them. This is an entirely legitimate role for external aid to play, but if shortages of specialists are likely to be a long-term problem, there may be more cost-effective approaches than relying on secondment of expensive Australian staff (e.g., paying higher allowances to retain nationals in post, recruiting actively in markets with lower salaries than Australia, or exploring ways to contract out specialist functions). There is certainly a case for a more transparent discussion of alternative ways of using budgets.

3. Learning from successes

Australian assistance has on occasions missed opportunities to lock in earlier achievements when developing new activities. The team came across examples in all three countries where achievements or promising approaches were inadequately followed up in the next phase of support. These include work on gender issues under the Women’s and Children’s Health Project, support to build capacity in equipment maintenance under the Medical Equipment Maintenance Project, the wireless system in Vanuatu, and examples of short-term advisers starting initiatives that successors did not carry forward. This is not an argument for allowing activities to run on indefinitely, but simply for the need to review a project’s exit strategy before it is closed. The management of successive phases of support to the Village Health Worker Program in Vanuatu provides a positive example of building on earlier achievements—with extensions granted on several occasions to ensure there were no gaps between phases, and a transition towards increased government involvement and ownership to build sustainability.

Cross-program learning has not featured strongly in AusAID’s approach. AusAID’s country programs in PNG and Solomon Islands included important programs working with churches, civil society organisations and communities during the

review period. The team found little evidence of cross-sector collaboration or lesson-learning across programs. Similarly, a number of churches in PNG are working with assistance from Australian NGOs, funded through the AusAID supported Church Partnership Program, to develop materials and resources to support the management and governance of rural health facilities. The products generated by these partnerships could be of equal value to government-run facilities, although linkages have not yet been developed.

The team also found little evidence of learning from locally adapted, country-led solutions. The team encountered examples where local communities have supported health facilities and individuals facing health emergencies, and of community-driven approaches to resolving local conflicts motivated by the need to access shared health and other facilities. There are also good local initiatives in government. In PNG, for example, the introduction of a star-rating system for hospitals has been a positive innovation. Policies and plans are only likely to succeed if they account for how things actually work, and are compatible with the incentives acting on those required to implement them. The extreme cultural and linguistic diversity, and the importance of personal relationships in all three countries, illustrates the need to encourage, accommodate and learn from locally adapted, bottom-up solutions, particularly in PNG.



CHAPTER 5: RECOMMENDATIONS

To inform thinking about improved approaches for the future, the team offers the following recommendations:

1. AusAID's strategy for the health sector should be informed by deeper analysis of opportunities and constraints for improving service delivery.

This requires analysis of what is needed to improve service delivery for the poor and vulnerable, address gender constraints, and what is likely to be possible given the political economy. There will be some areas of sector policy that Australia will have difficulty with, some areas of implementation where government systems work imperfectly, and some areas of policy or institutional weakness where it is at present impossible to engage. In countries where AusAID wishes to support the health sector, it should use dialogue to ensure that policies support service delivery and that sensible allocation decisions are made across the sector as a whole. In this context, AusAID should determine:

- > the focus of policy dialogue, the forums for pursuing chosen issues, and the leverage or influence to be applied. Policy cannot be advanced ahead of government recognition that action is required, and the policy agenda needs to be prioritised to reflect implementation capacity. If progress is not being made on issues critical to sector performance, AusAID has the option of taking them up at a more senior level to break the deadlock, or using some form of conditionality. For issues that are important but less critical, it may be necessary to wait for a better reform opportunity, while supporting pro-reform measures such as policy analysis or civil society advocacy capacity; and
- > the scope to use Australian aid to increase the sustained impact on services for the poor. In principle, AusAID should aim to reach agreement on the health budget as a whole but if systems for allocating and expending resources do not work in the interests of the poor, there may be a case for earmarking Australian aid to address the imbalance. For example, earmarking aid to provincial and district level spending is an option worth considering in all three countries, supported by an understanding that Australian support would be additional to a baseline of existing shares or levels of spending.

AusAID should also ensure it monitors opportunities to engage in policy dialogue, and has the flexibility to recognise and respond to new opportunities provided by changes in leadership or by other developments.

2. AusAID’s strategy should recognise that government is the key to building sustainable health services for the poor in the three countries studied.

In all three countries it is possible and necessary to work within government policies and institutions. Non-government service delivery can be part of the long-term solution, but it will need funding following donor withdrawal. The most plausible source of funding is government—community, corporate or private contributions are only partial alternatives, especially if access to the most disadvantaged is an objective.

In some cases, important parts of the health system may be ineffective or mired in corruption, with little prospect of engaging government on reform. In these cases, negotiating alternatives such as parallel project-style programs and procedures insulated from those of government may be justified. Where this is the case, the team recommends the following principles be adopted.

- > Remain engaged with government on how financing of services for the disadvantaged can eventually be assumed by government, using their procedures, even where service delivery is by way of non-government routes.
- > Accept the responsibility to continue support until government is willing and able to take over. This is particularly important where AusAID has assumed a vital function, such as drug procurement and financing in Solomon Islands.
- > Be as government compatible as possible in the way funds are disbursed and managed. In particular, keep costs and supervision arrangements to levels that government can afford to adopt and scale up; and model procurement and financial procedures closely on those of government.

3. AusAID should continue its efforts to build a sector partnership with government and other development partners, working towards a full sector-wide approach.

