



Analysis

Papua New Guinea's health sector

**A review of capacity, change and
performance issues**

**Joe Bolger, Angela Mandie-Filer and
Volker Hauck**

A case study prepared for the project 'Capacity, Change and Performance'

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Study of Capacity, Change and Performance

Notes on the methodology

The lack of capacity in low-income countries is one of the main constraints to achieving the Millennium Development Goals. Even practitioners confess to having only a limited understanding of how capacity actually develops. In 2002, the chair of Govnet, the Network on Governance and Capacity Development of the OECD, asked the European Centre for Development Policy Management (ECDPM) in Maastricht, the Netherlands to undertake a study of how organisations and systems, mainly in developing countries, have succeeded in building their capacity and improving performance. The resulting study focuses on the endogenous process of capacity development - the process of change from the perspective of those undergoing the change. The study examines the factors that encourage it, how it differs from one context to another, and why efforts to develop capacity have been more successful in some contexts than in others.

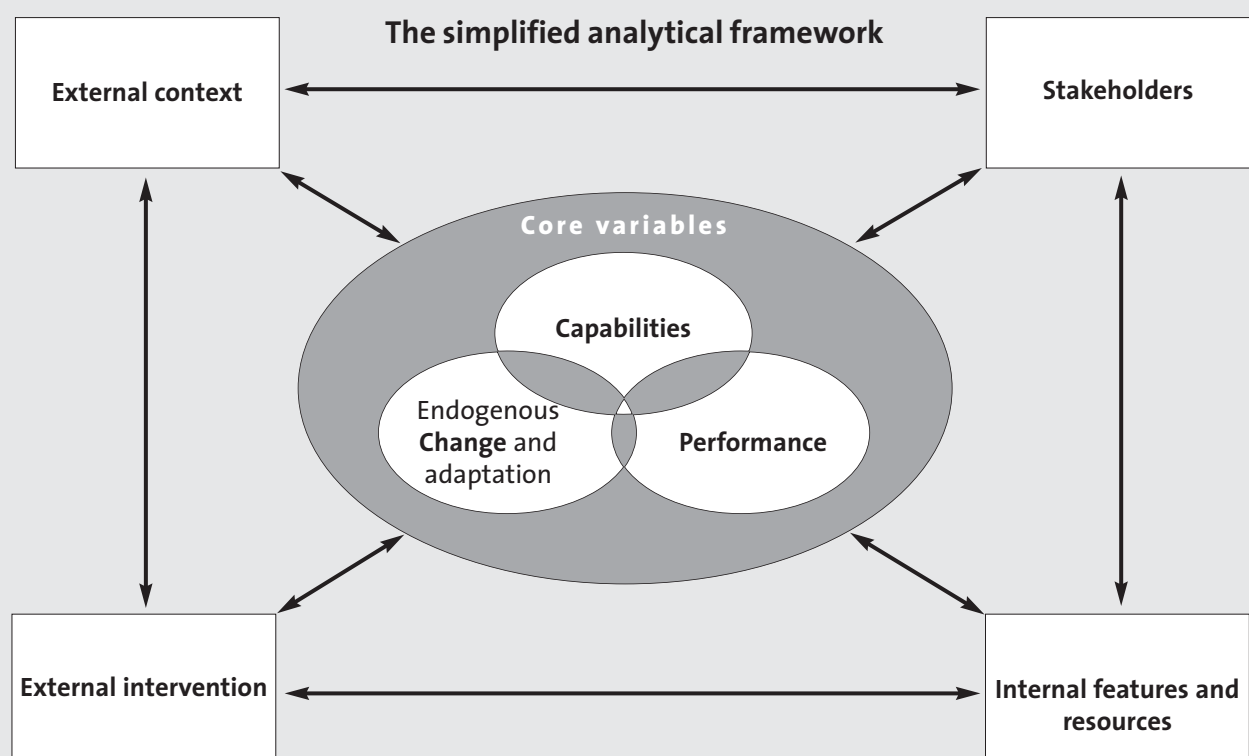
The study consists of about 20 field cases carried out according to a methodological framework with seven components, as follows:

- **Capabilities:** *How do the capabilities of a group, organisation or network feed into organisational capacity?*
- **Endogenous change and adaptation:** *How do processes of change take place within an organisation or system?*
- **Performance:** *What has the organisation or system accomplished or is it now able to deliver? The focus here is on assessing the effectiveness of the process of capacity development rather than on impact, which will be apparent only in the long term.*

- **External context:** *How has the external context - the historical, cultural, political and institutional environment, and the constraints and opportunities they create - influenced the capacity and performance of the organisation or system?*
- **Stakeholders:** *What has been the influence of stakeholders such as beneficiaries, suppliers and supporters, and their different interests, expectations, modes of behaviour, resources, interrelationships and intensity of involvement?*
- **External interventions:** *How have outsiders influenced the process of change?*
- **Internal features and key resources:** *What are the patterns of internal features such as formal and informal roles, structures, resources, culture, strategies and values, and what influence have they had at both the organisational and multi-organisational levels?*

The outputs of the study will include about 20 case study reports, an annotated review of the literature, a set of assessment tools, and various thematic papers to stimulate new thinking and practices about capacity development. The synthesis report summarising the results of the case studies will be published in 2005.

The results of the study, interim reports and an elaborated methodology can be consulted at www.capacity.org or www.ecdpm.org. For further information, please contact Ms Heather Baser (hb@ecdpm.org).



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Acronyms

ADB	Asian Development Bank	HSSP	Health Sector Support Programme (AusAID)
AMC	Australian managing contractor	JICA	Japanese International Cooperation Agency
AusAID	Australian Agency for International Development	NDoH	National Department of Health
ANU	Australian National University	NGO	non-governmental organisation
CACC	Central Agencies Coordinating Committee	NHP	National Health Plan
CBSC	Capacity Building Service Centre	NOL	New Organic Law (also known as the Organic Law on Provincial and Local Level Government)
CCAC	Community Coalition against Corruption	NSA	non-state actor
CMC	Churches Medical Council	OECD	Organisation for Economic Cooperation and Development
DAC	Development Assistance Committee	PNG	Papua New Guinea
DPM	Department of Personnel Management	PSRMU	Public Sector Reform Management Unit
DWU	Divine Word University	SWAp	sector-wide approach
ECDPM	European Centre for Development Policy Management	TA	technical assistance
GoPNG	Government of Papua New Guinea	UNFPA	United Nations Population Fund
HR	human resources	USAID	United States Agency for International Development
HSDP	Health Sector Development Programme (ADB)	WHO	World Health Organization
HSIP	Health Sector Improvement Programme (GoPNG)		
HSIPMU	Health Sector Improvement Programme Management Unit		

Acknowledgements

This case study, and the parallel study, *Ringling the Church Bell: The role of churches in governance and public performance in Papua New Guinea*, were made possible through the generous support of the Australian Agency for International Development (AusAID). The authors would like to acknowledge, in particular, the support of Bernadette Whitelum, formerly of Corporate Affairs, AusAID, who was the agency's key interlocutor with the European Centre for Development Policy Management (ECDPM) on this initiative from the outset. Bernadette advised the team on the substantive focus of the two studies and AusAID's interest in sponsoring this research in the context of the broader ECDPM study on *Capacity, Change and Performance*. Donna-Jean Nicholson, of AusAID's Policy and Multilateral Branch, ably guided us through the final stages of this process.

We would also like to thank Peter Lindenmayer, health and HIV specialist in AusAID's PNG Branch, for his valuable advice and for sharing resources with the team before and after the field assignment, and Kerrie Flynn, from Corporate Policy, AusAID, for her spirited logistical and organisational support related to this undertaking. Furthermore, we would like to express our appreciation to all of the other AusAID staff, in Canberra and Port Moresby, as well as representatives of the Australian managing contractor, who gave generously of their time to respond to our many questions, offer feedback on our preliminary findings and generally educate us about reforms in PNG's health sector.

The study would also not have been possible, of course, without the contributions of our Papua New Guinean friends and colleagues - from government, NGOs and church organisations - who shared their experiences and views on developments in the health sector and broader change processes in PNG. We hope the report does justice to their efforts to improve the lot of their fellow citizens. Martina Tuarngut Manu played a helpful role in PNG taking care of logistical concerns for the research team.

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Finally, we would like to thank our colleagues at ECDPM, in particular Heather Baser, the coordinator of the international study on *Capacity, Change and Performance* and Peter Morgan, ECDPM Associate and Research Director for the study, who offered advice on the design of the research project and feedback on drafts. The support offered by ECDPM's administrative staff, especially Tilly de Coninck, is also acknowledged.

As always, the views and opinions expressed in this report are those of the authors and do not necessarily reflect those of AusAID, the government of Papua New Guinea or ECDPM.

Summary

This report is based on a study of reforms in Papua New Guinea's health sector. The study was funded by the Australian Agency for International Development (AusAID) and undertaken by the European Centre for Development Policy Management (ECDPM) as part of a larger international study on *Capacity, Change and Performance*. The wider study is being coordinated by ECDPM under the aegis of Govnet, the working group on governance and capacity development of the OECD's Development Assistance Committee (DAC).

Drawing on the framework adopted for the broader ECDPM study, this report examines the current reform process in PNG's health sector from a capacity development perspective. It addresses a number of factors influencing capacity development, change and performance in the sector, including issues internal to the National Department of Health (NDoH), capacity issues at sub-national levels, the institutional 'rules of the game' that guide attitudes, behaviour and relationships in the PNG context and in the emerging health sector SWAp, and broader contextual factors. The study takes the health sector as the main unit of analysis, but with significant regard to NDoH given its central role in planning, standards and setting overall policy direction. The report highlights how the different levels of PNG's broader 'capacity system' are interdependent, with constraints and opportunities at one level influencing possibilities at the other levels.

PNG and its health sector

PNG is one of the most diverse countries in the world - geographically, biologically, linguistically, as well as culturally. It has more than 700 languages, over 1000 dialects and many tribes, sub-tribes, clans and sub-clans spread across its 20 provinces. It also has abundant natural resources, although this has not led to economic prosperity for the majority of its people. In fact, the level of poverty has increased faster in PNG in recent years than in neighbouring countries, and it now ranks 133 out of 175 countries on the UNDP Human Development Index.

PNG is presently being guided by its fifth National Health Plan - *Health Vision 2010* - which aims to 'improve the health of all (5.3 million) Papua New Guineans, through the development of a health

system that is responsive, effective, affordable, and accessible to the majority of our people'. Specific priorities include increased services to the rural majority (85% of the population), many of whom presently do not have access to basic health services.

The government of Papua New Guinea (GoPNG) and the donor community are moving towards a sector-wide approach (SWAp) to health reform, consistent with international development cooperation trends. AusAID and the Asian Development Bank have been the major contributors to the SWAp. However, despite significant investments in the sector in recent years, the health of Papua New Guineans is 'at best plateauing' and a number of health indicators are actually declining.

Main review findings

The report contends that while PNG has a fundamentally sound national health policy, implementation has fallen short of the mark. Relying on a capacity development lens, the report explores some of the reasons why NDoH has been 'successful' in policy development, but less so in policy implementation. It suggests that PNG's policy development strengths are rooted in the experience and commitment of senior actors in the sector and are buttressed by a broad consensus in PNG on the importance of health services. Shortcomings in implementation are attributed to a number of factors, some of which are internal to the sector, including management issues, relationships, financing arrangements, the skills of health practitioners, and external factors, such as the institutional rules which affect the behaviour of sector stakeholders. Despite the implementation challenges, the team noted a number of 'success stories' which have emerged.

Looking at the external context, the report highlights a number of factors which have influenced NDoH and the sector at large in various ways, including the macroeconomic environment, the political context, law and order problems, the precarious investment climate, and deteriorating infrastructure. In many cases, this combination of factors has resulted in the cessation of health services, particularly in rural areas. The spread of HIV/AIDS is a particularly significant emerging challenge. Ongoing difficulties in the

governance of the country and challenges in the public sector institutional context have also affected efforts to enhance capacity and improve performance in the sector. The report focuses on two aspects of the public sector institutional context: the relations between NDoH and GoPNG's central agencies, and relationships among the various levels of government - national, provincial, district. In the latter case, the decentralisation reforms of 1995 are seen as having disrupted the link between national policy makers and those responsible for delivery of health services at the district level, with attendant consequences for implementation of the national health policy.

The study suggests that many of the contextual factors, particularly those in the broader 'action environment' are beyond NDoH's control, although they have a significant impact on sector performance and efforts to enhance capacity. On the other hand, NDoH has actively addressed challenges in the public sector institutional context as a way of protecting or furthering its own objectives - not as part of a capacity development strategy, but out of an acknowledgement of the potential for factors in the broader 'capacity system' to enable or constrain health reforms. The report concludes that these contextual challenges have the potential to drain resources and confidence away from important change processes in PNG, including those in the health sector. On the other hand, some of the successes in the sector highlight the importance of specific factors, such as the attitudes or skills of managers to deal with important contextual variables, or the ability of organisations or particular units to isolate themselves from 'dysfunctions' in the broader system.

The report also discusses how patterns of stakeholder interactions have affected processes aimed at improving capacities and performance in the health sector. The report notes that sector stakeholders represent a complex set of institutional relationships - some based on common interests, others with different interests or priorities. While NDoH has successfully engaged a broad range of stakeholders in health policy development processes, 'managing' stakeholder interests at the operational and administrative levels has been much more of a challenge given diverse organisational interests. Nevertheless, some

operational level successes are noted in the area of stakeholder collaboration, such as state-church cooperation in service delivery and in the training of health workers.

Among the donor agencies, AusAID and ADB, in particular, are seen as important external stakeholders. The approach to capacity development embraced by donors, as well as NDoH, is described in the study as 'emergent', with a gradual movement over time towards a more holistic and explicit focus on capacity issues.

With regard to individual and organisational capacity within NDoH, and the sector more broadly, the report notes that NDoH has specific strengths (e.g. policy development, health information systems) as well as various weaknesses. Initiatives aimed at enhancing capacity in the Department and the sector have focused substantially in the past on human resource development, although in recent years increasing attention has been given to broader organisational and systems issues. Nevertheless, the report suggests that more explicit attention may need to be given to issues in the broader 'capacity system', as well as the 'soft' capacities (e.g. attitudes, values, leadership) which can be important drivers of change processes.

The report also draws on some of the 'successes' in the sector to reflect on the question of how successful practices emerge from a significantly challenged environment. The Church Health Service and other examples highlight the importance of factors such as effective leadership, commitment of service providers, a desire to give back to the clan or community, the ability to 'seize space' or use capacity creatively, effective collaboration among diverse stakeholders, and community involvement.

The study team also looked at endogenous strategies for organisational change and adaptation to improve capacities and performance, reflecting first on the question of how PNG stakeholders think about the issue of capacity. It appears that capacity is seen substantially (although not exclusively) by most PNG stakeholders as a question of skills, or by some as an organisational issue. Despite this relatively narrow orientation, there is a clear recognition within certain

circles of the influence or importance of 'higher-level' capacity issues - organisational, sectoral, societal - although these are often described as risks rather than capacity issues to be 'managed'.

The report concludes by underlining the value of relying on a systems perspective on capacity development in PNG's health sector and thinking in terms of a complex 'capacity ecosystem'. It suggests that the system in PNG is a complex of competing and occasionally complementary policy objectives, institutional arrangements, relationships, incentive systems, and political interests, some of which support efforts to strengthen sector capacity and improve performance, and others which can undermine it. The study also points to the importance of Papua New Guinean culture, traditions and diversity as factors influencing organisational behaviour, stakeholder collaboration, and even the perceived legitimacy of the state.

