Evaluation Report for the Bougainville Healthy Community Project

Bridges to post-conflict communities

Commissioned by the New Zealand Ministry of Foreign Affairs and Trade for the New Zealand Aid Programme

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Contents

About this report

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Abstract

This independent evaluation was conducted to inform NZMFAT and LMNZ about the progress to date of the Bougainville Healthy Community Program; the lessons learned; and suggestions for future design of a next five-year phase and implications for rollout in PNG. The evaluation focused on village level assessments in 19 villages and hamlets in four Districts, through consultation with communities, Chiefs, Village Health Volunteers, District Facilitators, District Authorities; and key informant interviews with ABG, NDOH, other Donor Partners and NGOs. Over 30 relevant documents and data were reviewed. Findings indicate that this is a highly effective public health/community development model which has been well planned and well executed. It is rare to see such a holistic logic in a project, that has been effectively implemented within the enormous constraints and challenges of a post-conflict setting. One of the strengths of the Program is the willingness over the years, to evolve and adapt as lessons are learned. Communities and individuals have changed and improved their health behaviours as a result of the BHCP activities and interventions. With a shortage of health workers, Village Health Volunteers play an important role in referrals to health centres for key conditions such as TB, malaria and leprosy. Along with Chiefs, they also mobilise communities for preventive measures such as immunisation, and can play a greater role in encouraging health seeking behaviour for antenatal care, birthing in health facilities and testing for STIs and HIV. It is a critical time to build on the keen interest and momentum for change within the ABG and communities, and to develop the right linkages and partnerships for the future development of Bougainville.

Executive Summary

Background and context of the Activity

The New Zealand Ministry of Foreign Affairs and Trade (NZMFAT) has provided funding to the Leprosy Mission of New Zealand (LMNZ) to support health initiatives at community level in Bougainville, an autonomous province of Papua New Guinea. Funding has been provided since 2005, with a new model commencing in 2009.

This independent evaluation assessed the overall performance of the Bougainville Healthy Communities Programme (BHCP) since 2009. BHCP is currently designing the next phase of its program to roll out activities to all 13 districts of Bougainville and is in negotiation with NZMFAT for a new multi-year Grant Funding Arrangement (GFA) from 2013. This evaluation provides a timely analysis to inform the **activity design** and the **development of the GFA**.

Purpose and objectives of the evaluation

The primary purpose of this evaluation was to:

- assess **progress** to date against outcomes, objectives and outputs;
- provide NZMFAT, the Autonomous Bougainville Government (ABG), and the Leprosy Mission New Zealand (LMNZ) with '**lessons learned**' from BHCP activities to date and **suggestions for improvements to guide developmen**t of the next stage of the BHCP programme; and
- provide a clear indication as to whether continued funding to BHCP via LMNZ is still the **most appropriate modality** for delivering the activity under a new GFA.

The secondary purpose of this evaluation was to:

provide 'lessons learned' from BHCP activities to date and suggestions to guide any plans for a possible future rollout of a similar activity in other regions of Papua New Guinea (PNG).

Scope of the evaluation

While the programme has been running since 2005, the focus of the evaluation will be the period since 2009, when a new model was put in place based on lessons from the earlier period.

New Zealand funds other health initiatives in Bougainville – in particular the *Direct Facility Funding trial*. While this evaluation did not cover this initiative in detail, linkages or enhanced leverage opportunities were noted between the programmes. Likewise, **AusAID** has completed the process of assisting the Autonomous Bougainville Government (ABG) to develop a *Health Master Plan* and an *institutional strengthening programme for the DoH*. These were outside the scope of the evaluation but points of linkage and enhanced leverage were noted.

Methodology

Mixed quantitative and qualitative analysis informed the methodology, including document review and assessment of data collected; village level assessments and consultation in 19 villages and hamlets in four Districts [Siwai, Kieta, Tinputz and Buka] with community members, Chiefs, VHVs, DFs, District Authorities; and key informant interviews with ABG, NDOH, AusAID and other NGOs.

Key findings and conclusions

The BHCP is an excellent example of well-planned and well executed public health and community development model. It is rare to see such a holistic logic and rationale in a project, which has been effectively implemented within the enormous constraints and challenges of a post-conflict setting. One of the strengths of the Program is the willingness over the years, to evolve and adapt as lessons are learned.

The BHCP aligns with NZ Aid Program's priority countries; promoting human development (through investment in health); improving resilience and building safe and secure communities through good governance. BHCP is less focussed on economic development.

It also aligns well with PNG NDOH Health Strategy and the ABG Constitution and the *Bougainville Plan for Health 2012-2030* ('Master plan') which identifies four priority areas for the next 3 years: maternal health; rebuilding the health system infrastructure; developing and growing the health workforce and forming a Bougainville Health Authority. The BHCP was mentioned in a number of areas in the Plan, most notably being identified as a 'key lever.'

More recent interventions aimed at advocating to and training Village leaders and Chiefs have proved most promising with tangible results seen in villages with supportive, trained Chiefs.

The Program is highly relevant to beneficiaries and greatly appreciated by communities. However, communities also expressed other concerns and urgent needs that affect the health of their community: failing cocoa crops, sago palm failure used for traditional roofing, appropriate materials for pig fencing, no mobile phone coverage (including the health centre) in Siwai, cost of equipment such as brush cutters to keep villages clean. Access to safe water, good sanitation and hygiene underpins a healthy environment and for many communities visited this is lacking.

BHCP has contributed to greater access to immunisation, TB-DOTS, malaria and leprosy services, however more attention could be given in the next phase to increasing health seeking behaviour in communities for antenatal care, STI and HIV testing, family planning and birthing in health facilities. Given that ABG data indicate lower rates in these areas, VHV actions should be reflected in increasing service statistics in health facilities which can then be attributed to BHCP and VHV/community action.

Communities reported lower numbers of people suffering from malaria, TB and pneumonia since BHCP had trained VHVs and Chiefs and they had taken action. It may be timely in the next phase to include wider social media (e.g. radio and talkback, billboards) to improve messaging.

Communities reported improved health practices such as cleaning villages and separating rubbish, hand washing (although this was constrained by poor access to water sources in some areas), fencing pigs (except in Buka), building pit latrines (except in coastal areas).

Not all trained VHVs were active however and it is critical that villages are empowered to widen the network of 'volunteers' where it is not working effectively. Referrals to health facilities do occur and in some cases the sick person is accompanied by the volunteer. However the concept can be widened so that more people in the community feel empowered to refer someone who is ill, and not just to wait for a volunteer to do so. In essence this means a shift in thinking from 1-2 volunteers in each village, to one where many villagers receive knowledge and skills (from volunteers but also other sources such as social media) and assist in appropriate referrals. The emphasis of the goal should be to increase **health literacy** in villages, not just to train volunteers.

Village leadership was most impressive in all but 1 village and their commitment and enthusiasm is a positive outcome for BHCP. It was pointed out that the 'Chief' system which is operating more strongly in Bougainville than in other parts of PNG is essentially a 'volunteer' system; gaining the commitment from Chiefs drives many changes in the village.

Integration of volunteers into the health system was working well in Siwai and Tinputz, in the DFF health facilities. These sites provide positive models where VHVs (and others) were able to mobilise children for supplementary immunisation, gaining an increase in coverage from 60% to 90% within one week. For example in Tinputz the Officer in Charge (OIC) has the name and contact mobile for all VHVs and has called them to bring in patients who need treatment or follow up; VHVs also accompany Nurses when they conduct Outreach and Patrol visits to remote communities. In Siwai the HEO has identified suitable VHVs for further training as Community Health Workers (CHW) as the health facility is so short of staff. District Facilitators in 3 Districts are well integrated with District Authorities and are highly regarded by the District Executive Manager. They are seen to contribute grassroots knowledge of villages which assists with planning and priority setting. At the central level, more detailed discussion of how and where BHCP should be integrated needs to take place; the Program is seen as relevant to a number of Divisions and integration needs to be carefully negotiated. The level of Village Assembly has not yet been addressed by BHCP, and Care International is currently developing a training curriculum for leaders at this level. It is important that both Care and BHCP communicate about the curriculum and also about which Chiefs may have already had BHCP training so that a strategy can be developed to avoid overlap.

Summary of lessons learned and recommendations

The BHCP has had greater impact in communities where leaders are supportive, local governance is strong and communities well organised. Communities benefit the most in Districts where BHCP has been able to partner well with others on other urgent public health issues such as water, sanitation and hygiene (WASH). While such partnering introduces additional complexities, communities expressed appreciation at the results. Developing a strong NGO Forum for sharing information and avoiding overlaps needs to be driven by the ABG, or it will not happen.

BHCP has trained over 600 Chiefs/leaders and 1,400 volunteers, however not all are active. A shift in the model beyond training to one of improving community health literacy could be considered in the next phase. Other health promotion methods and media such as radio, soap operas, and billboards could be used to strengthen messaging. Technical expertise and staff from NDOH could be engaged to assist with this. Engaging Youth through school/peer education also needs to be tackled in the next phase.

Linking with other ABG Divisions such as Education and Local Level Government will improve the reach of the Program, especially if laws are passed about healthy environments such as animal fencing; and School health curriculum reinforces messages from BHCP and DoH.

Leadership and Governance training has already started as a relatively new but critical component in BHCP. The existing L&G curriculum needs to be reviewed for content to be practical and useful for leaders. As there are a number of stakeholders in this component, it is important that this be addressed soon.

Integration of the BHCP into the ABG needs to be worked through carefully with relevant stakeholders over the next 6-12 months. This will require developing a clear vision with an Action Plan, timeline and budget for the process. Already there is evidence of VHVs linking with health facilities; District Facilitators with District Health Authorities; however at the Central level more needs to be done to develop protocols and guidelines for this integration to be rolled out effectively to all Districts.

Data linkages and Monitoring and Evaluation need to be addressed soon, and summary feedback presented to villages, District authorities and health facilities regularly. Reflection meetings are perceived positively and should continue, using a more explicit Contribution Analysis methodology.

The BHCP is a successful Program and high level advocacy through an appropriate Forum could be beneficial in 2013. Providing recognition of volunteers, involving local politicians, District Authorities and leaders is also an important strategy to keep volunteers engaged and something like a Volunteer Appreciation Day in Districts could be introduced.

Background and context of the Activity

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This independent evaluation assessed the overall performance of the Bougainville Healthy Communities Programme (BHCP) since 2009. BHCP is currently designing the next phase of its program to roll out activities to all 13 districts of Bougainville and is in negotiation with NZMFAT for a new multi-year Grant Funding Arrangement (GFA) from 2013. This evaluation provides a timely analysis to inform the **activity design** and the **development of the GFA**.

Purpose, scope and objectives of the evaluation

Purpose

The primary purpose of this evaluation is to:

- assess progress to date against outcomes, objectives and outputs;
- provide NZMFAT, the Autonomous Bougainville Government (ABG), and the Leprosy Mission New Zealand (LMNZ) with 'lessons learned' from BHCP activities to date and suggestions for improvements to guide development of the next stage of the BHCP programme; and
- provide a clear indication as to whether continued funding to BHCP via LMNZ is still the most appropriate modality for delivering the activity under a new GFA.

The secondary purpose of this evaluation is to:

provide 'lessons learned' from BHCP activities to date and suggestions to guide any plans for a possible future **rollout of a similar activity in other regions of Papua New Guinea** (PNG).

Scope of the evaluation

While the programme has been running since 2005, the focus of the evaluation will be the period since 2009, when a new model was put in place based on lessons from the earlier period.

New Zealand funds other health initiatives in Bougainville – in particular the *Direct Facility Funding trial*. While this evaluation did not cover this initiative in detail, linkages or enhanced leverage opportunities were noted between the programmes. Likewise, **AusAID** has completed the process of assisting the Autonomous Bougainville Government (ABG) to develop a *Health Master Plan* and an *institutional*

strengthening programme for the DoH. These were outside the scope of the evaluation but points of linkage and enhanced leverage were noted.

Finally, the **ABG** is part way through a multi-year process of drawing down national powers and functions from the Government of Papua New Guinea, as part of the peace process – this is currently being undertaken in a gradual way. In early September, PGK100m was supposedly released to the ABG, and observers noted that only a small percentage would be spent on health, however all this is currently speculation.

Objectives and evaluation questions

The evaluation objectives and questions remained as stated in the Terms of Reference for the evaluation.

Objective 1: **Assess Relevance**. Specific questions included, but were not limited to:

- To what extent does the Programme and the current approach, continue to be relevant to beneficiaries, the New Zealand Aid Programme and partner country/regional development priorities?
- What lessons can be learned from BHCP activities to date and recommendations made to improve the relevance of the next stage of the BHCP programme?

Objective 2: **Assess overall effectiveness**. Specific questions included, but were not limited to:

- What progress has been made to date in achieving intended outcomes, objectives, and outputs?
- To what extent is the Programme providing benefits to different stakeholders?
- To what extent, and how, are crosscutting issues being effectively addressed?
- What factors are enhancing or constraining progress towards intended outcomes (e.g. management of risk), and what lessons can be learned, particularly for replication in remaining districts of the Autonomous Region of Bougainville (ARB)?
- What unintended outcomes are evident as a result of the Programme (positive and negative)?

Objective 3: **Assess efficiency**. Specific questions included, but were not limited to:

- Are resources being used in the best possible way in order to provide value for money?
- What could be done differently to improve the efficiency of implementation?
- Is funding to BHCP via LMNZ is still the most appropriate modality for delivering the Programme? Provide recommendations on the continuation of the current approach and/or necessary changes of approach in future support for/development of BHCP.

Objective 4: **Assess sustainability**. Specific questions included, but were not limited to:

- How well prepared is BHCP for full integration into the ABG DoH by 2014? What are the key issues/risks?
- To what extent are the ABG and relevant partners prepared to manage the integration of BHCP activities? What are the key issues/risks?
- To what extent are there likely to be continued positive outcomes after LMNZ management and New Zealand funding ends?
- What will constrain/enhance the sustainability of the results of the BHCP? How might the constraints and risks identified be mitigated?

A higher priority for this evaluation will be assessing broad *relevance* and *sustainability*. Issues of *effectiveness* will need to be considered through Contribution Analysis. *Efficiency* will have less emphasis as this issue would be best addressed through financial auditing and other NZMFAT grant monitoring mechanisms.

Methodology

Quantitative baseline data were collected by BHCP in 2009 and provided a reference against which to assess progress. In addition, PNG census and health information provide additional data sources that indicate health concerns and priorities for the ABG, however it is difficult to determine the reliability and validity of the data. Document review of BHCP Annual Reports and Reflections from 2009-2012 was also conducted.

Qualitative methodology was the main method to gain insight into the 'why' and 'how' questions. Views, opinions and perceptions of a range of stakeholders and key informants were critical to assessing the relevance, sustainability and also effectiveness and efficiency. Interviews and qualitative assessment took place over 17 days in Papua New Guinea, including 12 days in Bougainville from August 26th to September 12th 2012.

In addition to the key stakeholder interviews with the NZ High Commission, PNG NDOH, ABG (various Divisions), District Authorities, Council of Elders and LMNZ, triangulation interviews with BHCP staff, District Facilitators and VHVs were conducted during site visits. Other key informants were also interviewed, including WHO, AusAID, World Vision, Oxfam, Care International and MSF.

Given the timeframe and logistical constraints, the evaluation was only be able to sample a limited number of Districts and Villages – a total of 19 villages and hamlets in four of the eight Districts covered by the BHCP. The rationale for Village selection was to include a mix of perceived *struggling*, *average* and *model* Villages (as assessed by LMNZ-BHCP and discussed with Evaluator). Field assessments were conducted in the Districts of Siwai, Kieta, Tinputz and Buka, while also driving through and observing villages in Panguna, Bana and Wakunai.

Discussions were held with a range of staff from local authorities - District Executive Managers; District Health Officer (where available); Council of Elders representatives involved in health (e.g. COE Health Minister). In Siwai discussions included a constable, the President of the Women's Federation, an LLG Officer and COE from several areas.

Assessments at village level included a review of the local Health Facility and a 'Village Walk' to elicit more informal views and to triangulate with Community Discussions and Village leaders. During these walks (lasting from 15 minutes to 3.5 hours) individual conversations were held with leaders, women, volunteers, auxiliary police and District Facilitators to cross-check observations and comments. This information was most valuable as these more private conversations allowed for sensitive information to be gathered (such as problems of home-brew and gambling; leadership tensions). Notes were written up of these conversations at the end of the meeting, while in transit to the next site.

Community discussions with Village Health Volunteers (VHVs), women, men and young people were also conducted to ensure a range of views was included. Participants were selected by Village leaders in consultation with VHVs and BHCP staff. While this is less than ideal, it was important that selection involved local stakeholders.

Focus groups of around 8-10 people are ideal, but this is often unpredictable and allowances had to be made for local circumstances. What transpired in most villages was that women, men and young people were all present during the consultation, with numbers ranging from 8-36. While the VHV and often another community leader (a mix of female and males) presented a summary and broad views, others then added opinions. The aim of gaining as many views as possible on BHCP and health services and community concerns was effectively met in what eventuated to be a Community Discussion/Consultation.

One issue that emerged early in Community Discussions in the first District, Siwai, was the long distances women and children travelled to fetch clean water. From the first village onwards, the walk around the village was structured to include a visit to the water source. In general it was women and children who 'led' the walk, although the Chief and other men followed in some villages. In Kieta the walk was led by the Auxiliary policewoman and policeman in uniform.

Informal discussions during the village walks proved most instructive. Walks ranged from 15 minutes to 3.5 hours. In Siwai, Kieta and Tinputz the walk was planned to include neighbouring hamlets and villages, to understand the range of living conditions faced by villagers and therefore took longer.

Community Consultation was facilitated by an independent Interpreter using 'pidgin' for the first 3 villages in Siwai District, and by local villagers for the remaining Districts as most spoke in pidgin or English. As noted, opportunistic discussions with villagers in their homes during the Village Walk also allowed for cross-checking of information gathered

from the larger meetings. In short, all conversations and meetings with several hundred people during the evaluation period were considered in the analysis and recommendations.

Limitations of the evaluation (and the effect of these on the evaluation)

The BHCP covers over 400 villages in 8 Districts and only 19 of these villages and hamlets in four of the eight Districts were able to be visited. The selection of Districts and Villages was made with the agreement of the Steering Group and LMNZ-BHCP, which had more detailed knowledge of the settings. It is unclear if the selected villages were representative; however the differences between the Districts allow an assessment to be made about relevance and effectiveness in differing contexts. Ideally all Districts should have been sampled, but transport difficulties and timing made this impossible. The differences between perceived 'struggling, 'average' and 'model' villages were sometimes difficult to detect, although the level of leadership commitment could be discerned.

As stated, participant selection was done by Village leaders with the VHV; however this is not anticipated to have a serious impact on the validity, as findings echoed with numerous other reports.

Large groups were consulted rather than smaller focus group discussions in all except Buka District. Essentially the result was a Community Discussion/Consultation with which community members were familiar. Vocal participants consulted with others during the question time, and then spoke on their behalf. Other views were added during the Village Walk, limiting the risk of excluding voices. The impact of having larger groups did not appear to compromise the findings and was able to gain a range of views, which was complemented by private conversations during the Village Walk.

Findings and conclusions

The BHCP is an excellent example of well-planned and well executed public health and community development model. It is rare to see such a holistic logic and rationale in a project, which has been effectively implemented within the enormous constraints and challenges of a post-conflict setting. One of the strengths of the Program is the willingness over the years, to evolve and adapt as lessons are learned.

BHCP set the ultimate goal of creating **healthier Bougainville communities** through 'villages and government **sharing responsibility** for health'. The levels of the intervention are therefore *village* and *government* and the project clearly documents strategies, activities and results aimed at both levels. However there are four levels of government in Bougainville which provides additional complexity.

