The Independent Review of AID Effectiveness

This submission is based on evidence through living and working with health programmes funded totally or partially by AusAID in Papua New Guinea and the Northern Territory of Australia.

Papua New Guinea
Background:
I have lived and worked in Papua New Guinea (PNG) from 1968 to 1975 with the Australian Administration and then with the PNG government until 1983. I returned to PNG in 1995 until 2006. During this time I worked with short and long term health programmes funded by AusAID. I have been in a position to understand and measure the implementation of the different health programmes I was associated with as I worked and lived alongside the Melanesian people. The various programmes included volunteers, churches, non government organizations and dedicated AusAID PNG National Health partnership programmes.

Volunteers:	The majority of volunteer programmes worked hard and were only effective when their skills matched the goal of well designed governing programmes that matched the PNG National Health Standard policies and programmes.
Churches:	The majority of churches before independence did not recognize the Melanesian people as equal. Since independence the Christian religion and the Melanesian culture has become entwined.
Non Government Organizations:	Majority of these organizations did not have clear programmes with goals that match PNG National Health policies and programmes and in many cases have other agendas that undermine proclaimed goals.
AusAID partnership programmes:	These partnerships include the above mentioned as well as direct National, Provincial, District and community government programmes based on the National Health policies and programmes.

1995 – 2006 My perspective is based on factual evidence through implementing AusAID funded health programmes in Papua New Guinea. I have divided my observations under the following headings.

Cultural Competence:
Good communication is recognizing and working with the culture of the community. The Australian government has been working with the PNG government for more than fifty years; however during my experience with the implementation of AusAID health programmes there was little evidence of working with the Melanesia culture as I understood the culture. The PNG

Melanesian culture traditionally encompasses three levels of relationships with a customary line of command. My understanding and concept of this culture I call the Trinity concept; a shared unspoken assumption that is culturally central to all known language groups throughout PNG and is the primary relationship of an individual, family and clan concept that is valued and continuously strengthened to maintain a safe socio-economic security net that will support the individual member of the clan. There was an assumption by the majority of AusAID staff and technical advisers that their commencement orientation was sufficient; especially if it had included a Melanesian person. What I found was that Melanesians do not discuss the Trinity Concept as it is an inherent part of them and there is an assumption by the Melanesians that this is known behaviour.

Management:

The PNG government welcomes and encourages global health support for their health programmes. This health support is channelled through various pathways to match government policy projects and programmes: direct funding for government health programmes, identified equipment, advisers, international volunteers, education and training and internal and overseas twinning and exchange programmes. The current outcome is that even though there is good policy and programmes with ongoing global support, the health morbidity and mortality statistics continue to rise.

If Australia's aid programme is welcomed and encouraged by the PNG government then why has there been a gradual decline in basic health services since 1975; in particular health services to rural populations? The current situation is that the majority of rural people have to travel to major hospitals for treatment that was once offered at Community Health Centres (CHC) and Community Health Posts (CHP) with support of outreach health patrols.

Management Outcomes:

- The infant mortality records show in 1975: 97 deaths per 1000 births and in 2008: 53 deaths per 1000 births. These statistics reflect the collection of data only and that is where the comparison ends. In 2005 many rural (CHC) and (CHP) were not functioning on a daily level (if at all) and staff have acknowledged at meetings to misreporting and unreported statistics. A result of where health care from centres was unpredictable, meant that many families gave up trying to seek treatment from district and CHC and CHP and did what they could with traditional medicine and support; however this left many antenatal women and babies at risk. It was common knowledge that many health centres were closed by political interests, individual health staff or senior health staff leaving junior staff to manage without support or supervision: and commonly the free health service was not free as the community was being charged outpatient fees that often exceeded a family's micro cash budget earned through their family garden. Sick people could not always afford the cost of transport if available and the health fee. Another deterrent to families seeking treatment at some locations was that even if people had the money they were reluctant to face the verbal and aggressive abuse by a drunken staff person.

- Some health partners continue to write reports concerning health programmes which have in fact been written and implemented many times in many different forms over the last twenty years with no improvement.
- There have been assumptions that some health strategies that work in other countries will work in PNG but many of these have failed mainly because they did not address the culture or the difficulty in reaching eighty percent of the population who live in the rural areas spread over a broad geographical area.
- Many support partners have worked alongside PNG health staff at National, Provincial, District and community level over the past twenty years to assist the health staff continue and maintain these vital services but to no avail.
- My personal observations noted:
  Some AusAID posted staff to PNG National Health programme had no health background or management experience. This was a disservice to all as senior technical advisers'skills were often not sought, understood or recognized if and when discussions took place.
- AusAID health programmes often became focused on reports; however due to many agendas by various partners the reports did not always fully reflect clearly the health site situations for AusAID posted staff to understand. In some cases this was controlled and filtered by the management/director of technical advisers: reports, discussions, workshops and who one could talk to was filtered, limited and controlled to a degree that removed critical information. Management/director of one large health programme stated that future health programmes would employ technical staff without a clinical health background. My experience based on evidence showed non-clinical health technical staff were unable to measure the difference between what was on site and what was needed to ensure that the required change could be supported. The outcome was that "warm and fuzzy" reports were submitted by these technical advisers which suited some managers/directors rather than the reports that were able to measure and identify or recognize the gaps at Provincial, District and community levels. The question has to be asked, "What were these particular technical advisers writing about when they rarely left their base in the Provincial office or why would they need to leave the Provincial base on a frequent programme to visit the Districts and their community when they could not measure implementation? Rather than the management/director trying to support Provincial field programmes to work, some technical advisers were offered other in-country placements by management, thereby preventing unfavourable reports. If another placement was offered (that had not been requested by the technical adviser) by the Manager/Director and not taken then the contract was not renewed. Many different ways were used by Managers/Director to prevent renewal of contracts or shorten contracts to ensure reports were "challenging but achieving a lot": rather than here are the issues and here are the possible solutions. This style of reporting benefitted many PNG senior health managers, Administrators, Politicians and Bishops who had no intentions of supporting the health programme partnership except where there was a personal gain.