Finally, the report suggests that capacity issues need be more at the forefront of deliberations in PNG on health reforms, not just as a series of technical constraints to be 'solved', or gaps to be filled, but as a complex of issues - soft and hard - which need be dealt with in a complementary and systematic manner in order to address the development challenge of improved health for all Papua New Guineans. Doing this, it is argued, will require a clear commitment to and shared appreciation of what capacity development entails, rooted in a broader partnership involving the National Department of Health, other government actors (including senior representatives of central agencies), decentralised levels of government, civil society actors and donor partners.

League of Nations mandate. The Highlands region, thought by outsiders to be too hostile for habitation, was only 'explored' as of the late 1920s by prospectors searching for gold. Astonishingly, they found over one million people living in fertile mountain valleys whose cultural traditions had remained virtually unchanged for thousands of years. During World War II, PNG was invaded by Japanese forces and, after being liberated by the Australians in 1945, it became a United Nations trusteeship, administered by Australia. PNG gained limited home rule in 1951, became self-governing in 1973 and achieved complete independence in 1975.

The majority of Papua New Guineans live in rural areas and rely on subsistence or small-scale cash crop agriculture for their livelihoods. However, PNG also relies substantially on the export of non-renewable resources (copper, gold, silver, natural gas) as well as timber, coffee, copra, palm oil, cocoa, tea, coconuts and vanilla for foreign exchange and government revenues. The mining sector alone accounts for 72% of the country's annual export earnings and 24% of GNP. The economy averaged real annual GDP growth of 3.4% between 1978 and 1998, led by the mining and petroleum sectors, but it suffered a setback during the financial crisis of the late 1990s. PNG's per capita GDP in 2003 was US\$647.⁴

While its abundant resources provide PNG with great potential for economic diversification, growth and self-reliance, it has not resulted in economic well-being for the majority of the people. In fact, most social indicators remain low and the level of poverty has increased faster than in neighbouring countries in recent years. According to the UNDP Human Development Index, PNG ranks 133 out of 175 countries.

In terms of governance, executive power in PNG rests with the National Executive Council (cabinet), which is headed by a prime minister. The single-chamber parliament is made up of 109 members from 89 single-member electorates and 20 regional electorates. A relatively large number of parties are represented in parliament, as well as some independents. Each province has a provincial assembly with members drawn from the ranks of national members of parliament (MPs) and leaders of local-level governments (see box 1). PNG has had regular national elections since independence, but the state is seen as being weak with institutions of governance often described as politicised, corrupt or dominated by personalities. It is also perceived as remote, particularly

in the further reaches of the country where services are often not available and representation is weak.

1.3 PNG's health sector: background

Papua New Guinea's health sector is presently guided by its fifth National Health Plan, *Health Vision 2010*, which outlines the policy directions and priorities for the period 2001-2010 (NDoH, 2001a). It builds on lessons from previous health plans and draws, in particular, on the recommendations from the mid-term review of the 1996-2000 plan. The current plan aims to 'improve the health of all Papua New Guineans, through the development of a health system that is responsive, effective, affordable, and accessible to the majority of our people'. It also recognises that resources are limited and thus focuses on selected priority areas and on increasing efficiencies within the sector. The plan highlights five major policy objectives:

- increase services to the rural majority;
- expand health promotion and preventive services;
- reorganise and restructure the health system;
- develop staff's professional, technical and management skills; and
- upgrade and maintain investments in health infrastructure.

The main building blocks supporting implementation of the plan are: the *National Health Administration Act*, which provides a framework for the planning and coordination of provincial health services; the *Minimum Standards Act*, which outlines the service requirements for district health services; partnership agreements which address national-provincial funding and performance issues; and a performance monitoring framework (see Annex 3).

PNG's national health system relies on a network of 2400 aid posts (approximately half of which were closed in 2003 due to lack of staff and supplies), 500 health centres, 18 provincial hospitals, a national hospital, and 45 urban clinics (Izard and Dugue, 2003: 9). The government is the largest provider of health care, although the Church Health Service operates approximately half of the rural health centres and sub-centres. The churches are also responsible for training many of PNG's health workers, including nurses (six schools) and community health workers (14 schools). In addition, the Pacific Adventist University has a school of health sciences, and the Divine Word University (DWU) runs a health administration pro-

Notes

- 4 Exchange rates as of November 2004: US\$1 = 0.76 = AU\$1.27 = Kina (PGK) 3.05.

groups remained isolated for millennia, each shaping its own culture, language and rules.

While English is now the main medium of government communication (especially at the national level and for educational instruction), there are three official languages - Pidgin, English and Motu. There are also more than 700 distinctly different languages, and over 1000 dialects spoken by many tribes, sub-tribes, clans, sub-clans and family groupings. The country has approximately 5.3 million people, 52% of whom are female, and the population has grown rapidly since independence in 1975 at an average annual rate of 2.5%. Half of the population is now under 19 years of age, and over 85% live in relatively isolated areas with limited or sometimes no access to basic services. The average life expectancy is 54 years and adult literacy is estimated to be 52%. The churches

play a very strong role in PNG society, including in the delivery of social services, and up to 99% of Papua New Guineans identify themselves as Christians.

The eastern part of New Guinea was first visited by Portuguese and Spanish explorers in the 16th century. A permanent European presence followed in the 1880s, when missionaries and traders began to settle in accessible coastal areas. In 1884, Germany declared a protectorate over the north-eastern part of New Guinea and several nearby island groups, and Britain declared the southern coast (the area called Papua) and adjacent islands a protectorate. In 1902, British New Guinea was placed under the authority of the Commonwealth of Australia; the formal Australian administration of the Territory of Papua started in 1906. During World War I, Australian troops entered German New Guinea and retained control under a

Box 1: Governance arrangements in Papua New Guinea	
Political structures	Administrative structures
National level	
- National Parliament - National Executive Council - Ministries	- National departments - Statutory bodies
Provincial level (20 provinces, including the national capital district)	
- Provincial assembly - Provincial executive council - Provincial committees - Joint provincial planning and budget priorities committee	- Provincial administration - Provincial treasury - Provincial audit service
District level Each province is divided into districts. There are 89 districts in total.	
Joint district planning & budget priorities committee	- District administration - District treasury
Local-level government (LLG) Each district is divided into LLGs. There are 284 LLGs	
Ward level Each LLG has many wards. There are 5747 wards in total	
Communities and villages Each ward is made of many hamlets, villages and non-traditional village areas.	
Note: Of the 66-77,000 public servants in PNG, less than 1000 are at the ward and community levels	

1 Background

1.1 About this study

This report is based on a study of health sector reforms in Papua New Guinea (PNG). The study was funded by the Australian Agency for International Development (AusAID) and undertaken by the European Centre for Development Policy Management (ECDPM) as part of a larger international study on *Capacity, Change and Performance*. The wider study is being coordinated by ECDPM under the aegis of Govnet, the working group on governance and capacity development of the OECD's Development Assistance Committee (DAC). Eighteen case studies will feed into the larger study with the aim of providing insights into how external organisations can support endogenous capacity development¹ processes.

This study, which was undertaken in parallel with a second study, *Ring the Church Bell: The role of churches in governance and public performance in Papua New Guinea* (Hauck et al., 2005), examined the current reform process in PNG's public health system² from a capacity development perspective. It addresses a number of factors influencing capacity development, change and performance in the sector, including issues internal to the National Department of Health (NDoH), capacity issues at sub-national levels, the institutional 'rules of the game' that guide attitudes, behaviour and relationships in the PNG context and the emerging health sector SWAp, and broader contextual factors which influence efforts to enhance performance. The study takes the health sector as the main unit of analysis, albeit without any pretence of being exhaustive. Within that frame, the focus is mainly on the Government Health Service, and the NDoH, given its central role in planning, standards and setting overall policy direction for the sector. The significant role of the churches in the sector is acknowledged, but is not considered in detail given the substantive focus of the parallel study.

AusAID initiated this study as a contribution to its own internal reflection and learning about capacity development and how to deal with capacity issues in the context of health sector programming in PNG. The study was also seen by ECDPM as contributing, in

the context of the wider international study, to improved understanding of the implementation of sector-wide approaches (SWAp), notably in the health sector, in low-income countries contending with governance challenges. Prior to submission of this case, the research team produced a short report for AusAID outlining preliminary observations and potential issues relating to future support for health reforms in PNG.

Finally, it should be noted that this is not an evaluation, and that this report does not seek to pass judgement on any of the organisations or groups referred to in it.

1.2 Papua New Guinea: context

Papua New Guinea is one of the world's most diverse countries - geographically, biologically, linguistically as well as culturally.³ Located to the north of Australia, PNG is made up of the eastern part of the island of New Guinea (the Indonesian province of Irian Jaya occupies the western half) and a series of islands to the north and east - Manus, New Britain, New Ireland and Bougainville (see figure 1). Nearly 85% of the main island is covered with tropical rain forest and vast areas of wetlands, which are home to around 6% of the world's flora and fauna. The central part of the main island, known as the Highlands, rises into a wide ridge of mountains, up to 4500 metres high, a territory that is, in parts, so densely forested and topographically forbidding that some indigenous

Figure 1. Map of Papua New Guinea



(Source: Papua New Guinea Post-Courier Online).

Notes

- 1 For a glossary of terms used in this report, see Annex 2.
- 2 The 'public health system' in PNG includes services provided by the government as well as the churches. The term is used interchangeably with 'health sector'.
- 3 Economic and other data in this section have been compiled from various sources, including PNG's National Statistics Office, the government of Australia (Foreign Affairs and Trade), the Asian Development Bank and the CIA World Factbook.

gramme and collaborates with other health training institutes.

Health Vision 2010 is being implemented in a context with multiple challenges - macroeconomic, political and institutional. Key among these are PNG's decentralisation efforts which, according to a number of respondents, have contributed to the deterioration of health services, particularly in rural areas. Of particular significance is the 1995 *Organic Law on Provincial Government and Local Level Government* (commonly referred to as the New Organic Law, NOL), which transferred responsibility for rural health services to local governments, thus limiting the role of NDoH essentially to policy development, standard setting and monitoring and evaluation. Critics see this as having broken the 'policy-implementation' link and undermining the ability of NDoH to direct local health authorities and hold local governments accountable for sector performance.

At the time of PNG's independence in 1975, health services were centrally administered by the Department of Public Health in the capital, Port Moresby, through regional and provincial health offices. District officers had day-to-day control over public servants in the regions and districts, but did not exercise line authority. With PNG's first attempt at decentralisation in 1977, health functions were divided into transferred functions (to the provinces), delegated functions and national functions. Responsibility for public servants was handed over to the provincial governments with the functions and funding. The degree of authority retained by the central administration depended on the nature of the service, i.e. whether it was transferred, delegated or national. By and large, the provinces adopted a standard organisational and administrative structure for provincial health services. However, in the 1980s some provinces began to modify their approach, including further decentralisation, in some cases to the district level. This led to confusion in the system and ultimately a decline in performance, accompanied by the suspension of many provincial governments, usually due to financial mismanagement.

The latest changes introduced in 1995 through the New Organic Law represented a further decentralisation, giving provinces and local level governments greater control over public spending, but without any checks and balances to ensure that national policies are implemented appropriately. As a result of these

changes, government staff in the 89 districts (including health staff) now report directly to their district administrator, although technical direction is still supposed to come from the responsible line department.

In terms of external support, the government of Papua New Guinea (GoPNG) and the donor community are moving towards a sector-wide approach (SWAp) to health reform, consistent with international development cooperation trends. This reflects a desire to rationalise sector support and to move away from multiple projects which have imposed a significant administrative burden on the government. AusAID and the Asian Development Bank (ADB) have been the major contributors to the evolving SWAp, and both are now considering options for a next phase of support. For donors, the movement towards a SWAp has entailed, among other things, support for PNG's overall health policy, increased financing of annual activity plans through trust accounts, and the adoption of common management arrangements, including performance monitoring systems. AusAID, in particular, has also provided a great deal of technical assistance at national and provincial levels to strengthen capacity. These external contributions feed into PNG's Health Sector Improvement Programme (HSIP), which is the umbrella for national health reforms.

Despite significant investments in recent years,⁵ PNG's *Health Sector Medium-term Expenditure Framework* notes that 'the health of Papua New Guineans is at best plateauing' (NDoH, 2003a). A number of health indicators have actually declined, such as those relating to immunisation, mortality from malaria, malnutrition and availability of medical supplies.⁶ Former Health Secretary Dr Nicholas Mann described the challenges facing NDoH, the health sector and the government as follows:

'Last year [2002], 82% of the health budget was spent on paying salaries, maintaining buildings and equipment and purchasing basic supplies. If this trend continues, health care in priority areas will suffer... Last year, 82% of our health budget went to just 'keeping the doors open'. This means we had less than 20% of all our health money for interventions to prevent or treat illnesses. If we are to provide the same number of staff strength and maintain the same number of facilities, by 2004 we will only be able to commit four percent of our health budget to directly treating health, and by 2007 only one percent'.⁷

Notes

- 5 Public sector expenditures on health increased by 65% between 1996 and 2001, but the bulk of additional resources were from foreign assistance (see NDoH, 2003c).
- 6 From NDoH, *Final Review of National Health Plan 1996-2000*, cited in Izard and Dugue (2003: 18).

The remainder of this report discusses some of the capacity issues underlying these challenges, and the strategies being employed to respond to them.

1.4 Structure and orientation of this report

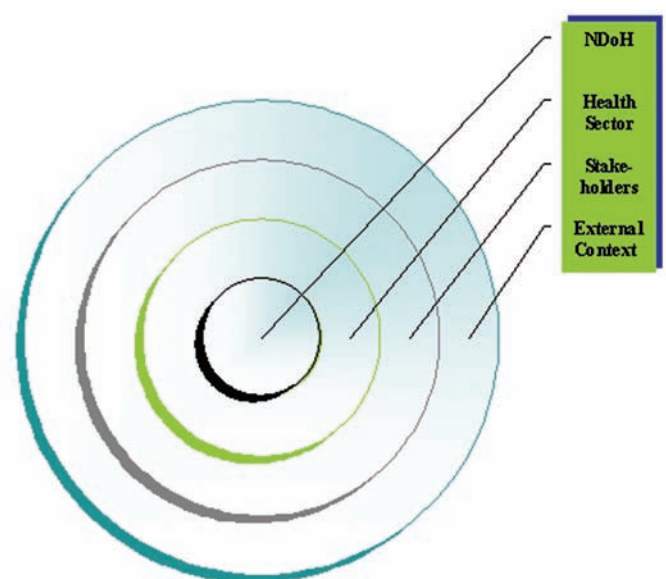
In the PNG context we can distinguish four levels whose features shape capacity, change and performance, as illustrated in figure 2. We begin by discussing the impact of the external context on NDoH and the health sector as a whole. We then consider the impact of stakeholder relationships, including external donors, on capacity development. This is followed by a discussion of internal organisational and systems features in NDoH and the sector, and how endogenous change strategies have influenced capacity and performance. As the discussion will show, the different capacity levels or dimensions are interdependent, with constraints and opportunities at one level influencing possibilities - strategies, behaviours and performance - in others. Figure 2 highlights, in broad terms, the notion of a capacity system with each level potentially serving as a capacity 'enabler' or constraint for the other levels. Drawing on this systems perspective, the report reflects on the mix of capacity development interventions within and across levels, the strategies underlying these interventions, the impacts of capacity influencers, and the implications of these various considerations for capacity development and performance in PNG's health sector.

To consider different ways in which capacity development is or can be supported in the PNG context, this report also draws on a typology developed by Boesen et al. (2002), shown in box 2. It suggests that capacity

development can rely on either a 'push strategy', i.e. concentrating primarily on internal issues, or a 'pull strategy', i.e. focusing on factors external to an organisation. The approach can also be either predominantly 'functional' or 'political'. In reality, of course, these approaches or orientations are not mutually exclusive.