Given the high level goal of the BHCP to improve health status, attention needs to be paid to tackling the broad determinants of health. BHCP can only address some of those determinants. It will be important for

stakeholders in the next phase to consider issues of 'contribution' and 'attribution' and to identify other gaps that impact on health status. This will mean reviewing health facility data more closely and also continuing Reflection meetings to include a wide range of stakeholders.

Seven OUTCOMES with targets are described, ranging from HIGH level of '*Improved health* in Bougainville rural communities' to three MEDIUM level outcomes of '*Improved access* to basic healthcare in of rural BV'; '*Reduced incidence of preventable disease and sickness'*; and '*Improved health practices in rural communities'*.

LOWER level outcomes include *'Village based **knowledge** on preventing illness and disease, identifying its occurrence and ability to refer people to health facilities for diagnosis and treatment'*; '*Village **leadership** able to identify village health (and other) needs, prepare development plans and utilise village and government resources to address them'*; and *'BHCP Healthy Communities model **integrated** within government health system and enhanced collaboration between village communities, local level government, District health facilities and their workers and programs'*.

The Outcomes/Results framework provides a clear logic for **six listed Outputs/Activities aimed at different audiences**:

1. Village Health Volunteers (VHVs)
2. Chiefs
3. Health workers in health facilities
4. Village Health Committee
5. Leaders, Local Level Government, Council of Elders
6. Healthy Community Model

More recent interventions aimed at advocating to and training Village leaders and Chiefs have proved most promising with tangible results seen in villages with supportive, trained Chiefs.

As the Program develops and communities become more empowered, there is a tension between the level of health services that government delivers and what realistic changes communities can make. Even if all villages in Bougainville improve their healthy environment and take responsibility for their health, there is still a need for a functioning health system able to deliver appropriate, accessible, quality health care services. Tensions increase, for example, when shortages of medical and equipment supplies occur at local health facilities, often resulting in reduced community trust in the system and increasing cynicism. These shortages are mostly beyond the control of even the ABG, as wider PNG problems are being currently addressed.

Access to safe water, good sanitation and hygiene underpin a healthy environment. Villagers in communities with poor access to a safe water source (often a long walk down slippery jungle paths) requested BHCP to link them to organisations able to provide such technology and hardware. In Kieta where BHCP was able to link with WASH projects (Oxfam NZ), villagers said their lives had been transformed and they saved hours of time getting water. Coastal villages were concerned that they were unable to utilise standard pit latrines and felt they needed

technical support to change their 'ocean and beach toilets' methods. There is no doubt that working with external partners is a complex and sometimes difficult process, but where it does work, villagers are enormously appreciative and there are health and wellbeing benefits.

The *Bougainville Plan for Health 2012-2030* ('Master plan') identifies four priority areas for the next 3 years: maternal health; rebuilding the health system infrastructure; developing and growing the health workforce and forming the Bougainville Health Authority. The BHCP was mentioned in a number of areas in the Plan, most notably being identified as a 'key lever.'

> "Peace, well distributed economic growth, education of our children, access to clean water supply and sanitation, nutritious food supplies, adequate housing and safe transport will all make a contribution to health. Some of these broad health issues although they sit outside the health sector, are included in the strategies of this plan. In particular, the **Bougainville Healthy Communities project is seen as a key lever to positively influence these broader determinants of health by supporting village level development.**"

The Master plan also recommended that BHCP expands 'into all districts and introduce village health treasury concept as a way of empowering communities to address sustainability of Bougainville healthy community program.' (p.28). It also recommended that BHCP be merged into the mainstream health system (p.30).

An additional issue raised was the focus on strengthening links between Bougainville Traditional Health Association and BHCP. This was seen as important because BHCP includes training on herbal medicines as part of the training for volunteers and peer educators. Medicinal herb gardens have been established in primary schools. (pp. 50-51)

Other issues which are relevant to future planning for BHCP include:

- Engaging community-based organizations in planning, delivering and evaluating health services (p.30);
- Donor coordination and resource pooling to reduce complexity and align donor support with the plan. (p.24) and;
- Enhancing communication, cooperation, reporting and coordination with central agencies and other Bougainville sectorial departments, especially with the Departments of Treasury, Planning, Finance and Provincial and Local Level Government. (p.30)

Of particular note for BHCP for the future is the recommendation to ensure '*every maternal death (in health facility and in community) is reported, investigated and audited. Ensure that practices improve as a result. Report maternal deaths to the Minister of Health on a* ***monthly*** *basis'*. ('Master plan' p.33).

BHCP Volunteers currently collect and report on data 6-monthly, however this is too late to get action on identifying causes and preventing further maternal deaths.

Of note in the latest MEL report was 6 maternal deaths in Kieta. If the data are accurate, each maternal death should be seen as a matter of great concern and urgency and Health Authorities should be notified by the BHCP Program Manager **immediately** for follow up. At the moment this is not being done, as the data are only reported to BHCP at six-monthly intervals. Volunteers, leaders and communities should have it made clear that any maternal and child death is not 'normal' and the causes need investigation. This more aggressive approach is required to reach the Health MDGs and governments all over the world are being asked to address these matters with strong leadership. BHCP can play a powerful role in this, acting more closely with the Division of Health, who could assist by devising clear questions that volunteers and communities can ask about the causes of deaths. This information can then be fed back into the Health Division response.

Table 1, over the page, documents key findings reported against Evaluation themes and questions.

BHCP Results Measurement Framework and Logic

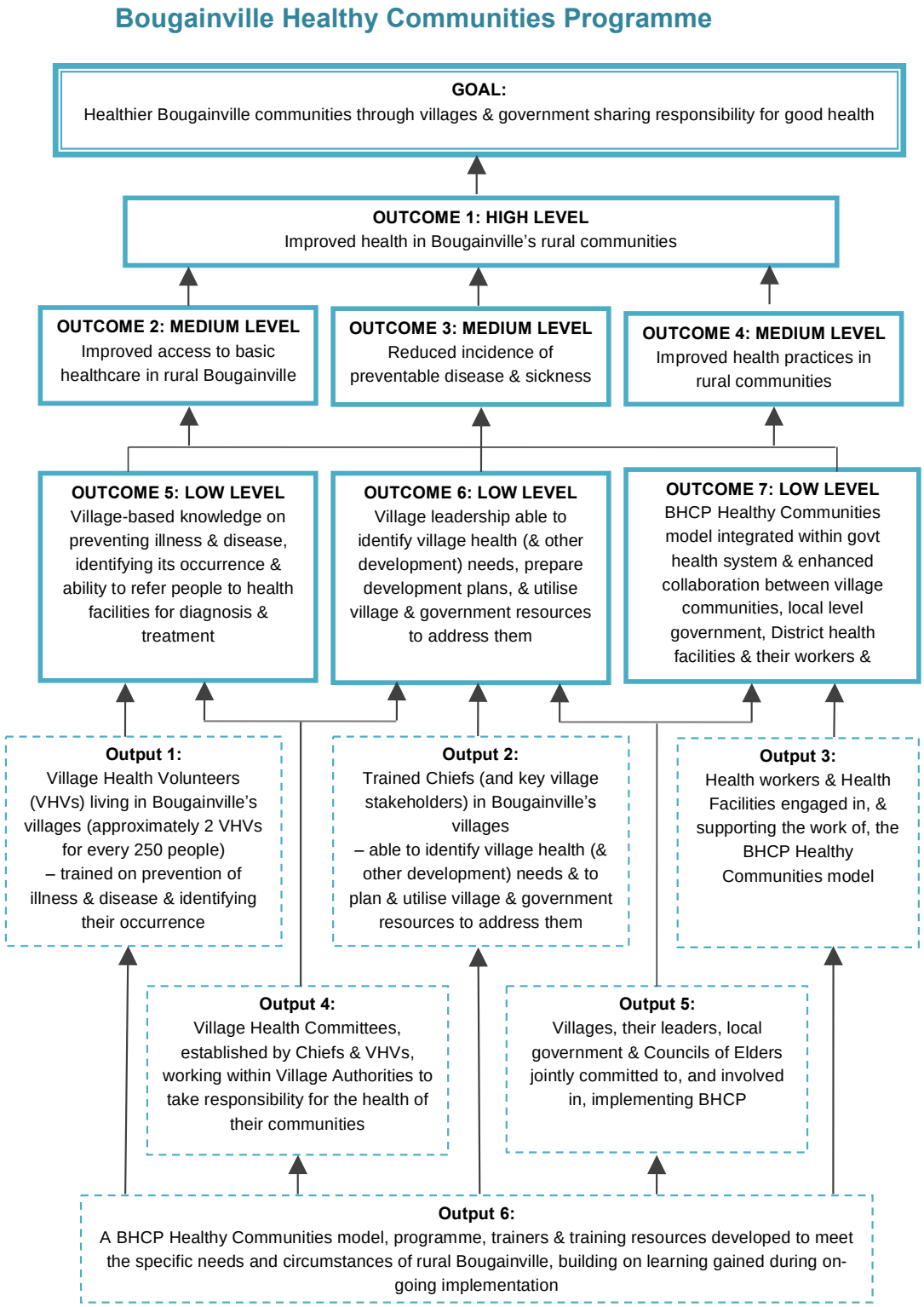


Table 1: Findings reported against Evaluation Themes/Questions

Focus/Question	Findings
Objective 1: Assess Relevance	
1. To what extent does the Programme and the current approach, continue to be relevant to beneficiaries, the New Zealand Aid Program and partner country/regional development priorities?	* The Program aligns well with the ABG Constitution and Master plan for Health and PNG NDOH. * BHCP aligns with NZ Aid Program's priority countries; promoting human development (through investment in health); improving resilience and building safe and secure communities through good governance. BHCP is less focussed on economic development. * The Program is highly relevant to beneficiaries and greatly appreciated by communities. * However, communities also expressed other concerns and urgent needs that affect their healthy community: failing cocoa crops, sago palm failure used for traditional roofing, appropriate materials for pig fencing, no mobile phone coverage (including the health centre) in Siwai, cost of equipment such as brush cutters to keep villages clean. While these are beyond the 'core business' of BHCP which has focused on health components, they are nevertheless important to consider when engaging with communities.
2. What lessons can be learned from BHCP activities to date and recommendations made to improve the relevance of the next stage of the BHCP programme?	* The BHCP has had greater impact in communities where leaders are supportive and local governance is strong and communities well organised. * Communities benefit the most in Districts where BHCP has been able to partner well with others (e.g. Oxfam NZ in Kieta) on other urgent public health issues such as water, sanitation and hygiene (WASH). While this is difficult, lessons learned from the successful partnership could be considered in the redesign. * Younger volunteers struggle to influence Chiefs and leaders. They should generally be excluded from VHV program but an explicit Youth Engagement strategy using peer education and radio should be included in the next stage of the BHCP.

Focus/Question	Findings
Objective 2: Assess overall effectiveness	
1. What progress has been made to date in achieving intended outcomes, objectives, and outputs?	Progress can be traced for outcomes 2-7 while outcome 1 will require comparison against health data and health centre service statistics in future: * BHCP has trained over 1,400 volunteers, many of whom have contributed to improve access to immunisation, TB-DOTS and leprosy services. Division of Health and WHO data indicate lower levels of ANC, and very low rates of STI testing (including HIV), in some districts low uptake of FP and birthing in facilities with trained birth attendants. This has been raised in the Health Master plan and more attention could be given in the next phase to increasing health seeking behaviour in communities for antenatal care, STI and HIV testing, family planning and birthing in health facilities. This should be reflected in increasing service statistics in health facilities which can be attributed to BHCP and VHVs/community action. * Communities reported lower numbers of people suffering from malaria, TB and pneumonia since BHCP had trained VHVs, Chiefs and they had taken action. It may be timely in the next phase to include wider social media (e.g. radio, talkback, billboards) to strengthen messaging. Currently the MEL coordinator is assessing the value of SMS messaging methods; however the impact of this will depend on the mobile phone coverage in Bougainville. * Communities reported improved health practices such as cleaning villages and separating rubbish, hand washing (although this was constrained by poor access to water sources in some areas), fencing pigs (except in Buka), building pit latrines (except in coastal areas). * Not all trained VHVs were active however and it is critical that villages are empowered to widen the network of 'volunteers' where it is not working effectively. Referrals to health facilities do occur and in some cases the sick person is accompanied by the volunteer. However the concept can be widened so that more people in the community feel empowered to refer someone who is

Focus/Question	Findings
	ill, and not just to wait for a volunteer to do so. In essence this means a shift in thinking from 1-2 volunteers in each village, to one where many villagers can receive knowledge and skills (from volunteers but also other sources such as social media) and can assist in appropriate referrals. The emphasis of the goal should be to increase **health literacy** in villages, not just to train volunteers. * Village leadership was most impressive in all but 1 village and their commitment and enthusiasm is a positive outcome for BHCP. It was pointed out that the 'Chief' system is operating more strongly in Bougainville than in other parts of PNG and is essentially a 'volunteer' system; gaining commitment from Chiefs drives many changes in the village. * Integration of volunteers into the health system was working well in Siwai and Tinputz, in the DFF health facilities. These sites provide positive models where VHVs (and others) were able to mobilise children for supplementary immunisation, gaining an increase in coverage from 60% to 90% within one week. In Tinputz the OIC has the name and contact mobile number for all VHVs and has called them to bring in patients who need treatment or follow up. VHVs also accompany Nurses when they conduct Outreach and Patrol visits to remote communities. In Siwai the OIC HEO has identified suitable VHVs for further training as Community Health Workers (CHW) as the health facility is so short of staff. District Facilitators in 3 Districts are well integrated with District Authorities and are highly regarded by the District E/M. They are seen to contribute grassroots knowledge of villages which assists with planning and priority setting. At the central level, more detailed discussion of how and where BHCP should be integrated needs to take place; the Program is seen as relevant to a number of Divisions and integration needs to be carefully negotiated. A sense of urgency over the next 18 months is needed to ensure these discussions result in agreement.

Focus/Question	Findings
	* The level of Village Assembly has not yet been addressed by BHCP, and Care International is currently developing a training curriculum for leaders at this level. It is important that both Care and BHCP communicate about the curriculum and also about which Chiefs may have already had BHCP training so that a strategy can be developed to avoid overlap.
2. To what extent is the Programme providing benefits to different stakeholders?	* Villages where leaders have been supportive and volunteers active, have gained benefits in terms of healthier living environment and reduced need for health services. * Access to health services has improved for some conditions such as immunisation (e.g. SIA in Tinputz); TB-DOTS and leprosy treatment and diagnosis. * Health facility staff, where engaged, have utilised VHVs to encourage villagers to attend immunisation and in Tinputz to accompany the Nurse on Patrol (to remote villages). * Various ABG Divisions see BHCP as a vehicle for furthering their work – e.g. Local Level Government (LLG), Peace, Veterans Affairs, and CD. BHCP model is perceived as critical to improving health because it fosters self-reliance where communities and individuals take responsibility. * Data linkages and timely reporting from villages need to be addressed urgently. Any maternal or child death in villages should be notified to the BHCP PM immediately, for action by health services. A review of the MEL indicators to merge with DoH data requirements should be conducted soon. Some reporting issues also need clarification, and have been discussed with MEL officer.
3. To what extent, and how, are crosscutting issues being effectively addressed?	The Program is keen to retain its health focus and core activities, but more attention to cross-cutting issues needs to be given explicitly in the next design phase. * For example, in terms of gender, women volunteers with many children or heavy family

Focus/Question	Findings
	responsibilities were less effective as VHVs. More women leaders are emerging, and adopting a strategy for engagement with them would be beneficial in the next phase. * Environmental issues are critical and the next phase should consider partnering with environmental experts to assist with latrine design for coastal areas; sustainable agriculture and building materials; and attention to the atolls requiring relocation due to rising sea levels. * Peace and human security are fundamental to healthy communities and linking carefully with various peace-building and conflict resolution initiatives could be considered. A balance between core 'health business' and these broader concerns need to be struck, often best addressed through partnering strategically.
4. What factors are enhancing or constraining progress towards intended outcomes (e.g. management of risk), and what lessons can be learned, particularly for replication in remaining districts of the ARB?	* Increasing inequalities within Bougainville is a concern, with those in paid employment clearly more wealthy compared to villagers whose only income is from (failing) cash crops e.g. cocoa. While there are other forms of cash income in other parts of Bougainville (e.g. gold and small business) the majority of villagers still rely on cash crops. The use of Community Treasury or Common Funds is a new initiative and BHCP has the opportunity to document how it is being used to provide health benefits. * Engaging Chiefs and leaders prior to VHV training is a critical first step for success. * Volunteer recruitment, selection and motivation are critical to the success of the Program. Lessons have been learned about volunteers which should be shared broadly. * Some District Facilitators play a positive role with District Authorities in planning; engaging with District Executive Managers enhances progress. * Exchange visits between Model Villages have proved effective in advocacy for the BHCP model, and also for communities to gain and learn from each other. * Transport infrastructure is a major impediment to implementation in the remaining 5 Districts,

Focus/Question	Findings
	where villages are even more remote. 2013 should focus on consolidation, integration and linkages. * The uncertainty about the political and economic future of Bougainville makes it difficult to plan for integration and ownership by ABG.
5. What unintended outcomes are evident as a result of the Programme (positive and negative)?	* BHCP is mostly recognised and referred to as a "beautification" program, although that is not one of stated goals or outcomes. However the cleaning up and planting of flowers and gardens is very obvious and has led to great individual and community pride. One unintended outcome has been the growth in interest from young men and women in cultivation and propagation. Flowers are now being sold in Buka. * The Exchange visits between villages has led to some innovation, experimentation and positive 'competitiveness'. At present there are 11 Model Villages – the processes for this need to be documented and promoted – perhaps even with a sign as you enter the village.
Objective 3: Assess efficiency	
1. Are resources being used in the best possible way in order to provide value for money?	Papua New Guinea in general and Bougainville are extremely expensive sites to conduct business and projects. BHCP seems to be doing as well as possible in terms of value for money, however staff need to be realistic about the future given integration goals and the low levels of investment in the Health sector. It would be unwise to create too large a gap between the conditions for BHCP staff and those working in the ABG.
2. What could be done differently to improve the efficiency of implementation?	Good planning could assist with improving efficiencies, but this needs to balance against staff working conditions, e.g. being away on weekends from families when 2 week training courses are run. The logistics and scheduling of transport in particular can lead to improved efficiencies.