Dialogue in all three countries has yet to reach the stage of focussing on how government and donor resources can be jointly programmed to support national health priorities. The portfolio of aid-supported activities continues to rely heavily on technical assistance and supports a range of specialist services and vertical disease-specific programs. With potentially unstable governments, commitment to a shared strategy, plan and budget may be shallow and temporary. The team suggests trying to promote broader dialogue inside and outside government to develop wider ownership of some key policies.

As part of developing an effective partnership, AusAID should work with government and other development partners to establish effective institutional arrangements for dialogue and review (Box 5.1).

As the leading donor, AusAID has an important role in maintaining a focus on a limited agenda of key issues, supporting progress where and when possible, including providing technical support for preparing and operationalising decisions as required.



There are limitations on AusAID's ability to apply conditionality in relationships with close neighbours, but there is scope to leverage increases in aid to promote the key reforms government has already prioritised. Effective engagement in policy dialogue by AusAID requires the deployment of senior and qualified staff at appropriate points.

BOX 5.1: INSTITUTIONAL ARRANGEMENTS FOR DIALOGUE AND REVIEW

- > an annual review of performance and discussion of priorities and resources for the coming budget (ideally at the start of the budget calendar);
- > a smaller discussion to review the budget and to confirm earlier funding indications (ideally on the eve of the financial year);
- > a senior committee, which meets more frequently, chaired at top official level by the ministry/department, and including donor representation—this committee would be responsible for keeping progress of key programs and reforms under review and prioritising the agenda;
- > regular sub-national reviews involving churches, civil society organisations and women's organisations to feed results and conclusions into the national review—in other countries this approach has been valuable in building ownership and understanding and peer-to-peer learning;
- > monitoring against a limited number of key performance indicators to support the annual review, verified by effective quality control and supplemented and validated by periodic surveys to collect population based data; and
- > gender disaggregation for at least some key performance indicators, supplemented by analysis on gender policy implications for the health system.

4. Partnership should be based on transparency with respect to planning and reporting on aid finance.

The team recommends that AusAID should:

- > Communicate to government its likely support to the health sector for as many years as possible at the start of the financial year and as far as possible in the format used by government. Reporting on actual expenditure should also be provided in the format and frequency requested by government.
- > Provide comprehensive data to government, including disclosure of technical assistance costs as a foundation for dialogue on alternatives.
- > Conduct an annual dialogue with government on allocation of AusAID support to the health sector, preferably in the context of broader discussions involving other donor partners. Uncommitted funds should be deployed to help fill financing gaps within the overall plan and budget agreed to with government. Where the budget has yet to become a reliable guide to actual spending patterns, AusAID resources may need to be earmarked, but they should be used for under-funded priority programs identified in the government budget. To ensure additionality, earmarking will normally need to be supported by an understanding of the level of government spending.

- > Ensure funds can be used to support desirable shifts in priorities, such as addressing the need for higher spending by provinces and districts.
- > Address financial management issues through dialogue and strengthening of systems.

5. AusAID should progress towards using government systems for financial management of aid flows.

Government systems should be the foundation for the design of AusAID support, with attention paid to strengthening systems over time, supporting those responsible for financial management, and including additional checks and assurances where essential to safeguard Australian funds.²⁰ Where parallel arrangements are put in place, the feasibility of making the transition to a more sustainable solution should be kept actively under review.

The fundamental risks of using the government system can be reduced by providing support for building systems and capacity, and for ensuring compliance with financial procedures, while applying reasonable controls that do not become a barrier to implementation (Box 5.2). Support for financial management within health needs to be coordinated with Ministry of Finance to ensure it is fully compatible with the overall government financial management system.

²⁰ For the latest assessment of international experience on aid management within government budgets, see *Putting Aid on Budget: A Synthesis Report* Moroko Ltd., April 2008, accessible at <http://www.africa-sbo.org/>



BOX 5.2: MANAGING FIDUCIARY RISK

Where development partners provide financial support using government procedures, common elements in the approach to managing fiduciary risk include:

- > a prior financial accountability assessment, with an action plan to address weaknesses, with regular reporting against agreed progress indicators, periodic systems and value-for-money audits;
- > an annual process for agreeing on the sector budget and work plan to be jointly supported, with progress monitored through regular (at least quarterly) physical and financial monitoring reports, prepared to agreed formats;
- > funds released based on statements of expenditure and bank reconciliations, supplemented by periodic checks of a sample of transactions to verify compliance and weighted to those posing the greatest risk
- > timely internal and external audit of systems and transactions, with close monitoring of follow-up of audit findings, including support for Parliament and civil society to strengthen external oversight;
- > supplement formal accounting with independent sample-based tracking studies, and support for transparency (public display of budgets and fees) and a community role in ensuring accountability (examples of these supplementary means to enforce accountability are at Annex C); and
- > press government to take effective action in cases of misappropriation.

To avoid reputational risks, AusAID can add additional safeguards to ensure there is no appearance of wrongdoing with aid funds. AusAID can, for example, acquit only expenditures for which accounting is in order. Where problems come to light through random checks or at audit, AusAID can either ask government to meet the cost from the budget while proposing other expenditures to AusAID, or insist that misused funds be repaid or reduced during the next tranche by the relevant amount.

6. Support to build health systems capacity should be fully integrated as part of a broader strategy and plan that addresses other factors critical for improving performance.

Capacity building efforts alone will rarely be sufficient to achieve change. To be effective these efforts need to be supported by a broader set of interventions, including supportive policies, adequate human and financial resources and supportive institutions and systems. AusAID should recognise explicitly the limitations of technical assistance and give more attention to identifying the necessary and sufficient conditions for capacity to be built. There is a need for deeper analysis of the policy, institutional, and incentive issues that affect organisational and individual performance, and to engage with government in dialogue on what needs to change for performance to improve.

