Involving the Private Sector in Rural Health Service Delivery

INTRODUCTION

Health indicators in Papua New Guinea (PNG) are poor, with infant mortality rate at 48 deaths per 1,000 live births in 2012 and maternal mortality rate at 230 per 100,000 live births in 2010.¹ These estimates are relatively high compared with regional and global averages.

Communicable diseases remain the leading cause of morbidity and account for about 44% of deaths in 2011.² In particular, the prevalence of HIV and AIDS in PNG is an ongoing issue, although more recent figures show that the epidemic has not reached the levels predicted. The number of HIV diagnoses in the country has increased since the mid-1990s with the rollout of rapid diagnostic testing through voluntary counseling and testing as well as provider-initiated counseling and testing (see Figure).³ While PNG has the largest HIV epidemic in Oceania, it is categorized as a concentrated HIV epidemic (as opposed to generalized epidemic) with an estimated prevalence in 2013 of 0.82% of the population aged between 15 and 49 years in urban Highlands areas, 0.28% in the Momase region, and 1.06% in the national capital district.⁴

HIV prevalence is mostly concentrated in rural development enclaves, which are the local centers of economic activity related to corporate agriculture and mining and whose populations usually have higher disposable income and subsequently higher trends of transactional sex.

The management of primary health care in the country started to decentralize in 1998 through the Organic Law on Provincial Government and Local-Level Government. Over the years, the capacity of provincial governments to deliver quality health services has generally been declining. Funding for

¹ Online database of the World Health Organization.
³ There was no national surveillance system until 2010.
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Involving the private sector in rural health service delivery depends largely on provincial government priorities. Most rural health services are not a priority and hence underfunded.

In rural areas, partnership with nonstate actors is essential to improve access to and quality of health services. For many years, the PNG Government has been in partnership with the churches in delivering rural health services. The rural development enclaves test the usefulness of other partnerships such as with the private sector.

Such partnerships are in line with the government’s Vision 2050 and Development Strategic Plan 2010–2030. The plan calls for a joint effort among all stakeholders, including the private sector, development partners, churches, civil society, and community-based organizations. Likewise, the National Health Plan (2011–2020) includes in its key strategies the expansion of public–private partnerships (PPPs). Addressing PPP, the National Department of Health (NDOH) created the National Health Sector Partnership Policy in 2013.

This publication describes a project using PPPs to improve primary health service delivery in selected rural development enclaves of PNG, with HIV as the entry point. The lessons from the project can help guide the government in future partnerships with the private sector in the delivery of rural health services.

THE RURAL ENCLAVES PROJECT

In 2006, the Asian Development Bank (ADB), in collaboration with the Governments of Australia and New Zealand, provided a $22 million grant to the PNG Government to help the country manage responses to the HIV epidemic focusing on high-risk rural areas such as the rural development enclaves.5

The resulting project, i.e., the HIV/AIDS Prevention and Control in Rural Development Enclaves Project (or simply Rural Enclaves Project), was carried out with six private companies operating in eight provinces across the country.

The project ran from 2006 to 2012 and had three components:

- Establishing PPPs and interagency partnerships in rural enclaves to extend and improve rural health service delivery and HIV prevention and care;

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5 ADB contributed $15 million and the governments of Australia and New Zealand $7 million. Meanwhile, the Government of PNG contributed $3 million.
6 Six companies include Barrick (Kainantu) operating in the Gulf, Southern Highlands, and Hela provinces; Porgera Joint Venture in Enga province; Ramu Agri Industries in Madang mainly and extending to Morobe province; and WR Carpenters & Co. Estates in Western Highlands and Jiwaka provinces.
rehabilitate rural health infrastructure; upgrade facilities for HIV prevention, testing, and care; train health workers; and develop leadership for HIV advocacy;

- Changing community behavior and social marketing of condoms and strengthening the capacity of church leaders and health workers; and

- Strengthening and expanding HIV surveillance system by supporting the NDOH to establish a national HIV surveillance system.

Using PPP arrangements, selected rural enclave operators assisted in rehabilitating rural health infrastructure for primary health care and upgrading health facilities for HIV prevention, testing, and care by providing management and supervisory support to civil works. The rural enclave operators allowed the use of their own vehicles and company housing for the contractors' accommodation, and provided minor logistical support. They were also expected to restructure their own health services to continue with surrounding communities and expand HIV preventative services along with other primary care services.

**EXPERIENCES FROM THE RURAL ENCLAVES PROJECT**

The project contributed to improving not only HIV prevention and care activities but also the overall primary health services in rural communities within the enclaves. HIV activities are one component of health service delivery in rural areas where the need for quality primary health care remains high. The project exceeded its targets with 154 buildings renovated at 78 health facility sites. It also provided general medical equipment for primary health care to each of the renovated health facilities and ensured the availability of CD4 machines in each enclave to enable specialized HIV services. There was a notable increase in the number of people from surrounding communities accessing these health services. The project reached more than 250,000 people living around the supported enclaves. All rural enclave operators agreed that the project improved

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7 The government provided comprehensive HIV treatment and care based on NDOH HIV Management Guidelines. This included provision of prophylactic or preventive treatment, antiretroviral therapy, and supportive counseling for medication adherence and safe sex practices.