Focus/Question	Findings
3. Is funding to BHCP via LMNZ is still the most appropriate modality for delivering the Program? Provide recommendations on the continuation of the current approach and/or necessary changes of approach.	LMNZ has provided a sound management and accountability structure that is valuable to consider in the integration. Given Outcome 7 (Integration), it is important that these more political and economic discussions be held soon with ABG DoH regarding future plans. Finding the most appropriate funding modality will require detailed costing information and negotiation, based on a clearer picture of the next phase. There are a number of options, including funding through ABG and then to other NGOs including LMNZ to deliver various outputs; or a partnership MOU with ABG-LMNZ and other NGOs. Changes could be phased in over the next 2 years – but the ultimate shape of the structure will depend largely on the budget being allocated to ABG, DoH and other divisions related to BHCP work.
Objective 4: Assess sustainability	
1. How well prepared is BHCP for full integration into the ABG DoH by 2014? What are the key issues/risks?	Two meetings were scheduled with ABG Divisions during the evaluation period. Participants indicated that they valued the Program and could see benefits in continuation, from their various standpoints. A meeting of relevant ABG Divisions is planned after delivery of the Evaluation report, in October, and it would be timely to begin concrete discussions on integration. This is a critical period to build on momentum and will require a dedicated action plan and budget. At the time of review, BHCP was not well prepared for full integration. But this will be the focus of the next 18 months.
2. To what extent are the ABG and relevant partners prepared to manage the integration of BHCP activities? What are the key	The *Bougainville Plan for Health 2012-2030* mentions BHCP on 4 occasions and recommends merging BHCP into the mainstream health service. However the process for integration is nascent and mechanisms need to be planned with LMNZ, NZMFAT over the next 6-12 months – setting goals, a timeline, activity plan and budget. At the time of review, the ABG and partners

Focus/Question	Findings
issues/risks?	are not well prepared to manage the integration. Key risks remain budget and staffing shortages in the Division of Health and ABG in general. Creation of a Project Management Unit within ABG may assist with planning for integration. * The TIIG was not able to meet monthly as planned, but I believe it was an unrealistic expectation, and that such high level meetings should be focused on specific results, with a tight timeframe and clear outcomes expected. Busy people do not like to have meetings just because they are scheduled; rather the need has to be clear and pressing. Review the technical advisory role in the next phase.
3. To what extent are there likely to be continued positive outcomes after LMNZ management and New Zealand funding ends	* Village and women leaders and Chiefs are likely to remain committed to the goals of healthy communities long after funding ends. Building the knowledge, skills and attitudes of communities is likely to be sustained; however some refreshing through future campaigns may be useful. * The role of District Facilitators may be absorbed into District planning structures with some ABG funding. However the rebuilding of health facilities and the human resources for the health system will require a long-term funding commitment to sustain.
4. What will constrain/enhance the sustainability of the results of the BHCP? How might the constraints and risks identified be mitigated?	* To date 50 villages have established a Village Treasury or Common Fund. These funds have the potential to be utilised for health related common goods, such as improving water sources or transport to health facilities. It will be important for these processes to be documented and lessons learned shared. * Bougainville and PNG require a long-term investment strategy to ensure the gains made are sustained. BHCP is in a good position regarding sustainability because in most cases, once communities accept the message, they can drive the changes themselves. However if the health system fails, then increasing community cynicism may jeopardise positive gains made.

Lessons learned

Management and Accountability

- There is good evidence that the BHCP has been effectively managed through LMNZ, to ensure effective implementation and progress. The relationship between LMNZ and local BHCP staff is positive and supportive, with a clear focus on results. Project management and communication from a distance is always difficult however LMNZ has managed the process well, with dedicated staff providing regular feedback, scheduling frequent trips to Bougainville at key points. Of note, is that LMNZ has encouraged learning and flexibility in the model to accommodate lessons learned in the process.
- LMNZ have taken accountability seriously and have effectively negotiated contract variations with NZHC over the years, however it may be important to start with more realistic targets in future. The benefits of LMNZ engagement in Bougainville need to be considered when planning the integration phase. It could be constructive to have the LMNZ Program Manager spend a prolonged period in Bougainville during the re-design and integration phase. This will be a critical period for the on-going success and sustainability of the model, and it will require delicate negotiations and relationship-building with new partners.

Volunteerism Model: Village Health Volunteers

- Attrition of VHVs is a problem in all Districts for many reasons, but possibly more in some Districts than others. The support and supervision from District Facilitators' is critical to the retention of VHVs. A new Cluster Team Leader Volunteer covering several villages has been trialled which appears promising. While no cash payments are made to VHVs, other forms of motivation and incentives are provided. There is great interest in developing volunteers, and a number of NGOs grapple with this issue. BHCP can share lessons learned and also work with ABG and COE on how communities can encourage and support volunteers.

Youth Engagement

- VHVs who are younger find it difficult to get leaders involved and communities engaged. It may be worth excluding young people in selection criteria for VHV training. However youth engagement is critical in the long-term and may require additional expertise in peer education. The model of peer education is recognized and used by many NGOs working on SRH and youth, including NZ Family Planning International. Currently Care International has been working in Bougainville with youth, specifically on HIV and SRH, but they will be exiting in some Districts (e.g. Buka). They are keen to discuss how best to link youth volunteers with BHCP.

Broaden VHV training to health literacy model

- BHCP has trained over 1,400 VHV to date and over 600 leaders. This is a great outcome given the difficulties of working at village level in a post-conflict country with huge infrastructure challenges. However not all trained VHVs are active, and in the next phase it may be useful to emphasise the goal to increase health literacy in villages, not just to train volunteers. This will require a slight shift in the model for BHCP staff, but is likely to be more sustainable. In addition, a Training team of 5 staff will be difficult to absorb in the ABG DoH which has so few Public Health and Health Promotion staff.

Integrating VHVs with health facilities

- VHVS have been effectively integrated in some District health facilities, providing positive exemplars. A clear plan for orientation, attendance of health staff at VHV training sessions, referral systems and communication needs to be implemented for all active VHVs.

Integrating District Facilitators with District Authorities

- Because of their knowledge at village level, the role of District Facilitators has great potential to add-value to District Authority planning and prioritisation processes. Discussions with ABG LLG regarding the role and integration of DFs are at a critical stage. Some Districts are already utilising DFs effectively but there needs to be clear Central ABG approval and procedures mapped out.

Mapping Health Facilities

- BHCP has unique information about village level concerns. VHVs, Cluster Team leaders and DFs know which health facilities are staffed, utilised and have medical supplies and which are empty and not utilised. The Health Master plan will require a mapping of health facilities (Aid Posts, Community Health Posts, sub Health Centres) and it would be beneficial to link with BHCP to clarify the realities on the ground.

Using Social Media and Campaigns

- BHCP has utilised a community mobilisation model effectively and is exploring SMS messaging. However it has not yet tackled using social media, radio and other health promotion methods. PNG NDOH Health Promotion/Healthy Islands Division has staff with expertise and skills to develop such messaging (desk top publishers, video and film experts). However they have no budget for travel to Bougainville. ABG has limited health promotion staff and it may be beneficial to utilise PNG NDOH staff, who are familiar with appropriate community messaging, to support ABG and BHCP.

Legal and School Education approaches

- The Division of Local Level Government raised the issue of approving and enforcing laws in rural areas on 'animal fencing' and 'Community Work Days' and 'Village hygiene'. Combining this 'top-down' approach can complement BHCP's grassroots or 'bottom-up' approach. Introducing and improving health messaging in the School curriculum was also suggested, which will require collaboration with the Education Division.

Leadership and Governance Training

- The Leadership and Governance aspect has evolved from seeing how effective it has been to engage with Chiefs and leaders. However L&G was not core business for BHCP, nor are trainers experts in this field. The current material is very theoretical and was being reviewed; it would need extensive changes to engage adult learners. As there are many stakeholders in this component, it will be important to develop a strategy in October and consider options.
- Currently Care International are working on an L&G curriculum for Village Assembly leaders; BHCP will need to discuss potential overlaps of participants with them.

Focus on WASH Partnerships

- Safe water, sanitation and hygiene are fundamental to healthy communities. Many villages in Bougainville do not have access to safe water and toilets, and have to walk long distances to safe sources. Where WASH projects have been implemented, villagers report that their lives have been transformed. It is important that the next phase and redesign take into account the critical need for WASH in order to improve health outcomes.

Partnerships and MOUs with other NGOs

- BHCP has unique information on and networks in over 400 villages in Bougainville, with clear ideas on which have strong governance and an organised community. Such information could assist other NGOs to determine where to work most effectively, rather than a more ad hoc approach. It would be worthwhile for other NGOs and Donor Partners to link with BHCP and District Authorities prior to setting up projects in villages.

Build on momentum within ABG for integration

- Keen interest in BHCP was shown by other ABG Divisions – LLG, CD, Education, Veteran's Affairs, Peace, Communications, and Health Promotion. It is important that this be followed up to ensure that the potential for improving community health is maximized, while not compromising on the Program. It will require careful and thoughtful engagement, but should not be left on hold for too long. A mechanism for collaboration and planning should be developed,

along with a plan for prioritizing activities, a timeline and budget. Other relevant Divisions may also need to be engaged, e.g. Primary Industry.

Building on positive lessons learned: Exchange visits

- Engaging Chiefs and Village leaders including women has been very positive. The Exchange visits between Model Villages has also had a big impact on key stakeholders and leaders as well as villagers. These positive activities could be expanded and budgeted for in the next 2 year period prior to integration.

MEL and Data Linkage

- A number of definitional and statistical issues need to be clarified in the MEL reporting. These have been discussed with the MEL officer and include: validity of reporting on trends at District level with different villages and response rates; clarifying denominators; reporting on new cases as well as cumulative; only using 'average per village' where it makes sense; definitional issues such as what is a 'referral' and 'skilled birth attendant'. Data may need to be re-entered onto Xcel spread sheets once an assessment has been made of the shift to free access software which did not work.
- It is timely to review the data collected in the MEL to ensure that it links with data that is being collected by DoH. In addition, it is difficult to get a reasonable response rate every six months from VHVs; this impacts on the comparisons and interpretations drawn from the data. Working with ABG and WHO on linked data collection and analysis would be beneficial.
- Data also needs to be collected at the **level of the intervention** and summary information be fed back annually to villages so they can see progress. This will improve the response rate and validity of trend analysis. While some feedback has been provided at District level, each village needs to see their own 'performance', even if only a few positive indicators, along with some areas to improve.

Reflection meetings and Contribution Analysis

- Reflection meetings have provided a positive feedback system, and can be used more explicitly in the future to determine 'contribution' of BHCP (Appendix E). Ideally BHCP should have been set up as a before and after study with comparison villages prior to intervention. This would have allowed for a deeper analysis of effectiveness and impact. However even at this stage, it is possible to document what is happening more broadly in all villages that could contribute to positive health outcomes, compared to the changes in BHCP villages/Districts.

Recognition for volunteers and villages

- Volunteers are not only motivated by financial gain, but many are also committed to their communities. Giving them recognition through a formal ID card; ensuring that their families do receive free medical care as promised; and also public acknowledgement of their work are all important to continue. In addition, providing a t-shirt similar to those other NGOs provide would also give an identity and recognition for their efforts.
- At the end of this phase BHCP and ABG government members and District Authorities could organise 'District conferences' to formally recognise the work of volunteers. Villages that have attained 'Model status' could also be acknowledged with a letter, plaque or billboard sign for their village.

Transport options for District Facilitators

- The road system in Bougainville is gradually being rebuilt, with new bridges and improved surfacing. However in most Districts the only transport around villages is either walking or bicycle; there are not many motor bicycles or PMVs seen on the roads. However for District Facilitators to achieve their work plans, they need to be able to visit most villages in their District or at least Clusters annually. It is important that BHCP-LMNZ and ABG consider this issue seriously or risk falling behind on implementation. There are many risks associated with addressing the transport issue, including misuse of vehicles and lack of maintenance leading to wastage.
- One option to consider would be to locate a vehicle with District Administration, so that other community level staff (such as LLG, CD, DPI and DHO) can also benefit. This would encourage collaboration and sharing, but would require clear protocols and agreement about ownership, servicing, rosters etc. Another option is to provide mountain bikes or motorbikes, and discussions with JICA/JOICFP might be useful as they have provided this in other PNG Provinces.

Review and formalize ABG-NGO coordination mechanisms

- It is important that NGOs work in alignment with ABG on priority issues and locations. Many key informants suggested that ABG revitalize and 'drive' NGO coordination as it would not happen without that impetus. One option could be that the Project Management Unit takes on this role to institutionalize improved coordination systems with NGOs and Donor Partners.
    - develop TOR, Activity Plan and budget for it (3 monthly with senior level engagement; i.e. High level stakeholder meeting)
    - ABG develop MOU with each NGO – transparency of what each are doing and points of intersection that can be developed further
    - Identify overlaps with other NGOs – linkages agreed and MOU developed

- Agreement on volunteer incentives
- Plan for 'sharing' of NGO vehicles with relevant government partners (e.g. BHCP took out DoH Health Promotion Officer in Buka to village meetings)

Review ABG-Donor Partner coordination mechanisms

- It has been proposed that a Donor Summit be planned for 2012 which could be an excellent forum to formalize ABG-Donor Partner relationships and to develop future plans to ensure that funding will also benefit villages and communities, not just build administration.

High level advocacy

- At an appropriate time BHCP, LMNZ and the NZ High Commission should promote the benefits that have resulted from BHCP and initiate a high level advocacy event, involving senior levels of ABG, PNG government, NZ High Commissioner or Minister for Foreign Affairs and Trade. The good news story from this Program can be shared, and commitment mobilised for the future. It could also recognise the hard work of volunteers, Chiefs, District Authorities and health staff working together to improve the health in villages.

Recommendations

BHCP-LMNZ

1. Sharing lessons learned: BHCP to document lessons learned to share more widely (short 1-2 page summary) on:
   - VHV recruitment, retention and motivation
   - VHV linkages to Health Centre: how it can work
   - District Facilitator role: how to work with District Authorities
   - What makes a Model Village (and list them)

2. Documenting the role of VHVs with examples and follow up:
   - BHCP to develop an Activity Plan for linkages of active VHVs and DF to all Health Centres – using the model where it is working (e.g. Monoitu and Tearoki HC) and report on progress.
   - BHCP to demonstrate where HC health workers have been invited to Trainings, and what role they play (eg Referral session).
   - BHCP to document plan for Orientation sessions of VHVs to HC – report on that.
   - On-going refresher training can be organised by other organisations (eg first aid) and a list of active VHVs could be shared - with their consent.
   - BHCP to explicitly articulate VHV role for improving health seeking behaviour/ 'demand creation' for priority health issues like STI/HIV testing; ANC; delivery in health facilities, family planning and immunization.

3. BHCP need to clearly articulate criteria for categorising villages – at least for 'beginning', 'progressing', 'struggling' and 'model' villages. The hierarchy provided by the logic is a good basis but this needs to be developed further; a communication strategy for village leaders will highlight more clearly what they are working towards.

4. BHCP to develop a Youth Engagement Strategy in the next phase and consider partnering with other organisations that have a track record of successful peer education models.
   - BHCP to commence discussion with Care International and other NGOs such as NZ Family Planning International regarding youth engagement strategies with a focus on SRH.

Division of Health, with BHCP and other partners

5. BHCP to work with DoH and WHO in the coming 6 months on data, analysis, definitions (e.g. what is a referral), reporting and linkages. It would also be beneficial to plan for broader technical assistance on data analysis and reporting for ABG, DoH (Aid post, health centre staff), BHCP and other local NGOs.

6. BHCP in the next phase to consider engaging with NDOH/ABG Health Promotion to include a component on social marketing and media, including radio programs ('soap operas'), billboards with health messaging.

7. DoH and BHCP to consider how best to utilise community expertise in mapping health facilities and contribute to a health facility rationale and plan.

8. BHCP to consider collecting village data annually but split into two cycles of reporting, on half the villages. Feedback to Chiefs and VHVs in each village should be provided annually in a short summary document. Also feedback should be provided in a short report to District E/M and OIC at health facility.

9. BHCP to engage more broadly with other ABG Divisions in the next phase to develop a plan on how to maximise health messaging and health literacy, in particular with the Divisions of Local Level Government, Community Development and Education.

10. BHCP to continue Reflection meetings as an effective form of feedback but consider using 'Contribution Analysis' more explicitly (Appendix E).

11. DoH/BHCP to work on an ABG internal advocacy and engagement plan over the next two months to coordinate an action plan for integration.

ABG, with BHCP and other partners

12. ABG, BHCP-LMNZ and NZHC to consider the value of a high level advocacy forum to mobilise commitment and also to recognise volunteers and others involved in improving the health of rural Bougainvilleans.

13. ABG and BHCP-LMNZ to consider a District Volunteer Appreciation strategy for the end of phase in 2014.

14. ABG to coordinate a regular NGO Forum to ensure optimal use of resources and benefit to communities.

15. ABG to review coordination mechanism with Donor Partners.

Appendix A: Terms of Reference for the Evaluation

This appendix contains a copy of the terms of reference for the evaluation.

Appendix B: Evaluation Plan

This appendix contains a copy of the final evaluation plan.

Appendix C: List of Data Sources

This appendix contains a list of data sources used in the evaluation

Appendix D: List of Stakeholders and Key Informants

This appendix contains a list of stakeholder and key informants consulted in the evaluation.

Appendix E: Contribution Analysis

This appendix contains a paper that describes a Contribution Analysis methodology, which is relevant to the Reflection process.

Appendix F: Determinants of health graphic

Appendix G: Steering Group comments and evaluator responses

Acknowledgements

This report is the result of my learning from committed and passionate people living and working in PNG and the Autonomous Region of Bougainville. In particular the staff from BHCP-LMNZ spent much time in the planning and execution of this evaluation process. Travelling along painfully bumpy roads, through rivers and streams in heat and mud has been a major learning about the lives of people in rural Bougainville. Their positive spirit and amazing welcomes were an inspiration for me to give voice to their views. So many staff from government, non-government, WHO and donor partners provided their time, views and information willingly. The New Zealand High Commission staff assisted in the Port Moresby logistics despite busy schedules. To all, my thanks, as this evaluation would not have been completed without your commitment to your work and communities.

Glossary of Acronyms

The following acronyms are used in this report.

Acronym	Description
ABG	Autonomous Bougainville Government
BHCP	Bougainville Healthy Communities Programme
CD	Community Development
CHW	Community Health Worker
COEs	Councils of Elders
DFs	District Facilitators
DFC	District Facilitation Coordinator
DoH	ABG Division of Health
GFA	Grant Funding Arrangement (with NZAID)
OIC	Officer in Charge
LMNZ	Leprosy Mission New Zealand
MEL	Monitoring, Evaluation and Learning system for BHCP
NDOH	PNG National Department of Health
OIC	Officer in Charge
PM	(BHCP) Programme Manager
PNG	Papua New Guinea
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
TB-DOTS	Tuberculosis Direct Observation of Treatment Short Course (treatment protocol)
TIIG	Technical Integration Implementation Group (ABG DoH-BHCP coordination and planning working group)
VAs	Village Authorities
VHVs	Village Health Volunteers

Appendix A: Terms of Reference for the Evaluation

Terms of Reference for the Evaluation of Bougainville Healthy Communities Programme (BHCP)

Final 16 July 2012

Prepared by: Alicia Kotsapas,
PNG Development Officer,
in consultation with PNG Post
(Robert Turare and Rebecca Lineham)

Background information

Ten years after peace was established on Bougainville following the civil conflict, the defining feature of poverty is the near absence of Government-delivered social services to rural areas. The health infrastructure was severely damaged during the conflict and is only slowly recovering. Progress is impeded by inadequate funding, insufficient qualified health staff, inconsistent medical supplies, and significant leadership challenges.

The Bougainville Healthy Communities Programme (BHCP) aims to improve the health of communities in Bougainville through development of a sustainable village-based community health programme, linking with Bougainville's formal health structure at the district level. For maximum effectiveness, and to support programme sustainability, the BHCP targets all community health issues. While its primary focus is at the community level, BHCP actively engages with the formal health sector and works with the Division of Health (DoH) to strengthen the delivery of formal health services in Bougainville.

The BHCP works through traditional structures to train and empower village people to improve the health of their own community and access formal healthcare services when needed. Currently, the BHCP is a project of The Leprosy Mission NZ (LMNZ) which is responsible for overall management of the Programme and its staff which are based in Arawa, Bougainville. The BHCP is managed locally by a Bougainvillean Program Manager.

The BHCP was established in 2005 following a request from the Autonomous Bougainville Government (ABG) to LMNZ, to develop a health programme that would deliver basic health education to the rural majority of Bougainville and maintain the gains made by its predecessor leprosy control programme. In making the request, the ABG committed

to the BHCP and to fully taking it over and funding it as a Government programme by 2014.

The New Zealand Aid Programme has been the sole funder of BHCP through its implementing partner LMNZ since its inception. The first phase of the BHCP, which ran for three and a half years beginning in August 2005, developed the BHCP model in four pilot districts. The second five year phase (current phase) of the BHCP formally commenced in 2009 and aims to: consolidate the BHCP model in the pilot districts, expand the programme across Bougainville's remaining nine Districts, and integrate the BHCP within the ABG's DoH.