The team recommends that technical assistance conform to the same disciplines as other aid forms—that is it should:

- > have clear and monitorable objectives agreed to with government;
- > be appraised against alternatives based on cost effectiveness of approach; and
- > be fully integrated and costed within a jointly supported health plan.

7. AusAID should ensure greater continuity and coherence between phases and types of support.

AusAID should apply explicit procedures to protect the benefits of project interventions by planning the exit strategy and approving extensions as necessary to secure sustainability. On a related but broader issue, successive major commitments need to be planned to avoid instability in the level of support, given the central role AusAID plays as the largest donor to the health sector.

While regional programs offer economies of scale in small country settings where some interventions might be otherwise unaffordable, a clear match with national priorities is essential. Where regional interventions are being considered on efficiency grounds or in response to requests from Pacific Health Ministers, careful attention must be paid to meshing their approach with national programs, to achieve well-balanced support and to safeguard coherent policies and strategies appropriate to the national context.

8. Further analysis of the factors influencing AusAID’s ability to provide a relevant response to the health challenges in the countries studied is warranted.

The team recognises that while many of the recommendations in this report are challenging, they are not out of line with aid practice elsewhere. Australia, for example, is a signatory to the Paris Declaration and recently reconfirmed its commitment to this reform agenda at the High Level Forum in Accra. Australia is also a signatory to the International Health Partnership which embodies the same principles for the health sector. However, the team recognises that translating high-level political commitment into action is not straightforward, especially where this entails for AusAID an apparent reduction in direct control and a greater need to manage uncertainty in the operating environment.

The team suggests conducting in-depth discussions with AusAID staff to help them develop a better understanding of the incentives and perceived constraints affecting choices about ways of working. Such an exercise would also help overcome unintended obstacles. Potential lines of enquiry include:

- > distinguishing between perceived external constraints,²¹ and internal factors more related to the culture and capacity in AusAID, which can be addressed through leadership and organisational development strategies;
- > identifying factors inhibiting the development of a more comprehensive and holistic accountability framework which positions fiduciary accountability in a broader context of performance; and
- > examining what more is needed to make poverty and gender analysis central to all aspects of the AusAID’s work.

²¹ See the evaluation of the implementation of the Paris Declaration, particularly the recommendations for donor authorities http://www.oecd.org/document/60/0,3343,en_21571361_34047972_38242748_1_1_1_1,00.html



In addition, the team suggests there is scope for AusAID to review and use practical techniques—proven to be effective elsewhere—to build support for new ways of working (for example, Box 5.3).

BOX 5.3: THE SPECIAL PROGRAM OF ASSISTANCE TO AFRICA: APPROACHES USED BY DONORS

- > Engaging national audit offices and senior procurement and disbursement staff in discussion of why it was important to use government systems and how their fiduciary concerns could be addressed. The experience in the United Kingdom’s Department for International Development (DFID) was that the audit offices in particular proved far less resistant than had been assumed, and DFID financial management staff were willing to find ways to reconcile their concerns with the objectives of the country program staff.
- > Involving senior financial management staff directly in missions that were responsible for reaching agreement on how funds would be managed. Involving staff at the level responsible for writing financial management guidance—this gave greater flexibility in discussions than was possible among more junior staff, who were understandably less comfortable about proposing innovations for which there was no precedent.
- > Jointly design missions with other donors—this approach, based on ‘safety in numbers’, helped encourage agencies to innovate. If judgements turned out to be wrong, agencies felt they would suffer less criticism if they could show that others had also thought the approach was worth trying.
- > Having senior managers publicly endorse a small number of high-profile examples of innovative approaches was sufficient to stimulate rapid replication across the DFID.

ANNEX A: TERMS OF REFERENCE— HEALTH SECTOR EVALUATION IMPROVING THE PROVISION OF BASIC SERVICES FOR THE POOR

I Background

- 1.1 The Office of Development Effectiveness (ODE) periodically undertakes evaluations of key aspects of the Australian aid program. Improving basic services for the poor was identified as a significant challenge for the aid program in the ODE's 2007 Annual Review of Development Effectiveness. During 2008–09, ODE will evaluate the performance of the Australian aid program in three key service sectors: health, education and water supply and sanitation. These terms of reference relate to the health sector evaluation.
- 1.2 As a proportion of its total aid program, Australia is more engaged in environments characterised by low capacity than any other donor. Internationally donors are questioning the effectiveness of traditional models of engagement in these settings (project-based, non-state, short-term, humanitarian-focused). But there is a tension between the longer term objective of building local capacity for sustainable improvement and the more immediate needs of the poor for enhanced service delivery. For example, a recent AusAID performance report for the health sector found that gains in strengthening policy and planning capabilities within local health systems had not yet influenced the delivery of services themselves. Similarly, there is tension in applying conventional models of delivery based on government as the primary agent, given that government capacity and/or willingness to provide services typically starts from a low base in these environments.
- 1.3 Improving the effectiveness of basic services is important for at least two reasons.
- > Globally, achievement of the Millennium Development Goals requires that development progress is made. Specific attention is required in health, education and water and sanitation provision, given these measures are lagging progress against the poverty indicator. Among many countries of most significance to the Australian aid program, performance has been mixed with key indicators of human development apparently stagnating or deteriorating in some cases.