The typology in box 2, and the levels of capacity in figure 2, are provided to help frame the discussion in this paper. The thinking underlying both leads to the proposition that efforts to enhance capacity and per-

Figure 2. Capacity levels: PNG's health sector



Box 2: Different ways of supporting capacity development

	<i>Predominantly functional approach</i>	<i>Predominantly political approach</i>
<i>Interventions focusing on internal system elements (push strategy)</i>	Strengthening formal organisational structures, systems and skills, e.g. through training, organisational change processes, infrastructure support, etc.	Seeking to change internal dynamics, e.g. by supporting reformers, changing internal competitive pressures, providing performance-based benefits to key staff, etc.
<i>Interventions focusing on external stakeholders and factors (pull strategy)</i>	Strengthening the capacity of the organisation to deal with 'functional' external actors.	Seeking to change external pressures or supporting, building or maintaining external stakeholders.

Source: Adapted from Boesen et al. (2002).

Notes

- 7 Health Secretary Dr Nicholas Mann, reported in The National, 6 August 2003, p.17.

formance in PNG's health sector can best be understood by looking both inward at the technical and organisational challenges facing NDoH, and other key sector actors, as well as by examining the broader capacity system of which they are a part. Furthermore, capacity development interventions can be thought of in terms of the relative emphasis on 'functional' capacity issues versus political, power or relationship issues.

The paper also contends that while PNG has a fundamentally sound national health policy, implementation has fallen short of intended objectives. Relying on a capacity development lens, the report explores some of the reasons why NDoH has been successful in policy development and less so in implementation. In brief, it is suggested that PNG's policy development strengths are rooted in the experience and commitment of senior actors in the sector and are buttressed by a broad, although not forcefully articulated consensus in PNG on the importance of health services. Shortcomings in policy implementation are attributed to a number of variables, some internal to the sector, e.g. management, human resource planning, organisational culture, and others external, including some of the institutional rules that affect the behaviour of sector stakeholders. Despite the implementation challenges, the team noted a number of 'success stories', which lead to some reflections on how successful practices can emerge from a significantly challenged environment.

2 External context: the impact on PNG's health sector

The study team looked at how the external context has influenced efforts to improve capacity and performance in the National Department of Health (NDoH) and the sector at large. For purposes of this study, this context includes PNG's broader 'action environment',⁸ which includes a host of social, economic and political variables, the political and governance situation in the country, and the public sector institutional context.

2.1 PNG's 'action environment'

A number of factors in PNG's 'action environment' influence NDoH, and the health sector at large in various ways. These include the macro-economic environment,⁹ which affects people's wellbeing, their capacity to access the health system, as well as financial allocations to the sector. In addition, PNG's political context has been quite unstable for a number of years with regular changes of government and lack of consistent leadership on policy reforms. In a recent four-year period, for example, there were four different health ministers. Frequent, hotly contested elections have also contributed to communal tensions. More generally, persistent law and order problems have been highly disruptive as they deter people from using the health system, prevent health personnel from taking on assignments in difficult areas and have led to the closure of health facilities in some parts of the country. Law and order problems also contribute to a precarious investment climate with consequences for local enterprise and public finances. Other factors, such as deteriorating infrastructure (roads, health centres) affect service delivery in very direct ways. In many cases, this combination of factors has resulted in the cessation of health services, particularly in rural areas where up to 50% of the aid posts in some provinces have been shut down and many more are operating at diminished levels.

The spread of HIV/AIDS is a particularly significant emerging challenge in the PNG context. Estimates of the numbers of cases vary significantly, but according to the WHO an estimated 100,000 Papua New

Notes

- 8 The term 'action environment' is taken from Grindle and Hildebrand (1994).
- 9 PNG's real GDP contracted in 4 of the 5 years leading up to 2002. As a result, the government's fiscal situation deteriorated significantly, leading to sharp cuts in spending (ADB, 2002b: 6). PNG's national debt also climbed from 44% of GDP in 1992 to 72% in 2003 (ADB, 2003b: 4).

Guineans (2% of the population) are HIV positive and the rate of infection is increasing by 20% per annum.¹⁰ A 2004 newspaper editorial suggested that 'the spread of HIV/AIDS has gone past the stage of being an epidemic. No longer is it an epidemic spreading rapidly through a community but a pandemic spreading over the whole nation. International experts now say PNG faces the threat of an AIDS pandemic of sub-Saharan Africa proportions unless enormous efforts are taken to stem the virus spread'.¹¹ The National Health Plan noted that 'if the [HIV/AIDS] epidemic is left to run at the present rate of increase, 70% of hospital beds in the country could be occupied by AIDS patients in 2010. For every 5% increase in HIV prevalence in PNG, the total national spending on health will need to increase by 40%' (NDoH, 2001a: 15).

2.2 Political and governance context

According to Okole (2002) and Reilly (2001: 61), many of the challenges faced by PNG relate to the functioning of its democratic institutions. Standish (2002: 2) noted that 'Representative democracy in PNG has increasingly come to be characterised by a diffuse and fragmented party system, high candidacy rates, very low support levels for some successful candidates, vote splitting, low party identification on the part of the electorate, high turnover of politicians from one election to the next, frequent "party-hopping" on the part of parliamentarians and, as a consequence, weak and unstable executive government'. This has left the doors open for high levels of corruption, nepotism and mismanagement of government resources, all of which contribute to the deteriorating capacity situation, as well as the relatively poor performance of the state and the national economy.

In a rapidly changing society like PNG, the clan remains the primary unit for mobilising support, dealing with customary land issues, hereditary wealth, mobilising labour, and generating resources for business development. This fidelity to clan is often reflected, as well, in the public service, where traditional obligation and reward systems (such as the *wantok* system¹²) can influence decisions, including awarding of positions or determining who benefits from government programmes. PNG's modern state institutions are thus superimposed on various traditional customs and institutional arrangements, not

all of which fit easily with contemporary Western standards of governance.

PNG's provincial government system was introduced, in part, to respond to the great diversity of the country. However, the general consensus is that the provinces, with some exceptions, have not been very effective in responding to the basic needs of communities. This has led to changes in PNG's governance landscape since 1975, including the elimination of direct elections at the provincial level and attempts to further devolve powers to the district level. Many critics argue though that the districts have insufficient capacity to manage the responsibilities assigned to them, including delivery of health services. Some commentators also note that decentralisation reforms have resulted in a 'politics of local narcissism' and a patronage-based political culture which has not been countered balanced by 'serious nation building' or development of a national political consciousness (Patience, 2004).

National level politicians have probably 'benefited' most from decentralisation as their power has increased relative to central government bureaucrats and local politicians since independence. Early on, MPs came to resent the control of local development funds by provincial politicians which led in 1984 to the creation of new development funds controlled by national MPs. Initially these funds were a relatively modest Kina 10,000 per annum for each MP (about US\$4500 at the time) but now are worth Kina 1.5 million (US\$500,000) per year. However, accountability for these funds is weak and disbursements are often based on narrow political considerations rather than government policies and priorities. Control of local development funds has also enhanced the economic importance of electoral processes, as victory ensures politicians access to large sums of public monies, as well as status in their clan and community groups. One consequence has been increasingly violent elections (the worst being in 2002 in areas such as the Southern Highlands) with widespread intimidation, ballot rigging and kidnappings.

In response to some of these governance challenges, a number of initiatives have been introduced, including the 2001 *Integrity of Political Parties and Candidates Law*, which is intended to enhance political stability by protecting new governments from votes of no confidence during their first 18 months in office. The law also places restrictions on parliamen-

Notes

10 'WHO warns PNG of AIDS scourge', *PNG Post-Courier Online*, 23 September 2004.

11 'AIDS threat too serious for PNG', *PNG Post-Courier Online*, 28 July 2004.

12 *Wantok* literally means 'one language' in pidgin, but more generally refers to the set of traditional customs and obligations associated with being a member of a social group.

tarians who might otherwise switch parties for opportunistic reasons. In addition, the government has supported a number of public sector reform processes,¹³ largely foreign funded, although their success has been variable.

2.3 Public sector institutional context

The functioning of PNG's public sector needs to be understood in light of the broader governance situation described above. The public sector institutional context refers to the rules and procedures for government operations (e.g. financial, personnel management), relationships among institutional actors (line ministries, central agencies, decentralised administrators, elected officials), the financial resources governments (at various levels) have at their disposal, concurrent policies, and structures of formal and informal influence (see Grindle and Hildebrand, 1994). This report will examine in particular the relationships between NDoH and other central government agencies, and relationships among the various levels of government - national, provincial, district - under PNG's system of decentralisation.

One of the questions of interest to the research team was the manner in which NDoH 'manages' its external environment, and how effective it has been in that respect. A first observation is that many of the factors described above, particularly those in the broader 'action environment' (e.g. the economic situation, law and order problems) are clearly beyond the Department's control, although it is fairly evident that they do have a significant impact (albeit difficult to measure) on sector performance and efforts to enhance capacity. On the other hand, NDoH has actively addressed challenges in the public sector institutional context (e.g. public sector reforms, decentralisation) relying on various means (see more below). While the latter are not part of a capacity development strategy per se, they reflect an acknowledgement, by NDoH and external stakeholders, of the potential of factors in the broader 'capacity system' to enable or constrain health reforms.

Overall, the study team found the context within which NDoH and other sector actors operate to be extremely challenging, and according to many observers it is likely to get more difficult before it gets better. NDoH and other actors are thus faced with an ongoing challenge to manage their external

environment (or capacity system) as effectively as possible - i.e. to limit constraints and seize opportunities - and to use the human, financial and other assets available to them, including relationships, as creatively as they can to sustain or improve sector capacities and performance. Efforts to address capacity and performance issues need be understood in light of these broader contextual challenges, which have the potential to drain resources and confidence away from important change processes in the sector. On the other hand, some of the successes in PNG's health sector (see section 5) highlight the importance of specific variables, such as the attitudes or skills of managers, to deal with important contextual factors, or the ability of organisations or particular units to isolate themselves from 'dysfunctions' in the broader system.

3 Stakeholder relationships and external interventions

The research team endeavoured to understand how patterns of stakeholder interactions have influenced processes aimed at improving capacities and performance in PNG's health sector. A premise of the broader ECDPM study is that the stakeholders of an organisation or system - more specifically, their interests, conflicts in expectations, modes of behaviour, resources, relationships and intensity of involvement - can shape the process of capacity and performance improvement. Their behaviour can also shape demand, performance, legitimacy, commitment and sustainability.

3.1 PNG stakeholders: who they are and how they collaborate to support capacity development

The National Department of Health and the health sector at large are part of a broader system of governance and service delivery (public and private) in PNG. Within that system, NDoH is a major social sector actor whose interests are regularly reflected in national development policies and priorities. However, like other actors, NDoH has to compete for limited resources and do its best to ensure that its policies and priorities are not undermined by deci-

Notes

- ¹³ The current *Strategic Plan for Supporting Public Sector Reform 2003-2007* (GoPNG, 2003a) seeks to support the government's medium-term development strategy. It includes initiatives related to 'good governance', one of three objectives in the strategy for 'recovery and development', and focuses on performance management, affordability and service delivery.

sions beyond its direct control, the agendas of other departments or agencies, or that it is not overwhelmed by some or all of the external factors described above. It also has to ensure, to the extent possible, that broader government policies and procedures are informed by health sector interests and are supportive of the Department's priorities.

Within the health system, numerous stakeholders function at various levels: national, provincial and district. Together they represent a complex set of institutional relationships - some of them based on common interests, others with different interests or priorities. Key stakeholders at the national level include: the Departments of Health, Finance, Personnel Management, Provincial Affairs and Local Government, National Planning and Rural Development, Community Development, the National Monitoring Authority, the National Economic and Fiscal Commission, the Churches Medical Council (CMC), the Central Agencies Coordinating Committee (CACC), the Institute of Medical Research, and various tertiary education institutes. Stakeholders at the provincial and district levels include the provincial assemblies, provincial/district administrators, joint provincial/district planning and budget priority committees, provincial health boards, provincial hospitals, district health offices, aid posts, health centres, the Church Health Service, community-based health care providers and, of course, the users of the health care system. NDoH's role is central given its overarching mandate for health policy, standards and oversight in the sector (see box 3).

As alluded to in the previous section, NDoH is conscious of the need to manage stakeholder interests effectively in order to advance its own objectives. For example, the Department has a record of successfully engaging a broad range of stakeholders in health policy development processes, which helps explain why there appears to be broad consensus on PNG's health policies. At the operational and administrative levels, however, management of a diverse range of stakeholder interests has been more of a challenge for NDoH, despite regular efforts through formal and informal mechanisms (e.g. national-provincial consultations, partnership agreements). Some of NDoH's challenges are structural in nature, such as the vertical disconnect between NDoH and the provinces/districts following from the 1995 New Organic Law. NDoH launched a number of initiatives (see section 4.3) to respond to the challenges associated with the NOL,

Box 3: National Department of Health

The mandate of NDoH is to

- oversee the establishment, maintenance and development of a health care system in the country;
- set policy and fix standards for the improvement of the health of the population; provide technical advice and support for the operation of health facilities and the delivery of services;
- oversee the management of public hospitals in accordance with the Public Hospitals Act; and
- maintain a national health information system.

Source: Thomason and Kase (undated: 4).

but according to many respondents and commentators, fundamental problems with the law remain, at least from a health delivery perspective, which suggests a disconnect between the vision of decentralisation in PNG, which is substantially politically driven, and the policy objective of improved health services, especially in rural areas.

Other challenges reflect differences in organisational priorities and expectations among national government actors. For example, the Departments of Finance and Personnel Management are mandated to manage the size of the public service and contain the overall costs of government - both legitimate objectives. However, the provinces have borne a disproportionate share of the cuts in public service positions in recent years, and since health is the sector with the largest proportion of staff, it has taken the greatest share of these cuts. In fact, the *Functional and Expenditure Review of Rural Health Services* suggested that 'health positions have been cut (often arbitrarily) in response to DPM staff ceilings' (GoPNG, 2001a: 17). Interestingly, teaching positions have not been similarly affected as they come under a different service structure managed by the Teaching Service Commission. This experience underlines the importance of organisational arrangements and responsibilities for decision making on staffing levels to the realisation of sector policy objectives.

Stakeholder collaboration is also important to support capacity improvements in NDoH and the sector more broadly. At the sector level, there are various examples of stakeholder collaboration which have contributed to enhanced capacity or more effective utilisation of existing capacity. Government-church collaboration, in particular, has been extremely important - the churches operate about half of PNG's health facilities and make a major contribution to training of health workers. The Churches Medical Council (CMC)¹⁴ plays a central role as it facilitates coordination among the churches and between the churches and government. The CMC was founded in the early 1970s and has been involved in a range of activities from negotiating financial arrangements for church health facilities with the government to promoting church-government policy dialogue. It also organises annual conferences in advance of the GoPNG's National Health Conference, which provides the CMC Board and members with an opportunity to formulate their views on key issues so that they can be conveyed to the government in a timely manner. The CMC is a unique mechanism for stakeholder collaboration in PNG as it provides a regular forum for a diverse group of church-based organisations to exchange views on health reforms while serving as an importance interface with the government.

In the context of health reforms, the SWAp itself is another factor which can influence relationships amongst domestic stakeholders, occasionally bringing to the fore differences in organisational interests. For example, the Health Sector Improvement Programme Management Unit (HSIPMU), which has been proposed within NDoH, is seen by some as impinging on traditional central agency responsibilities for coordination with development partners. Efforts have been made to manage potential tensions of this sort between line and central agencies by engaging the latter in sector reform processes. For example, under the ADB's Health Sector Development Programme (HSDP) - the first step towards the health SWAp - the Department of Finance was designated as the executing agency and NDoH the implementing agency, a recognition of the importance of broad-based ownership and effective collaboration under the SWAp. A programme coordination committee was also established through HSDP with members from various government agencies and the provinces to broaden stakeholder involvement. Similar arrangements have been made through AusAID's Health Sector Support Programme (HSSP).