8 These machines are used to count the CD4 T lymphocytes in a patient's blood to determine the stage of HIV infection, which then helps the clinicians know when to start HIV patients on life-saving therapy.
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public relations and fostered goodwill with local communities.

The people responded well to increased access to HIV testing and services at the project-supported health facilities. In 2010, a viable HIV surveillance system set up through sites in 16 provinces were reporting on HIV. More than 56,000 HIV tests were recorded at the project-supported health facilities by the end of 2010. Toward its end, the project provided supervision, equipment, and training to 111 facilities. Population Services International reported increased awareness of healthy sexual behavior during a qualitative survey. More than 4 million condoms were distributed. Their use, especially with casual partners, increased from 67% in 2008 to 77% in 2010.

However, broader health system constraints have impacted ongoing sustainability of project outcomes. Only 50 of the 111 supported health facilities could provide HIV testing by the end of 2011 because of the unavailability of test kits caused by national logistical challenges, and because of the constraints related to inadequate supervision and management. The project relied on the enclave operators, who, in partnership with the district and provincial health officers, provided the resources and oversight to ensure effective delivery of services. Yet the supervision of and monitoring by the district and provincial health officers was sporadic in some provinces.

Project sustainability also relied on buy-in from private sector partners. The facilities within company boundaries generally offered a good standard of service to their workforce and immediate communities, but only one rural enclave operator could move outside company boundaries to provide supervision and support for government and church health facilities.

The project showed that PPPs could be an effective way to expand rural health services for HIV prevention and care as long as clearly defined partnership agreements with and expectations from private sector partners are made. Not all project-supported enclaves were successful because of varying levels of commitment, health service delivery capacity, resources, and company policy constraints.
LESSONS FROM THE RURAL ENCLAVES PROJECT

Partnership Memorandum of Agreement Must Be Realistic

Development of a PPP should take all project aspects into account. Partnerships in the rural enclaves project were set up through memoranda of agreements (MOAs) signed by the rural enclave operator, NDOH, and provincial governments. In the project design, the government envisioned the MOAs to be tailored to each rural enclave’s health and HIV needs. However, the MOAs were drafted using a standard template oriented toward the civil works components as compared with the health promotion, staff training, and supervision components. Future MOAs setting out PPPs for health should

- be based on a realistic assessment of capacity of all partners and current health service standards (civil works, public health, clinical service delivery, and health promotion);
- be tailored to specific community needs, requirements of the private sector partner, and provincial health plans and priorities;
- spell out clear roles and responsibilities of each partner and list the agreed upon annual targets and deliverables; and
- include mechanisms for review of the performance of each party with regard to agreed upon targets.

An informed capacity assessment should always be the foundational activity to defining any PPP and identifying what needs to be set out in the MOA. The process will also identify partners with whom the government could work to deliver services and be included in joint planning exercises and stakeholder meetings.

Be Specific

New partnerships could start around specific issues that all partners clearly want to address. Building a relationship among enclave operators, government, and churches takes time. It may be useful to start collaborating on a specific issue, and then further develop collaboration with a broader scope and agenda. When success is achieved, partnerships can evolve to address more complex issues.

In the rural enclaves, some companies were concerned about the rising incidence of HIV and had already begun HIV testing and treatment services. The project harnessed this opportunity with partnerships emphasizing HIV prevention and control.

The expectation was that the government and church health facilities would function more effectively with technical, managerial, and logistical support from the enclave operators. However, most enclave operators had difficulty following through...
with provision of regular support to health services in their areas, given their main priority was their own business and workforce productivity. A phased approach could have been adopted in the partnership arrangements to allow for assessment to take place before extending the scope of private sector’s obligations.

Understand the Advantages of Each Partner

Each partner brings skills, expertise, and experience that need to be recognized. Every partner has objectives and benefit expectations, which should be realistic and transparent. Benefits and expectations can be understood after an informed capacity assessment.

In the enclaves project, support to government health facilities posed accountability risks to enclave operators because issues can arise that are beyond their control, such as unqualified church and government clinic staff and irregular drug supply from the area medical stores. Coordinating primary healthcare activities in the province is the role of provincial and district health officers, and lack of staffing and supervisory skills limited the effectiveness of the partnership.

Other concerns during the project included (i) whether it was reasonable for enclave operators to follow government or ADB procedures for civil works, and (ii) who would handle disputes with landowners about government or church facilities as these were beyond the enclave operators’ responsibility.

A solution to these concerns would be an initial discussion on such constraints. In preparing the agreement, each partner will benefit from being specific about its roles and functions and accordingly outline its limitations as well as expertise and skills. Benefits and shared risks should be known and understood by all parties.