- > Poor services may be both a symptom and a cause of country capacity constraints. For many of the poor, better governance equates directly with better services. Improvements in the quantity, quality and equity of basic services may, therefore, make a significant contribution to strengthening and reinforcing state capacity to meet people's needs.

1.4 In line with a number of other countries, the Australian Government has committed to increase significantly the volume of official development assistance it provides. Australian Official Development Assistance is set to more than double by 2015. But notwithstanding the need for increased support and improved performance, exactly how to scale up aid effectively in environments characterised by low government capacity also presents particular challenges.

2 Objectives

- 2.1 The purpose of the health sector evaluation is to inform understanding about how Australian aid can support sustainable improvement in the delivery of essential health services to the poor. It will do this by assessing the effectiveness of previous Australian support to health service delivery in selected countries and drawing lessons about what has worked and what has not, to identify improved approaches for the future.
- 2.2 The evaluation will generate insights into what aspects of Australia's current approach should be continued, and what Australia should be doing differently. In identifying these lessons, consideration should also be given to the scope for Australia to increase its support to health in these environments.

3 Scope

- 3.1 The evaluation will focus on three case study countries: Papua New Guinea, Solomon Islands and Vanuatu, with field visits to each of these countries. All or part of the evaluation team will also visit Fiji to meet key regional health organisations.
- 3.2 It will review all major Australian activities supporting the delivery of essential health services that have completed within the last five years and assess their contribution to health service performance in these countries. In light of the results, the evaluation will also consider the extent to which current and planned aid activities reflect adequately the lessons of previous Australian support and international experience.
- 3.3 For the purposes of study in the case study countries, the health system is defined broadly to encompass all stakeholders involved in the financing and delivery of essential health services. It includes private sector and not-for-profit organisations, in so far as they are relevant, as well as public sector health bodies.

3.4 The primary interest of the evaluation is to determine what has worked and what has not worked. While this will entail a focus on the areas of Australian support, the aim is not to attribute results to Australian funds in a narrow sense. It is recognised that in most cases Australia will have contributed jointly to reforms with other stakeholders and the evaluation will examine the effectiveness of this joint effort.

3.5 The evaluation will address the following core question:

Is the approach by the aid program to improving the delivery of essential health services for the poor effective?

In order to identify what has been achieved and why, the evaluation will consider a series of subsidiary questions, organised under three, related headings:

- (a) relevance of Australian support;
- (b) appropriateness of the approach taken by Australia to provide support; and
- (c) effectiveness of Australian support.

3.6 Relevance of Australian support

Potential evaluation questions are:

- (i) Is the predominant model of health service delivery supported by the Australian aid program fit for purpose in meeting the priority service needs of the poor?
- (ii) Are the planned improvements in health service delivery supported by the aid program sufficient to improve priority health outcomes for the poor?
- (iii) Has Australian support been based on an adequate assessment of the constraints to service delivery for the poor, including political economy factors, the impact of conflict (where applicable) and the willingness and capacity of stakeholders to deliver the necessary improvements?
- (iv) Has the aid program supported the right stakeholders in the health system?
- (v) Were the objectives of Australian support: directed at priority constraints, realistic given capacity, amenable to aid-based solutions and capable of delivering improved services to the poor within a reasonable timeframe (i.e., a clear line of sight between Australian support and priority improvements in health services for the poor)?
- (vi) Have sufficient resources been directed to address the targeted constraints?



- (vii) Has the design of Australian support achieved the right balance between long-term capacity development and short-term, visible results?
- (viii) Does the previous and current pattern of assistance provide a sound basis to scale up assistance effectively for health service delivery?

3.7 Appropriateness of approach

Potential evaluation questions are:

- (i) Has the strategy to improve service delivery supported by the aid program been coherent, realistic as well as costed and based on consultation and buy-in among stakeholders?
- (ii) Has alignment of Australian support with partner governments been appropriate given assessment of capacity and commitment and, where applicable, the impact of conflict?
- (iii) Has Australian support been sufficiently harmonised with other international and national actors to manage the risks of fragmentation?
- (iv) Has the choice of instruments and modalities for Australian support been appropriate, given local context and timing/sequencing issues? Are current modalities adequate to enable a scaling up of support to health service delivery?
- (v) Has the aid program adequately managed the risks of Australian support eroding existing local capacity?
- (vi) Has the approach taken by Australia addressed concerns of aid volatility and predictability?
- (vii) Where relevant, has Australian support been sufficiently whole-of-government to address linked political-security-development issues?
- (viii) Has adequate, timely performance information been available and have appropriate changes been made to approach of the aid program in the light of this?

3.8 Effectiveness of Australian support

Potential evaluation questions are:

- (i) What outcomes have been achieved as a result of Australian support and have these improved the delivery of essential health services?
- (ii) Has access to essential health services increased for the poor, women and other vulnerable groups?
- (iii) What factors explain variations in the outcomes achieved and system performance within the case study countries?

- (iv) Has Australian support helped improve the productivity of the system, including: incentives to deliver better services, more efficient delivery mechanisms, increased resources at the front-line, and greater reach of services to the poor and other vulnerable groups?
- (v) Has Australian support strengthened key accountabilities within the health system between policy makers, service providers, civil society organisations and poor service users?
- (vi) How sustainable are the gains that have been achieved, in terms of the effectiveness of Australian support in building:
 - > political support and pro-poor policy making capability?
 - > system capacity, including financial viability and harnessing skills of state and non-state providers?
 - > voice and participation of the poor or advocacy groups in the system?

3.9 As far as possible, the evaluation should differentiate service users by poverty, gender, disability and other relevant dimensions of vulnerability.

