SECTOR ASSESSMENT (SUMMARY): HEALTH[1]

Sector Road Map

1. Sector Performance, Problems, and Opportunities

1. The Government of Papua New Guinea (PNG) and its development partners have made efforts to improve the health situation in the country. A sector-wide approach (SWAp) was initiated in the early 2000s to enhance government ownership and donor harmonization in the sector. This effort, however, has not led to the effective delivery of health services to the majority of the population, especially in rural areas. The latest health indicators showed mixed results, indicating a great need for systematic and targeted efforts to improve the health sector and the health status of the population.

2. Infant mortality and under-5 child mortality rates have been improving. Yet the latest figures show that infant mortality was 57 per 1,000 live births and under-5 child mortality was 75 per 1,000 live births in 2006, the second highest in the Pacific region. The immunization coverage indicates that the percentage of children under one year old receiving three doses of triple antigen or measles vaccine still remain around 60%.[2]

3. Maternal mortality, a major health concern in PNG, has been increasing in the past 10 years. In 2006, it was estimated at 733 per 100,000 live births, which was nearly double the estimate of 370 in 1996. It is also the highest in the Pacific region. Women in rural areas face a greater risk of maternal death than those in urban areas because of their limited access to reproductive health care. About three-quarters of rural women reported at least one antenatal visit during their pregnancy. However, only 47% of deliveries in the rural areas were assisted by professional health staff, compared with 88% of deliveries in urban areas. Moreover, 55% of deliveries by rural women occurred at home, compared with less than 13% of deliveries by urban women. Regional disparities are also evident in rural areas: women in the Momase Region were less than half as likely as women in the Islands Region to deliver with health staff assistance (32% versus 72%).

4. Communicable diseases (e.g., pneumonia, malaria, tuberculosis, diarrheal diseases) continue to be the main causes of morbidity and mortality in PNG. Despite being preventable, malaria and pneumonia are the two leading causes and account for one-third of all recorded deaths in PNG.[3]

5. PNG was declared to have a generalized HIV epidemic since 2004 when HIV prevalence for women attending an antenatal clinic reached 1%. Since then, efforts have been directed at preventing the spread of sexually transmitted infections (STI) and HIV/AIDS through increased awareness, distribution of condoms, and behavioral change programs. Efforts have also been made in establishing a better surveillance system, given the lack of capacity and systematic approaches for surveillance. The national prevalence rate as of December 2007 was estimated at 1.6%, with a total of 28,294 people diagnosed with HIV/AIDS. The HIV epidemic in PNG is driven by heterosexual transmission, including high rates of transactional sex. Reflecting this trend, the prevalence rate tends to be higher for females than males, especially for females

[1] This summary is based on data from National Statistical Office of Papua New Guinea (PNG). 2009. *Demographic and Health Survey: 2006 National Report*. Port Moresby. All health indicators regarding child and maternal mortality, and reproductive health care are from *Demographic and Health Survey*.

[2] Government of PNG, National Department of Health (NDOH). 2010. *National Health Plan 2011–2020.* Port Moresby (working draft, February 2010, volume 2, pages 111-113).

[3] NDOH. 2010. *National Health Plan 2011–2020.* Port Moresby (working draft, February 2010, volume 2, page 23).

20–24 years old.[4] The HIV epidemic is also increasingly becoming a rural problem with a higher prevalence rate in rural than urban areas. This poses a significant challenge for the country in controlling the spread of HIV/AIDS, given poor health services, limited transport and information, and low literacy rates in rural areas.

6. The health system has been deteriorating and health services, especially in rural areas, have become increasingly inaccessible to the population. Hundreds of rural health facilities have either closed or are not fully functioning.[5] Despite substantial financial support from donors, the health system functions poorly for several reasons, including lack of institutional and technical capacity to manage financial and human resources, lack of coordination by national and local governments, poor infrastructure and transportation access, and security issues.

7. Successive efforts to decentralize services have contributed to the declining capacity of the health system. With the introduction of the 1995 New Organic Law on Provincial and Local Level Governments, the responsibility for rural health services was transferred to provincial and local governments. This limited the role of the National Department of Health (NDOH) mostly to policy development, standard setting, coordination, and monitoring and evaluation.[6] Decentralization policies did not adequately address implementation issues, leading to the fragmented system where the role and authority of each government level is not well defined. For example, provincial governments were not obligated to allocate a specific portion of the budget for delivering health services. An analysis of provincial-level expenditures on health in 2008 found that provincial governments spent on average only 25% of what was needed to support a minimum standard of health services within the province.[7]

8. A lack of resources is a problem for some provinces and districts in the decentralized system. The biggest challenge, however, is the lack of proper financial flow, control mechanisms, and management capacity to utilize available resources effectively and deliver services to where they are needed most. Shortages of human resources for a growing population, low staff morale, and lack of community support for health services exacerbate the situation.