Purpose of the evaluation

These Terms of Reference (TOR) set out the purpose and approach for conducting an independent evaluation of the BHCP. BHCP is currently designing the next stage of its programme to complete the roll out of activities to all 13 districts of Bougainville and is in negotiation with MFAT for a new multi-year Grant Funding Arrangement (GFA) from 2013. An evaluation at this time will provide useful analysis to inform the activity design and the development of the GFA.

The primary aims of this evaluation are to:

- assess progress to date against outcomes, objectives and outputs;
- provide the ABG and LMNZ with 'lessons learned' from BHCP activities to date and suggestions for improvements to guide development of the next stage of the BHCP programme; and
- provide a clear indication as to whether continued funding to BHCP via LMNZ is still the most appropriate modality for delivering the activity under a new GFA.

The secondary aim of this evaluation is to:

- provide 'lessons learned' from BHCP activities to date and suggestions to guide any plans for a possible future rollout of a similar activity in other regions of Papua New Guinea (PNG).

A separate but related piece of work will examine some of the challenges faced by BHCP in fully integrating into the DoH and provide options for addressing these challenges. This evaluation is also expected to inform that piece of work.

Furthermore, the evaluation will provide useful lessons for similar activities funded through the New Zealand Aid Programme which incorporate a Village Health Volunteer approach and those which aim towards integration within national and provincial systems.

While the level of reporting has been adequate in identifying key achievements and challenges relating to the activity, as no formal

independent evaluation of the activity has been undertaken since the commencement of Phase II in 2009, both the New Zealand Aid Programme and LMNZ consider an evaluation at this point to be timely and appropriate for the purposes outlined above.

The results of the evaluation will be reported and disseminated to relevant stakeholders including, but not limited to:

- New Zealand Government, Ministry of Foreign Affairs and Trade.
- Bougainville Healthy Communities Programme/The Leprosy Mission NZ.
- Autonomous Bougainville Government including the Executive Council, Chief Administrator's Office, and Divisions of Health and Planning.
- Government of Papua New Guinea, including National Department of Health, Department of Finance and Treasury, National Department of Planning and Monitoring and Department of Personnel Management.
- AusAID PNG's Health Program and Sub National Program

Scope of the evaluation

Time period

The time period to be covered by the evaluation is 2009-2012.

Geographic focus

The geographic focus is Bougainville, PNG.

Target groups

The target groups are:

- Primary stakeholders: The Leprosy Mission NZ; ABG Division of Health (both HQ and health facilities in participating areas), Councils of Elders responsible for participating villages; traditional and elected Village Leaders; VHVs – those trained and wanting to be trained by BHCP; and women, men, youth and children in rural communities - those who have been beneficiaries of BHCP and those who have not.
- Secondary stakeholders: MFAT; villages and health facilities in non-participating areas; other health services providers in Bougainville including church facilities, National Department of Health senior management and National VHV Coordinator; and AusAID PNG's Health Program and Sub National Program.

Issues outside the scope of this evaluation

While the programme has been running since 2005, the focus of the evaluation will be the period since 2009, when a new model was put in place based on lessons from the earlier period.

New Zealand funds other health initiatives in Bougainville – in particular the Direct Facility Funding trial. This evaluation does not cover these initiatives, but if linkages or enhanced leverage opportunities between the programs are identified, the report should note them. Likewise, AusAID is in the process of assisting the ABG to develop a Health Master Plan. An institutional strengthening program for the DoH is also being designed by AusAID. These are outside the scope of the evaluation but any points of linkage and enhanced leverage should be noted.

Finally, the ABG is part way through a multi-year process of drawing down national powers and functions from the Government of Papua New Guinea, as part of the peace process – this is currently being undertaken in a gradual way. Any observations about the link between BHCP and that process should be recorded.

Evaluation criteria and objectives

Criteria being assessed

The DAC criteria that will be assessed in this evaluation are Relevance, Effectiveness, Efficiency and Sustainability.

Objectives and evaluation questions

The objectives of the evaluation are to:

Objective 1: Assess Relevance. Specific questions could include, but not limited to:

- To what extent does the Programme and the current approach, continue to be relevant to beneficiaries, the New Zealand Aid Programme and partner country/regional development priorities?
- What lessons can be learned from BHCP activities to date and recommendations made to improve the relevance of the next stage of the BHCP programme?

Objective 2: Assess overall effectiveness. Specific questions could include, but not limited to:

- What progress has been made to date in achieving intended outcomes, objectives, and outputs?
- To what extent is the Programme providing benefits to different stakeholders?
- To what extent, and how, are crosscutting issues being effectively addressed?
- What factors are enhancing or constraining progress towards intended outcomes (e.g. management of risk), and what lessons can be learned, particularly for replication in remaining districts of the Autonomous Region of Bougainville (ARB)?

- What unintended outcomes are evident as a result of the Programme (positive and negative)?

Objective 3: Assess efficiency. Specific questions could include, but not limited to:

- Are resources being used in the best possible way in order to provide value for money?
- What could be done differently to improve the efficiency of implementation?
- Is funding to BHCP via LMNZ is still the most appropriate modality for delivering the Programme? Provide recommendations on the continuation of the current approach and/or necessary changes of approach in future support for/development of BHCP.

Objective 4: Assess sustainability. Specific questions could include, but not limited to:

- How well prepared is BHCP for full integration into the ABG DoH by 2014? What are the key issues/risks?
- To what extent are the ABG and relevant partners prepared to manage the integration of BHCP activities? What are the key issues/risks?
- To what extent are there likely to be continued positive outcomes after LMNZ management and New Zealand funding ends?
- What will constrain/enhance the sustainability of the results of the BHCP? How might the constraints and risks identified be mitigated?

Methodology for the evaluation

Principles/approach

The principles underpinning the evaluation are strongly based on the various stakeholders working in partnerships, and participation with community members, ensuring transparency and independence. In support of a consultative and participatory approach, the evaluator is expected to engage MFAT, LMNZ, ABG, target communities and other stakeholders as appropriate in the evaluation.

Evaluation Plan

A detailed evaluation plan will be developed by the evaluator (using or being guided by the *Evaluation Plan Template*) after a desk-based literature review, and prior to the commencement of the in-country field work in PNG. The evaluation plan should be appended to the main report.

The person who will approve the evaluation plan is Steve Hamilton, Evaluation Steering Group Chair.

The plan may need to be redrafted if it does not meet the required standard or is unclear. The evaluation plan **must** be approved by the **Evaluation Steering Group** prior to the commencement of any field work or other substantive work. The evaluation plan is to be appended to the main written report.

The intended results of the BHCP (i.e. the goal, outcomes and outputs) will be clarified and described in a Results Diagram (program logic, logic model) in the evaluation plan.

The evaluation plan will describe how cross-cutting issues will be considered throughout the evaluation.

Team composition

The evaluation will be undertaken by a single evaluator with assistance from a local facilitator for the in-country fieldwork aspect of the evaluation. The attributes (knowledge, skills, experience) required of the evaluator are:

- Evaluation experience for international development activities, including as either a Team Leader or the sole team member.
- Research, report writing and presentation.
- Experience working with civil society.
- Health sector expertise, in particular community health practices and issues in the Pacific context.
- Strategic planning, design and programme management skills.
- Some knowledge of Tok Pisin desirable, as is knowledge/experience of Bougainville.

Governance and management

The evaluation is commissioned by MFAT, supported by LMNZ. The evaluator will be accountable to MFAT, through the appointed Evaluation Steering Group.

Oversight of the evaluation process will be the responsibility of the Evaluation Steering Group. LMNZ and the ABG as key partners, will be represented on the Evaluation Steering Group.

The Evaluation Activity Manager (Alicia Kotsapas, PNG Development Officer) is responsible for day-to-day management and administration of the evaluation. Their responsibilities include contracting; initial briefing the evaluator if they are based in New Zealand and arranging a briefing for the evaluator with LMNZ; managing feedback from reviews of the draft report; and liaising with the evaluator throughout to ensure the evaluation is being undertaken as agreed.

The Activity Manager (Robert Turare, Development Programme Coordinator) and New Zealand Aid Programme Manager (Rebecca Lineham) at the New Zealand High Commission in PNG will be responsible for briefing and liaising with the evaluator in-country.

Outputs and milestones

No.	Output/milestone	Description	Inputs	Due date	Indicative payment proportion of fees or fixed price contract
1	Evaluation Plan	Desk-based review, briefing and finalised evaluation plan	5 fee days	22 August 2012	10%
2	Field work complete	Field work complete and results provided to stakeholders during a stakeholder workshop	12 fee days	5 September 2012	0%
3	Draft report	Preparation of the draft report and submission to MFAT	3 fee days	12 September 2012	55%
4	Final report	Acceptance/approval by MFAT after any revisions of the draft are completed, and debriefing	3 fee days	28 September 2012	35%

Reporting requirements

Copies of the report are to be delivered by email to the MFAT PNG Development Officer (alicia.kotsapas@mfat.govt.nz). The Final Evaluation Report (4 bound copies) should be couriered to MFAT, attention: MFAT (International Development Group) PNG Development Officer. The Final Evaluation Report can include CD or DVD containing relevant data and associated analysis, and photos.

The written Evaluation Report is expected to be around 50 pages long and be guided by the New Zealand Aid Programme *Evaluation Report template*.

The Evaluation Report must contain an abstract suitable for publishing on the New Zealand Aid Programme website. Instructions for the abstract can be found in the *Evaluation Report template.*

The evaluation report must meet quality standards as described in New Zealand Aid Programme Activity Evaluation Operational Policy. These quality standards are based on 2010 DAC Quality Standards for Development Evaluation and New Zealand Aid Programme Activity evaluation operational policy, guideline and templates.

The Draft Evaluation Report will be reviewed by MFAT staff, stakeholders and/or external experts. Further work or revisions of the report may be required if it is considered that the report does not meet the requirements of this TOR, if there are factual errors, if the report is incomplete, or if it is not of an acceptable standard. The Evaluation Steering Group will be responsible for approving the Final Evaluation Report.

It is MFAT policy to make evaluation reports publicly available (e.g. on the New Zealand Aid Programme website) unless there is prior agreement not to do so. Any information that could prevent the release of an evaluation report under the Official Information or Privacy Acts, or would breach evaluation ethical standards should not be included in the report. The Final Evaluation Report will be approved for public release by Jacquie Dean, Deputy Director – PNG Programme.

Relevant reports and documents

Relevant documents will be provided to the evaluation team prior to the evaluation. These key documents include:

MFAT

- MFAT/LMNZ Grant Funding Arrangement (2009-2012)
- MFAT/LMNZ Grant Funding Arrangement (2005-2008)
- International Development Group Policy Guidelines
- New Zealand Aid Programme Participatory Evaluation Guideline
- New Zealand Aid Programme Screening Guide for Cross-Cutting issues

LMNZ

- LMNZ BHCP Programme Proposal (2009)
- LMNZ Country Strategy Document
- LMNZ Health Strategy Document
- LMNZ Monitoring and Evaluation Handbook (2010, and subsequent updates)
- BHCP Integration Plan (revised April 2010)
- BHCP Results Management Framework (2011)
- MEL Report to period April-October 2011

PNG/Bougainville

- ABG Strategic Plan
- ABG Health Master Plan
- PNG National Health Plan 2011-2020
- PNG National Report: Demographic and Health Survey 2006 (National Statistics Office)

Approval

Approved by:

Steve Hamilton

Development Manager - PNG
Evaluation Steering Group Chair

16 July 2012

Appendix B: Evaluation Plan

NEW ZEALAND
MINISTRY OF FOREIGN AFFAIRS & TRADE
Aid Programme

Evaluation Plan for Bougainville Healthy Communities Project

Contents

About this evaluation plan	
Prepared by	Anna Klinken Whelan, Senior Associate, Time plus Talents
Status	Draft, 15/8/2012; Final 22/8/2012

Approved by	Steve Hamilton, Development Manager (Evaluation Steering Group Chair)
Approval date	21 August 2012

Introduction

Background and context to the Activity

The New Zealand Ministry of Foreign Affairs and Trade (NZMFAT) has provided funding to the Leprosy Mission of New Zealand (LMNZ) to support health initiatives at community level in Bougainville, an autonomous province of Papua New Guinea. Funding has been provided since 2005, with a new model commencing in 2009.

This evaluation will assess the overall performance of the Bougainville Healthy Communities Programme (BHCP) since 2009. BHCP is currently designing the next phase of its program to roll out activities to all 13 districts of Bougainville and is in negotiation with NZMFAT for a new multi-year Grant Funding Arrangement (GFA) from 2013. This evaluation is timely and will provide useful analysis to inform the **activity design** and the **development of the GFA**.

Scope of the evaluation

While the programme has been running since 2005, the focus of the evaluation will be the period since 2009, when a new model was put in place based on lessons from the earlier period.

New Zealand funds other health initiatives in Bougainville – in particular the *Direct Facility Funding trial*. This evaluation will not cover these initiatives, but it is important to document linkages or enhanced leverage opportunities between the programmes. Likewise, **AusAID** is in the process of assisting the Autonomous Bougainville Government (ABG) to develop a *Health Master Plan*. An *institutional strengthening programme for the DoH* is also being designed by AusAID. These are outside the scope of the evaluation but any points of linkage and enhanced leverage will be noted in the evaluation report.

Finally, the **ABG** is part way through a multi-year process of drawing down national powers and functions from the Government of Papua New Guinea, as part of the peace process – this is currently being undertaken in a gradual way. Any observations about the link between BHCP and that process will be recorded.

Purpose of the evaluation

The primary aims of this evaluation are to:

- assess **progress** to date against outcomes, objectives and outputs;

- provide NZMFAT, the Autonomous Bougainville Government (ABG), and the Leprosy Mission New Zealand (LMNZ) with '**lessons learned**' from BHCP activities to date and **suggestions for improvements to guide developmen**t of the next stage of the BHCP programme; and
- provide a clear indication as to whether continued funding to BHCP via LMNZ is still the **most appropriate modality** for delivering the activity under a new GFA.

The secondary aim of this evaluation is to:

provide 'lessons learned' from BHCP activities to date and suggestions to guide any plans for a possible future **rollout of a similar activity in other regions of Papua New Guinea** (PNG).

New Zealand Aid Programme evaluation principles underpinning this evaluation

The evaluation will address the following Development Assistance Committee (**DAC**) evaluative criteria: relevance, effectiveness, efficiency, and sustainability. Questions around these four issues are designed to address primarily relevance and sustainability. Effectiveness is a complex principle in this project as many factors beyond the control of the BHCP impact on effectiveness; however it will be considered in the methodology and analysis. Efficiency is a lower priority and should be addressed through annual reporting and Auditing processes.

The design and principles underpinning the BHCP and evaluation are strongly based on the various stakeholders working in partnership, and participation with community members, ensuring transparency and independence. A highly consultative and participatory approach will be used and key stakeholders such as NZMFAT, LMNZ, ABG, target communities and other stakeholders will be engaged from the start.

Objectives and Evaluation Questions

The evaluation objectives and questions are as stated in the Terms of Reference for the evaluation.

Objective 1: **Assess Relevance**. Specific questions will include, but are not limited to:

- To what extent does the Programme and the current approach, continue to be relevant to beneficiaries, the New Zealand Aid Programme and partner country/regional development priorities?
- What lessons can be learned from BHCP activities to date and recommendations made to improve the relevance of the next stage of the BHCP programme?

***Objective 2:* Assess overall effectiveness**. Specific questions should include, but not limited to:

- What progress has been made to date in achieving intended outcomes, objectives, and outputs?
- To what extent is the Programme providing benefits to different stakeholders?
- To what extent, and how, are crosscutting issues being effectively addressed?
- What factors are enhancing or constraining progress towards intended outcomes (e.g. management of risk), and what lessons can be learned, particularly for replication in remaining districts of the Autonomous Region of Bougainville (ARB)?
- What unintended outcomes are evident as a result of the Programme (positive and negative)?

***Objective 3:* Assess efficiency**. Specific questions should include, but not limited to:

- Are resources being used in the best possible way in order to provide value for money?
- What could be done differently to improve the efficiency of implementation?
- Is funding to BHCP via LMNZ is still the most appropriate modality for delivering the Programme? Provide recommendations on the continuation of the current approach and/or necessary changes of approach in future support for/development of BHCP.

***Objective 4:* Assess sustainability**. Specific questions should include, but not limited to:

- How well prepared is BHCP for full integration into the ABG DoH by 2014? What are the key issues/risks?
- To what extent are the ABG and relevant partners prepared to manage the integration of BHCP activities? What are the key issues/risks?
- To what extent are there likely to be continued positive outcomes after LMNZ management and New Zealand funding ends?
- What will constrain/enhance the sustainability of the results of the BHCP? How might the constraints and risks identified be mitigated?

A higher priority for this evaluation will be assessing broad *relevance* and *sustainability*. Issues of *effectiveness* will need to be considered through Contribution Analysis. *Efficiency* will have less emphasis as this issue would be best addressed through financial auditing and other NZMFAT grant monitoring mechanisms.

Stakeholder Analysis

Stakeholders were identified in the Terms of Reference. Some additions have been made.

- **Primary stakeholders**:

  The Leprosy Mission NZ (including BHCP staff/District Facilitators); ABG Division of Health (both HQ and health facilities in participating areas); Councils of Elders responsible for participating villages; traditional and elected Village Leaders; VHVs – those trained and wanting to be trained by BHCP; and women, men, youth and children in rural communities - those who have been beneficiaries of BHCP and those who have not.

- **Secondary stakeholders**: NZMFAT; villages and health facilities in non-participating areas; other health service providers in Bougainville including church facilities, National Department of Health (NDoH) senior management and National VHV Coordinator; AusAID PNG's Health Program and Sub National Program, WHO.

This table shows the stakeholders and outlines their interest in the evaluation, any issues or constraints and their expected involvement. Confidentiality will be an issue to consider for all stakeholders.

Stakeholder	**Interest/stake**	**Issues/constraints**	**Involvement/ participation**
LMNZ BHCP staff	Primary	Openness to concerns raised during evaluation	Consulted and involved from the start
ABG	Primary	Political/budgetary	Involved from start
ABG- DOH HQ and District	Primary	Political/budgetary	Involved from start
Council of Elders	Primary	Power/gender issues	Consulted
Village leaders	Primary	Power/gender issues	Consulted
VHVs	Primary	Power/gender issues	Consulted
Community – women, men, youth, children	Primary	Power/gender issues Literacy Access	Consulted separately; Village walks to gain informal views
PNG NDOH - VHV Co-ord Public Health	Secondary	Political/financial	Consulted
Other NGOs in PNG-BV: WV, Oxfam, Care, Save Children,	Secondary	Linkages and overlaps?	Consulted

Stakeholder	Interest/stake	Issues/constraints	Involvement/ participation
AusAID – PNG Health Program	Secondary	Political/financial Linkages/overlaps	Consulted
WHO – PNG and BV	Secondary	Political/financial Linkages/overlaps	Consulted
Non-participating villages	Secondary	Power/gender issues Literacy Access	Consulted if time
Churches in BV	Secondary	Linkages/overlaps	Consulted

Evaluation Design

Intended Results of the Activity

The Results framework has evolved over the period of the BHCP and the current logic is described in the diagram (over page). In this diagram the ultimate **goal** of **healthier Bougainville communities** is described as through 'villages and government **sharing responsibility** for health'. Given the high level goal of the BHCP to improve health status, attention needs to be paid to tackling the broad determinants of health. BHCP can only address some of those determinants. It will be important for stakeholders to consider issues of 'contribution' and 'attribution' and to identify other gaps that impact on health status.