4 Management arrangements

- 4.1 The evaluation will be managed overall by AusAID’s ODE in close cooperation with the evaluation team leader. The team leader will be responsible for producing the final evaluation report in discussion with ODE.
- 4.2 In each of the selected countries, fieldwork will be conducted by the core team led by the evaluation team leader with additional local team members as necessary. The team leader will be responsible for coordinating team members’ written contributions.
- 4.3 A small reference panel will also be established to contribute to the design and product of the evaluation. This will comprise a representative of AusAID’s Health and HIV/AIDs Thematic Group and key advisers, but external experts may also be contracted to provide specific advisory support. The panel would have no direct management role but would provide advice to the team leader. A final decision on the composition of the reference panel will depend on identifying appropriate, available external members.



5 Approach and outputs

5.1 The evaluation will be implemented in three phases.

Phase 1: Preliminary research

5.2 ODE will lead this preparatory phase. It will comprise:

- > consultations with AusAID staff to identify key documents and contacts for each of the selected countries and obtain views about the objectives and performance of Australian support;
- > a document review and analysis of available secondary data on the program of Australian support in each of the selected countries;
- > an email survey to health system stakeholders in the case study countries, to provide preliminary findings and guide the evaluation's choice of key issues to follow up during Phase 2;
- > a review of international experience of health service delivery in challenging environments. ODE will contract external researchers for this task; and
- > the Phase 2 design process, involving synthesis of the findings and discussions with the core team members and reference panel.

5.3 Outputs for Phase 1 will be:

- > a concise synthesis report for each selected country, summarising Australian support to the health sector and the available evidence on the results;
- > questionnaire survey results;
- > literature review synthesising international experience; and
- > detailed design for Phase 2.

Phase 2: Fieldwork

5.4 The core team will conduct fieldwork in each of the selected countries. The core team will be supplemented by local team members for each country visit. The duration of each country visit will depend on the detailed design developed during Phase 1 but it is anticipated that each visit will be for between 10 and 14 days.

5.5 ODE will liaise closely with AusAID posts to coordinate as far as possible with existing planned reviews and ensure there is no duplication or avoidable burden on the programs. To this end, ODE may also participate in the design and implementation of these reviews.

- 5.6 Fieldwork will be primarily based on semi-structured interviews and focus group meetings (as appropriate) with key stakeholders identified by the team. These will include AusAID field staff, government staff (at different points in the delivery ‘chain’), managing contractors, other donors, the private sector (as appropriate) and relevant Non-Government Organisations and Civil Society Organisations. Again, detailed design will depend on the findings from Phase 1, but at this stage it is anticipated that the evaluation will also hold discussions with intended beneficiaries on a case study basis to assess local perceptions of service quality, constraints on access, and views on interaction with service providers.
- 5.7 Fieldwork will be conducted at a number of sites in each of the selected countries, as well at the central level. Choice of sites will be informed by *inter alia* available poverty analyses, variation in health service delivery agents and variation in outcomes of Australian support and performance of the health services. A key role of the evaluation will be to identify the factors that explain the differing results observed and consider the implications for future Australian support.
- 5.8 Phase 2 outputs:
- > debrief with in-country stakeholders for each case study country; and
 - > summary visits reports for each country visit, providing an outline of initial findings and key conclusions from each. The team leader will coordinate the input from each team member and reports will be available soon after completion of each country visit for dissemination within AusAID.

Phase 3: Report drafting and finalisation

- 5.9 The team leader will be responsible for drafting the final evaluation report, in discussion with ODE. A workshop will be held in Canberra following completion of all country visits to present and discuss the team’s findings. The purpose of the workshop will be to assist the team leader finalise the report.
- 5.10 In addition, it is anticipated that the team leader and ODE will present the findings to the Parliamentary Secretary for International Development Assistance.
- 5.11 The team leader will submit a draft report for peer review within AusAID. ODE will be responsible for organising the peer review. The team leader will finalise the report following the peer review.



ANNEX B: HEALTH SYSTEMS IN THE CASE STUDY COUNTRIES

Outline of systems

All three countries have a network of health services coordinated by a central ministry of health which is responsible for stewardship of the health sector, liaison with central agencies, standard setting and national level planning. Rural health services (health centres, dispensaries and aid posts) form the backbone of the service delivery network and take a public health approach—providing primary, preventive and promotive services. These are augmented by national programs overseen by the central ministry (e.g., for sexual and reproductive health, immunisation and malaria).

To improve service coverage for remote areas, the countries use a mix of mechanisms. Papua New Guinea (PNG) and Vanuatu use volunteer village based workers to treat minor injuries and common diseases (e.g., upper respiratory tract infections and malaria) but not maternal health care (prenatal or postnatal care or deliveries) or immunisations. More complex cases are referred to the formal care system which also provides most maternal health and immunisation. PNG also relies on outreach ‘patrols’ to provide some care. In Solomon Islands, where there are no village health workers, nurses undertake regular outreach visits to provide basic primary care, maternal health care and immunisation.

Nurses (and/or village health workers) provide most patient services in all three countries. There are few doctors outside the hospital sector and by far the majority of doctors are based in referral hospitals.

PNG has a far more complex health care system mainly because of the semi-federal arrangements under the Organic Law. This places responsibility for delivery of rural health services with provincial governments and district administrations, while responsibility for overall standards, planning and referral hospitals rests with the National Department of Health (NDOH). Provincial governments rely on national and provincial revenue for service delivery and until recently there have been significant differences in funding between provinces. The NDOH is also responsible for supplying pharmaceuticals. The health and education sectors are responsible for nursing, allied health and medical education.