NDoH has also made efforts to engage stakeholders through GoPNG internal mechanisms, or other means, in order to influence relevant actors or to keep plugged into broader governance and administrative change processes of consequence to the sector. For example, NDoH negotiated successfully with the Department of Finance to secure recentralisation of appropriations for the Church Health Service and for hospital funding, which was very beneficial in terms of expediting cash flows to relevant facilities. NDoH has also cooperated with the Department of Finance on reforms under the ADB-sponsored Financial Management Improvement Programme (FMIP), which has resulted in improved public health expenditure reporting, thus addressing an important concern of the Department of Finance and donor partners.

Despite some 'successes' though, the situations described above underline the difficulty of managing a broad range of stakeholder interests, and ensuring effective use of capacity and consistent 'all of government' buy-in on sector reforms, including the SWAp. They also point to some of the risks associated with a predominantly 'functional-push strategy', i.e. focusing on internal systems and skills, particularly if insufficient attention is given to issues of power, competing interests and the informal dynamics of stakeholder relationships. Ultimately, the impact of this set of institutional relationships and associated 'rules of the game' remains an open question, albeit one that could limit sector reforms over the longer term if not managed effectively. The situation is probably accentuated by what is seen by some as a 'crisis of governance'. The result, crisis or not, is a set of inter-organisational tensions which require ongoing negotiations on a range of policy, programming and administrative fronts. The challenges are enhanced in a highly stressed context with actors being pushed by diverse interests, operating within constrained fiscal parameters and not having the benefit of consistent political leadership and support. These tensions also play themselves out in a context which has not traditionally demonstrated high levels of bureaucratic collaboration (see section 5.2).

Given all of this, a question which arises for NDoH is whether current mechanisms and strategies for engaging stakeholders are working as effectively as they might, or if there is a need for changes in the way reform issues are negotiated amongst stakeholders. Recent reforms, such as the establishment of the

Notes

- 14 The CMC represents 27 church groups involved in the delivery of health services in PNG. The Council works closely with NDoH and have their office in NDoH headquarters in Port Moresby.

Central Agencies Coordinating Committee (CACC) in the Prime Minister's office, are seen by some as promising, but respondents suggested it is too early to say how successful they might be in bridging differences among stakeholders. It is also widely acknowledged that SWAp mechanisms need to be strengthened to ensure regular dialogue between government and donors on strategic issues, as well as ongoing coordination and problem solving. An additional question for NDoH's consideration is the extent to which it should rely on formal mechanisms versus 'political' strategies to influence stakeholders and address pressures in the broader environment.

3.2 External interventions: an evolving approach

AusAID and the ADB are the largest external contributors to PNG's health sector. Other donors include the European Union, WHO, JICA UNFPA and USAID. The ADB has supported PNG's health sector since 1982 through four loans. The first three loans focused on rural health services, while the fourth, the Health Sector Development Programme (HSDP) (US\$60 million over five years), underwrote long-term reforms in the delivery system. The HSDP was completed at the end of 2003 and the Bank is now assessing options for a next round of support to the health sector.

ADB's HSDP was advanced as a new approach, with elements of a SWAp. It was intended to support implementation of the National Health Plan (1996-2000) and to reflect the changes introduced through the NOL. It included technical assistance to support improvements in health monitoring, budgeting and accounting, with support provided by the HSDP Secretariat to NDoH and the provinces. While progress was made through the HSDP in financial reforms and increasing access to drugs and funds for rural facilities, targets in other areas were not met. In a review of the HSDP, Izard and Dugue (2003) attributed at least part of this to an attitude of 'non-compliance' among district-level staff who refused to recognise HSDP procedures or the authority of the provincial health advisers. This underlined, once again, the challenge of concurrently implementing sector reforms and a new approach to decentralisation which significantly changed relationships among sector stakeholders.

AusAID, for its part, commenced the design phase for its Health Sector Support Programme (HSSP) in 1999,¹⁵ which was followed by a transition plan to

the HSSP as part of an ongoing progression towards a SWAp. The HSSP, with funding of US\$70 million over six years, supports GoPNG's Health Sector Improvement Programme (HSIP). The HSSP ends in 2005, but AusAID is now developing plans for the next phase of support to the health sector. AusAID moved from budget support to PNG in the 1980s, to programme/project support in the 1990s, and is now shifting towards sector programmes - in health and 'law and order' - reflecting AusAID's desire to be more holistic in its approach and to pay more attention to local ownership, policy dialogue, management, leadership and inter-sectoral issues. In support of these changes, AusAID has decentralised a number of staff from Canberra to Port Moresby over the past few years. These changes also responded to the concern within PNG's health sector that they were 'drowning in projects' that placed significant demands on government systems and made it difficult to maintain a clear, overall sense of the reforms.

3.2.1 Capacity development strategies and methods

In 1996, the GoPNG requested Australian support to implement the 1996-2000 National Health Plan and to improve delivery of services in the context of the New Organic Law. Initially, the support was to focus on three provinces, but later it was decided to broaden the approach to address health service delivery across all provinces, although with an initial focus on six provinces. Early in the HSSP, the need for a broad human resource development strategy was acknowledged, and the intent was that this would form the basis for a strategy for 'human resource capacity development' in the sector, although this did not proceed fully given NDoH instability at that time and uncertain commitment by donor partners.¹⁶ A broad strategy for capacity development for the health sector was thus not articulated in the HSSP's foundation documents, nor has one been developed since by AusAID or NDoH.

An Australian managing contractor (AMC) was engaged by AusAID in 1999 to support implementation of HSSP. As of mid-2004, the AMC had 14 foreign advisers in Port Moresby, 13 in the provinces, and 20 local consultants, all supported by the contractor's professional staff in Australia. The AMC's approach has been described as a 'quality improvement strategy' to ensure that advisers focus on clearly defining how they develop capacity, in consultation with their PNG partners.

Notes

¹⁵ Initially the HSSP was called the Rural Health Assistance Programme.

¹⁶ Parts of the strategy that did proceed included workforce planning, policy development, database, and some work on performance monitoring.

The approach to capacity building was discussed at a 2001 HSSP Programme Coordinating Group (PCG) meeting. It was agreed that the HSSP would 'examine a formalised approach to defining and supporting a range of capacity building strategies between advisers and their PNG partners; partner branches and provinces, and the development of support systems for the health sector' (PNG HSSP, 2004: 3). Areas to be covered included: individual adviser-partner capacity building plans; capacity mapping; joint capacity planning and prioritisation (e.g. budgets, resources); development of tools for systems (e.g. policy development, medium-term expenditure framework); and development of organisational processes (e.g. HSIP mechanisms, vetting of provincial health budgets). In other words, the approach would rely on elements of both push and pull strategies, but with a predominantly functional orientation.

Over the past few years, the AMC has prepared a number of documents on 'capacity building' outlining concepts, approaches and a 'vision' based on multiple levels, from individual to societal.¹⁷ Operationally, the AMC's responsibilities under the HSSP have been mainly, although not exclusively, at the individual and organisational levels. There was no expectation that they would take a 'whole of sector' approach, although inputs over time have increasingly involved a range of policy, systems and institutional concerns. Examples of HSSP's capacity building work at the individual, organisational and sector levels include support for:

- preparation of the National Health Plan;
- provincial strategic planning processes linked to the performance measurement framework and outcomes;
- annual activity planning process and systems, including expert panel review;
- hospital strategic planning process linked to hospital standards;
- development of a partnership policy and process, and agreements with the Churches Medical Council;
- reorganisation of selected health services at provincial level;
- development of a new procedures manual for the provinces;
- development of a health centre kit;
- development of a national health radio network;
- competency-based training;
- a review of competency requirements for community health workers, leading to an updated training curriculum;

- clarifying management competencies required by provincial and district health managers, leading to the development of in-service management training; and
- capacity mapping within NDoH in order to identify gaps, strengths and areas where performance needs to be enhanced.

The HSSP has also supported twinning arrangements, such as between selected PNG provincial hospitals and Australian hospitals, and between PNG's Institute of Medical Research and NDoH to undertake applied health services research. In addition, the HSSP has facilitated inter-provincial arrangements, e.g. between hospitals on infection control, and visits by the Morobe provincial health management team to other provinces to advise on performance measurement and financial management.

Based on the material available, and feedback from interviews, it appears that AusAID and the ADB have relied on a staged approach to capacity development under the SWAp, with significant emphasis upfront on technical assistance (TA) inputs to strengthen local skills and systems, and reliance on external TA to support NDoH and the provinces to deal with a range of policy, planning and partnership-based issues. Various respondents noted the benefits of an iterative approach, as it allows stakeholders to refine their approach to capacity development over time. On the other hand, the approach has not, as yet, been grounded in a systematic assessment of capacity issues within the sector, or beyond. Nor has it benefited, at this stage, from structured learning processes to derive lessons about capacity development processes - what works, what doesn't and why.¹⁸ The capacity mapping exercise proposed by the HSSP team and NDoH senior staff (mid-2004) is a partial response to the need for a more systematic consideration of functional capacity issues. It also reflects NDoH's intent for HSIP stage 2 to 'more explicitly plan the capacity building activities in the sector (at sectoral, system,

Notes

¹⁷ The *Annual Review 2003* describes capacity building as 'the long-term systematic process of achieving the management goals of the HSIP, including the establishment, support and enhancement of systems and procedures for effective planning, resource allocation, accountability, monitoring and evaluation, and human resources development at all levels of the health sector' (PNG HSSP, 2004: 2). The same document offers AusAID's definition of capacity building which is broader and less operational: 'the process of developing competencies and capabilities in individuals, groups, organizations, sectors or countries which will lead to sustained and self-generating performance improvement'.

¹⁸ The exception is the first *Capacity Building Plans, Annual Review 2003*, prepared for AusAID by the HSSP team (PNG HSSP, 2004).

organisational and individual levels)' in support of the continued development of the SWAp.¹⁹

With reference to the typology of Boesen *et al.* (2002), the findings above suggest that the approach to capacity development in PNG's health sector has relied on elements of both push and pull strategies, but with a predominantly functional orientation. The 'push' aspect (which has been more dominant) relates to the emphasis on internal issues which are primarily of a functional nature - skills, formal organisational structures and systems. These have been supported mainly through TA, mentoring relationships and twinning arrangements. There is less of a deliberate or planned 'pull strategy', as internal actors simply deal with external stakeholders on a pragmatic basis in response to threats to their organisational interests. These responses are both formal and informal in nature.

Elements of a 'political' approach have been introduced, although somewhat piecemeal, as external advisers and PNG colleagues have collaborated to tackle broader sector and governance challenges affecting the health system. In a sense, the health SWAp and broader governance reforms (e.g. decentralisation) have necessitated a shift towards a pull strategy with increasing attention given to political/power issues in the public sector and broader external context in recognition of their significance to sector reform processes. This is a 'logical' progression, but also one that increases pressure on and expectations of NDoH, as a central actor in the sector, to 'manage' not only internal capacity issues, but challenges in the broader capacity system as well.

3.2.2 External support: moving forward

Based on experiences to date with the health SWAp, the GoPNG has indicated that it wants to modify the approach in the next phase - essentially to expedite the strengthening of local capacity, greater reliance on local systems, and reduced emphasis on external advisers. Among the challenges for the parties negotiating the next phase will be satisfying PNG stakeholders' desire for greater control and ownership of

health reform processes, while assuring AusAID and other donor partners that PNG systems are sufficiently strong to merit sizeable financial investments.²⁰ In other words, the issue of PNG capacity will be key, including establishing clear understandings of requirements for capacity investments, the time frames needed to develop capacity, and the most effective methods to support mutually agreed objectives.

The *Health Sector Resourcing Framework* (AusAID, 2003d) proposes a way forward for the next phase of Australian support. It calls for 'a significant shift in the nature of AusAID's support', with a further move away from project-based assistance towards a broader modality which can 'address deep seated systemic issues of the entire health sector' (AusAID, 2003d). The proposal calls for continued budget and other support (estimated at US\$40-45 million per year), including provisions for a 'Capacity Building Service Centre' (CBSC) - a technical assistance facility for AusAID TA - which is described as demand-oriented, flexible and linked to the service delivery priorities of the provinces, as well as central functions to support rural health services. The Centre is to be managed by an Australian contractor, but will report to the NDoH (through the HSIPMU).

The next phase proposal, including the CBSC, represents a further progression in the approach to capacity development. For example, it will continue the move towards greater reliance on PNG systems, including having the HSIPMU take over responsibility for capacity building inputs from the CBSC, likely within five years. The CBSC's activities will also be aligned clearly with NDoH's priorities and the work-plan details of various sector stakeholders. At the same time, the proposed approach still appears to lean to a considerable extent on a functional orientation to capacity issues with significant, albeit diminished, reliance on TA as the 'tool of choice' for capacity development. Based on the documents available at the time of the study, less attention appears to have been given explicitly to broader systemic issues and factors in PNG's enabling environment, which could ultimately be as important, if not more so, than TA in either advancing or thwarting change in the sector. Furthermore, as a demand-driven mechanism, the CBSC runs the risk of responding to discrete and relatively isolated capacity needs, rather than mutually reinforcing investments, particularly in the absence of a comprehensive capacity development strategy for the sector.

Notes

- 19 Details of the capacity mapping exercise were still being negotiated with development partners at the time of this study. The ToR describe capacity mapping as a 'process for identifying, planning and resourcing capacity building interventions and support to the sector'. It is expected that it will look at 'capacity needed to ensure performance ... capacity gaps and strengths' in relation to the health priorities in the Medium-term Expenditure Framework, the functions of the HSIPMU and associated needs at the provincial level.
- 20 The ADB (2003b: 23) suggested that 'stakeholders and especially donor partners will not be able to adopt the systems until they are significantly strengthened'.

The proposal also talks about contributing to 'sustained and self-generating performance improvement'. NDoH and other actors will have to consider what types of strategies will be required to support 'sustained improvement' in a context where domestic resources to the sector are expected to decline, the overall economic situation is precarious, the governance situation is strained and an AIDS epidemic is looming. These realities may call for prioritisation of capacity development strategies which are particularly sensitive to a 'high stress' environment - e.g. focusing on low-cost interventions, improved capacity utilisation (versus developing 'new' capacities), shedding ineffective capacity, promoting best practices, networking, sharing of resources, or encouraging new incentive systems.

These considerations aside, PNG's experience in establishing and indigenising a 'capacity building facility' will be instructive to learn from - e.g. how it is geared up and mainstreamed within GoPNG, what strategies are utilised, the extent of reliance on external versus domestic inputs, mechanisms for learning about capacity development, how the CBSC collaborates with PNG stakeholders outside the health sector, its potential for enhancing coordination of external resources, and the Centre's overall effectiveness in strengthening sector capacity and contributing over time to improved performance.

Finally, on the way forward, while the proposals for the next stage have been endorsed by GoPNG, there is still a question, as suggested above, as to how these externally funded capacity development interventions will fit into a domestically driven vision of change. For example, what is GoPNG's overall assessment of the capacity challenges facing the health sector? What are the strategic priorities, or entry points, to respond to these challenges? What capacities or capabilities, in particular, need to be developed? How should interventions be sequenced? What mix of individual, organisational and systems level interventions is required, and how can these be managed to ensure complementarity? How will future health sector initiatives be coordinated with broader governance reforms in PNG? And what is foreseen in terms of support for initiatives at the community level and outside the Government Health Service? In essence, what is the 'theory of change', what strategy will be adopted to implement that 'theory', and how will the government ensure that the changes envisaged are sustained?

4 Internal organisational issues and systems features

This section considers issues and features within NDoH, and the sector more broadly, which have influenced processes aimed at improving capacities and performance. As noted in the ECDPM methodology, capacity and performance can be developed, sustained, improved or downgraded partly by their relationship to various features of the organisational setting or system of which they are a part. Relevant features in this case include organisational values and culture, internal and external relationships, structures, resources and strategies.