Seven OUTCOMES with targets are described, ranging from HIGH level of '*Improved health* in Bougainville rural communities' to three MEDIUM level outcomes of '*Improved access* to basic healthcare in of rural BV'; '*Reduced incidence of preventable disease and sickness'*; and '*Improved health practices in rural communities'*.

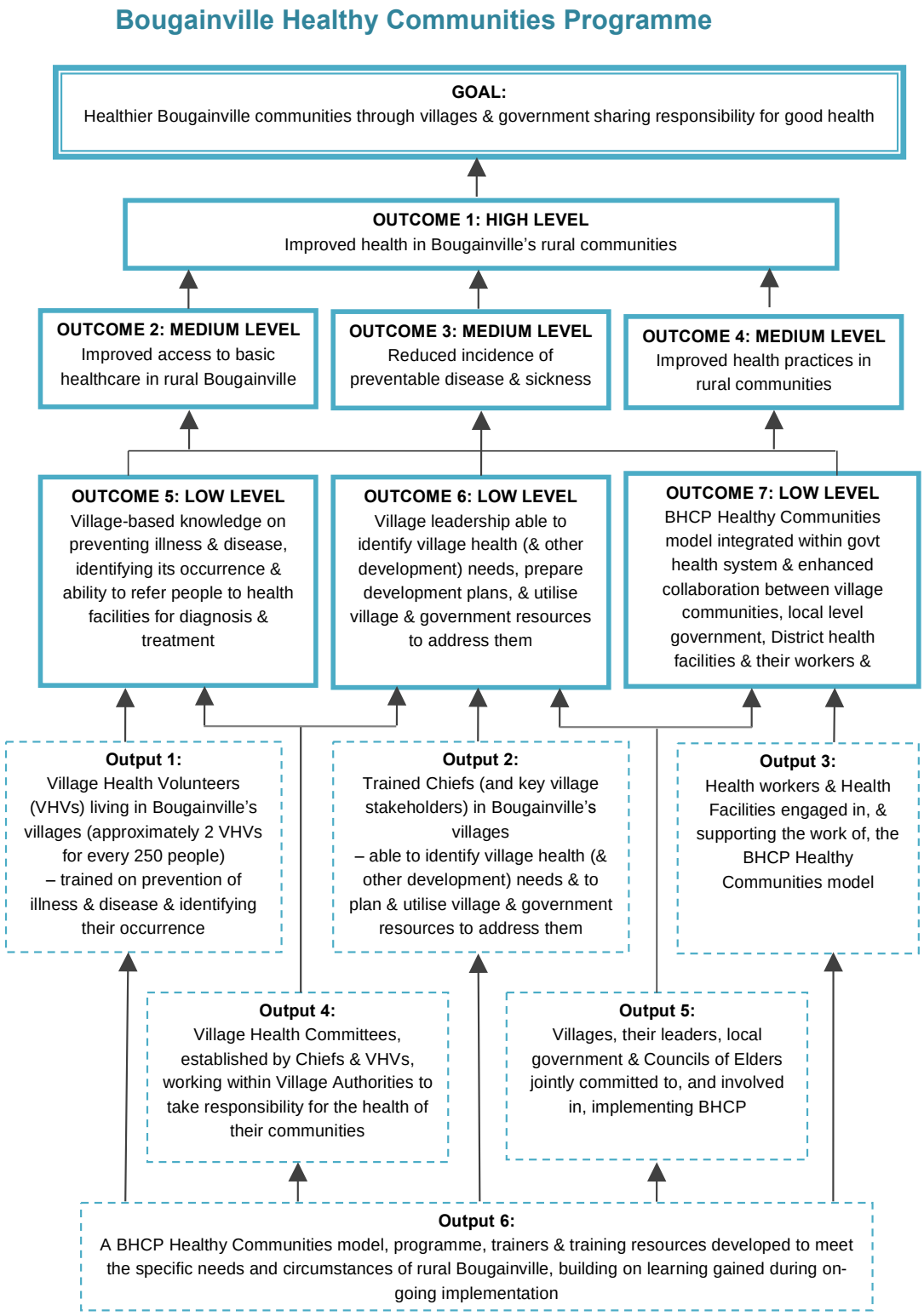
LOWER level outcomes include '*Village based **knowledge** on preventing illness and disease, identifying its occurrence and ability to refer people to health facilities for diagnosis and treatment'*; '*Village **leadership** able to identify village health (and other) needs, prepare development plans and utilise village and government resources to address them'*; and *'BHCP Healthy Communities model **integrated** within government health system and enhanced collaboration between village communities, local level government, District health facilities and their workers and programs'*.

This Outcomes framework provides a clear logic for the **six listed Activities/Outputs**.

A full Monitoring, Evaluation and Learning (MEL) system was developed specifically to meet BHCP's needs. It was developed and trialled, and fully operational by September 2009. The MEL collects data for all indicators for all Project Outcomes and Outputs. Baseline data were collected in March-August 2009.

Village Health Volunteers (VHVs) record their daily/weekly activities related to BHCP over a 6-monthly period (Mar-Aug and Sept-Feb). This information is collated and entered onto Village Monitoring Forms with support from BHCP District Facilitators. 'Most Significant Change' stories are collected annually. This information is collated and analysed by BHCP's MEL Coordinator/Trainer and a 6-month summary report is produced, including comparative data going back to the baseline period.

BHCP RESULTS LOGIC (2011)



Information Collection

A wide range of information sources will be used, in order to gain as comprehensive a picture as possible in the limited timeframe. Quantitative data from previous baseline surveys, census and health statistics will be analysed. Detailed Monitoring, Evaluation and Learning (MEL) reports, Annual reports and Reflection reports will be reviewed and key themes extracted to address the Evaluation questions. Training materials and methods will be reviewed in-country. Qualitative information from interviews, focus groups, Village walks and participant observation will be critical to informing the evaluation, and will be analysed through thematic analysis.

This table shows what information will be collected and how.

Question	Information required	Information source	Method
Objective 1: Assess Relevance			
1. To what extent does the Programme and the current approach, continue to be relevant to beneficiaries, the New Zealand Aid Program and partner country/regional development priorities?	Perceptions of key stakeholders; Relevant reports and government and donor planning documents.	NZMFAT, PNG DOH, ABG Communities AusAID WHO Other Missions?	Document review Interviews Focus groups Village walk
2. What lessons can be learned from BHCP activities to date and recommendations made to improve the relevance of the next stage of the BHCP programme?	Detailed MEL Reflection reports Stakeholder perceptions	LMNZ-BHCP staff ABG PNG DoH NZMFAT AusAID WHO Communities	Document review Interviews
Objective 2: Assess overall effectiveness			
1. What progress has been made to date in achieving intended outcomes, objectives, and outputs?	Detailed MEL Reflection reports	LMNZ-BHCP NZMFAT Communities	Document review Baseline data
2. To what extent is the Programme providing benefits to different stakeholders?	Detailed MEL Reflection reports MSC stories	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Document review Interviews Focus groups Village walk

Question	Information required	Information source	Method
3. To what extent, and how, are crosscutting issues being effectively addressed?	Detailed MEL Interviews	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Document review Interviews Focus groups Village walk
4. What factors are enhancing or constraining progress towards intended outcomes (e.g. management of risk), and what lessons can be learned, particularly for replication in remaining districts of the ARB?	Detailed MEL Interviews Reflection reports MSC stories	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Document review Interviews Focus groups Village walk
5. What unintended outcomes are evident as a result of the Programme (positive and negative)?	Interviews Reflection reports MSC stories	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Document review Interviews Focus groups Village walk
Objective 3: Assess efficiency			
1. Are resources being used in the best possible way in order to provide value for money?	Annual reports Budget review	LMNZ-BHCP staff ABG PNG DoH NZMFAT Communities – CoE/Districts	Document review Budget review Interviews Review training materials/method
2. What could be done differently to improve the efficiency of implementation?	Perceptions of stakeholders	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Interviews Review Training methods
3. Is funding to BHCP via LMNZ is still the most appropriate modality for delivering the Program? Provide recommendations on the continuation of the current approach and/or necessary changes of approach.	Perceptions of stakeholders	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Interviews
Objective 4: Assess sustainability			

Question	Information required	Information source	Method
1. How well prepared is BHCP for full integration into the ABG DoH by 2014? What are the key issues/risks?	Perceptions of stakeholders DoH budgets	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Interviews
2. To what extent are the ABG and relevant partners prepared to manage the integration of BHCP activities? What are the key issues/risks?	Perceptions of stakeholders Processes and Strategic Plans	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Interviews Participant observations
3. To what extent are there likely to be continued positive outcomes after LMNZ management and New Zealand funding ends	Perceptions of stakeholders	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Interviews Participant observations
4. What will constrain/enhance the sustainability of the results of the BHCP? How might the constraints and risks identified be mitigated?	Perceptions of stakeholders	LMNZ-BHCP staff ABG PNG DoH NZMFAT	Interviews Participant observations

Detailed Description of Evaluation Methods

Quantitative baseline data were collected in 2009 (check original) and provide a valuable resource against which to assess progress. In addition, PNG census and health information provide additional data sources that indicate health concerns and priorities for the ABG. This information will be reviewed and cross-checked (with local sources), regarding reliability and validity. However such data really assist with longer-term trend analysis. Addressing the complexity of the broader determinants of health is beyond the scope of this evaluation but should be considered in the design for the next phase of BHCP. Document review of BHCP Annual Reports and Reflections will also be conducted.

Qualitative methodology will be used to gain insight into the 'why' and 'how' questions. Views, opinions and perceptions of a range of stakeholders are critical to assessing the relevance, sustainability and also effectiveness and efficiency.

In addition to primary stakeholder's interviews with NZ High Commission, PNG NDOH, ABG and LMNZ, triangulation with BHCP staff, District Facilitators and VHVs will be conducted during site visits.

Given the timeframe and logistical constraints, this evaluation will only be able to sample a limited number of Districts and Villages. The rationale for Village selection is to include a mix of perceived *poorly performing*, *average* and *model* Villages (as assessed by LMNZ-BHCP and discussed with Evaluator). Villages from the 5 pilot Districts plus some comparisons with newer Districts (where lessons have been learned) will be included and a final decision is yet to be made, depending on logistics and agreement from the Villages. At this stage we are proposing to conduct field assessments in Kieta or Panguna; Siwai or Bana; Wakunai or Tinputz; Buka and Buin.

Assessments will include a review of the Health Facility and a 'Village Walk' to elicit more informal views and triangulate with interviews/focus groups. Interviews will, where possible, be conducted with District Administrators (District Executive Managers and Health Officers); Village leaders; Council of Elders; District Health Committees; Village Health Committees. Focus group discussions with Village Health Volunteers (VHVs), women, men and young people will be arranged to ensure a range of views are included. Informal discussions will also be used where appropriate.

Participants will be selected by Village leaders in consultation with VHVs and BHCP staff. While this is less than ideal, it is important that selection does involve local stakeholders. Opportunistic discussions will also allow for cross-checking of reliability of information.

Focus groups of around 8-10 people are ideal, but this is sometimes unpredictable and allowances will need to be made for local circumstances. It is estimated that around 30-40 people per village will be consulted. The aim is to gain as many views as possible on BHCP and health services and concerns in general.

Focus groups will be facilitated and an Interpreter used to 'whisper translate' so that the Evaluator will be able to engage in discussion.

Appendices include preliminary questions to be covered in stakeholder interviews, and for focus groups, and a Checklist for participant observation.

Data/Information Analysis

Interview notes will be taken and audio-taping of Interviews and Focus Groups, if permission/consent is given. Participant Observations will be recorded at each site. All notes, tapes and observations will be included in a thematic analysis. All data sources and information will be cross-checked for facts, and full ranges of opinions will be included in the analysis.

Cross-Cutting Issues

The evaluation will include a section on gender, environment, health and human right issues:

- The BHCP is largely a community level activity, and addressing gender issues is critical to its success. This evaluation will make an assessment of gender dynamics that might impact on the implementation and future design.
- Environmental improvements are critical to the success of the BHCP and a section will be included on major environmental concerns and how BHCP is addressing them or not.
- A range of Human Rights assessment tools are available, but due to time constraints will not be used. However an assessment of the intersection between human rights and health [in particular maternal mortality as a human rights issue, where concerns about accessibility, availability, acceptability and quality] will be made.
- Development cooperation contributes to the development of the capacities of "duty-bearers" to meet their obligations and/or of "rights-holders" to claim their rights. In relation to health, a rights-based approach means integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of health-related policies and programmes. These include *human dignity*, attention to the needs and rights of *vulnerable* groups, and an emphasis on ensuring that health systems are made *accessible* to all. The principle of equality and freedom from *discrimination* is central, including discrimination on the basis of sex and gender roles. Integrating human rights into development also means *empowering* poor people, ensuring their *participation* in decision-making processes which concern them and incorporating *accountability* mechanisms which they can access.

Ethical Considerations

Ethical considerations will be addressed through a number of processes:

- All participants will have explained to them, the purpose of the evaluation, how the information they provide will be used in the report and whether they prefer to provide such information confidentially and anonymously (if possible).
- Informed consent will be obtained verbally at the start of each interview and focus group, and recorded by facilitator.
- Participants will be asked if they would like to have their names recorded as having contributed to the evaluation and report.
- Participants will be asked if they would like to have comments attributed to them, or to remain confidential in the body of the report.
- It is unlikely that there will be any harm from the evaluation process, but community participants will have explained to them that their relationship with LMNZ-BHCP and health facilities will not be affected by their participation (either positively or negatively).
- Issues around gender norms and power dynamics in focus groups will be addressed with LMNZ-BHCP and VHVs at the start of the period in Bougainville.
- Photographs are a useful means of documentation and permission will be sought from relevant leaders and from community members.
- A draft Information Sheet is attached (Appendix D)

Limitations, Risks and Constraints

With any evaluation there are potential risks. This table outlines potential or actual risks, limitations and constraints.

Risk/limitation/constraint	Likely effect on evaluation	How this will be managed/mitigated
Civil unrest/security concerns	Major	Involvement of local staff; security briefing with NZHC, ABG, LMNZ-BHCP
Key stakeholders not available	Major	Seeking early set-up of meetings through local staff
Travel arrangements delayed locally	Major	Bookings made early; local LMNZ-BHCP involvement
Transport problems en route (break-down; weather; illness)	Medium	Local back-up plans; other sites selected if necessary; discussion with NZMFAT if problems
Local communities unwilling to participate	Major	Local BHCP VHV involvement critical
Illness within team	Major-medium	Preventive health measures (check malaria treatment)

Feedback of Findings

The aim will be produce a 'no surprises' final report. Even with variations of opinions, a clear analysis of findings can be presented. Findings will be discussed with key stakeholders during interviews, and again in debriefing sessions. After each site visit, feedback will be provided to the Village team and LMNZ-BHCP staff, and will further inform the evaluation process.

Feedback from stakeholders will be incorporated into the draft report and an opportunity for final review by LMNZ-BHCP and NZMFAT will be structured at the end.

Ideally a stakeholder meeting with all stakeholders would be scheduled to achieve common understandings and consensus. However this is costly and time-consuming, but may be important to consider during the design phase and/or at the end of project evaluation in 2014.

Documents to be used in the Evaluation

Documents to be used in the evaluation include:

- 2009 BHCP Proposal - Final 230309 (incl. budget sheets)
- BHCP Annual Report 2009
- BHCP Annual Report 2010
- BHCP Annual Report 2011
- BHCP Integration Impl Plan Revised May 2010
- MEL Report 2009
- BHCP MEL Handbook - May 2010
- Results Measurement Tables - BHCP - 29 Nov 2011
- MEL REPORT March- August 2011 - JK 3 Apr '12
- MEL REPORT September 2011 - Feb 2012 - DRAFT 3 Aug '12
- AusAID-funded Capacity Diagnostic Assessment for Bougainville
- Concept Paper on Improving Individual Health through a Modified Healthy Islands Concept, Bougainville (2003)
- BHCP Annual Reflection Workshop, 2009
- BHCP Annual Reflection Workshop, 2010
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- Vital base line statistics and aspiration goals for the Health Sector on Bougainville - Salim 17 Oct '12 copy
- Public Health Profile 2010_Bougainville - Salim 17 Oct '11 copy
- BHCP Activity Completion Report (2) Brent
- BHCP Training materials in-country
- Add

Timeline

This table shows the timing of key activities and deliverables.

Key activity	**Deliverable (output)**	**Timing**
Evaluability Assessment, Desk Review and	Evaluation Plan	10th – 15th August
Stakeholder Interviews Port Moresby NZHC, NDoH, AusAID, WHO, World Vision, Care, Save the Children, Oxfam- TBC Stakeholder Interviews- BV ABG, LMNZ, WHO Fieldwork – site visits/walks Interviews - village leaders, VHVs, DF FGD women, youth, men Debrief – LMNZ, ABG, NZHC	Situational Analysis and Debrief	August 26th - Sept 12th
Analysis and Write up of Draft Report	Draft Report	Sept 18th
Feedback and modify Draft Report	Final Report	Sept 28th

Appendices

Appendix A: Preliminary Questions for Stakeholder Interviews

This appendix contains a preliminary list of questions that will be asked in interviews for the different stakeholder groups.

Questions for NZMFAT – Context and plans PNG/Bougainville
PNG/Bougainville context and future plans re development; autonomy; budget processes; political

Future NZ plans/funding for PNG – possible linkages with other missions?

District Facility Funding trial – goal, objectives, how does it work in PNG/Bougainville? Linkages? Issues/concerns

BHCP specifically – questions *based on objectives*

- To what extent does the Programme and the current approach, continue to be relevant to beneficiaries, the New Zealand Aid Programme and partner country/regional development priorities?
- How has MFAT/NZHC supported LMNZ-BHCP during implementation – processes and mechanisms
- What lessons can be learned from BHCP activities to date and recommendations made to improve the relevance of the next stage of the BHCP programme?
- What progress has been made to date in achieving intended outcomes, objectives, and outputs?
- To what extent is the Programme providing benefits to different stakeholders?
- To what extent, and how, are crosscutting issues being effectively addressed?
- What factors are enhancing or constraining progress towards intended outcomes (e.g. management of risk), and what lessons can be learned, particularly for replication in remaining districts of the Autonomous Region of Bougainville (ARB)?
- What unintended outcomes are evident as a result of the Program?
- Are resources being used in the best possible way in order to provide value for money?
- What could be done differently to improve the efficiency of implementation?
- Is funding to BHCP via LMNZ is still the most appropriate modality for delivering the Programme? Provide recommendations on the continuation of the current approach

and/or necessary changes of approach in future support for/development of BHCP.

- How well prepared is BHCP for full integration into the ABG DoH by 2014? What are the key issues/risks?
- To what extent are the ABG and relevant partners prepared to manage the integration of BHCP activities? What are the key issues/risks?
- To what extent are there likely to be continued positive outcomes after LMNZ management and New Zealand funding ends?
- What will constrain/enhance the sustainability of the results of the BHCP? How might the constraints and risks identified be mitigated?

Questions for PNG DOH

Future plans for health funding/facilities; development and health impact assessment; achieving MDGs etc.

Value of LMNZ/BHCP to ABG; how do they connect/liaise; benefits to government/communities; problems and issues of concern; other ideas for improvement; is LMNZ the best host for such a model; are there other ways community health can be improved – looking at main health problems?

Data sources on health improvements – births, deaths, cause of illness etc.

Health Information Management systems – hospital, clinics, posts etc.

Should BHCP focus on key districts/villages rather than complete coverage? Should it be staged?

Other good models of village/community health programs in PNG – esp. in remote areas

PNG MDGs - Maternal/baby deaths – causes? Maternal death audit system?

It may need more than community/VHV training, but also nurses/midwives/ doctors? – is someone addressing this?