9. The current health problems in PNG, which are linked mainly to the heavy burden of communicable diseases and a lack of basic reproductive health care, indicate that large gains in health outcomes could be achieved through effective interventions focused on primary health care and health promotion. Strengthening primary health services with effective outreach services, such as immunization of children and educating women on the basics of safe childbirth, would improve the current poor health status of the rural population.

2. Government's Sector Strategy

10. The new National Health Plan 2011–2020, aligned with the PNG Vision 2050 and the Long-Term Development Strategy 2010–2030, sets out the government's health planning

[4] PNG National AIDS Council Secretariat and Partners. 2008 and 2010. *PNG: UNGASS Country Progress Report*. Port Moresby.

[5] Almost one-third of aid posts—the lowest administrative health facilities in rural areas—have been closed in the past 10 years. NDOH. 2008. *Annual Health Sector Review*. Port Moresby.

[6] J. Bolger, A. Mandie-Filer, and V. Hauck. 2005. *Papua New Guinea's Health Sector: A Review of Capacity, Changes and Performance Issues.* Canberra: AusAID.

[7] National Economic and Fiscal Commission. 2009. *Walking the Talk: Review of All Expenditures in 2008 by Provincial Governments.* Port Moresby. The figure (25%) cited here includes expenditures from provincials funds only, excluding expenditures from Health Sector Improvement Program (HSIP).

framework, with key results areas and strategies,[8] financing arrangements, a performance monitoring framework, and an implementation plan.

11. The goal of the National Health Plan is "to strengthen primary health care for all, and to improve service delivery to the rural majority and urban poor."[9] The plan introduces a new concept of "community health posts" for rural areas. Primary health deliveries and routine immunizations are expected to be conducted at these facilities with strong community involvement such as through community health volunteers.[10] This plan acknowledges the importance of extending partnerships with resource providers, private health care providers, churches, and nongovernment organizations at the rural health service level. Churches and other organizations currently provide almost half of the health services in rural areas. The NDOH is planning to specify roles, responsibilities, and authority for each level of government in relation to the National Health Plan.

12. In the early 2000s, the NDOH initiated a sector-wide approach, the Health Sector Improvement Program (HSIP), but few substantive outcomes have been produced. It has made progress in harmonizing donors' projects by minimizing project duplications and utilizing comparative advantages of each donor. A pooled HSIP donor trust account has been created under the program to support activities in capacity building for national and local governments, policy development, and financial and resource management, as well as to provide equipment, facility renovation, and medical and technical institutes support.[11] While the HSIP has assisted the NDOH in using the fund appropriately, there is a considerable burden for the NDOH and the provincial government staff to keep proper documentation for requisitions, slowing down the process of using the HSIP. The Asian Development Bank (ADB), the Australian Agency for International Development (AusAID), Global Fund, the New Zealand Agency for International Development (NZAID), and the United Nations (UN) are participating in the account, while other donors are waiting for more promising results.

13. The national government has introduced direct financial support to district governments. However, it has created a more complex financial and political arrangement for the NDOH and local governments in managing the health system. To streamline and provide more authority to provincial governments, the national parliament passed the Provincial Health Authority Act in 2007 which enables provinces to create a single provincial authority for the management of health service delivery within the province. The three provinces signed for pilot implementation in 2009 and the new National Health Plan expects to roll out the Provincial Health Authority to other provinces.[12]

3. ADB Sector Experience

14. An ongoing ADB project, HIV/AIDS Prevention and Control in Rural Development Enclaves, has increased the number of patients visiting rural health facilities for HIV/AIDS

[8] The eight key results areas are (i) improve service delivery; (ii) strengthen partnership and coordination with stakeholders; (iii) strengthen health systems and governance; (iv) improve child survival; (v) improve maternal health; (vi) reduce the burden of communicable diseases; (vii) promote healthier lifestyles; and (viii) improve preparedness for disease outbreaks and emerging population health issues.

[9] NDOH. 2010. *National Health Plan 2011-2020*. Port Moresby (working draft, February 2010, volume 1, page 10).