The health care systems in Vanuatu and Solomon Islands are simpler. This reflects both their smaller populations (Vanuatu’s population is 230 000, Solomon Islands 500 000 and PNG six million) and that responsibility for health service delivery rests solely with the national government, even though in both cases the management of rural health services has been de-concentrated to provincial offices of the ministry of health. The provincial health offices are responsible for fixed facilities and outreach services, as well as supervision of health workers at various levels. The national ministry of health in Vanuatu and Solomon Islands is responsible for paying and deploying health staff,



procuring and distributing drugs and medical supplies and overseeing and funding facility development.

Non-state actors play an important role in PNG and Vanuatu. In PNG, the churches provide 50 per cent of the country's health services. In Solomon Islands, there is less evidence of concerted action by Non-Government Organisations (NGOs), and the churches play a limited role.

In all three countries, NGOs are active in health promotion, particularly with HIV/AIDS and malaria which are well-funded by the international community (particularly through large global and regional initiatives). Although governments are improving their capacity to provide policy guidance and oversight for non-state providers, there is much room for improvement. In PNG, the NDOH now acknowledges the need to strengthen the capacity of the Christian Medical Council to monitor the performance of its constituents and to develop some form of result-based contract to underpin the provision of subsidies. Umbrella organisations responsible for dialogue and liaison between NGOs and government exist, but their focus is almost exclusively on HIV/AIDS and not on the health system as a whole.

In all three countries, the health ministry is responsible for the interaction with donors (including the Global Fund to Fight AIDS, TB and Malaria) and United Nations agencies to determine funding priorities and technical inputs. The World Health Organization, the United Nations Children's Fund and the United Nations Population Fund provide considerable technical and policy support, often on a regional basis and in conjunction with the public health support functions of the Secretariat for the Pacific Community, which operates under the direction of the Pacific Ministers for Health. A range of regional health programs also operate, providing for economies of scale, improving cost effectiveness of specialist inputs and leading to greater consistency of policy and approaches across the Pacific. Australia and New Zealand both have regional as well as bilateral programs.

Summary of issues

Health systems financing. Higher spending has enabled Vanuatu and Solomon Islands to provide reasonably effective health services at affordable cost and close to the majority of the population. These countries generally succeed in staffing health facilities and keeping them supplied with drugs and consumables. The high level of spending enables them to do this despite serious inequalities in the way resources are allocated, with too great a concentration on the capitals, and hospital-based services. The imminent decline of the logging industry means that Solomon Islands face difficult choices on how to prioritise health spending given diminishing resources and increasing demand for tertiary care.

The problem in PNG is of a different order of magnitude, with lack of resources and of staff having forced the closure of many aid posts, and with a significantly higher



proportion of the population living beyond the effective reach of health services. The performance of PNG's health system needs to be assessed in the context of lower and declining real per capita spending and a far more difficult set of service delivery challenges.

Workforce. Workforce shortages in PNG, Solomon Islands and Vanuatu are largely the result of insufficient training to replace an ageing nursing and primary care workforce with nursing retirements in Vanuatu outstripping training by a ratio of more than 2:1. Weak coordination between central agencies and among donors has meant the problem has fallen through the cracks.

Medical training also varies across the three countries. Solomon Islands and Vanuatu are too small to sustain a medical school and rely on training provided at the University of PNG and Fiji School of Medicine (and more recently in Cuba). Vanuatu remains dependent on aid-funded expatriate clinical and pharmacy specialists. PNG is able to train enough doctors for its own needs, including surgical and paediatric specialists (although obstetrics and gynaecology, anaesthesia and rural medicine remain areas of need).

In all three countries, an excessive share of the health workforce is located in the capital. In Solomon Islands, 58 per cent of the medical work force is concentrated in the National Referral Hospital in Honiara. The main issue concerns how to prevent increasing demand for costly forms of curative care from taking an increasing share of limited resources; this may require some limits on what the PNG Government will finance or provide, and possibly some exploration of insurance-based financing mechanisms to meet middle class demands for curative care.

Attracting staff to work in remote locations is a major problem, especially in PNG where many facilities have closed for lack of staff. Addressing this problem requires national attention to boost training and improve incentives (including providing and maintaining staff housing), plus locally specific solutions to bring services closer to the population. Solomon Islands also have limitations around facility maintenance and staff housing, although the situation is not as critical as in PNG.

Drug procurement and distribution. PNG has faced long-running problems in the procurement and distribution of drugs, with stock-outs of several months' duration and including essential items for delivering adequate primary and preventive care. Many problems stem from inefficiency and corruption in the Ministry, although there have also been problems of coordination in an institutionally complex delivery system. Solomon Islands and Vanuatu have been relatively more successful in getting drugs and supplies to point of service delivery, with stock-outs generally of short duration and amenable to backup arrangements with neighbouring facilities. Both countries depend on financial and technical assistance for maintaining drug supplies.

Facility and equipment maintenance. Maintenance is relatively neglected in all three countries. In PNG this is a symptom of the general lack of resources, as well as the



preference of local politicians to spend on new facilities rather than maintaining what exists; in Solomon Islands and Vanuatu, centralised budget management makes it time consuming to obtain approval for necessary repairs and replacements.

In Vanuatu, communities are engaged in facility maintenance and development through their health committees. However, areas where the health service is responsible for facility upkeep are more fragile. For example, although vaccine supply appears to be satisfactory, the cold chain has virtually collapsed and this contributes to the very high vulnerability to importation of vaccine preventable diseases in the rural communities and remote island provinces noted above.