Local Needs Require Local Ownership

Partnerships and collaboration among various partners must be established on the basis of local needs and capacity, with local health authorities leading the process. The involvement of the provincial administration officers and provincial health managers during project design and in every step of project management is key to strengthening their commitment and building their ownership of project outcomes. They can help find funding and resources in the long run. Provincial health department staff will benefit from technical assistance in setting up partnerships and enhancing their capacity to coordinate health service delivery in their province. NDOH may consider providing technical support in this regard.

Practical ways in which the government and private sector can help make a partnership work include joint planning meetings, alignment of private sector activities with provincial plans, joint monitoring and supervisory visits, joint training activities, regular review meetings, and keeping up a dialogue that can build trust and respect.

Appoint a Focal Point to Sustain Commitment

A facilitator or focal point in both the government and the enclave assists in coordinating and bringing parties together on a regular basis. With this responsibility, the government facilitator should not be a temporary hire for the duration of the project. In the enclaves project, the provincial or district health manager facilitated partnerships, but often relied on the project staff.

Each enclave operator was to provide a focal point person dedicated to managing project activities locally. Operators that had a focal point position were the most successful. With a focal point person, relationships with other partners improved.

Civil works, health facilities, and staff houses were a large component of the project, overseen by the enclave operators. The focal point person or local project manager followed through on agreements, followed up on civil works, negotiated with local contractors and did troubleshooting. They also did regular monitoring and liaised with provincial and district health managers for supplies and joint supervisory visits.

However, when such a local project manager left the enclave site or the company, the others did not pick up his or her responsibilities. Commitment needed to come from senior management to ensure that support was maintained. With support from senior management, one operator expanded staff and negotiate separate agreements with the Evangelical Church of PNG to support some of the church’s health staff and facilities.
The project set up a coordinating committee on each site with membership made up of MOA signatories to ensure that all parties were communicating and working together and resolving any problems. However, the committees met irregularly and lacked strong commitment. Such meetings need a clear purpose and agenda. One enclave operator restructured the meetings to make them more relevant to all partners; their meetings became the venue to share information and conduct training for the local health service providers.

While supervision should be supportive, activities have to be monitored and evaluated regularly to keep them on track. This requires local data collection and immediate analysis by supervisors and feedback to the staff. Local staff and local partners need to understand and monitor their progress by themselves.

Experience from the project showed that joint supervision of the government and enclave staff during construction and upgrading of health facilities quickly sorted out issues.

**Supervision Must Be Supportive**

Supportive supervision of health workers and practices is essential before improvement in health access and delivery can be made. District health managers need to be more active in overseeing service delivery. Poor clinical supervision contributed to less than half the HIV testing centers remaining functional by 2011. The project provided a monitoring checklist to the focal point of all rural enclave operators to be used for their monthly support visits. One operator adapted the checklist more innovatively by changing the monitoring approach from “ticking boxes and judging staff performance” to an approach that guided staff in solving issues. This approach improved staff motivation and performance.

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**Stronger Government Participation Is Needed**

Increased participation of the national and provincial governments is necessary to propel service improvements in districts. Funding agencies and government need to build on the experiences of the rural enclaves project to ensure the right enabling conditions for effective service provision. This includes maintaining the investments in health facility infrastructure; providing regular supervision, training, and retraining of staff; and maintaining equipment and supplies.

Regular visits to clinics and health centers by district health managers and provincial health specialists will help them keep abreast of what needs
Integrate Public Health Programs into Primary Health Care

Integration is cost-efficient for the health system, allowing a single solution to similar problems that occur in different public health programs. Integration of HIV services into primary health-care services proved beneficial in the rural enclaves project. Assessing the impact of linking the tuberculosis control program with HIV activities, for instance, could be done to fully understand the gains of this approach.

Find Ways to Sustain the Activities

Enclave operators could explore the feasibility of using the government tax credit scheme to fund activities to continue the work started under this project. The private sector makes it clear that, while they are willing to support the government in improving health services, they are not willing to pay for government’s responsibility. While some operators are using their own funds to extend health services to the local communities, it cannot be assumed that they will continue to do so without some government assistance.

Private sector companies have been using the tax credit scheme to support social sector activities in local communities around their sites. Where applicable, this scheme could also be used to fund activities that began during the project. For this, NDOH could take the lead to negotiate the conditions of a tax credit scheme with the Department of Treasury to support rural health services. Trust funds and foundations are other mechanisms for sustainable financing.

Collaborate with Other Sectors to Improve Health Nationwide

National and provincial health authorities need to take advantage of all possible avenues of collaboration to improve people’s health. Some sectors, like infrastructure, water supply and sanitation, energy, and education, can have a huge impact on the health of the population. To take all possible impacts, positive or negative, into account, national and provincial health authorities should seek more collaboration and partnerships within the government.

Physical infrastructure, such as health facilities, staff housing, and roads, are essential for health service delivery, especially in rural areas. However, building a health center is not enough; the health center must also be accessible to both the communities and health service providers. This should be taken into consideration when planning new roads and other infrastructure projects.