Questions for ABG

Value of LMNZ/BHCP to ABG; benefits to government/communities;

Processes for engaging with BHCP - how do they connect/liaise; integration plans and strategies

problems and issues of concern; benefits to government/communities; problems and issues of concern; other ideas for improvement; is LMNZ the best host for such a model; are there other ways community health can be improved – looking at main health problems?

Data sources on health improvements – births, deaths, cause of illness etc.

Health Information Management systems – hospital, clinics, posts etc.

Should BHCP focus on key districts/villages rather than complete coverage? Should it be staged? How does BHCP contribute to Health Planning

Maternal/baby deaths in Kieta – why? Causes of death - Delays; lack of transport; education etc…really need to explore this. A maternal death should rarely happen; Maternal death audit system?

It may need more than community/VHV training, but also nurses/midwives/ doctors? – is someone addressing this?

Future plans for health funding/facilities; development and health impact assessment. Budget planning processes within PNG and in ABG – how much does Health get?

BHCP specifically – questions based on objectives

- To what extent does the Programme and the current approach, continue to be relevant to beneficiaries, the New Zealand Aid Programme and partner country/regional development priorities?
- What lessons can be learned from BHCP activities to date and recommendations made to improve the relevance of the next stage of the BHCP programme?
- What progress has been made to date in achieving intended outcomes, objectives, and outputs?
- To what extent is the Programme providing benefits to different stakeholders?
- To what extent, and how, are crosscutting issues being effectively addressed?
- What factors are enhancing or constraining progress towards intended outcomes (e.g. management of risk), and what lessons can be learned, particularly for replication in remaining districts of the Autonomous Region of Bougainville (ARB)?
- What unintended outcomes are evident as a result of the Programme (positive and negative)?
- Are resources being used in the best possible way in order to provide value for money?
- What could be done differently to improve the efficiency of implementation?
- Is funding to BHCP via LMNZ is still the most appropriate modality for delivering the Programme? Provide recommendations on the continuation of the current approach and/or necessary changes of approach in future support for/development of BHCP.
- How well prepared is BHCP for full integration into the ABG DoH by 2014? What are the key issues/risks?
- To what extent are the ABG and relevant partners prepared to manage the integration of BHCP activities? What are the key issues/risks?
- To what extent are there likely to be continued positive outcomes after LMNZ management and New Zealand funding ends?

- What will constrain/enhance the sustainability of the results of the BHCP? How might the constraints and risks identified be mitigated?

Questions for LMNZ

Go back to logic diagram – if we want to improve health status then we need to tackle determinants of health. What can be tackled? What needs collaboration/ partnerships to achieve (eg improved education, jobs, roads, WASH)?

If we want to improve access to health services then that is another strategy – does improved access to HS improve all health outcomes? In which diseases and health conditions?

Should BHCP focus on key districts/villages rather than complete coverage? Should it be staged? Is all Bougainville considered **rural**? (see goal)

Maternal/baby deaths in Kieta – why? Delays; lack of transport; education etc…really need to explore this. A maternal death should rarely happen; Maternal death audit system?

It may need more than community/VHV training, but also nurses/midwives/ doctors? – is someone doing this?

VHV – motivations; incentives; selection; benefits etc.

Village Heads; Council of Elders – strategy for engagement? Motivations, Incentives; benefits

BHCP specifically – questions based on objectives

- To what extent does the Programme and the current approach, continue to be relevant to beneficiaries, the New Zealand Aid Programme and partner country/regional development priorities?
- What lessons can be learned from BHCP activities to date and recommendations made to improve the relevance of the next stage of the BHCP programme?
- What progress has been made to date in achieving intended outcomes, objectives, and outputs?
- To what extent is the Programme providing benefits to different stakeholders?
- To what extent, and how, are crosscutting issues being effectively addressed?
- What factors are enhancing or constraining progress towards intended outcomes (e.g. management of risk), and what lessons can be learned, particularly for replication in remaining districts of the Autonomous Region of Bougainville (ARB)?
- What unintended outcomes are evident as a result of the Programme (positive and negative)?
- Are resources being used in the best possible way in order to provide value for money?

- What could be done differently to improve the efficiency of implementation?
- Is funding to BHCP via LMNZ is still the most appropriate modality for delivering the Programme? Provide recommendations on the continuation of the current approach and/or necessary changes of approach in future support for/development of BHCP.
- How well prepared is BHCP for full integration into the ABG DoH by 2014? What are the key issues/risks?
- To what extent are the ABG and relevant partners prepared to manage the integration of BHCP activities? What are the key issues/risks?
- To what extent are there likely to be continued positive outcomes after LMNZ management and New Zealand funding ends?
- What will constrain/enhance the sustainability of the results of the BHCP? How might the constraints and risks identified be mitigated?

Questions for AusAID – Plans and linkages

Future AusAID priorities/plans/funding for PNG – possible linkages with other missions?

Information on *Health Master Plan* – goal, objectives, funding etc.

Institutional strengthening programme for the DoH – PNG and Bougainville

Knowledge and views of BHCP - Linkages, issues/concerns – synergies

- To what extent does the Programme and the current approach, continue to be relevant to beneficiaries, and AusAID development priorities?
- What lessons can be learned from BHCP activities to date and recommendations made to improve the relevance of the next stage of the BHCP programme?
- To what extent are there likely to be continued positive outcomes after LMNZ management and New Zealand funding ends?

Questions for WHO – Plans and linkages

WHO priorities/plans for PNG – funding available for these?

Coordinating mechanisms – donor harmonization?

Village level programs contribution to improved health status?

Health worker education and training and deployment issues in PNG/BV

Knowledge and views on BHCP

Questions for other NGOs – Plans and linkages

Knowledge and views on BHCP

Coordinating mechanisms

Appendix B: Focus group questions (to develop with BHCP staff)

- What are the biggest concerns you have for your family and village?
- Do you feel that you are able to address these concerns with your Village leaders and District authorities?
- Has your Village been involved in BHCP activities? In what ways?
- Explore views on aspects of involvement of BHCP activities – eg VHVs, VHC, CoE involvement, needs assessment and planning
- What were the most significant results from BHCP you heard or saw?
- How close is the Health Facility to your Village? Explore views on health facilities and staff (AAAQ)

Appendix C: Checklists for Participant Observation

Review of Health Facility

Building size; state;

Medications and equipment available

Staffing – how many, qualifications, roles

Data collected - ?targets set

Linkages with BHCP?

Village Walk – to triangulate with interviews and FGD; also to seek informal views

Size of village; design

Presence of toilets/household

Waste disposal facilities; water sources

Animal and farming practices

Cleanliness and general appearance

Level of involvement of villagers

Views on community needs; Views on BHCP

Appendix D: Proposed information about evaluation for Consent

Evaluation of Bougainville Healthy Communities Project

The New Zealand Ministry of Foreign Affairs and Trade (NZMFAT) has provided funding to the Leprosy Mission of New Zealand (LMNZ) to support health initiatives at community level in Bougainville, an autonomous province of Papua New Guinea. Funding has been provided since 2005, with a new model commencing in 2009.

This evaluation will assess the overall performance of the Bougainville Healthy Communities Program (BHCP) since 2009. BHCP is currently designing the next phase of its program to roll out activities to all 13 districts of Bougainville and is in negotiation with MFAT for a new multi-year Grant Funding Arrangement from 2013. This evaluation is timely and will provide useful analysis to inform the **activity design** and the **development of the GFA**.

Dr Anna Klinken Whelan, an independent consultant with Time plus Talents, has been appointed as the Evaluator for this mid-term evaluation.

You have been identified as a key stakeholder and we would appreciate your views on BHCP, and more broadly, the health situation in Bougainville.

Your views will be incorporated into a Report that will go to NZMFAT and LMNZ-BHCP. Any comments that you make will be considered in the analysis, but the information will be reported without names in the report [unless you request naming].

We would however like to recognise your contribution by acknowledging you as a contributor to the report. Would you like to have your name recorded?

It is not anticipated that you will experience any harm from participating in the evaluation, and we assure you that your relationship with LMNZ-BHCP will not be affected.

Your participation in this evaluation is voluntary and you can withdraw or stop the interview or discussion at any time. We seek your informed consent to participate in this evaluation.

Should you have any concerns about this evaluation or the process, please contact Alicia Kotsapas (Alicia.kotsapas@mfat.govt.nz)

Should you wish to contact the Evaluator, Dr Anna Klinken Whelan please feel free to email: annakwhelan@gmail.com

Or on mobile PNG number to add and later on +61 402985532 .

This appendix contains a copy of the final evaluation plan.

Appendix C: List of Data Sources

This appendix contains a list of data sources used in the evaluation

- 2009 BHCP Proposal - Final 230309 (incl. budget sheets)
- BHCP Annual Report 2009
- BHCP Annual Report 2010
- BHCP Annual Report 2011
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- Public Health Profile 2010_Bougainville - Salim 17 Oct '11 copy
- BHCP Activity Completion Report (2) Brent
- BHCP Training materials in-country
- The Bougainville Plan for Health, 2012-2030 ('Master plan')
- Autonomous Region of Bougainville: Health Service Agreement
- ADB, Proposed Loan and Administration of Grant and Loan Papua New Guinea: Rural Primary Health Services Delivery Project: Report and Recommendations of the President to the Board of Directors, July 2011
- Australia-PNG Health Delivery Strategy, 2011-2015
- Abraham Opito, ARB Health Capacity Diagnostic Assessment STI and HIV report
- ARB HIV and AIDS, key facts
- Ritchie, Rotem & Hine (1998) Healthy Islands: from concept to practice, *Pacific Health Dialog*, Vol 5, No 1: 180-186.

Appendix D: List of Stakeholders and Key Informants

Organisation	Name	Role/title
NZHC 27/8	Rebecca Lineham	New Zealand Aid Programme Manager
	Robert Turare	Development Programme Coordinator
	Svend Müller	Direct Facility Fund Manager
AusAID 28/8	Aedan Whyatt	First Secretary, Health
	Clement Totavun	Assistant Program Manager, Health Focal point Bougainville
	Avi Hubert	Program Manager, Health and HIV
HHSIP 28/8	Abraham Opito	HIV Decentralisation Adviser
WHO 28/8	Dr William Adu- Krow	Country Representative
	Dr Mohammed Salim Reza	Technical Officer-Public Health Advisor
NDOH 28/8	Miriam Pahun	Leprosy focal point
World Vision 28/8	Marlon Villanueva	ACSM Technical Adviser/Senior Grants Operations Manager
	Boniface Wadiri	(by phone in Buka)
ABG meeting–	Chris Siriosi	CEO Law, Justice; Acting Chief Administrator
Buka 29/8	Raymond Masono	Deputy Administrator, Policy
	Hubert Kimai	CEO - LLG
	Ephraim Eminoni	Special Projects Officer
	Tom Sansan	LLG District Officer
	Amato Sahoto	First Secretary (Health Ministry)
	Dr Anthony Pumpara	CEO Health
	Alois Pukienei	Director Public Health
	Roselyn Gatana	Family Health Program Officer
	Greg Kuiai	BHCP
LMNZ-BHCP	Matt Halsey	LMNZ
29/8	Greg Kuia	District Facilitator Coordinator
30/8	Ruby Mirinka	Program Manager

Staff meeting 30/8 – followed by separate team and individual discussions	Nehemiah Wesman Gilson David John Kemaroy Greg Kuiai Anthony Kuweh Naomi Naina Clarice Harepa Nerolyne Arti Ignatius- Novona	Operation Manager Finance MEL coordinator Facilitation Coordinator Senior Trainer Trainer Trainer Trainer Trainer
30/8-1/9	John Taunei - Buin John Pangolopa - Bana Robert Karuta - Panguna	District Facilitators (3)
District Facilitators met in the field	Charlie Rerevairi Philip Pitainu Paias Marko Paul Marko Gordon Purpuru Terence Kuuiis Roselyn Gasi Elywne Siima	Wakunai Siwai Kieta Kieta Tinputz Buka Buka Wakunai
Siwai District	Joseph Noro	District Executive Manager
31/8	David Mikisa	Pongo COE Chairman
	Isaiah Sihang	Ramu COE Chairman
	Paul Potungah	Pongo COE Assembly clerk
	Ruth Hogupo	Women's Federation President (Siwai)
	John Tsirova	Constable
	John Tsiaka	Acting Executive Manager
	David Kouro	VHV (Bana)
	Joseph Kivwov	LLG Officer
	John Lempo	Rino COE Chairman
	John Kara	Observer
HC visit	Launoa Mortomdatso	HEO, Monoitu Health Centre
Kieta District	Joachim Miarama	Acting District Executive Manager
3-4/8	Peter Harvin	Kieta District Health officer, Arawa Health Centre
	John Era	COE Chairman
Tinputz Dist	Blaise Vosivai	District E/M
5/9	Sister Tabuthi	District Health Officer
	Inoch Magun	COE Health Chairman
	Sr Justina Tovira	Nursing Officer, OIC Tearouki HC

Buka District	Robert Norg	Health Promotion Officer, Div Health
6/9	Anthony Korewa	COE representative
	Anita Kakage	Nursing Officer, OIC Hanahan sub-HC
ABG meeting	Paul Kebori	Deputy Administrator, Operations
Buka 7/9	Dr Anthony Pumpara	CEO Health
	Alois Pukienei	Director Public Health
	Roselyn Gatana	Family Health Program Officer
	Robert Anelsia	CEO Division Media & Comms
	Stephanie Elizah	Division Media and Comms
	Mana Kakaronis	Division of Community Development
	Nick Pensiai	Division of Peace and Reconciliation
	Aaron Pita	Division of Veteran's Affairs
	Amato Srhoto	Ministry of Health
	Dr Md. Salim Reza	WHO Bougainville
	Roselyne Kenneth	AusAID Buka
	Boniface Wadari	World Vision Bougainville
	Marion Jacka	Care International
	Mastone Zaunda	MSF
	Ruby Mirinka	BHCP
	Greg Kuiai	BHCP
Port Moresby		
NDOH 11/9	Dr Paul Aia	Director TB Program
	Mr Posiani	Executive Manager, Public Health
	Jubal Agale	Healthy Islands Coordinator
AusAID 11/9	Lara Andrews Clement Totavun	Focal point Bougainville
Opportunistic		
UNDP South	Peter Siunai	South Bougainville Manager
Oxfam NZ	John Standsfield	Advocacy & Campaign Manager
WorldVision	Dwayne and Rosanna	Grants Officers?
VSA Arawa	Libby Kerr	
Peace and Rec	Dennis Kuiai	First Secretary, Ministry Peace & Reconciliation

Appendix E: Contribution Analysis

https://communities.usaidallnet.gov/fa/system/files/Contribution%2BAnalysis%2B-%2BA%2BNew%2BApproach%2Bto%2BEvaluation%2Bin%2BInternational%2BDevelopment.PDF

2006 International Conference Holiday Inn Esplanade, Darwin, Australia 4 – 7 September 2006 Final Papers

Contribution Analysis – A New Approach to Evaluation in International Development

Fiona Kotvojs Kurrajong Hill Pty Ltd and Cardno ACIL

Abstract

Since the mid-1990s there has been growing pressure on international donors to demonstrate the effectiveness of publicly funded aid initiatives. In Australia and elsewhere the need to show that programs have achieved desired outcomes has witnessed a shift from past preoccupations with the measurement of program implementation, inputs and outputs to a stronger focus on assessing program impact. However, an issue associated with this trend is that development assistance projects are frequently delivered over short time frames (three to five years). This sector reality has meant that donors can often only measure success in terms of progress toward results, rather than reveal a causal link between a program and outcomes.

To address this, the Australian Agency for International Development (AusAID) has looked to alternative approaches to evaluate development assistance programs. In Fiji, 'contribution analysis' (Mayne, 1999 and 2001) has been introduced across three programs as a means to consider progress towards outputs and intermediate and end outcomes. This approach recognises that it takes time to achieve an impact and so does not attempt to prove an impact before an impact could realistically be achieved. Furthermore, contribution analysis does not seek to definitively prove contribution, but rather seeks to provide plausible evidence to reduce the uncertainty about the 'difference' a program is making (Mayne, 2001).

Contribution analysis was introduced into the AusAID funded Fiji Education Sector Program (FESP) in 2005. Here it is being used to evaluate the contribution FESP is making towards the Ministry of Education achieving their priorities. AusAID is also applying contribution analysis to evaluate the contribution that AusAID's program as a whole is having in supporting Fiji to achieve their national priorities as articulated in Fiji's National Strategic Development Plan. This paper discusses what contribution analysis is, the specific approach to introducing contribution analysis into FESP, and provides early identification of the challenges faced and benefits gained with this new and innovative approach to aid and development program evaluation.

Donor Environment for Evaluation

Since the 1990's there has been a growing demand for public sector agencies to focus on impact and to integrate various forms of accountability into management and evaluation strategies (CIDA, 2002). This has led to a recognition that evaluation needs to extend beyond the inputs and outputs to outcomes. The importance of evaluating intermediate outcomes to provide early indications of progress (or otherwise) and enable corrective action to be implemented more quickly is widely accepted. An increased focus on intermediate outcomes to reflect the logical cause and effect chain is now widely promoted (for example, Van Doorn and Litjens, 2002).

Australia has followed the international trend. All Commonwealth Government Agencies are now required to report on both output and outcomes. Reflecting the government requirements and recommendations made by the Development Assistance Committee (Van Doorn and Litjens, 2002), AusAID started moving towards a system of outcomes monitoring and reporting. This sought to define the extent to which project outputs had, or were likely to, achieve anticipated and sustainable outcomes (AusAID, 2000). From 2003 the pressure on AusAID to demonstrate results grew.

The recent White Paper on the Australian Government's Overseas Aid Program emphasised the need for a greater focus on performance outcomes and implementation of a better basis for assessing the impact of aid efforts (AusAID, 2006). This changed environment led to consideration of alternative evaluation approaches which were more outcomes focused.

The move toward outcome based evaluation and reporting of institutional strengthening activities has presented specific challenges. Timeframes are such that donors have to measure success in terms of progress towards results rather than fully achieved results (CIDA, 2002). However, many donor agencies seek outcome based evaluation from early in the program, often within one or two years.

The second challenge is accountability. In the past accountability focused on what programs could control and assigned blame when things went wrong. This has led to a reluctance to accept outcome level accountability as it is often beyond the programs' control (Mayne, 2001). However, knowledge of whether the expectations about the programs' outcomes are correct and have

been efficiently gained can only be achieved if program managers are willing to accept some form of accountability for outcomes at this level. In practice, outcome level accountability is now being demanded and evaluation is often being used only as an accountability tool (Barton, 1997).

As a program seeks to monitor higher order outcomes, the issue of attribution becomes more complex. Attribution involves drawing causal links and explanatory conclusions between observed changes and specific interventions (Iverson, 2003). At a product or output level, these links are usually relatively easy to draw. At higher levels (program, agency, sectoral or national outcomes), this is more difficult. Determining whether the outcome was caused by the program, partner government programs or other donor activities, is difficult and rarely done. In practice, many evaluations identify whether the outcome was achieved and if it was, assume the program can take credit for this. However demonstrating a clear contribution of the program to the outcome is crucial if the value of the program is to be demonstrated and to enable decisions to be made about its future direction (Mayne, 2001).

Contribution analysis, as proposed by Mayne (1999), provides an approach to monitoring and evaluation which addresses these challenges.

What is Contribution Analysis?

The term contribution analysis is widely used in financial assessment of business units/products and to a lesser extent in other fields such as media campaign analysis, medicine and biology. In these areas, contribution analysis quantifies the contribution made by specific resources towards final outcomes. These applications assume clear attribution of input to outcome. This is significantly different to Mayne's (1999) use of the term contribution analysis.

In the context of public sector program evaluation, contribution analysis is "a specific analysis undertaken to provide information on the contribution of a program to the outcomes it is trying to influence" (Mayne, 1999, 6). It aims at "finding credible ways of demonstrating that you have made a difference through your actions and efforts to the outcomes" (AusAID, 2004a, 1).