[10] The ideal type of community health posts will be staffed by three health workers skilled in maternal and child health, midwifery, health promotion, and community awareness programs (volume 1, page 12).

[11] NDOH. 2008. *2008 Annual Activity Plan; Health Improvement Branch*. Port Moresby.

[12] The three provinces are Milne Bay Province, Eastern Highlands Province, and Western Highlands Province.

testing and treatment through health partnerships in the targeted rural areas.[13] Under the current partnership model, six private companies collaborated with the government in renovating health facilities and providing health training for health workers and communities on HIV prevention and care. The project has demonstrated that health partnership is an effective strategy to enhance operational efficiency and improve the delivery of health services in rural areas. This model can be expanded to deliver more comprehensive rural health services. The government acknowledged the advantages of the partnership model and introduced it in the National Health Plan 2011–2020 as an innovative approach to make partnerships with resource providers, private health care providers, churches, and nongovernment organizations for more effective service delivery.

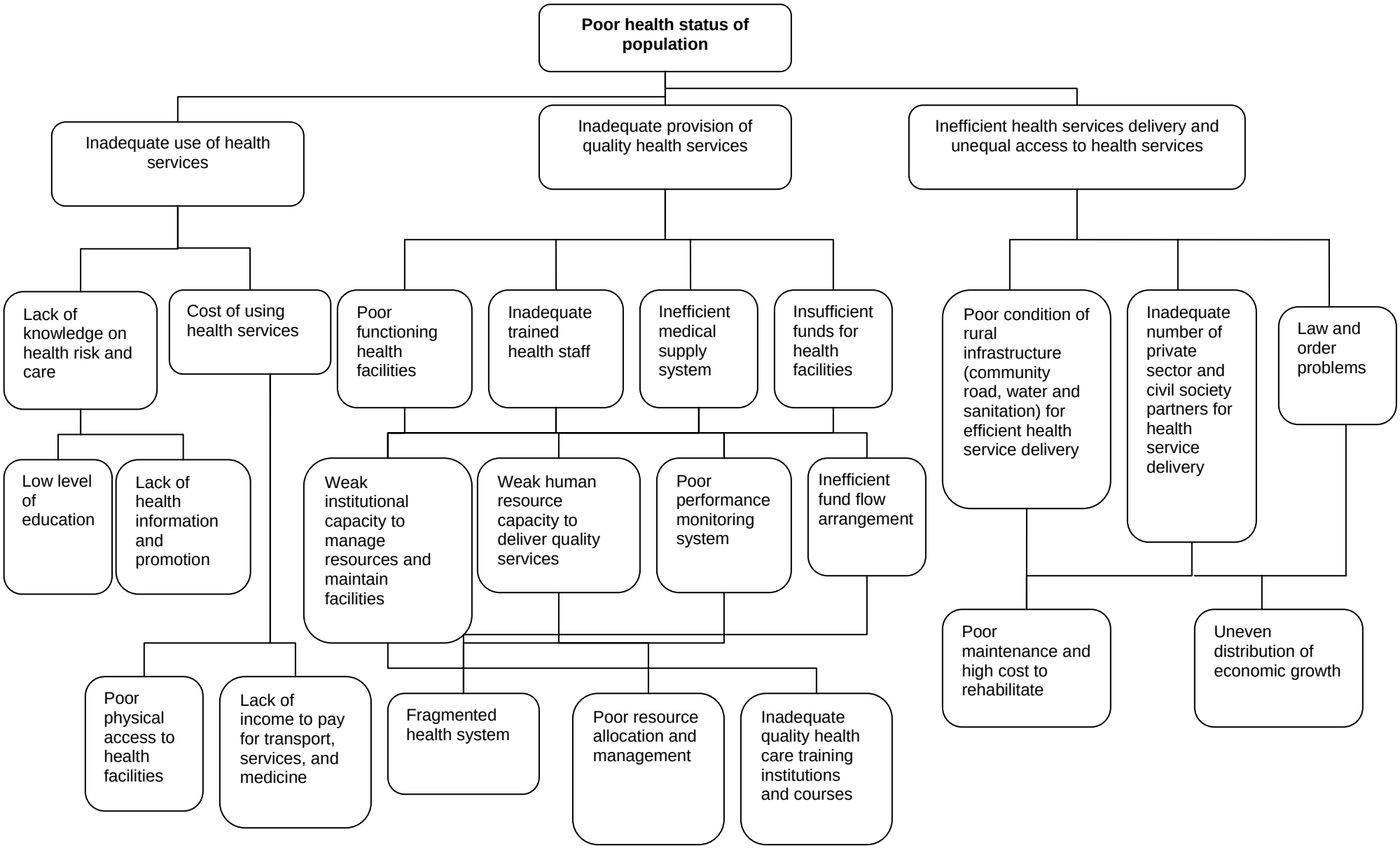
15. ADB will continue to assist the government with a new project for *Strengthening Rural Primary Health Services Delivery*. ADB is assisting the NDOH through project preparatory technical assistance (TA) to develop details of the community health post concept as a step toward strengthening service delivery in rural areas. The TA will also assist with producing costing tools for resourcing rural primary health services, and provide baseline information to support NDOH's implementation plans for community health posts. ADB's assistance builds on its previous TA for Health Sector Support,[14] which included (i) costing analysis for facility-level primary health services to help the government's planning for health financing; and (ii) government contracting models with private entities for more efficient health service delivery. The new project on rural health services (expected in 2011) will contribute to establishing quality primary health services through partnership models and other mechanisms.