4.1 NDoH: capacity strengths, weaknesses and strategies

The study did not include a detailed examination of the Department of Health's capacity, and understanding of key internal issues was hampered by the limited access to senior NDoH staff and modest documentation on internal capacity issues. Nevertheless, some general observations can be offered on internal organisational features affecting capacity and performance. The first is that NDoH is generally seen as being 'reform minded' or 'forward looking' in relation to other government departments. This is attributed, in part, to the long-serving senior managers who have brought years of experience and a high level of commitment to their tasks. Manifestations of the Department's reform orientation include the National Health Plan, which is well regarded, and the leadership shown by the Department in initiating the SWAp. These sorts of intangible assets are seen as crucial to reform processes, such as the one PNG's health sector is undergoing.

The research also suggested that NDoH has other technical strengths, such as drafting legislation and the national health information system, although both the reliability of the data collected and the uses to which it is put (e.g. by sector managers) were questioned. The NDoH has also benefited from the inputs and support of external advisers, including for the Medium-term Expenditure Framework for the sector (2004-2006), which has helped to link sector plans more realistically to budgets.

In addition, the Department has demonstrated its capacity to respond to broader governance reforms by taking a proactive role in helping the provinces implement the New Organic Law. The 2001 review of rural health services by the Public Sector Review Management Unit (PSRMU) noted that: 'In many ways, the NDoH has made far greater strides in implementing the reforms than any other national government department. Its achievements include:

- instituting a uniform system of programme planning and budgeting, and training staff across the country in its use;
- development and enactment of the *National Health Administration Act*, which established a framework for standard-setting and oversight of the sector by NDoH, and consultation and liaison through a tiered hierarchy of health boards;
- establishment and orientation of provincial health boards in most provinces;
- development of the 2001-2010 National Health Plan as a blueprint for the whole health sector, establishing priorities that aim to use scarce resources to benefit the maximum number of people and address the priority health problems;
- development of standards for performance management, including minimum standards for district health services;
- establishment of donor funding programs that leverage greater spending by provinces on health, including the negotiation of Health Sector Improvement Programme agreements with 14 provincial governments; and
- design and dissemination of public health programmes that address priority causes of death and disease, including TB and malaria programmes' (GoPNG, 2001a: 10-11).

Respondents and documentation also pointed to a number of weaknesses in NDoH relating to strategic management, human resource management, organisational arrangements and relationships, all of which influence internal effectiveness and the ability to address sector issues. For example, the senior executive management committee was described as too big and cumbersome, and as not holding regular meetings, which raised questions about the overall strategic direction within the Department. Other internal capacity issues noted by respondents which affect NDoH's performance included: specific gaps in staffing (e.g. for monitoring and research, the immunisation programme), financial management, pro-

blems in lines of command and communication, and limited advances in performance-based approaches. Acknowledging some of its internal weaknesses, NDoH engaged a consultant to help it address a number of issues, including the role of the core executive group vis-à-vis the broader senior management group, the organisation of its branches (e.g. how to ensure a match between staffing and sector needs), the role of the HSIPMU, and how to be more responsive to provincial needs.

The Department has also developed a *Human Resources Development Strategy* (NDoH, 2002) pursuant to the new National Health Plan. As noted above, it recently initiated a capacity mapping exercise, to be guided by a 'capacity building reference group' with representatives from NDoH, the provinces and the PSRMU. The mapping exercise will provide inputs to guide 'capacity building interventions', and associated resource allocations, under HSIP stage 2 and the Medium-term Expenditure Framework 2004-2007. These undertakings reflect the Department's recognition of the need to think systematically about capacity issues, although next steps will have to be thought through carefully, in concert with other sector stakeholders, in part to ensure that factors external to the Department are adequately addressed.

In terms of overall orientation, as suggested in section 3, NDoH's efforts to address internal organisational issues have focused to a considerable degree on human resource development, with increasing attention to structures, relationships and strategic management. 'Soft capacities' such as learning, organisational values and incentive systems appear to have received less attention. Furthermore, NDoH seems to have focused to a considerable degree (not unlike many organisations) on the development of new skills and competencies, and less on strategies explicitly aimed at making more effective use of existing capacities, or even 'creative destruction' of capacities that are no longer relevant or have proven to be ineffective. Consideration of the latter may merit greater attention in future, particularly in light of PNG's fiscal situation and the unlikely prospect of increases in the health workforce.

4.2 Sector priorities and needs: the human dimension

The National Health Plan 2001-2010 identified human resources management as one of the priorities in the

sector requiring most attention. However, questions have been raised with respect to the capacity of the NDoH Human Resources branch to address the priorities outlined in the plan. One source attributed this, at least in part, to public sector reforms and downsizing (PNG HSSP, 2000: 77). Workforce planning, training and mobilisation have also been limited by the lack or poor use of information. For example, decisions on student intake for pre-service training have not been based on solid information about future sector needs. Consequently, PNG has an excess of graduates in some areas, and persistent skills shortages in others, e.g. midwives, general nurses for rural health services. In addition, national health staffing statistics are only pulled together on an irregular basis, despite the existence of a computerised information system. Thus, the HR branch has 'no direct access to information on health sector employees ... [as] reliable records of those employed through NDoH are not available [and] numbers of permanent staff in hospitals are not known' (ADB, 2003b: 6).

One of the challenges in HR management in PNG's health sector is the diffused responsibility. As indicated in the 2002 *Human Resources Development Strategy* (NDoH, 2002), human resources are the responsibility not only of NDoH, but also of DPM, the national training institutes²¹ and local level managers. As a result, many HR initiatives are launched in response to individual organisational needs without fitting into an overall, coordinated sector strategy. Decentralisation has also contributed to poor use of human resources as the expansion of health facilities is not linked to the availability of qualified staff. These realities point, once again, to the importance of structures, relationships, integrative mechanisms, and incentives for collaboration to ensuring effective planning and use of capacity in the sector.

Another factor influencing efforts to enhance capacity is the limited supply of appropriately qualified people to enter the sector as health workers, especially women and people from rural areas, given their low level of participation in formal secondary education. Training schools for community health workers and nurses, as well as medical schools, have also recently increased their entry requirements, although the number of eligible applicants still exceeds the number of places available. The demand for additional staff is expected to increase as PNG's population doubles over the next 25 years, putting pressures on the health budget, which NDoH will be hard pressed

to meet. Ironically, large numbers of staff have been retrenched in recent years with the expectation that the money saved would be used for other priorities. However, the net result was not only a loss of services but a negative impact on the budget given the generous retrenchment package. Mobilising new recruits or posting existing staff to rural areas (where the needs are greatest) are also problematic given concerns about safety and adequate housing. The HR development strategy has called for a review of incentives and partnerships with villages and local governments to address constraints of this nature.

The institutional capacity for training nurses and health workers also decreased in the ten years leading up to 2002 as ten nursing schools were closed, leaving six active schools and one new nursing programme at the Pacific Adventist University. There are 14 schools for community health workers, all run by the churches, but many are understaffed and some are reducing their intake. The institutional landscape for tertiary health education and training in PNG is thus changing, as some schools close and new actors, such as the Divine Word University (DWU), emerge. A number of organisations, such as the College of Allied Health Sciences, have amalgamated with DWU, while others have established affiliations with the new university. Organisations such as DWU operate as independent corporate bodies and therefore are not subject to government rules for hiring and firing, which affords them greater flexibility to address their needs and priorities. It will be interesting to observe how entities such as DWU, and their affiliates, perform and respond to the requirements of the health sector, in light of the new institutional arrangements and their greater flexibility relative to state-run organisations.

4.3 The institutional 'rules of the game'

At the level of PNG's broader health and governance systems, there are a number of challenges, some of which have been alluded to already. This section looks at two aspects relating to the institutional 'rules of the game'. The first has to do with the relationships between NDoH and central agencies in the GoPNG. As noted in section 3, NDoH's relationships with other government agencies and departments (e.g. Personnel Management, Finance, National Planning and Rural Development, and Treasury) have consequences for performance of the Department itself and the sector more broadly. Securing the cooperation of those central agency partners is tremendously

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- 21 Responsibility for tertiary level health training has recently been transferred to the Office of Higher Education, which consults NDoH on human resource requirements for the sector.

important to NDoH, whether it be on health financing, personnel management, coordinating relationships with donor partners or influencing relationships with the provinces and districts.

The move towards a SWAp has yielded some successes, in terms of enhanced NDoH-central agency relations, while some challenges remain. Under the ADB's HSDP, for example, after early disagreements between NDoH and Finance over the control of health funds, agreements were successfully negotiated. The HSDP Secretariat was then placed within the Department of Finance, which played a key liaison role vis-à-vis the other central agencies, besides providing valued support to the provinces. On the other hand, there continues to be a perception that the Departments of Personnel Management and Finance have not been sufficiently responsive to personnel management and performance issues affecting the health sector.

A second aspect has to do with the relationships between NDoH and the provincial and district level governments. One dimension of this concerns the financing arrangements between the various levels of government. PNG's health care system is financed by the national government, provinces, donors and user fees. GoPNG allocates funds directly to the NDoH as well as to provincial hospitals and church-run health services. It also provides block grants to the provinces which fund health as well as other functions. However, since the block grants have traditionally supported a range of functions, from agriculture to community development, commitments to the health sector have not always been guaranteed. In recognition of this, NDoH negotiated to have a portion of the national grant 'ring-fenced' for use within the health sector at the provincial and district levels. Not surprisingly, some provincial actors see this as contrary to PNG's policy of decentralisation and as unduly limiting their authority to commit funds to locally determined priorities, even including non-health items that may affect the sector. As one (non-health) provincial official stated: 'We cannot conduct maternal and child health patrols because there are no roads and many health workers have left their posts because of lack of access to provincial headquarters and because supervisors cannot get to visit them. In addition, at the district level, resources such as vehicles from other sectors need to be shared for health work, and ring fencing health money may cause other sector officials to stop cooperating'.

Another important feature of the intergovernmental rules of the game in PNG is the New Organic Law. The 1995 amendment to the law was introduced as a response to, among other things, the perceived shortcomings of the provincial government system. Nine years on, however, the consensus within the health sector is that it has contributed to the deterioration of health services, for a number of reasons. One is that given the technical nature of health services, there is a need for a high level of vertical integration amongst actors at various levels. The obligation of provincial health staff, for example, to report to the provincial administrator, a generalist, as opposed to the provincial health adviser - NDoH's 'senior representative' in the province - is seen as disrupting this link. Second, there are not enough qualified staff in PNG to manage these functions in 89 districts, particularly in the context of a shrinking public service. Also, as noted by our respondents, and in many reports, the Organic Law has limited NDoH's ability to influence provincial governments and districts in terms of how they set priorities and fund implementation of the national policy.

Provincial revenue-generating capacity was also diminished as a result of the NOL and provinces have not lived up to their own funding commitments for the sector.²² Even when funds are committed by the provinces, they often do not reach district health facilities since the latter may not have access to banks or other means of cashing cheques. These financing and cash flow problems have contributed to diminished service delivery (especially in rural areas) with real consequences for overall sector performance. Domestic financing problems have also led to greater reliance on donor funds for recurrent expenditures, which has raised concerns about fungibility and the sustainability of sector investments. Attempts to influence capacity and performance, particularly at the sub-national level, need be seen in light of these broader considerations.

The 2001 *Review of Rural Health Services* (GoPNG, 2001a) listed several other challenges posed by the Organic Law, including the following:

- While planning has been devolved to the district level, planning capacity at that level is limited. As a result, district level plans and budgets tend to be unrealistic and initiatives are not prioritised or linked well to government policies.
- The involvement of politicians in budgeting (through the joint provincial/district planning and

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²² It was agreed at the 2000 provincial Governors' Conference that at least 15% of discretionary provincial funding would be allocated to health. In 2001, however, the provinces allocated an average of 3.3% of their internal revenues to health, and some of them none at all.

budget priorities committees) has crowded out technical managers, which has affected sector-based planning and priority setting.

- Discretionary spending by national MPs at the district level is not linked to provincial or district level plans or budgets, which means that when such funds are spent on health facilities, for example, they may not correspond to national priorities or take into account recurrent costs.
- Hospital CEOs, senior clinical staff and provincial health advisers with the knowledge and experience to run the health system (and to whom district staff report on technical matters) cannot discipline staff in rural areas, nor direct them with regard to financial and material resources.
- There is no provision for reviewing the overall sectoral allocation, or sectoral allocations among provinces, or among districts within provinces. No one individual has responsibility for considering needs and allocating resources holistically.
- Provincial governments and district administrations use different budget formats, which means certain items, e.g. from the national health policy, may be left out or can not be accounted for in expenditure reports at local or national levels.

Nevertheless, NDoH's response to the Organic Law is a good example of a capacity enabling strategy to deal with a legislative constraint which affects capacity and performance at the system and inter-organisational levels. First, the Department drafted the *National Health Administration Act (1997)* and a user handbook that clearly spelled out the responsibilities of the various levels of government in relation to the National Health Policy, taking into account the provisions of the NOL. The Act also created a parallel health board system with national and provincial boards given mandates to advise their respective levels of government and liaise with each other on performance issues.²³ In addition, the Act provided a means by which NDoH could negotiate for increased authorities for provincial health advisers at the provincial level in the 'national interest', a provision that has been accepted by some provinces, but not all. More recently, NDoH has also considered establishing a bureau at the national level to coordinate provincial health issues (somewhat analogous to the Churches Medical Council), which could help to improve relationships and communications between the two levels of government.

5 Capacities: what makes for effective capacity?

5.1 NDoH: capacity enablers and constraints

The preceding section touched on the issue of NDoH's core and organisational capacities. Here, we discuss what makes for effective core capacities (e.g. policy and planning), based on the limited access of the review team to Department staff. Key factors appear to include having a critical mass of like-minded, professionally qualified staff who have made a long-term commitment to the sector, and are motivated to innovate and make a difference. Among senior staff, it was also observed that many are relatively near the end of their public service careers and therefore might feel less restrained in pressing for change than they might have earlier on. In practical terms, the profile of senior staff points to the need for the Department to think about succession and to ensure that its credibility and legitimacy with relevant stakeholders are not diminished as responsibilities are handed over to the next generation of leaders. More generally, NDoH's experience underscores the importance of institutionalising the values, commitment and other 'capacity enablers' that can motivate staff and drive change processes.

In terms of organisational capacities, these factors also help explain the 'successes' of the Department in policy development and in other areas, such as health information systems. Additional factors include an environment which has traditionally been supportive of health as a policy priority, even if this is not always translated effectively into health as an operational priority of government. What appears to encumber these organisational capacities are a range of factors, some touched on already, including: organisational shortcomings within NDoH, some structural, others related to skills or management culture; inter-departmental and inter-governmental tensions; problems of policy coherence; and arguably the lack of a strong constituency outside of government to advocate for performance improvement and greater accountability.

5.2 PNG's public health system: key capacity influencers

As noted earlier, the extent to which capacity is effectively utilised at the provincial and district levels is

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- ²³ While this seemed a good idea to strengthen national-provincial links, most provincial boards do not meet regularly and so have not become a real factor.

affected by the arrangements associated with the New Organic Law. Under the NOL, for example, provincial and district level health staff generally report to the provincial or district administrator, rather than to the provincial health adviser. Interestingly though, there are indications that sector performance has been higher in provinces where the provincial health adviser has been granted supervisory authority over health staff by the provincial administrator, notwithstanding the provisions in the NOL.²⁴ This underlines the importance of institutional arrangements, including lines of managerial control and accountability, to effective capacity utilisation and performance, especially in areas such as health which depend on highly specialised knowledge.