- Major health issues and gaps associated with specific diseases that impinged on field programmes and were contributing to an increase in morbidity and mortality were not to be mentioned in reports or at group discussions even though solutions were known.

Management Change based on Lessons Learnt:
PNG has excellent health policies and basic health programmes in place and what is needed is a change management approach by incorporating the cultural concept between Papua New Guineans and donor/partners as the foundation for a joint delivery of health services in PNG.

Solutions to:
Cultural Competence with Communication at all levels:
All communications need to acknowledge and include the customary line of command with this cultural concept to ensure information is shared with all clans and all families within each clan. The customary line of command may now be more than one person where religion or politics divides a clan. By using this line of communication it will ensure members of each clan will be included; thereby reducing exclusion, anger and misunderstanding and promote participation with two-way communication that allows the whole community to measure information against related actions. This cultural concept is entwined throughout business; including the management of donor/partnership funding. To implement a national change for management; the traditional culture of PNG needs to be recognized, understood and central to all discussions. The incorporation of this cultural concept between Papua New Guineans and donor/partners as the foundation for the joint delivery of health services will then support a change management approach with communication allowing other programme layers to be built on top.

Management of Current Needs:
The change required is not global funding alone in any of the forms and it is not about policies or programmes as these have been shown to work well for short episodes while global support is actively participating within the implementation of field programmes; however when the support is withdrawn at the end of contracts many basic health programmes that have functioned well for a few years stop within months.

The majority of health staff wish to perform effectively with good support and job satisfaction; however this is not happening and many of these skilled people are in the workforce but without positions or in positions where their skills are underutilized and prevented from improving the rural health service where eighty percent of the population lives.
Through listening to the needs of many Papua New Guineans, two needs are outstanding:

- **Security**, to be safe to go to work and to do the work that matches the person's skills and rightful position without fear.
- **Employment**, and employment obtained based on a person's skills to match the task and their willingness to contribute to the workforce.

These two needs can be addressed by a multi-prong approach that needs to first take into consideration some past and current situations to ensure that the good proven National Health policies and programmes are retained and supported. The long term cost-effective approach would acknowledge and include that the above two needs by health staff reflect security and National economic growth and this would require strong support of the Law and Justice System and impinge directly on the management and implementation of health funding to successfully match National policies and programmes. The Submission to the Senate Foreign Affairs, Defence and Trade Committee 30th August 2008 by Professor Helen Hughes and Gaurav Sodhi mentions many economic and Law and Justice needs of PNG. However under the United Nations Millennium Development Goals, Law and Justice is not a primary component.

PNG's geographically rugged terrain with a rapidly increasing population means that National funding support needs to be targeted strategically where the impact is holistic. A multi-prong programme would include: one section of the Law and Justice System programme to strengthen the National Law and Justice System for long term continuity of National Health policies and programmes. The other section of the Law and Justice System would support a provincial umbrella programme. An example would be that Law and Justice would accompany and work side by side with Provincial, District and Community health, education and agriculture and fisheries on a community infrastructure project such as roads and buildings. To support compliance with implementation of provincial projects and programmes for communities by senior provincial sector heads of departments; the Law and Justice System would first need to strengthen Provincial Administration.

Over the past ten years demonstrated evidence has shown that there has been little or no compliance by Papua New Guinean senior management to support rural services; so employing more teachers or health staff does not mean staff will go to work and work or have a functional building to work in or an accessible road for staff and patients. Without the reinforcement of an ethical code of conduct to support National policies and National programmes continuity of commenced programmes would quickly cease.

Strengthening through a multi-pronged programme of Law and Justice System, health, education and agriculture and fisheries and infrastructure would address the above two needs of the community and underlying third need.

1. **There is employment, and employment obtained based on a person's skills to match the task and their willingness to contribute to the workforce.**
2. **People will be safe to go to work and to do the work that matches the person's skills and rightful position without fear.**
3. **There will be a significant improvement overall for their children's future.**

Twenty years of global health funding and support in the various forms demonstrates that global funding alone is not the cure. The change required by management at all levels of government needs to be seen to take place to ensure the majority of skilled health staff can take their rightful place and implement the same known National Health policies and programmes to significantly improve the health of all Papua New Guineans.
Deidre Christie
1st February 2011.

Northern Territory of Australia

Based on two years of working with Federal Government funding in the remote Aboriginal and Torres Straight communities of the Northern Territory I recommend a designated and dedicated Primary and Preventive Health Team for family health to break the cycle of the ever increasing acute and chronic costly health system. This team and individual members need to be protected to ensure the resident acute and chronic staff cannot hijack these people into doing acute or chronic care.

Resident acute and chronic health staff need to be recognized for their excellent and ongoing care. A clear explanation needs to be done to ensure the resident staff understands the role of the dedicated Primary and Preventive Health Team to ensure there is no perception of criticism or conflict of interests.

Surely a simple beginning is to ensure the Public Health Standards that apply in other states are also maintained in the Northern Territory. This would significantly reduce many of the illnesses caused by infections.

Non-aboriginal people to understand what an Aboriginal person is saying when they say they are Aboriginal or Torres Straight would greatly assist and attitude and behaviour change in non-aboriginal people.
Deidre Christie
1st February 2011.