Unlike other uses of the term contribution analysis, there is no expectation that the degree to which the program has contributed to the outcomes will be quantified. Mayne's (1999) broader approach to contribution analysis attempts to describe what Hendricks (1996) calls a "plausible association"; where a reasonable person, knowing what has occurred/is occurring in the program agrees that the program contributed/is contributing to the outcomes. It does not prove a contribution, but provides evidence to reduce the uncertainty about the contribution made (Mayne, 1999).

Contribution analysis recognises that it takes time to achieve an impact and does not seek to prove an impact before it could be achieved. It provides information on whether a program is likely to achieve an impact. In terms of

accountability for outcomes, contribution analysis asks if everything possible has been done to effect the achievement of the intended results and what lessons have been learnt (Mayne, 1999).

Mayne initially (1999) identified nine elements in contribution analysis. He subsequently consolidated these into six steps (Mayne, 2001, 9). These are:

1. Develop the results chain (the program logic). This sets out the logic across all levels from activity through intermediate to end outcomes. It demonstrates the logical link between achievements at one level and higher levels. The outside factors that impact each level, clients, expected results and performance measures are specified. By recognising these, the problem of attribution is acknowledged.

2. Assess the existing evidence on results. The intended results will be clear from the results chain. Indicators to demonstrate achievement of the desired results at each level, and the availability of this evidence, can be determined. Mayne recommends use of multiple lines of evidence to provide more definitive information on attribution. Where evidence for links between elements of the results chain is weak, further evidence will be required.

3. Assess the alternative explanations. Identify the most likely alternative explanations and present evidence to discount these (if appropriate) and to support the program as a more likely explanation of contribution to outcomes. The burden of proof is then on others to demonstrate that some other factor was the main factor in the chain of events that led to the outcome.

4. Assemble the performance story. The evidence available is documented in a performance story (Dart and Mayne, 2005). This should convince a sceptical reader that the activities undertaken have made a difference (Mayne, 2003). Mayne (2003, 16) proposes that a credible performance story will set out the program context (including the results chain), planned and actual accomplishments, lessons learnt, approach for assuring the quality of information and (Mayne, 1999) the main alternative explanations for the outcomes occurring and show why they had no or limited influence.

5. Seek out additional evidence. Where an alternative explanation cannot be discounted, or the program cannot be shown to be a more likely contributor, the program logic should be reviewed and/or additional data gathered and evaluated.

6. Revise and strengthen the performance story. Where this can't be done, further evaluation is required or the program is not the key contributor to the outcomes.

Mayne does not attempt to differentiate contribution analysis from other forms of monitoring or evaluation, other than to emphasise its focus on

attribution. This emphasis promotes seeking alternative explanations to account for outcomes more than most other forms of evaluation. It makes explicit the fact that attribution cannot be proved, but only indicated. It is in this dimension that contribution analysis differs most from evaluation approaches normally used in the development sector.

Application of Contribution Analysis in Fiji

Australia (through AusAID) appears to be the first bilateral or multilateral donor to investigate application of contribution analysis to their development assistance programs. In Fiji, AusAID began to investigate mechanisms to provide a greater focus to determining the contribution of the Australian development assistance program to achievement of Fiji's National Strategic Development Plan in mid-2004. This would enable AusAID to more clearly demonstrate to stakeholders the value of the program (AusAID, 2004a). Discussions commenced in August with a workshop in Fiji. Participants included representatives from AusAID, the Department of National Planning, the three relevant Government of Fiji Ministries and the three AusAID programs (education, health, law and justice). In December, after consideration of alternative approaches to demonstrate AusAID's contribution to agency outcomes (AusAID, 2004b), it was agreed to apply contribution analysis to each program.

A further meeting (5 April 2005) clarified that contribution analysis would occur at two levels. At the higher level, AusAID would evaluate the contribution of the country strategy to Fiji's strategic objectives. At the lower level, each program would use contribution analysis to determine the contribution of program activities to the sector strategic objectives. It was agreed that this was a learning process and as such, each Program could develop and adopt an approach to contribution analysis which best met that sector needs. The lessons learnt would be shared and effective approach (or approaches) to contribution analysis developed.

Application of Contribution Analysis on Fiji Education Sector Program (FESP)

Underpinning the approach taken to implementation of contribution analysis on the FESP was the belief that contribution analysis was not a distinct monitoring or evaluation tool. Rather it was an approach to analysing evidence gained from a variety of monitoring and evaluation techniques which were already in place. This meant that FESP's monitoring and evaluation framework did not significantly change when contribution analysis was introduced. The focus was instead on the program logic and identifying alternative explanations for achievement of outcomes.

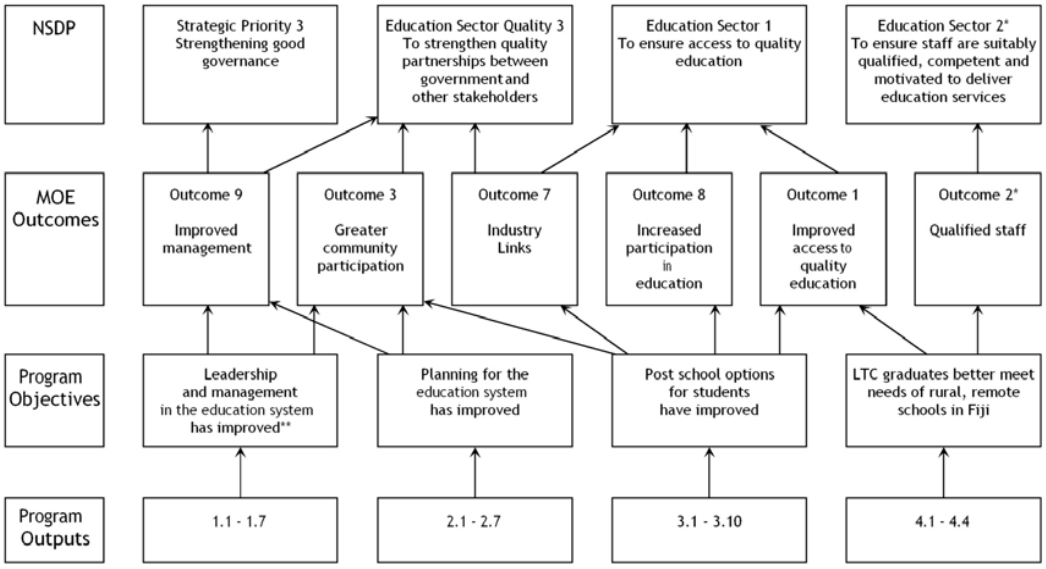
The first step was to review the program logic that had been documented in a program logical framework matrix. The links between each level in the hierarchy were analysed and clarified. The links between the program, Ministry of Education (MoE) and national objectives articulated in the

National Strategic Development Plan (NSDP) were refined and more clearly articulated. A graphical representation of these links was developed (Figure 1).

Figure 1: Graphical representation of program logic on FESP

Contribution analysis recognises that in "most cases what we are doing is measuring with the aim of reducing uncertainty about the contribution made, not proving the contribution made" (Mayne, 2001, p21). With this change in emphasis away from proof, the team were comfortable in monitoring high level indicators and establishing targets which are to be strived for and cannot be easily be met (stretch targets as defined by Mayne (2003)). Performance indicators were revised in the logical framework matrix to reflect the Ministry's targets.

The responsibility for monitoring and evaluating achievements at each level were specified. Advisers were responsible at program output and intermediate outcomes level, and the Monitoring and Evaluation Adviser at objective and outcomes level. Adviser Terms of Reference were restructured to more clearly reflect the relevant results chain, include



indicators for each level and initiate early thinking about alternative explanations for achievement of outcomes at each level.

During their first input, advisers were required to develop a plan for monitoring and evaluating the achievement of the indicators specified in their Terms of Reference (this had also been standard practice prior to introduction of contribution analysis). They also identified potential alternative explanations for achievement of outcomes and gather evidence to discount these (if appropriate).

At the completion of each input, advisers assess the evidence and alternative explanations and update their performance story. The format for this was

based on their Terms of Reference (Annex 1). This then feeds into their next input, promoting a monitoring and evaluation cycle. The Monitoring and Evaluation Adviser reviewed these and prepared a performance story at the Ministry of Education outcomes level.

It is important to recognise that the approach taken on FESP has not resulted in additional monitoring and evaluation than would have normally occurred. It has resulted in a different analysis and dissemination of monitoring and evaluation results.

AusAID have implemented a contribution analysis at the national level for the last two years. The approach taken for this has been quite different and largely built around focus groups. This process has been refined over the two years. It is recognised that while the process is beneficial, it can still be significantly improved. A discussion of this is beyond this paper.

Assessment of Implementation of Contribution Analysis on FESP to date

Iverson (2003) notes that Mayne's approach recognizes and begins to address some of the limitations of conventional evaluation methods. Early results on FESP support this, and show significant benefits from the introduction of contribution analysis.

Application of contribution analysis on FESP has provided two key benefits. The first is the inclusion of higher, often stretch, performance indicators and others outside the program's control. In general, like most public sector managers, managers of international development activities prefer to include indicators at a level over which they have control. Thus most indicators were at an output level. There was a reluctance to include indicators at outcome level as the program is unable to control these. Contribution analysis identifies contribution to a greater whole rather than seeking to lay blame or prove attribution. AusAID's recognition of this has made program managers more comfortable in monitoring against indicators for higher order outcomes. The indicators now developed provide information on progress towards, and contribution to, outcomes. This enables donors to better meet their accountability requirements without seeking to demonstrate impact before this is possible.

The second benefit has been providing a greater focus on donor harmonisation. When planning an activity, potential alternative explanations to account for anticipated changes were identified. This has increased awareness of other donor and agency activities encouraging greater coordination.

The way contribution analysis was introduced on FESP has improved the clarity of the program logic and more closely linked the program logic to each adviser's Terms of Reference. The introduction of contribution analysis enabled the performance indicators to be refined and these now better reflect the specific benefits the program is intended to achieve.

Contribution analysis has increased the use of qualitative evaluation methodologies on all programs. Prior to this, evaluations mainly used quantitative methodologies.

More broadly, AusAID has actively supported an increased focus on monitoring and evaluation over the last year. Vigorous discussion has occurred between AusAID, the partner agencies, and programs in each sector to determine approaches to introduce contribution analysis. The level of resources (both time and financial) to monitoring and evaluation has also been increased. Provided that the monitoring and evaluation activities remain of a high quality, this will enhance the overall quality of evaluations on the program. We anticipate that the more accessible reporting of monitoring and evaluation results will improve discussions of results from monitoring and evaluation.

Challenges in Applying Contribution Analysis

At this early stage, the challenges faced in application of contribution analysis relate to the way in which it has been applied rather that the technique itself. There have been a number of misconceptions. These include that contribution analysis:

- Is a different form of monitoring and evaluation and can therefore replace existing monitoring and evaluation. Some have not seen it as an approach to planning and analysing all information from a monitoring and evaluation program.

- Must use focus groups. While it is recognised that focus groups are one form of data gathering, it must be remembered that they are not appropriate in all cases.

- Must use the most significant change approach. This technique has been successfully introduced on (or to review) the three programs in Fiji and has produced some excellent results and benefits on FESP. However, it is also only one approach and is not appropriate in all cases.

- "Validates the anecdotal". Anecdotes on their own, can be quite misleading. Their use in a rigorous evaluation must be supported by other forms of evidence (Mayne, 2001, 20). Contribution analysis requires clear program logic. Its effectiveness as a monitoring or evaluation approach would be limited where the program logic was weak. This was not a challenge on FESP, but could be on other programs.

- While donors are moving towards monitoring outcomes, many donors still require monitoring and evaluation to "occur at outputs, activity and inputs level, providing information on inputs/outputs. ... (keeping) track of project implementation efficiency ... (providing) information on progress towards planned outputs in physical and financial terms" (AusAID, 2000). This is also reflected in the

Contractor evaluation responsibilities identified for the Fiji Program (AusAID, 2004b, 4). Contribution analysis is not designed to provide information at this level and it appears it doesn't consider efficiency. Those designing evaluations must recognise that other approaches will need to supplement contribution analysis to provide the full spectrum of evaluation information required by donors. This is not yet broadly recognised.

Conclusion

Contribution analysis has been successfully introduced into FESP to evaluate FESP's contribution to the Ministry of Education achieving their priorities. At this level it has already produced benefits due to both the technique itself, and the way in which it was implemented. Most notable benefits were the improved program logic, monitoring against performance indicators which better demonstrate progress towards outcomes, donor harmonisation and increased support for monitoring and evaluation. The challenges faced primarily reflect misunderstandings about evaluation, in particular the need to use a range of techniques to gather evidence to enable triangulation of findings. The limitations of contribution analysis to monitor and evaluate inputs and project implementation efficiency are also not well recognised.

The determination of whether contribution analysis is a suitable approach in a given situation must consider the purpose of the evaluation. If it is to consider program efficiency or monitor inputs and outputs, contribution analysis would not be a suitable approach. However, with the use of multiple methodologies in an evaluation, early results suggest that contribution analysis provides an appropriate approach for monitoring and evaluating progress towards intermediate and end outcomes.

Acknowledgements

I would like to acknowledge the support of the Fiji Ministry of Education, the Australian Agency for International Development (funding FESP) and Cardno-ACIL (the Managing Contractor) in the preparation and submission of this paper.

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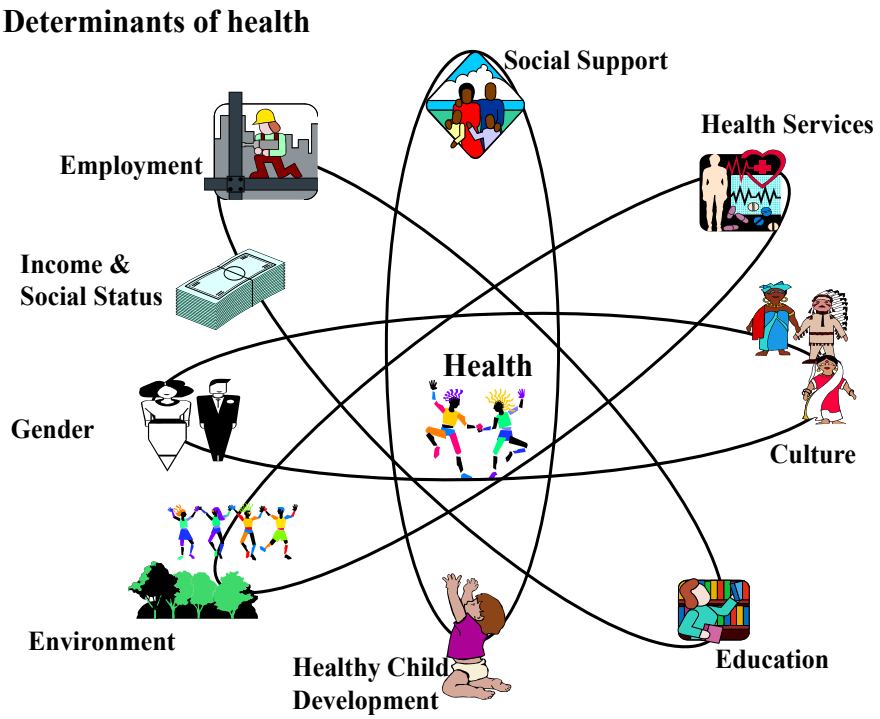
Appendix F: Determinants of health graphic



Appendix G: Steering Group comments and evaluator responses

BHCP Evaluation Report collated feedback from SGM

Summary

▪ The report is positive and supportive of the BHCP model and its impact, highlighting how delivery has evolved and adapted to suit the operational context as lessons were learnt.

▪ The report makes a number of very useful suggestions/observations which require further dialogue between LMNZ and ABG and consideration when designing the next phase of the project.

▪ Amongst these the report highlights wider issues such as leadership and livelihoods that impact on health status. This prompts the question of how BHCP can (or even should it) be involved in these areas without losing its health focus.

▪ The report notes wide variability in BHCP work performance, an analysis (with suggestions) of how to deal with the challenge-areas would be useful.

▪ Concerns were raised regarding limitations with the methodologies used, related to this are challenges to several of the conclusions drawn. Feedback from the SGM suggests that large group consultations, village walks and the selection criteria for villages visited may not allowed for sufficient interrogation, and triangulation, of the evaluation questions.

▪ The report could have benefited from being more constructively critical and analytical; this would have added more value in understanding of the BHCP work, especially for sustainability and integration imperatives. This may be linked to the methodologies used.

▪ The responses to the criteria of effectiveness and efficiency questions are quite limited.

▪ MFAT would like to see more detailed suggestions around the improvement of MEL

▪ It would be useful to arrange the recommendations section under specific stakeholders to implement e.g. DoH, ABG Administration and other partners.

Evaluator initial comments on feedback – to incorporate into final report

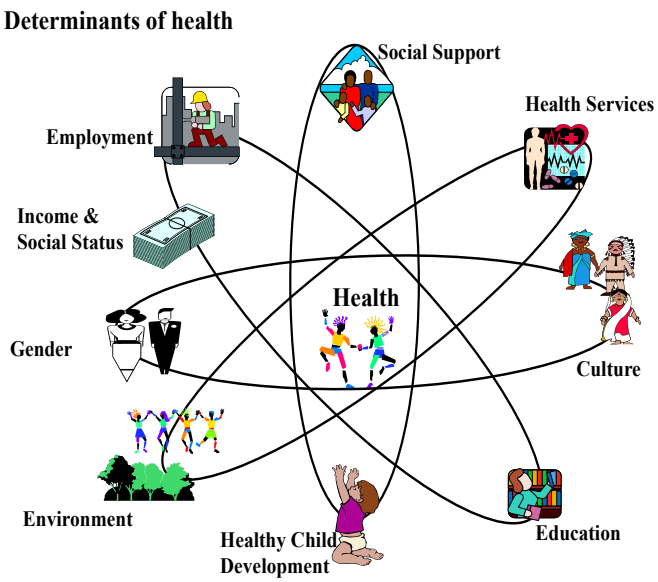
The responses to the criteria of effectiveness and efficiency questions are quite limited.	During telephone discussion with NZHC and LMNZ it was agreed these two criteria would be less of a focus; it would be hard to assess without access to detailed costing information and more time with the BHCP finance officer and team.
MFAT would like to see more detailed suggestions around the improvement of MEL	OK – but I would suggest that a meeting with DoH and LMNZ be held regarding MEL for the future.

Concerns were raised regarding limitations with the methodologies used, related to this are challenges to several of the conclusions drawn. Feedback from the SGM suggests that large group consultations, village walks and the selection criteria for villages visited may not allowed for sufficient interrogation, and triangulation, of the evaluation questions.	Assessment at village level was extensive, and included individual discussions with women, leaders and DF during the walk (which was 3.5 hours in some districts). This was complemented by community consultations and further clarification with BHCP team and DF. Of note is that the conditions to travel to all districts were extremely difficult and time consuming and time was limited. I have added a section to explain the private conversations.
It would be useful to arrange the recommendations section under specific stakeholders to implement e.g. DoH, ABG Administration and other partners.	OK – will do
'*Document review of BHCP Annual Reports and Reflections from 2009-2012 was also conducted'* pg.10 Where the twice-yearly detailed reports from LMNZ support advisor reviewed? These would have provided valuable contextual information on evolving issues and suggested responses	NO I DID NOT RECEIVE THESE, ONLY MEL AND ANNUAL REPORTS
'more attention could be given in the next phase to increasing health seeking behaviour in communities for antenatal care, STI and HIV testing, family planning and birthing in health facilities' pg.5 Please provide a brief analysis of why there is an apparent deficiency in this area. While Bougainville is currently a low HIV prevalence region in PNG, the rate of STI infection is of great concern. Perhaps STI could be a key area to consider in the next phase.	Most detailed comments pp. 6-7 relate to Executive Summary where these points cannot be addressed. Date from PNG including ABG indicate low rates of ANC and facility birthing and/or skilled birth attendants; low STI testing (inc. HIV). I do think this should be a key area to consider in next phase and partnering with NZFPI could be beneficial.