16. Other development partners are also supporting the finalization of the National Health Plan 2011–2020. AusAID assists with strengthening the government's financial management, service delivery, governance, technical and capacity training, and HIV/AIDS programs. The United Nations (UN) has been undertaking programs under the One UN Initiative since 2008 for a more collective program approach in PNG. The Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO) are the key UN organizations that provide TA to address tuberculosis, malaria, HIV/AIDS, and maternal and child health. The World Bank is reviewing the level and capacity of human resources in the health sector. All program areas assisted by development partners will be important for the new ADB-financed project, since the effective delivery of rural health services would greatly depend upon the government's institutional capacity to manage financial resources and its technical capacity to prevent communicable diseases and provide quality reproductive health care.

[13] ADB. 2006. *Report and Recommendation of the President to the Board of Directors: Proposed Asian Development Fund Grant to Papua New Guinea for the HIV/AIDS Prevention and Control in Rural Development Enclaves Project.* Manila (Grant 0042-PNG).

[14] ADB. 2006. TA4882-PNG: Health Sector Support in PNG.

Problem Tree for the Health Sector Sector



Source: Asian Development Bank

Sector Results Framework (Health, 2011–2015)

Country Sector Outcomes		Country Sector Outputs		ADB Sector Operations	
Outcomes with ADB Contribution	**Indicators with Targets and Baselines**	**Outputs with ADB Contribution**	**Indicators with Incremental Targets (Baselines Zero)**	**Planned and Ongoing ADB Interventions**	**Main Outputs Expected from ADB Interventions**
Increased and more equitable utilization of quality primary health services in rural catchment areas	Number of patient visits by gender and age (from 1.4 per person in 2007 to 2.5 in 2015) Percentage of pregnant women receiving at least one antenatal care (from 61% in 2008 to 66% in 2015) Percentage of children under 1 year old receiving DPT3 immunization by gender (from 61% in 2008 to 70% in 2015)	Increased and more equitable access to primary health services in rural areas	Number of renovated or rehabilitated rural health facilities (increased by 80 in 2015) Number of health facilities with minimum necessary medical equipment installed (increased by 80 in 2015) Number of health facilities with the required number of trained health professionals (increased by 80 in 2015) Increased population with new access to rural health services by gender and age (increased by 20% in 2015) Estimated percentage of population with awareness of new health facilities (increased by 50% in 2015)	**Planned key activity areas** Rehabilitation of rural health facilities and provision of minimum standards for quality primary health care services in rural catchment areas. **Pipelined projects with estimated amounts** Support for Strengthening Rural Primary Health Services Delivery (2011 loan, $20 million) **Ongoing projects with approved amounts** HIV/AIDS Prevention and Control in Rural Development Enclaves Project (2006 Grant 0042, $15 million)	**Planned key activity areas** **Pipeline projects** Rehabilitation of community-based rural health facilities Capacity development for human resources in the rural health sector Implementation of health promotion programs in rural communities by nongovernment organizations or civil society Strengthened relationships between local governments and non-state service providers **Ongoing projects** Rehabilitation of health facilities in rural development enclaves through health partnerships HIV/AIDS prevention activities through behavioral change programs and improved access to condoms Strengthened and expanded national behavioral surveillance for HIV/AIDS

DPT = diphtheria, pertussis, and tetanus
Source: Asian Development Bank