Organisational culture can also have a significant influence on capacity utilisation and performance. Evaluations and reviews of government activities and programmes in PNG often refer to the lack of a performance-based culture, including the absence of sanctions for bad behaviour or underperformance, and few rewards to recognise strong performance. Performance audits carried out at the provincial and national levels between 2000 and 2002, for example, noted the 'inability or unwillingness of management to take appropriate action in the event of suspected breach of statutory requirements or ethical business practice' (cited in Izard and Dugue, 2003: 42). This led to the conclusion that 'perhaps one of the greatest constraints to progress in the reform process is the inability or unwillingness of senior management to exercise personnel management options in relation to non-performance or breach of ethical business practices. NDoH's ineffectiveness in this area of management responsibility is entrenched, supported by non-responsive central government agencies, in particular DPM and DOF' (*ibid*, p.43).

Another relevant factor in the PNG context is the *wantok* system, which can influence organisational behaviour, including the use of authority to proffer advantage to someone from one's tribe, family or regional grouping. While obligations associated with the *wantok* system are widely accepted in PNG, they can clearly be at odds with 'modern' management

practices, including performance-based approaches, and consequently can have implications for 'effective' use of capacity.

Participants at a 2002 conference on policy making in PNG pointed to 'institutional incentives' as a factor limiting collaboration and holding back policy implementation. One suggested that the lack of coordination among departments and agencies with common policy concerns was 'the result of an organisational model which focused on delineating operational territory and defending it against outside agencies. In such a situation, coordination becomes a low priority of organisational leaders' (May and Turner, 2002: 3). The authors went on to note that some participants were 'optimistic about the role of the recently established Central Agencies Coordinating Committee (CACC) and the Public Sector Reform Management Unit (PSRMU) [while] others recalled the limited achievements of a similar institution in the 1980s and early 1990s, the Programme Management Unit (PMU), and reserved judgment on the new arrangements'.

On the question of motivation, the capacity of NDoH to motivate actors in (and outside) the sector, or to provide meaningful extrinsic incentives²⁵ to improve individual or organisational performance is limited. The Department has limited funds, few in-service training or professional development opportunities or other means to encourage higher levels of performance. NDoH drafted the *Minimum Standards Act* and has increasingly tied provincial transfers to performance in an effort to induce higher levels of performance. In view of their own financial and other capacity constraints, however, provinces have had trouble meeting the standards specified in the legislation, although financial shortfalls are, as mentioned below, also a result of provincial underfunding.

According to our respondents and documented sources, other variables that serve as capacity influencers and which affect the quality of service delivery in the sector include: poor planning, management and supervision, limited in-service training opportunities for health workers, demoralisation of staff, provision of salaries without funding support services, poor alignment of health infrastructure and staff with the needs of the population, the closure of rural aid posts (which increases pressures on central facilities and incurs patient transfer costs), poor maintenance of infrastructure and political interference in programmes (GoPNG, 2001a: 21).

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²⁴ On the other hand, the team was told of one province which 'went by the books', with health workers reporting to district administrators. One consequence of this was reportedly a drop in immunisation coverage from 80% to 30%, although the team was not able to verify this claim.

²⁵ 'Extrinsic' motivation refers to additional benefits or disadvantages, such as pay (or lack of pay), which can be used as incentives to change performance. 'Intrinsic' motivation refers to the satisfaction that a person derives from doing a job well or being recognised for their effort (Boesen *et al.*, 2002).

5.3 Explaining effective use of capacity

Despite the various difficulties noted above, there are numerous examples of effective use of capacity within the sector. This can be attributed, to a considerable extent, to highly motivated and committed individuals (and groups) who 'keep the system afloat' in various locales despite significant constraints, such as lack of funds, or problems with supplies and transport.²⁶ These individuals include church workers, aid post personnel, other public servants, and community-based workers such as the *Marasin Meris*²⁷ (one respondent noted the preponderance of women among PNG's health workers, suggesting that many of them would 'work for a smile'). Some of the factors which account for these positive examples include: effective leadership, the commitment or personal values of service providers, a genuine desire to make a difference or give back to the clan or community, the ability to 'seize space' or use capacity creatively, effective collaboration amongst diverse stakeholders, and community support or involvement.

Milne Bay, PNG's largest maritime province (80% of the population live on islands), is seen as one of the higher performing provinces. Its 'successes' include keeping 95% of aid posts open, a village health volunteer programme covering the whole province, regular reporting from health facilities, and various programming innovations which have been replicated elsewhere in the country. The province also pays the salaries of several doctors at the provincial hospital out of internal revenues to ensure availability of specialist services. Provincial health staff in Milne Bay attribute their 'successes' to various factors including good leadership and supervision, regular staff meetings, high levels of staff commitment, investing in management training and learning, recognising districts and facilities that perform well, ensuring transport equipment (especially boats) is well maintained, and working closely with local communities. In addition, many of the staff have served in the province for a long time. The experience in Milne Bay suggests the benefit of diverse strategies - push and pull, functional and political - to moderate the effects of systemic constraints and to ensure effective use of capacity. It also underlines the potential importance of intrinsic motivations, especially when combined with effective leadership, quality relationships, a strong sense of service and community links.

Further on the issue of 'good performance', most interviewees suggested that the level of performance

of the Church Health Service in PNG is higher than that of the Government Health Service,²⁸ for several reasons. First, workers in the Church Health Service are seen as being motivated by a sense of mission, reflected in longer-term commitments and a greater willingness to work in remote areas. A second factor has to do with financing arrangements, as funds for the provincial church health services are channelled directly through the Churches Medical Council (CMC). The certainty and timeliness of disbursements through the CMC are seen as contributing to greater efficiency and effectiveness in the church-run facilities. The financing arrangement put in place for the churches came about in response to the performance of a number of provinces which had been slow in passing along wages and operational support to church facilities. NDoH, the Department of Finance and the CMC agreed to withdraw funding for these facilities from the provincial governments and channel it through NDoH to the CMC which, in turn, is responsible for disbursing funds directly to church facilities throughout the province.

A third factor affecting the performance of church-run health facilities is the higher degree of control over personnel matters, in particular 'hire/fire' provisions which give them greater flexibility in staffing compared to the government service, where staff tend to be more firmly entrenched. Other factors include: better supervision, better support systems to deal with maintenance concerns, better funding for transport, and extensive reliance on radio networks. And despite the fact that the CMC operates out of

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- 26 The 2001 *Functional and Expenditure Review* noted 'its admiration for the dedication and commitment of health staff that it encountered in its six provincial visits. Without their commitment to their jobs and to the people of PNG the health system would have collapsed long ago. The Review came across many examples of staff who were continuing to perform miracles in conditions that would have sapped the dedication of less committed workers. Some of these staff had not been paid, or had received their wages only intermittently. None the less, they have continued to provide service to their community and in some cases to cover basic running costs out of their own pockets. In one case ... an aid post orderly in Sandaun province who had received nothing for eight months ... continued to work and to minister to the needs of his community' (GoPNG, 2001a: 9-11).
- 27 *Marasin Meris* - a pidgin term for medicine women - are community-based health workers who do initial diagnoses and refer patients to health centres.
- 28 This belief is challenged in a recent and controversial report (not publicly available) prepared by a team of two external consultants and a Papua New Guinean senior official in one of the provincial health offices. It suggests that there is no substantial difference in performance between the two services. The CMC welcomed the review, but not the way it was done, and set up a response group to offer feedback to NDoH.

the NDoH headquarters, the churches retain considerable independence in terms of managing their health facilities. Overall, this has been a positive feature, although it has also led to charges from some quarters that the churches are insufficiently accountable for the considerable public funds made available to them.

5.4 Policy implementation: competing interests and legitimacy

As suggested earlier, the performance of the health system as a whole is constrained by various problems in policy implementation. These shortcomings can best be understood in a broader historical context of policy reform and implementation in PNG.²⁹ The essential point made by various commentators is that there is a history of 'good policies' in PNG, with implementation falling short of expectations. As noted in some critiques, policy implementation in PNG tends not to be a linear, logical or 'neutral' process, but rather is characterised by intensely competing interests (political, bureaucratic, institutional) which often undermine 'sound policies'. Participants at the 2002 workshop on policy making in PNG highlighted the following reasons for poor implementation (May and Turner, 2002):

- the lack or misallocation of funds;
- the lack of administrative capacity;
- subversion of policies by political or bureaucratic actors;
- intrusion of patronage into service delivery;
- differences in priorities and difficulties in physical and verbal communication between central government and sub-national levels of government;
- the lack of coordination between different departments and agencies with common policy concerns; and
- the high rate of turnover of ministers and departmental secretaries.

The health sector in PNG has had to deal with each of these policy implementation challenges, to one degree or another.

Another factor one can speculate on is the 'legitimacy'

of national programmes in PNG, which is a relatively young country with a diverse and widely dispersed population. During the review, the team was made aware of a PhD thesis being prepared by a Papua New Guinean entitled: *The Hagen Mega State: Where does PNG fit in?*³⁰ The title underlines a perception in PNG (fairly widely held) that 'everything is local'. In other words, people's first point of identification and loyalty is to their clan or customary land group, then the broader linguistic group, and outward from there. This sense of identity is reflected in political processes, the push towards further decentralisation, the *wantok* system, and the obligations felt by national politicians, all of which have implications for implementation of 'pan-PNG' policies and programmes. As one interviewee commented, for people living in remote areas 'the state is neither seen nor felt. It is easier to seek divine intervention for healing than to seek medical help because people's capacity to access state help is eroded by its lack of presence'. This raises the question: how can national policies, on which there is little substantive disagreement, be translated into effective programmes and implemented in a context characterised by differing institutional, political and group-based priorities and interests, and where 'the state' is seen by many as a distant actor, at best? It also raises questions about the role and functioning of modern state institutions (including efforts to strengthen their capacity) in societies which are guided substantially by traditional cultural beliefs, relationships, leadership styles, and knowledge systems. Other traditional, non-unitary states with diverse and dispersed populations struggle with similar tensions. The question for PNG is how central or marginal these factors are to success in the health sector.

5.5 Sector financing

Between 1996 and 2001 the overall level of funds committed to the health sector increased by 65%, most of which came from foreign assistance. Domestic funding also increased, but at a much lower rate - from 4.8% of the national budget in 1996 to 6.2% in 1999. A recent report commissioned by ADB concluded that: 'central and provincial governments are not providing the financing needed by the health sector. Government allocations have fallen from 9.88% of discretionary recurrent expenditure in 2001 to 7.95% in 2003. Provinces are spending much less than the 15% of available funds promised by governors in 2000 and very little from their internal revenues, which in 2001 made up 64% of their income' (ADB, 2003b: 28). Levels of funding affect the sector

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29 See Thomason and Kase (undated) or May and Turner (2002).

30 Mt Hagen, or 'Hagen' as it is commonly referred to, is the capital of Western Highlands province, the most densely populated area of the country.

directly in many ways, from maintenance of facilities and vehicles, maternal and child health patrols, transfers of patients, to availability of basic drugs and medical supplies.³¹

With respect to the targeting of funds, it has been suggested that health expenditures in PNG have been poorly linked to sector priorities. The 2001 *Functional and Expenditure Review*, for example, reported that between 1996 and 2001 there was a significant increase in the proportion of capital to recurrent expenditures (GoPNG, 2001a). The proportion of the health budget spent on administration and support services increased by 76%, while spending on rural health facilities fell by 19%. The report also indicated that while the proportion of funding for salaries and wages increased substantially, staff resources actually declined, with some provinces losing up to half of their health staff. Further, in 2001 spending on health promotion, which is considered an important and cost-effective health investment, was less than 1%, well below recommended levels (see table 1). A consequence of these allocation patterns is that declining or insufficient resources have been available to deliver

on the health priorities outlined in national policy documents. This underscores, once again, the policy implementation challenge in PNG.

Part of the problem with the funding arrangements has been the largely unconditional nature of the grants provided by the government to the provinces, which has meant that they have not been obligated to spend specific amounts of money in support of national policies. This differs from the situation prior to 1995, when most funding was linked to specific priority areas, e.g. health, education and agriculture. After 1995, transfers from the national government were calculated on the basis of a formula in the Organic Law related to population, land and sea area. One result was that the transfers did not reflect the needs of poorer provinces. A new allocation formula has since been developed which takes into account key, measurable indicators: population, infant mortality rate, the number of disadvantaged districts, capacity to pay and capacity to spend.

5.6 Citizen participation

Another aspect of capacity is empowerment, which refers to participation, access and choice of citizens. Despite widespread concerns about the health sector in PNG, there does not appear to be a strong and vocal constituency outside of government and the church community to advocate for performance improvements and greater accountability. It has been suggested that this is due in part to the shortcomings of the sector in providing basic health services, especially outside the urban centres, which has led to diminished expectations on the part of Papua New Guineans. As one respondent noted, 'many mothers don't trust health centres because of past disappointments and others who have been let down by the formal health system have decided to resort to traditional healing practices'. Demands from PNG's citizens, therefore have not been as significant a driver of change, in relation to capacity development and performance, as might be expected.

In a review of community participation in the health sector, NDoH (2001b) indicated that a relatively small sample of methods has been used - volunteers, village committees, public education, incentive schemes and community mobilisation through public events or meetings - mainly drawing on international experiences. While experiences with these methods

Table 1.
Health expenditures by programme area in 2001.

Programme area	% of health budget
General administration	4%
Urban health facilities	29%
Rural health facilities	33%
Family health services	8%
Disease control	1%
Environmental health	1%
Health promotion	0%
Medical supplies and equipment	15%
Human resources development	5%
Support services	4%

Source: Independent Review Team (2002: 8).

Notes

- ³¹ PNG's annual health expenditures are the lowest in the South Pacific, at US\$27 per capita (ADB, 2003b: 14). A 2001 report by the WHO Commission on Macroeconomics and Health suggested that 'spending on health in low-income countries such as PNG needs to double from current global levels ... by about 2015 to have a substantial impact on the treatment of ill-health' (*ibid.*, p.27).

in PNG have not been subject to in-depth analysis, the NDoH suggested several key ways to support sustainable community participation in health activities:

- strengthen the capacity of local and district governments in community organising, priority setting, health information collection and analysis, health intervention planning and delivery, and programme evaluation;
- ensure an accurate understanding of a community's needs, resources, social structure, values and readiness to participate; and
- ensure that community entry is a careful process of engagement, building trust, information gathering, building awareness of needs and encouraging self-reliance.

The report also warned that 'projects that operate outside the pace and capacity of PNG's social and administrative systems are unlikely to succeed' (*ibid*, p.4). Notwithstanding this somewhat uncertain picture of community participation in health, future investments should look to the potential for community groups, research institutes, the media, local NGOs, and other relevant actors to play a stronger role in mobilising communities on health reforms or holding the government, and other service providers, accountable for the quality of services provided, for the use of public funds, and for effective implementation of policies. Arguably, in the absence of significant community participation, public awareness and effective accountability (important societal capacities), it will be difficult to sustain improvements in the sector.

6 Endogenous organisational change and adaptation

6.1 How stakeholders think about capacity and capacity development

The study team looked at endogenous strategies for organisational change and adaptation to improve capacities and performance. First, on the question of how PNG stakeholders think about the issue of capacity, it appears that capacity is seen substantially (although not exclusively) as a question of skills³² or as an organisational issue. This was reflected in the answers of many respondents who emphasised the need to strengthen the skills of personnel working in the health system as the best way to improve services. Despite this orientation, there is a clear recognition, particularly within 'official circles', of the influence or importance of higher-level capacity issues - organisational, sectoral or societal - although often described as external risks rather than capacity issues to be 'managed', or which require a strategic engagement as part of a broader capacity development strategy. The conceptualisation of capacity issues is similar in the church health community, although girded in that case by a clear recognition of the importance of certain capacity 'mobilisers', such as values, commitment and sense of mission, to performance.³³

NDoH's performance measurement framework offers one insight into how PNG stakeholders view capacity issues. The framework itself is well regarded, as it yields important data on diseases, sector activities and budget commitments. However, it does not draw out information on capacity improvements (e.g. technical or managerial skills, organisational aspects) and certainly not on 'higher-level' capacity issues, such as the extent to which reforms are strengthening governance systems, enhancing institutional relationships within the sector, or creating a more conducive environment for health reforms, although efforts are being made to broaden the scope of monitoring in the next phase of the health reforms. This orientation is not unique to PNG and reflects, in part, a tendency in sector programmes to focus on sector-based measures of performance, such as immunisation rates or mortality, rather than broadening monitoring to

Notes

³² This finding is confirmed in the *HSSP Capacity Building Plans, Annual Review 2003*, which noted that many Australian advisers found that 'individual partners, including some senior managers, still equate capacity building to formal training programmes that result in a certificate or diploma' (PNG HSSP, 2004: 17).