'It may be timely in the next phase to include wider social media (e.g. radio and talkback, billboards) to improve messaging.' pg.6 Good point suggest adding SMS texting, the software which allows queries is free, web-generated, and is currently being considered by the MEL Coordinator	Done
'it is critical that villages are empowered to widen the network of 'volunteers' where it is not working effectively' pg. 6. Agreed, any suggestions as to how this could happen?	It is about changing the focus in education/training - that volunteers need to spread messages back to villagers (that can then be documented.) The message back from DFs to leaders should be that communities, not just VHVs are accountable for changes. It is a CD/health promotion debate that has gone on for decades and I cannot really summarise in this report.
The goal should be to increase health literacy in villages, not just to train volunteers' pg.6 Is there evidence from the Evaluation that this is not currently the goal, albeit using terms other than health literacy?	It is a goal, but the focus from BHCP staff seems to be more on the VHVs and less on communities and their understanding.
'In Tinputz the OIC has the name and contact mobile for all VHVs and has called them to bring in patients who need treatment or follow up; VHVs also accompany Nurses when they conduct Outreach and Patrol visits to remote communities' pg. 6. A number of programs elsewhere in PNG that have introduced similar volunteerism concepts have failed but the BHCP program seems working quite well. It would be useful to include some factors that have contributed to a good VHV program *'District Facilitators in 3 Districts are well integrated'* pg.6 It would be useful to understand how they are well integrated and the dynamics/roles of the integration	I was unable to meet with the Volunteer coordinator in NDOH and cannot really comment on the success of other PNG volunteer programs. I know a perception of some stakeholders is that other PNG programs are more successful because the volunteers provide supplies (such as condoms and TB drugs etc.). Without more time for reviewing other volunteer programs, I would not be prepared to comment or compare further. I think this is included in S2:p 3. I am actually asking that BHCP write this up as a key lesson learned. What I gained was a brief insight; BHCP staff have much more detailed understanding of this dynamic, and can show the positive examples. I think writing up positive examples as stories makes it easier to replicate and use for training purposes.

'It is important that both Care and BHCP communicate about the curriculum and also about which Chiefs may have already had BHCP training so that a strategy can be developed to avoid overlap' pg.6 This has been suggested for over a year, is it possible to ascertain why this is not happening?	I think that both Care and BHCP leaders are extremely busy women and have been unable to connect. It could also be an unwillingness on the part of BHCP PM to engage directly without a clear direction to do so? It takes time and energy to work with other organisations that you cannot control.
'*Communities benefit the most in Districts where BHCP has been able to partner well with others (e.g. with Oxfam NZ in Kieta) on other urgent public health issues such as water, sanitation and hygiene (WASH)'* Pg.7 This conclusion is not possible with such limited evaluation coverage. It may be that in one or two observed cases this synergy has been positive. However this requires an interrogation of Oxfam work as well and there have been significant issues around their work.	I am only saying that the communities that had WASH were incredibly grateful and there were clearly benefits felt (less walking to safe water etc.). I am not assessing the Oxfam project or work but only the results as perceived by communities - and that was truly marked compared to areas where such projects had not been implemented. My conclusion is that communities really need WASH projects to truly become 'healthy communities'. I stick by that and note there is now a global focus on WASH. However how it gets implemented is always problematic, but should not be a reason to avoid it. Whether this is BHCP role or not is unclear; it certainly is a role for ABG and communities to work on
'Data linkages and Monitoring and Evaluation need to be addressed soon, and summary feedback presented to villages, District authorities and health facilities' pg. 7 Agreed. However did the Evaluator analyse the current methods of providing feedback to village and district authorities by way of reflection activities and identify the shortcoming? Certainly this feedback has been a powerful tool for strengthening Chief and community involvement in BHCP	Reflection meetings are positively viewed; what I am talking about is timing of feedback. In public health terms, it is critical that feedback is timely and focused on action and determining what changes are needed. There is a vast literature on this that I cannot include, but it is critical that attitudes to data change – and it is seen as important to making changes, not just to report on for a 6 monthly report. I am happy to talk further about this, but it has been highlighted in the report.

'*Document review of BHCP Annual Reports and Reflections from 2009-2012 was also conducted'* pg.10 Where the twice-yearly detailed reports from LMNZ support advisor reviewed? These would have provided valuable contextual information on evolving issues and suggested responses	No, I did not receive separate detailed report, only MEL and Annual reports from BHCP
'*The rationale for Village selection was to include a mix of perceived poorly performing, average and model Villages (as assessed by LMNZ-BHCP and discussed with Evaluator)'* pg.11 did this happen? There is limited evidence in the report of comparative findings between the different performing communities and suggestions for possible reasons and solutions]; '*What transpired in most villages was that women, men and young people were all present during the consultation, with numbers ranging from 8-36*' pg. 11 and '*Large groups were consulted rather than smaller focus group discussions in all except Buka District*' pg. 12. There can be real issues with this methodology—as true triangulation is not often possible. Elements of the larger group are often unwilling to express freely in front of others *It is unclear if the selected villages are representative'* pg. 12 was it not possible to define a range of categories being sought to test whether reasonable representation was being achieved? '*On a number of occasions, others added views during the Village Walk*' pg. 12 Village walks are a useful tool, but should be combined with others to achieve true triangulation	I asked repeatedly for a hierarchy of what is expected from villages and how this relates to performance. It was unclear to me how villages were considered 'struggling, average and model' although model was clearer. This is a piece of work that BHCP need to do; and I suggested it. I have addressed this in the method section. I had many 'private' conversations with women, leaders, volunteers, auxiliary police and others during the walk (often over many hours). This was the best strategy for gaining views; the Community Consultation was the more formal and 'known' form that provided the 'sacred' views, compared to the 'profane' views expressed during the walk. Again I asked for a categorization of villages and I think this piece of thinking has not yet been done. They were

'Given the high level goal of the BHCP to improve health status, attention needs to be paid to tackling the broad determinants of health' pg.12 what are the specific determinants that needs attention. The next phase could perhaps address these and the broader determinants given the high level goal of the program	
'It will be important for stakeholders in the next phase to consider issues of 'contribution' and 'attribution' and to identify other gaps that impact on health status' pg.12 Can this be further explained	I will include a paper on Contribution analysis in the appendix. It is a specific methodology.
'Tensions increase, for example, when shortages of medical and equipment supplies occur at local health facilities, often resulting in reduced community trust in the system and increasing cynicism' pg.13 What is causing this? Could the integration strategy deal with this? Have the views of NDoH, DoH, BHCP and Arawa Health Centre been tested on this point to get a stronger feel for the dynamics of this current situation	Broader PNG issue – currently in the process of a new solution due to poor management of the supply chain in the past. Long story!!
'In Kieta where BHCP was able to link with WASH projects (Oxfam NZ), villagers said their lives had been transformed' pg.13 This needs much more unpacking and explanation	It is very clear that in the villages in Kieta where they had piped water with taps and showers, their lives (esp. women) had been transformed. They said so and it was very clear. If you did not have to spend several hours a day getting to safe water source, and you could just turn a tap like we do at home, your life is transformed….

'Report maternal deaths to the Minister of Health pg. 15. This should be reported to the Division of Health who advices the minister	That is a quote from the Master plan which requires that all maternal deaths be reported to the Min of health. From BCHP point of view, the report would be to the DoH
'Of note in the latest MEL report was 6 maternal deaths in Kieta. If the data are accurate, this should be a matter of great concern and urgency and Health Authorities should be notified by the BHCP Program Manager immediately for follow up' pg.15 MEL Reports are distributed to DoH (Dr Pompara, Alois and co) Did the Evaluation determine how the information being contained in these reports is being used/responded to? With any subsequent suggestions/recommendations?	It is about timeliness and reviewing this in future. DoH and BHCP need to work together now to determine who notifies and when deaths get notified. It is not good enough for VHVs to just include them in a 6 month report. For example if a child death from diarrhoea is reported immediately to the DoH (maybe via the health facility) then outbreaks may be prevented. If a maternal death due to delay from lack of transport is reported, then another death may be prevented, because action is taken to address that. There needs to be thought given to what is important for MEL purposes to document project performance, but also to VHVs having data that are critical to health planning and responses. If not all deaths occur in health facilities, then their reporting of this is critical. It should (and must) inform a DoH response.
However, communities also expressed other concerns and urgent needs that affect their healthy community: failing cocoa crops, sago palm failure used for traditional roofing, appropriate materials for pig fencing, no mobile phone coverage (including the health centre) in Siwai, cost of equipment such as brush cutters to keep villages clean' pg.16 Yes, agreed. The link with livelihoods and other components is compelling. How can this be done without BHCP losing its primary focus?	A classical question in health promotion/public health literature! It is about partnerships and working with those who can address primary industry concerns; income generating activities etc. ABG needs to take on these issues, which is of course part of the broader political and economic issues within PNG.

'*Communities benefit the most in Districts where BHCP has been able to partner well with others (e.g. Oxfam NZ in Kieta) on other urgent public health issues such as water, sanitation and hygiene (WASH)*' pg.16 Very questionable conclusion. This requires much more multi-variant interrogation, as well as a closer look at Oxfam's work	I am sorry but I am talking about the impact on the communities not about Oxfam or the Oxfam/BHCP project specifically. It is clear that whatever it took to make that project work in Kieta had a remarkable impact. I am not interrogating Oxfam's work on this; I am saying that a lot more WASH needs to be done, and BHCP can contribute a lot to understanding which communities are ready and able to take them on…i.e. prioritizing as resources are not enough for all villages.
'*Younger volunteers struggle to influence Chiefs and leaders'* pg. 16 how did this observation compare with the issue that CARE is finding with its youth volunteers and achieving 'credibility' for behavioural change in the communities?	CARE approach focuses on peer education; therefore behavioural change is assessed by what youth do; not about their influence with leaders.
'*The level of Village Assembly has not yet been addressed by BHCP, and Care International is currently developing a training curriculum for leaders at this level. It is important that both Care and BHCP communicate about the curriculum and also about which Chiefs may have already had BHCP training so that a strategy can be developed to avoid overlap'* pg. 18. Agreed, although CARE has had trouble identifying just what the VA is and how it is evolving. There are significant differences between the north and other parts of Bougainville	Yes this is a big problem and I am unclear about the benefits of focusing on VA. I assume that ABG and donor partners are discussing this? The key for BHCP is to help CARE avoid overlap and 'double training' village leaders without some thought given to it.

'A review of the MEL indicators to merge with DoH data requirements should be conducted soon' pg.19 Yes, Good. However did the Evaluation understand that current MEL indicators were developed collaboratively with the DoH and its HMIS people and therefore explore what current thinking is about the merging process?	DoH need to give thought to MEL indicators; things change from when they are set up. The indicators are not bad in themselves, it is more about the timeliness of reporting. Are BHCP/VHV data going to inform DOH actions? That is the question to ask them; if village level data is not a concern to them, and they can get that data from elsewhere it is not a problem.
'*Environmental issues are critical and the next phase should consider partnering with environmental experts to assist with latrine design for coastal areas; sustainable agriculture and building materials; and attention to the atolls requiring relocation due to rising sea levels*' pg.19 Awareness required—yes—but this does appear a little like a shopping list—how realistic is this for BHCP? There is a danger that because of BHCP's success it may be pressured to become everything for everybody—leading to the tensions with, for example, the leadership training which the Evaluator has flagged.	I agree, but I was asked to address cross-cutting issues, and this is one of them. A healthy environment is part of a healthy community, and is already being addressed in part by BHCP. Again I say that WASH is critical to a healthy community and there is great expertise within the Pacific on such issues. Maybe part of next phase can be assigning budget to bringing over other Pacific experts to make an assessment of what is needed to get appropriate latrines in coastal areas. That would make a big difference to several dozen villages at least. In time, some atolls will require relocation of communities, and this is something that ABG will need assistance with – unlikely to be from BHCP?
'Increasing inequalities within Bougainville is a concern, with those in paid employment clearly more wealthy compared to villagers whose only income is from (failing) cash crops e.g. cocoa' Pg.18 This comment seems inaccurate. Did the Evaluator get a feeling for other sources of income in, at least, Central Bougainville? (gold, small business etc.). There is much more cash-generation around than this statement implies. How can cash incomes be more effectively used—and should that be a role for another player?	There is data to show that inequality of incomes in PNG is great and it is because there is less opportunity for cash income (apart from mining, logging etc.) which are curtailed in Bougainville. My assessment is a reflection of the Districts and villages I visited where there were few sources of income apart from cocoa and copra (no gold and few small businesses). There is definitely a sense that such cash activities are around, but at a fairly low level in most of the villages I visited. The question is as you say, how can cash incomes be used; the village treasury concept is the answer for BHCP, and could be very effective given time….

'Some District Facilitators play a positive role with District Authorities in planning; engaging with District Executive Managers enhances progress' pg.20 Does this imply that others do not? It would be useful to comment on the continuing issue for selection of/variable performance of DF's—this is critical in the current delivery model. The sampling of 3 rep districts (with, hopefully, one poorer-performing DF) could have allowed for this analysis	I feel that I can only comment on the DFs that I observed in the 4 Districts; I met and interviewed others and there is a sense that they are not all performing as well. Yes selection of DFs is a critical issue. Yes selection of Districts might have added a poorly performing one; although Buka was a good example of where new DFs have come on board and have had little time to impact on Buka villages (which were not good examples)
'Papua New Guinea in general and Bougainville are extremely expensive sites to conduct business and projects. BHCP seems to be doing as well as possible in terms of value for money' pg. 20 what value indicators have been used to generate this finding?	Cost of living; food supplies; meals; accommodation; airfares; petrol; vehicle repairs etc….
It would be unwise to create too large a gap between the conditions for BHCP staff and those working in the ABG. pg. 20 Can this be further explained?	NGOs are documented to provide better working conditions than those in government (HRH Hub) and this has caused a skewing of health staff out of health facilities and into NGOs. This is a major problem in Africa, Asia and Pacific. I am just warning BHCP to ensure that conditions are comparable to government, especially as integration is a desired outcome.
'Good planning could assist with improving efficiencies' pg. 20 Please provide further explanation to this statement	For example, where staff are conducting back-to-back trainings, and the Finance officer has to attend to provide payments, scheduling the car is critical. This is being addressed but I think that more attention could be paid to this, from personal experience with this evaluation even.

Given Outcome 7 (Integration), it is important that discussions be held soon with ABG DoH regarding future plans. Finding the most appropriate funding modality will require detailed information and negotiation, based on a clear picture of the next phase. There are a number of options, including funding through ABG and then to other NGOs including LMNZ to deliver various outputs; or a partnership MOU with ABG-LMNZ and other NGOs.' Pg.21 Integration of the program into the ABG DoH cannot be realised unless this is factored in the ABG DoH structure. Hence this needs to be discussed quickly with the DoH. requires further analysis using efficiency indicators. It would have been useful to analyse, and then comment on, the nature of the LMNZ management model (systems, inputs) as a factor in the success being described and whether that, or elements of it, would be required for the future and what part it could play in, for example, a phased-in integration scenario.	The underlying issue of budget and staffing has to be addressed with ABG before integration discussions go further. LMNZ provides a sound management and accountability structure that is valuable to consider in the integration. However I think that is more of a political discussion with NZHC and ABG with LMNZ. Yes it could be phased in over the next 2 years – but the ultimate shape of the structure will depend largely on the budget being allocated to ABG, DoH and other divisions related to BHCP work.
The first sustainability question and the first part of the second sustainability question do not appear to have been answered. Specifically; *'How well prepared is BHCP for full integration into the ABG DoH by 2014?* and *'What are the key issues/risks?'* and *'To what extent are the ABG and relevant partners prepared to manage the integration of BHCP activities?'*	To be honest, I would say that BHCP is little prepared for full integration by 2014, but I think that this is a key purpose for the next 2 years. Key risks are budget and staffing and willingness to integrate…as indicated ABG are not prepared to manage integration currently; BHCP/LMNZ is pushing it now, but it will require an intensive effort to get attention to this over next 18 months. A sense of urgency needs to be developed.
Key risks remain staffing shortages in the Division of Health and ABG in general' pg.22 how this is linked with the wider ABG budgetary challenges and directed donor support?	Yes linked of course

'The TIIG was not able to meet monthly as planned' pg.22 I am not sure that it was ever planned to meet monthly. Certainly when it was first established twice a year was considered sufficient	It was reported in annual report that the TIIG had not met monthly as intended, so I assumed that this was planned. I think twice a year is fine.
'*Attrition of VHVs is still a problem in some Districts more than others'* pg.23 Was this linked to the performance of DF's? If so, what advice could the Evaluator give?	Not always related to performance of DFs – also personal reasons (7 children etc.). I have made some suggestions already. This is another area for BHCP to document and reflect on in more detail.
'*Currently Care International has been working with youth specifically on HIV and SRH, but they will be exiting in some Districts (e.g. Buka)*' pg.23 Yes, BHCP and CARE should share and collaborate. However this has been asked for over a year now. Did the Evaluator explore why this has not been happening? Also did the Evaluator consider the costing of CARE—it is a much more expensive programme (by many factors) against beneficiary numbers, than BHCP, with huge overhead and external cost components. Was the CARE model analysed so that comparative or collaborative judgements could be more accurate?	Yes commented on above. I have not looked at CARE costing and I am not looking at CARE model, but more at the issue of youth engagement. This is a critical area for BHCP to address and develop a strategy on; perhaps having discussion with CARE who are already doing some youth work might help. Partnering with NZFPI may also provide valuable strategies and lessons learned form other Pacific settings
The Division of Local Level Government raised the issue of approving and enforcing laws in rural areas' pg. 24 Agreed, what does the Evaluator see as the link between the Division of LLG and the roles of Villages, VCC's and CoE's in identifying and mandating local laws	This is a big question and I am not sure that ABG has an answer on this; I certainly don't! I think there are too many levels of government to be honest!

'However L&G is not a core business of BHCP' pg.24 Yes, agreed. But its need has emerged in order to enhance the strength of the healthy communities work. The material changes are in the pipeline. Was the Evaluator aware of this?	Yes I am aware there is work being done on this, but I only saw draft material. Lots of stakeholders interested in influencing the shape of that material – which is good but also possibly a challenge!
One option to consider would be to locate a vehicle with District Administration' pg.26 Did the Evaluator get a feel for both the costs and the risk of attaching vehicles to district-level work?	Yes it's expensive, but that is what District level work will need. Staff who need to get out to the 'field' such as DPI, CD, LLG etc. will need to have access to vehicles. Yes it will cost a lot esp. with maintenance, but maybe setting up vehicle maintenance businesses nearby is another strategy to support? ☺
'Another option is to provide mountain bikes or motorbikes, and engagement with JICA would be advisable'. Pg. 26 A useful suggestion—but with operational and maintenance costs—could JICA support such a total package? Was this suggestion linked, in any way, to the variable performance of DF's	It's worth asking JICA/JOICFP? Yes DFs are less effective if they are not able to travel extensively to visit villages and provide supervision and support.
'BHCP to develop an Activity Plan for linkages of active VHVs and DF to all Health Centres – using the model where it is working (e.g. Monoitu and Tearoki HC) and report on progress' pg.27 Both of these locations are more atypical of the general BHCP context. Samples from much more challenged locations, albeit with more limited success, may more accurately reflect the chemistry involved in concocting exemplars	I am suggesting that documenting the positive lessons in a clear story will assist other poorer areas in seeing how DFs/VHVs could work better with health centres.