PNG and Solomon Islands have functional high frequency radio networks linking health facilities with each other and with provincial health offices. In PNG, the system is robust, mature and well maintained and is used appropriately for communication on both clinical matters and for supervision and administrative support. In Solomon Islands, the high frequency radio network is yet to achieve its potential, being used mainly for emergency clinical and supply problems. In Vanuatu, as far as we could see, the limited high frequency radio network is non-functional.

Health systems governance. Improving health sector governance and health sector organisations has tended to be the first port of call for health ministers and secretaries, as well as for international agencies, but often with an exclusive focus on the centre to the detriment of sub-national levels. Restructuring the health sector has frequently focused on the reorganisation of ministry headquarters, without sufficient attention to the institutions and incentives required to ensure operational implementation—be it province, district or sub-district level.

Solomon Islands and Vanuatu have been reluctant to decentralise health sector management. In Solomon Islands, there is a strong notion that central management systems have to be perfected before greater authority can be delegated to the provinces. This is in contrast to the bottom-up approach successfully taken in other countries, for example, Ghana, where health sector reform started with strengthening health management at district level and regional (provincial) level which in turn led to, and formed the basis for, reforms at the centre. In PNG, in contrast, the problem has been more the NDOH's struggle to re-establish some authority over provincial health services.

All three countries have focused too much on planning and too little on implementation. Systems for monitoring health sector performance at all levels are particularly important for guiding implementation and assessing whether intended improvements are on course. These systems are relatively well-developed in PNG, but not in Vanuatu and Solomon Islands. In Vanuatu, the lack of a functioning health information system exacerbates this situation.

Weak regulation. Statutory bodies in all three countries require strengthening. In PNG, both the Medical Council and the Nursing Council struggle to keep up



with just registering health professionals, and are unable to effectively perform their oversight function or pursue other relevant activities, such as continuing professional education or work on accreditation (although there has been some interesting progress with hospital accreditation in PNG). Professional societies in PNG are relatively well developed, whereas in Vanuatu, particularly the nursing association—usually strong in most countries—is virtually non-functional. As a consequence, issues of professional standards and quality of health care are unlikely to be addressed in the near future.

Managing performance. Managing the performance of facilities and staff in remote locations is a challenge in all three countries. Only PNG has a system of regular review of provincial performance, linked to a competition for annual performance awards for the best performing and most-improved provinces. This may be at too high a level to motivate individuals, although Milne Bay Province has also introduced reviews of district and facility performance, linked to a local competition to recognise better performing districts. No country has a system of primary care incentives, either for individual health workers or for community members attending health facilities. The effectiveness of such incentives depends on staff having the necessary resources and capacity to make it feasible for them to compete—a problem in an environment of drug shortages and problems accessing funds.

All three countries displayed examples of local level service delivery planning and staff had and were using manuals and handbooks to guide their work. All three countries have a schedule of supervisory outreach visits, but these happen at less than the intended frequency due to staffing, transportation and funding constraints. Clinical outreach by medical or senior nursing staff is uncommon. In Vanuatu, an international NGO, Save the Children Australia, plays a key role in training and providing supervision support for the village health workers who work closely with government health managers and other NGOs.

Health information. PNG and Solomon Islands have operational health information systems that capture and report information down to the level of community facilities; they allow regular monitoring of coverage and outcome indicators and, particularly in PNG, management and service performance data. The health information service in Vanuatu collects data only on diagnoses and occasions of service, but coverage is lower, the data is not systematically consolidated into useable reports, and the effort to collect it is largely wasted. None of the three countries makes full use of available facility level data on gender or more remote (and hence vulnerable) populations.



Community engagement. This varies across all three countries. In Vanuatu, community health committees are an integral part of community health facility management (although, in practice, they may not meet regularly). Community management is not in place in Solomon Islands; nevertheless, communities show strong support for their health services and loyalty to their health workers—both of which are likely to have a positive impact on system performance. PNG has excellent examples of community development-for-health initiatives that have arisen organically in response to poor provision of services at district and provincial levels.



ANNEX C: SELECTED HEALTH UTILISATION, OUTCOME AND IMPACT INDICATORS^{a,b}

Indicator	PNG		Solomon Islands		Vanuatu	
	Previous	Recent	Previous	Recent	Previous	Recent
Annual per capita out-patient contacts ^{c,d}	1.53 (2002)	1.43 (2007)	1.2–1.8 (2002–03)	2.0–2.5 (2007)	—	>2 (2007)
% of 1 year olds fully immunised against measles ^e	53 (2002)	53 (2007)	84–95 (2004)	87 (2005)	48 (2003)	37 (2007)
% of 1 year olds who have received a third dose of diphtheria, tetanus and whooping cough (DTP) vaccine	61 (2002)	68 (2007)	73–93 (2004)	88 (2005)	—	58 (2007)
Under 5 mortality rates per 1,000 live births	100 (2001)	64 (2005)	88 (2000)	37 (2003–07)	48 (2000)	36 (2006)
% of married women of reproductive age using any modern form of contraception	26 (1999)	36 (1997–2005)	—	27 (2003–07)	—	37 (2007)
% of births with skilled birth attendance ^f	—	41 (1997–2005)	—	85 (1997–2005)	—	79 (2007)
Maternal mortality ratio per 100,000 live births ^{g,h}	370 (indeterminate)	733 (indeterminate)	140 (2000–06)	118 (2006–07)	—	68 (2000–06)
Annual incidence of malaria per 1,000 population	245 (2003)	243 [range 101.3–409.5] (2007)	200 (2003)	128 (2007)	74 (2003)	23 (2007)