³³ See Brown *et al.* (2001) for an overview of measuring the effects of capacity building activities on developing country health systems (www.cpc.unc.edu/measure), and Boesen *et al.* (2002).

include measures of capacity improvement or changes in institutional behaviour associated with sector reforms.

At a more fundamental level, one Papua New Guinean interviewed offered the following observation on the influence of culture on PNG perspectives on capacity issues: 'All Papua New Guineans work when they need to sustain themselves. Few villagers for example, will go fishing for leisure or as a sporting activity and none will go to birds' nesting places for bird watching. Similarly, capacity building or development without first knowing and understanding why or why not is like building a canoe for displaying under one's house. Not many Papua New Guineans will participate in such activities unless they are forced to do so. And if this is the case, the activity will come to an abrupt halt once the source of pressure and force or coercion ceases. For many Papua New Guineans, "wok I mas I gat kaikai" ("work must produce food") is the one concept which influences their thinking and affects whether their participation is long or short term. Papua New Guineans must not be forced into creating or manufacturing capacity needs in order to comply with requirements or to qualify to participate. Rather, they must get involved because they understand why and because they feel the need to participate and gain new skills and ways of doing things'.

In other words, for Papua New Guineans, capacity development is a rather practical matter, rooted in their sense of what is important or necessary for their wellbeing, or that of their community. Commitments to capacity development, therefore, cannot be leveraged or induced unless what is being proposed responds to that fundamental reality.

6.2 Endogenous strategies

Consistent with the conceptualisation of capacity described above (e.g. section 4.1), formal capacity development efforts in PNG's health sector have focused substantially on the human dimension, i.e. training and professional development, with some attention to organisational issues. At this stage, PNG does not have a fully articulated 'strategy' for capacity development for the sector. NDoH has established a solid foundation of laws and systems as a basis for moving forward, e.g. the *National Health Plan*, *National Health Administration Act*, *Minimum Standards Act*, and the *National Health Information*

System. It also has a human resources development strategy in place and has addressed selected internal organisational issues. All of these are important, but the question is how these 'internal' reforms add up to or lead towards a 'capacity development strategy', and how they are matched by efforts (by NDoH and others) to influence factors external to the Department, i.e. in NDoH's 'enabling environment'. On the latter, as the capacity development literature indicates, performance is often influenced more by factors external to an organisation or system than by internal factors (e.g. staffing, structures, internal processes). While PNG's approach is not inconsistent with practices in other countries where the tendency is towards emergent or evolving approaches to capacity development, versus 'grand strategies', the implication in this context is that more may still need to be done over time to ensure that considerations relating to PNG's broader capacity system are factored into sector reform strategies and processes.

The team also noted that formal approaches to capacity development in the PNG context do not, by and large, give substantial regard to 'soft capacities' (e.g. (the) attitudes, values, motivations, traditional knowledge) that influence behaviour. In part, this reflects a tendency, again not unique to PNG, to default to training as the relatively easy, manageable tool for capacity development - one for which there is likely to be a fairly clear output, if not always a demonstrable change in organisational behaviour given the various constraining factors noted above. It also likely reflects a system under stress, as actors feel they cannot afford the luxury of looking beyond the 'basics'. A risk following from this, though, is losing sight of opportunities to build upon successes and to induce performance improvements within a significantly challenged environment, in line with the 'successes' discussed above. NDoH's HR development strategy, as one example, talks about incentives for rural health workers (housing, salary premiums, hiring locally etc.), but it is not clear how this or other 'soft capacity' issues have been addressed by relevant managers. More research highlighting the contribution of soft capacities, or capacity enablers, to success in the sector may be helpful in informing future strategies, and in ensuring that the focus is not exclusively on well documented problems or capacity 'gaps' (functional issues) in the system.

Participants at the 2002 Port Moresby conference on policy making in PNG offered some interesting reflec-

tions of their own on endogenous change strategies, noting a tendency in PNG to change structures and institutions when policies appear not be working rather than seeking to change behaviours. The 1995 Organic Law reforms were highlighted as one such example where sub-national structures were modified but did little, in a positive sense, to change behaviours to improve services for PNG's citizens. The fact that well performing provinces continued to perform relatively well after the reforms also led participants to speculate whether behaviours were more important to successful policy implementation than structures. They concluded that not enough is known about 'why some organisations appear to work well while others are poorly performing' (May and Turner, 2002: 5).

6.3 Role of non-state actors

Finally, one cannot overlook the role of non-state actors in endogenous change processes in the health sector. PNG's civil society is a diverse community of churches, business associations, labour unions, women's and youth organisations, policy institutes, NGOs, community-based organisations, and landowner groups. While the churches are prominent throughout PNG, many civil society groups based in and around the main cities rely on external support and are not as deeply rooted in PNG society as the churches.

As noted in the parallel study by Hauck *et al.* (2005), the churches have contributed to improved governance and service delivery in PNG in various areas (see box 5). While there are no broad, church-based strategies specifically aimed at enhancing capacity or improving public performance, the churches have played a key role in building capacities in the health sector, e.g. training health practitioners, advocacy, leadership development and sustaining service delivery throughout the country.

While the churches' capacities in these areas have emerged on a pragmatic and rather *ad hoc* basis, the increasing concerns about poor governance in PNG, and changes such as the introduction of the health SWAp, have led to increased inter-church exchanges and cooperation. Specific factors that help to explain the particular role taken on by the churches include their authority and legitimacy in PNG society, national networks, links with other institutions, and the important role of the churches' intermediary struc-

Box 5: The churches' contributions to governance and public performance

The churches in PNG are engaged in several key areas:

- public policy and decision making, e.g. supporting electoral processes;
- transparency and information sharing, through conferences, use of media or speaking out on governance issues;
- social justice and the rule of law, through their involvement in organisations such as the Community Coalition against Corruption CCAC);
- supporting enhanced performance in the health and education sectors, working through the Churches Medical and Education Councils; and
- facilitating and supporting reconciliation and peace building.

tures and organisations, including those responsible for training health workers.

In fact, many church communities in PNG operate under their own banners, but occasionally come together, either nationally through the Churches Medical Council (CMC), or at the local level, to collaborate in service delivery. The CMC has played a particularly important role in the health sector, serving as an intermediary between the government and the church-run facilities across the country. It has also played an important role in bringing together representatives of the Church Health Service to engage governments on policy and operational issues. Some churches have mobilised around major health issues, such as the emerging AIDS epidemic, although they do not always speak as a single, unified voice. Individual churches also engage with the government through informal bilateral channels, as necessary.

7 Performance

7.1 Overall sector performance

The study has taken a limited view of the term 'performance', focusing on the effectiveness of the process of capacity development, as opposed to the development impact of sector reforms. This section first offers a few comments though on overall sector performance. The government's own data indicates that performance in the health sector has declined in recent years, despite significant new investments and initiatives. The 2002 *Annual Sector Review* rated sector performance as 'below expectations', attributing it to a number of factors, including management and organisational shortcomings, weaknesses in staff skills, decision-making procedures, relationships amongst levels of government, poor infrastructure, equipment, supplies and other constraints identified elsewhere in this report. The review also observed that 'good people (management teams) can make poorly designed systems function well; conversely, poor performing management teams can make good systems perform poorly' (Independent Review Team, 2002: 16).

The 2001 *Functional and Expenditure Review* also noted that service quality in health centres and aid posts is deteriorating as a result of various factors, including deteriorating staff skills; non-existent supervision and support; poor transport and communication links; the lack of reliable, disease-free water supplies for health facilities; poorly maintained or non-existent medical equipment; and inadequate supplies of key drugs and medical supplies (GoPNG, 2001a).

Various other reviews (e.g. NDoH, 2003c) have also highlighted the significant variations in performance across provinces, leading some to conclude that it is possible to have relatively good health services in PNG within existing budget parameters. This assertion also suggests that there are specific factors within individual provinces which make a difference in terms of performance. The ADB's 2000 *Country Economic Review of PNG*, for example, points to a link between poverty levels and human development indices at the provincial level. Examining capacity issues in the health sector - functional, political, hard, soft - on a comparative basis across a number of provinces could also contribute to enhanced understanding of the reasons for performance variations.

Looking ahead, some commentators have suggested that the potential impact of HIV/AIDS has been underestimated, and that the effect on sector performance could be immense, perhaps even resulting in the collapse of the health care system unless significant measures are taken to address the problem.

In terms of departmental performance, NDoH is often described as being 'ahead of' other departments, as evidenced by the quality of its planning documents, reports, tools etc.. However, as highlighted above, health reforms, including the emerging SWAp, require various departments, agencies and levels of government to move forward together, otherwise NDoH's 'good policies' will not be implemented as intended. The risk, as one provincial respondent commented, is that 'the SWAp (or one could say 'the policy') stops here', because of the lack of capacity and the inability of stakeholders at various levels to effectively collaborate.

7.2 Effectiveness of capacity development

On the more limited question of the effectiveness of capacity development processes, it would appear that external inputs (e.g. through long-term advisers) respond to real needs in the health system, such as support for management reforms, training of provincial and district level staff. In fact, various initiatives associated with the SWAp have been described as important building blocks for the sector. The SWAp itself has also provided a basis for discussions between NDoH and the provinces on capacity needs and issues affecting the use of capacity, such as financial commitments, performance standards and partnership agreements.

The effects of technical assistance (in particular the TA associated with recent AusAID support) on capacity and performance, are difficult to assess over such a relatively short period of time. Nevertheless, some anecdotal evidence and feedback from respondents suggested that many of the external advisers have made valued contributions to PNG's health reforms in areas such as strengthening of systems, and advising and training staff at various levels. So far, however, there has not been an overall review of the AusAID-funded TA under the HSSP, other than regular reviews of individual advisers by the Australian managing contractor. As a result, there is no formal documentation of capacity 'results' realised through these investments, other than in the first annual review of 'capacity building plans' prepared by the

contractor (PNG HSSP, 2004). The review itself is a useful document which provides insights on processes, priorities and activities undertaken in various locales, but given the relative newness of the capacity building plans, it mainly reports on output level capacity results. However, it does include reflections on 'conditions for success' for the HSSP advisers, which include:

- the need to take a 'stepwise approach', i.e. limiting the number of objectives;
- the need for early successes - reflecting, among other things, the fact that many health personnel are 'demotivated by the continual focus on poor performance';
- allowing sufficient time to strengthen capacity - linking capacity building plans to annual activity plans and strategic plans is seen as helpful in this respect;
- exposing partners to best practices, e.g. through twinning arrangements;
- joint development of plans - to strengthen ownership and ensure their 'owner friendliness';
- modelling management styles and work behaviours;
- ensuring a clear understanding of the context, including factors that affect efforts to build capacity; and
- addressing the limited understanding of capacity building/development, which is frequently equated with training.

At the same time, questions have been raised as to whether the various capacity development initiatives within the sector are sufficiently 'PNG-led' and, as suggested above, whether they are adequately informed by analyses of capacity issues affecting the sector. It is also not apparent that they are grounded in a common conception of capacity development. And as with many other capacity development initiatives internationally, there is a question as to the adequacy of the time frames. Donor and GoPNG documents appropriately underline the importance of long-term investments, but to this point, the focus has tended to be on short- to medium-term initiatives. NDoH does have a ten-year 'plan', although it is more a declaration of policy objectives incorporated into a medium-term expenditure framework, which guides annual planning processes. At this stage, however, there is no framework, or overarching guide, from either NDoH or the donors to give a sense of what 10-15 years of investments in capacity

development would achieve, and what types of capacity 'results' may reasonably be anticipated.

Concerns have also been raised with regard to the volume of TA, particularly in NDoH, and the coordination and management of TA inputs by NDoH. A recent ADB report described it as: 'a very costly workforce, whose objectives and expected results are not formally agreed upon; which may not always provide capacity building; which sometimes simply substitutes for local staff; whose performance is not measured by DoH; and ... whose presence may de-motivate national staff'. The report links this to 'unilateral planning and implementation practices of donor partners - the very practices which the HSIP/SWAp hopes to curtail' (ADB, 2003b: 26). In terms of moving forward, the report suggests that a clearer definition of capacity development objectives is required, as well as improved monitoring of progress towards expected results and a shift in focus from NDoH to the provincial level. It also notes the importance of increased harmonisation of TA procedures, movement towards pooled funding for TA, and a stronger role for NDoH in the planning and management of TA inputs.

8 Concluding remarks

This report has tried to underline the value of a broad, systems perspective on capacity issues in PNG's health sector. Peter Morgan, an adviser to the broader ECDPM research project, has noted the utility of thinking about capacity development in terms of a complex 'capacity ecosystem'. As Morgan suggests, the ability of organisations and systems to develop their own capacity 'is determined, in part, by their roles in complex networks and the existing relationships and distribution of assets and patterns of incentives that exist in that system' (Morgan, 2004: 6). As this case illustrates, the system in PNG is a complex of competing and occasionally complementary policy objectives, institutional arrangements, relationships, incentive systems, and political interests, some of which support efforts to strengthen capacity and improve performance, and others which have the potential to undermine it.

The case also illustrates that in PNG, the relationships among stakeholders, and the internal features of NDoH and the health sector more broadly, all contain elements that can potentially be a drag on change processes within the sector. The external interventions looked at, the emerging SWAp, and various endogenous change processes are attempts to address some of those constraints with the objective of enhancing performance. Increasingly, these efforts are based on a broader and more purposeful approach to capacity issues, although in a sense they remain a work in progress as stakeholders strive towards a common view of capacity development and a shared appreciation of the best strategies to respond to the capacity challenges in the sector.

One of these challenges, which is also mirrored in some of the other cases in the broader ECDPM study, is the stakeholders' difficulty in 'seeing' the complex capacity system and acting effectively to influence its various components. A corollary which flows from this is that the broader the capacity system, as is the case in sector-wide reforms, the harder it is to 'see', the more areas there are for contesting interests to play themselves out and, consequently, the more complex and potentially more difficult the change process. On the other hand, this case suggests that not coming to terms with key variables in the broader capacity system risks hampering reform efforts.

The challenge is therefore to ensure that key actors, such as NDoH, have the capacity to 'see' and effectively influence the broader system of which they are an important part.

The review has also highlighted the importance of Papua New Guinean culture, traditions and diversity as factors influencing organisational behaviour, stakeholder collaboration and even the perceived legitimacy of the state. The brief examination of successes in the health sector suggests the importance of intangible assets such as leadership, commitment and community support to enhanced performance, especially in a context with multiple constraints. The conclusion to be drawn from these observations is that 'soft' issues such as these are important capacity traits which need to be nurtured and factored into reform processes in order to build on successes and to work around systemic constraints.

All of this leads to the question posed by Ghanaian consultant Joe Annan about Ghana's health SWAp: 'is local capacity a constraint to getting at development challenges, or is local capacity itself the development challenge?' Arguably, capacity issues need be at the forefront of deliberations in PNG on health reforms, not just as a series of technical constraints to be 'solved', or gaps to be filled, but as a complex of issues - soft and hard - which need be dealt with in a complementary and systematic manner in order to address the development challenge of improved health for all Papua New Guineans. Doing this requires a clear commitment to and a shared appreciation of what capacity development entails, rooted in a broader partnership among the Department of Health, other national government actors (including senior level staff of central agencies), decentralised levels of government, non-state actors and donor partners. Working towards that shared appreciation will be among the challenges for PNG stakeholders as they move forward with reforms in the health sector.

Annex 1: List of interviewees and focusgroup participants

Many of the individuals listed below were interviewed both for this and the parallel study of the churches in Papua New Guinea.

Interviews in Papua New Guinea

National Department of Health (NDoH)

Dr Timothy Pyakalyia, Deputy Secretary/acting Secretary (at time of interview), NDoH
 Dr Gilbert Hiawalyer, Director, Monitoring and Research, NDoH
 Pascoe Kase, Director, policy, legal and projects, NDoH
 Peter Eapaia, Director, finance
 Mary Kurih, A/principal adviser, pharmaceuticals
 Lynda Koivi, A/principal adviser, information, HRM
 Mar Roiroi, principal adviser
 Judah Eparam, health promotion
 Dr James Wangi, disease control
 Andrew Posong, a/director, monitoring & evaluation

GoPNG (non-health personnel)

Peter Tsiamalili, OBE, Secretary, Department of Personnel Management
 Lari Hare, Deputy Secretary policy, Department of Personnel Management
 Robert Yass, Deputy Secretary operations, Department of Personnel Management
 Joseph Sukwianomb, social policy adviser, Public Sector Reform Management Unit (PSRMU)
 Mr Clant Alok, inter-governmental relations adviser, PSRMU

Provincial officials

Dr Theo, provincial health adviser, Morobe
 Thomas Kalana, provincial health officer, Madang
 Haru Yahamani, provincial treasurer, East Sepik
 Dr Geoffrey Mataio, CEO, Alotau Hospital, Milne Bay
 Steven Gibson, provincial treasurer, Milne Bay
 Dr Festus Pawa, provincial health adviser, Milne Bay
 Connie Mogina, health information officer, Milne Bay
 Constance Marako, community health liaison officer, Milne Bay
 Matilda Philemon, family health services coordinator, Milne Bay
 Titus Stomley, HSIP coordinator (training officer), Milne Bay
 Anthony Mala, CCLO southern region: WCH project, Milne Bay
 Agnes Tapo, nursing officer, Milne Bay
 Jenny Dobadoba, f/planning coordinator EPI/CCL radio network, Milne Bay
 Esther Barnally, supervisor - oral health, Milne Bay
 Wilson Napitalai, healthy life promotion officer, Milne Bay
 Jack Purai, coordinator - health extension, Milne Bay

Australian advisers

Dr Maxine Whittaker, HSSP deputy team leader (technical)
Dr Alan Hauquitz, HSSP hospital adviser, Madang
Dr Tony Partridge, HSSP health adviser, Morobe
Andrew McNee, adviser, NDoH

Church health officials

Vincent Michaels, government liaison, Churches Medical Council (CMC)
Fua Singin, general secretary, Evangelical Lutheran Church of PNG
Nena Naag, Lutheran provincial health secretary, Morobe
Abraham Yapupu, national secretary, Lutheran Health Services
Don Kudan, Lutheran provincial health secretary, Madang, and Chairman, Churches Medical Council
Pastor Thomas Davai, President, Seventh Day Adventist Union Mission
Baltasar Maketo, Director, Caritas-PNG, Catholic Development Agency
Raymond Ton, justice, peace & development officer, CARITAS-PNG
Sr Tarsicia Hunhoff, national secretary, Catholic Health Services

Civil society and academia representatives

Misty Baloiloi, Vice Chancellor, PNG University of Technology
Fr. Jan Czuba, President, Divine World University
Br. Andrew Simpson, Vice-President, Divine World University
Mel Togolo, Transparency International
Katherine Mal, representative of Provincial Assembly of Women, Madang
Matricia Mari, Madang Provincial AIDS Committee
Judy Michael, Madang Provincial AIDS Committee
Elizabeth Andoga, Save the Children in PNG
Tamara Babao, Save the Children in PNG
Anio Seleficari, Madang Provincial Council of Women
Taita Ranu, Madang Provincial Council of Women
Gisele Maisonneuve, Madang Provincial Council of Women

AusAID-PNG

Jeff Prime, first secretary
Tracey Newbury, first secretary, health
Dorothy Luana, activity manager
Cathy Amos, civil society

Interviews in Australia

AusAID - Canberra

Bernadette Whitelum, executive officer, corporate policy
Kerrie Flynn, research programme officer, corporate policy
Peter Lindenmayer, acting director, Health & HIV Section, PNG Branch
Ian Anderson, senior adviser, design and programs
David Hook, PNG civil society/churches
Robert Christie, manager, economic analysis, PNG Branch
Rachael Moore, policy officer, PNG Branch
James Gilling, senior adviser, policy and programmes (Economics)
Kirsten Hawke, PNG Branch

Australian National University (ANU)

Dr. Hartmut Holzknecht, visiting fellow, resource management, Asia-Pacific Programme

Professor Donald Denoon, Division of Pacific and Asian History

Cathy Lepani, PNG PhD candidate

Ruth Soavana-Spriggs, PNG PhD candidate

Jennifer Letau, PNG PhD candidate

Ruth Turia, PNG PhD candidate

Other

David Syme, CEO, Adventist Development Relief Agency (ADRA) Australia

Peter Heijkoop, executive director, Universal Financial Management Solutions, Pty. Ltd.

Annex 2: Glossary

This glossary includes terms relating to the two case studies undertaken in Papua New Guinea. A full glossary will be included in the final report of the broader international study on Capacity, Change and Performance coordinated by ECDPM.

Capacity: The ability of individuals, organisations or systems as a whole to perform effectively, efficiently, and in a sustainable manner.

Capability: Specific abilities that individuals, organisations or systems develop to do something in particular, such as to facilitate, learn, or to manage projects.

Capacity development: Capacity development has to do with the process of change and adaptation at a variety of levels, including the individual, the functional, the organisational, the multi-organisational and the institutional.

Empowerment: This aspect of capacity has to do with learning, participation and access to opportunity. It stems from personal engagement, identity and availability of choice, qualities that enable people to participate fully as citizens in society.

Endogenous change: The strategies and processes of change that take place within local organisations and systems and the factors shaping that change, including those associated with political economy, institutional incentives, organisational processes and human motivation.

Hard capacities: The tangible assets and resources of an organisation, such as its land, buildings, facilities, personnel and equipment.

Impact: Any effect, whether anticipated or unanticipated, positive or negative, brought about by a development intervention. In some cases, 'impact' refers to the long-term effects of an intervention on broad development goals.

Institution: A socially sanctioned and maintained set of established practices, norms, behaviours or relationships (e.g. trade regulations, land tenure, banking

systems, and an organisation's staff rules) that persist over time in support of collectively valued purposes. Institutions have both formal and informal rules and enforcement mechanisms that shape the behaviour of individuals and organisations in society.

Institutional rules of the game: The humanly devised constraints that structure human interactions. They are made up of formal constraints (such as rules, laws, constitutions), informal constraints (such as norms of behaviour, conventions, self-imposed codes of conduct), and their enforcement characteristics.

Organisation: A formal structure with designated roles and purposes; an entity composed of people who act collectively in pursuit of shared objectives. These organisations and individuals pursue their interests within an institutional structure defined by formal rules (constitutions, laws, regulations, contracts) and informal rules (ethics, trust, religious precepts, and other implicit codes of conduct). Organisations, in turn, have internal rules (i.e. institutions) to deal with personnel, budgets, procurement and reporting procedures, which constrain the behaviour of their members.

Soft capacities: The human and organisational capacities, or social capital of individuals, organisations and systems, including such things as leadership, trust, legitimacy, motivation, management knowledge and skills, systems and procedures (such as management information systems, and procedures for planning and evaluation).

Stakeholders: Individuals, groups or organisations whose interests and behaviours can, do or should affect the process of capacity and performance improvement.

Annex 3: Key elements of the PNG health system

The National Health Plan (NHP) 2001-2010

Endorsed in 2001, the NHP provides the policy framework for donor support to the health sector.

National Health Administration Act

Enacted in late 1997, it provides a framework for health planning and coordination between the NDOH, provincial and district authorities. The Act provides for:

- a legal mandate for the NHP and national health standards, with a requirement for provinces to develop their own 'provincial implementation plans';
- a structured procedure for the giving of 'technical directions' to health services to comply with nationally set health standards through the use of operational directives issued by the national departmental head;
- establishment of a three tiered consultative system of national and provincial health boards (PHBs) and district health management committees (DHMC);
- clarification of the health functions of the different levels of government, and public hospitals;
- clarification of the role of provincial health advisers and their relationship to provincial and national governments;
- a national health planning and data system, with obligations for other agencies to provide health information; and
- a procedure for withdrawal of health functions from provincial governments and local level governments (LLG) (to complement procedures already outlined in the Organic Law on provincial and local level governments).

The minimum standards for district health services

These standards form the basis for service planning, implementation and evaluation at provincial and district health levels, specifying:

- the components of health programmes required to implement the NHP;
- the minimum requirements for the provision of staff, equipment and facilities for the operation of health facilities and the delivery of health services and programmes in accordance with the NHP;

- procedures for planning, budgeting and managing the operation of health facilities and the delivery of health services and programs;
- guidelines for the preparation of provincial Annual Activity Plans; and
- the nature, frequency and manner of collection of information to be provided to the NDOH concerning any aspect of the implementation of the NHP.

The HSIP trust account

Under the ADB-funded Health Sector Development Programme (HSDP), as part of the 1994 structural adjustment programme, a trust account was established that mirrors the government's financial systems, although it stands alone and runs in parallel. The trust account has been used as a means of channelling money to the provinces. Since the funds are held in a bank account, it has enabled fast and flexible access to funds in the absence of government cash. The HSDP trust account has been used as the basis for the establishment of the *HSIP Trust Account and Procedures Manual*, which provides a consolidated mechanism for donors to channel funds to the provinces.

Whilst the trust account has provided an effective mechanism for channelling funds to provinces, its effectiveness has been hampered in some provinces by mismanagement. Ongoing remedial support and capacity building will be provided by HSSP, to enable all provinces to maximise their use of the trust account and to generally improve their financial management capacity.

Partnership agreements

Partnership agreements between the NDOH and each province have been developed with HSSP support. These agreements set out the respective commitments of the provincial government and the NDOH (with the support of its donor partners). The most important requirements for continued participation by a provincial government in the HSIP will be a commitment to implement the NHP in the province, and the maintenance of agreed levels of funding by the provincial government for health services and activities.

In developing the provincial Annual Activity Plans, the provincial governments are required to take steps to identify and access all available sources of funding for health service delivery, including provincial and LLG, churches, other non-government organisations (NGOs), other external agencies, donors, the business sector and revenue raised from user fees. The agreements also define the target performance levels for each province. Although the agreements have been accepted as the basis for the HSIP partnership, because they have only been in place for a short time and are currently being reviewed, thought will be required on how to ensure their timely review, and how to address non-performance against the agreements, should this occur.

The performance monitoring framework (PMF)

While the National Health Plan contains an extensive number of indicators, these cannot realistically be monitored on a routine basis. The PMF consists of a set of 19 core indicators (developed for national, provincial and district levels), derived from the NHP, and has been prescribed by the NDoH as compulsory reporting requirements for the health system. The objectives of the PMF are to operationalise a national system of performance monitoring that will support the monitoring needs of the HSIP and which can be used as part of the partnership agreements to define agreed levels of performance and HSIP assistance. During the previous annual planning period, HSSP carried out a review of the progress towards the achievement of the PMF indicators.

Source: PNG Health Services Support Programme, Annual Plan 2002-2003 (PNG HSSP, 2002a).

Annex 4: Methodology

The analytical framework guiding the research is based on a *systems perspective* on capacity development. The framework (see inside front cover) highlights the interconnected dynamics of capacity, change and performance which, in turn, are shaped by four factors: the external context, the roles and functions of stakeholders, internal organisational systems and features, and external interventions. In relying on this framework, the study highlights factors internal and external to PNG's National Department of Health, and the sector more broadly, which have influenced (positively or otherwise) domestic change processes. The analysis also draws attention to how capacity issues have been addressed at various levels (individual, organisational, sectoral, societal), how domestic and externally supported efforts have contributed to the effective utilisation of capacity, and the extent to which capacities have been utilised to create an enabling environment for change. The framework was used to organise an inventory of questions with respect to capacity and performance to guide data collection and analysis.

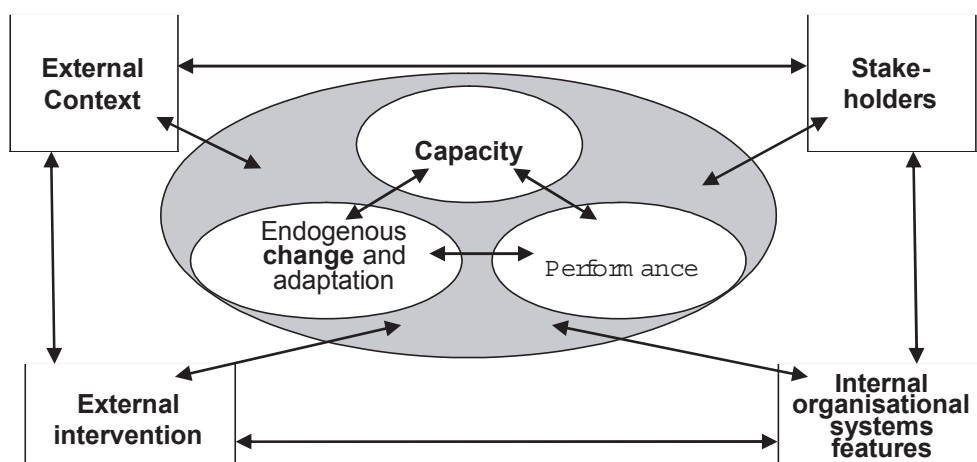
The field research for this study was carried out in Papua New Guinea (PNG) by a team of three consultants³⁴ between 19 April and 4 May 2004, and entailed interviews and focus group meetings with stakeholders in the capital, Port Moresby, and in three provinces - Milne Bay, Madang and Morobe. These provinces were chosen, in part, because of the team's interest in learning about relatively successful experiences in PNG's health sector and the role of

long-term external advisers. The team met approximately 75 stakeholders in PNG and Australia (see Annex 1).

A desk study was undertaken prior to the fieldwork. The team relied on documentation from AusAID, ADB, GoPNG and web resources (see the bibliography). The material collected was used for this and the parallel study of churches in PNG. Joint field work facilitated sharing of information and understanding of the processes that shape capacities within PNG's community of churches and within the health sector.

The team leader and the PNG consultant met with AusAID officials in Canberra at the outset of the mission. Immediately after the fieldwork, the team participated in a debriefing in Canberra. A workshop was also held in PNG at the end of the field assignment at which the team discussed and sought to validate preliminary findings with various stakeholders. A final draft report was sent to several interviewees for comment, and to verify the information and impressions articulated by the authors

Finally, the authors would like to note some of the limitations associated with the study. First, the time available for the field research, particularly in view of the breadth of the topic and the array of dynamics at play in a country as diverse as PNG. Second, the team was not able to meet some senior staff in the National Department of Health (NDoH) due to scheduling conflicts. The team endeavoured to address these limitations by reviewing a wide array of documentation, including available exchanges and commentaries by senior PNG and external stakeholders on sector reforms.



Notes

³⁴ Joe Bolger, team leader; Angela Mandie-Filer, consultant; and Volker Hauck, Senior Programme Officer, ECDPM, the Netherlands.

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