NOTES:

- a The data presented in this table have been collected from various sources—national health information systems, demographic and health surveys and other types of surveys (for example, multiple indicator cluster surveys). The validity of each data source is discussed in the relevant country working paper.
- b Millennium Development Goal indicators are shaded grey.
- c Data from all three countries include attendance at fixed facilities staffed by a trained health professional (a doctor and/or nurse and/or midwife) They do not include informal or community service points (for example, aid posts staffed by a community health worker or voluntary health worker), except in Solomon Islands where community outreach visits by trained professionals are included.
- d PNG and Solomon Islands data are based on 90 per cent to 100 per cent reporting compliance. Vanuatu data are from the two provinces visited, where reporting compliance was <90 per cent; annual contact rates are therefore only an estimate. None of the countries collect data that would allow adjustment of clinic attendance for increasing (or decreasing) utilisation of community service points.
- e Some publications report measles vaccine coverage in Vanuatu of 99 per cent. This was the coverage in urban areas of a 2006 supplementary immunisation activity (implemented in response to critically low coverage by routine vaccination services and the emergence of measles outbreaks in Fiji and the Marshall Islands). The data in the table reflect actual survey-based coverage estimates in the target age groups.
- f A skilled birth attendant is defined as a doctor, midwife or nurse.
- g PNG demographic and health survey data on maternal mortality are collected using the direct sisterhood method, whereby female respondents are asked to list all their siblings and additional information is sought about each deceased sibling (including age at death and whether pregnant, giving birth, or had given birth within the two months prior to death). It is therefore impossible to allocate with precision a year on which the estimate is 'centred'.
- h Maternal mortality rate estimates for Solomon Islands and Vanuatu are derived from routine reporting through the national health information survey. These data may not capture all maternal deaths, but have greater precision around the reporting period than the methods used for demographic and health surveys or multiple indicator cluster surveys.

ANNEX D: MINIMISING FIDUCIARY RISK WHEN USING GOVERNMENT SYSTEMS

Where development partners provide financial support using government systems and procedures, common elements in the approach to managing fiduciary risk²² include:

1. Prior financial accountability assessment, with an action plan to address weaknesses, with regular reporting against agreed indicators of progress and periodic systems and value-for-money audits.
2. An annual process for agreeing on the sector budget and the work plan to be jointly supported. Progress to be monitored through regular (at least quarterly) physical and financial monitoring reports prepared to agreed formats.
3. Financial accountability based mainly on timely submission of audited accounts (possibly commissioned from outside if the Auditor General lacks capacity). Release funds based on statements of expenditure reconciled to bank statements and timely submission of audited accounts. Donors do not require 100 per cent pre-audit of transactions (as is currently the case in PNG and Solomon Islands), but original documents need to be available for inspection. Periodic checks may be undertaken on a sample of transactions to verify compliance, focussing on areas of spending where risks of misuse are greatest. In cases of detected misuse, the donor may call for repayment of aid (or reduce future flows by the amount involved).

For an up-to-date summary of experiences in aid management within partner government budgets, see the recent synthesis report produced for the Collaborative African Budget Reform (CABRI) Initiative (www.cabri-sbo.org):

Moroko Ltd (2008) *Putting Aid On Budget: Synthesis Report*. A study for CABRI and the Strategic Partnership for Africa, April.

Additional elements that can reinforce accountability commonly include:

1. Using survey based tools to monitor the extent of problems in public finance management and feeding findings into the annual review process (as is done, for example, in Nepal education).

For useful references on survey based approaches to monitoring sector performance in public finance management: <http://www.dfid.gov.uk/aboutdfid/organisation/pfma/pfma-pets.pdf>

²² This reflects World Bank procedures, and is the system used in most general and sector budget support, including in Bangladesh and Nepal health and Kenya and Rwanda education.



For guidance on the approach for public expenditure tracking surveys:

<http://www.eldis.org/go/topics/resource-guides/education/key-issues/education-financing-and-pem/planning-and-budgeting&id=16749&type=Document>

However, for a cautionary tale:

<http://www.cmi.no/publications/file/?2812=public-expenditure-tracking-surveys>)

2. Strengthening downward accountability to communities, through greater transparency, strengthened channels of complaint and redress, and formal social audit approaches.

For references on social audit and community accountability:

<http://www.internationalbudget.org/auditorgeneral.htm>

Information specifically on social audits: <http://unpan1.un.org/intradoc/groups/public/documents/un/unpano24549.pdf>

3. Defined management criteria met by individual cost centres (e.g., provinces, districts or health facilities) before funds are received to manage. This approach has been used in Ghana health, with independent accounting firms assessing whether cost centres qualify, and capacity building support where needed. This approach also widely used in local government reform (including in PNG), often with incentives for continuous improvement in financial management.

More information: presentation by J. Steffensen at

<http://www.odi.org.uk/events/2008/11/12-13-reforming-for-results.html>

4. If the donor requires stronger safeguards against the risk of aid funds being shown to have been misused, it may notionally earmark support to areas of the budget that can be readily verified. In the 1990s, for example, the United Kingdom's Department for International Development (DFID) sometimes found it convenient to account for budget support against a specific part of the budget with few accounting problems (often the wage bill). Government received aid that was in practice fully fungible and as good as unearmarked support, but DFID maintained plausible deniability and minimised the risk of embarrassment in the event of misuse of budget funds.