Moving Toward a Sector-Wide Approach

Papua New Guinea

The Health Sector Development Program Experience

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Foreword

This report reviews the genesis, experiences, achievements, and remaining challenges of the first Sector-wide Assistance Program in Health in Papua New Guinea. The Health Sector Development Program (HSDP) was developed as part of the donor assistance to the economic recovery program of the mid-1990s. The HSDP supports the implementation of the Government Health Plan, 1996-2000, and the "organic law" reform process. The HSDP has led to improved health management and improved governance. Challenges remain. The HSDP did not succeed in preventing the slow and steady collapse of the health system in rural areas. A recent review of the health sector revealed the lack of performance based public service, the lack of prioritization of health services, a sound health policy but a lack of implementation, inadequate supervision, and inadequate focus on service delivery.

The report was prepared by Maryse Dugue and John Izard.

This report has been produced by the ADB so that all concerned with promoting the health of the people of Papua New Guinea may better understand what has been, and can be achieved and what more needs to be done. The report is entrusted to a wide readership.

JEREMY H. HOVLAND
Director General
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Contents

Abbreviations

ADB	Asian Development Bank
AGO	Auditor General's Office
AusAID	Australian Agency for International Development
CEO	chief executive officer
DALY	Disability Adjusted Life Years
DNPM	Department of National Planning and Monitoring
DOF	Department of Finance
DPALLG	Department of Provincial Affairs and Local Level Government
DPM	Department of Personnel Management
ERP	economic recovery program
FMIP	Financial Management Improvement Program
FSM	Federated States of Micronesia
HDI	Human Development Index
HEO	health extension officer
HPI	Human Poverty Index
HRD	human resource development
HSDP	Health Sector Development Program
HSIP	Health Sector Improvement Program

IMF	International Monetary Fund
IMR	Infant Mortality Rate
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
NCD	National Capital District
NDOH	National Department of Health
NZAID	New Zealand Agency for International Development
PCC	Program Coordination Committee
PDMC	Pacific Developing Member Country
PGAS	PNG Government Accounting System
PHA	Provincial Health Advisor
PHO	Provincial Health Office
PNG	Papua New Guinea
QALY	Quality Adjusted Life Years
SWAp	Sector-Wide Approach
TA	Technical Assistance
WB	World Bank
WHO	World Health Organization

Summary

While considerable health gains had been made in the first decade after Papua New Guinea's independence in 1975, progress in a number of key indicators has slowed since the early 1990s. The deterioration of health services has complex causes. A major causal factor was the macro-economic crisis of 1994–1995. Imbalances in Papua New Guinea's fiscal performance in the early 1990s resulted in a precipitous halt of government spending on goods and services in 1994. This was followed by an economic rescue effort by the International Monetary Fund (IMF) and the World Bank (WB), assisted by both Australia and Japan, in 1995–1996. The economic recovery package provided for government policy to redirect spending to the social sector, particularly in health and education. These events established a framework conducive to a health sector program loan as part of the overall rescue effort.

Assistance to the health sector in Papua New Guinea had focused in the 1980s and the early 1990s on improving access to rural health services by investing mainly in infrastructure (aid posts, health centers, staff housing). Evaluations did confirm the improved physical accessibility to health facilities in many remote parts of the country, but did show that extending facilities did not solve the problems of closure or limited operation of facilities due to shortage of staff, insufficient drugs, malfunctioning equipment, and poor maintenance of buildings.

The public health system had tried to cope with the situation essentially without any change in its management style. A series of reforms and policy initiatives were identified as critical to reverse the declining trend of health services. This paper describes and discusses the innovations brought to the health sector by the Health Sector Development Program (HSDP), which was designed to support the implementation of

long-term reforms. Focusing on the whole sector with a major emphasis on performance of rural health service delivery, the HSDP presented a fundamentally new approach to the assistance to the health sector. The HSDP was prepared and implemented at a time when a new law on decentralization of all Government's services and activities was passed. This new law has transferred the responsibility of rural health service to the local level governments, limiting the role and responsibility of the National Department of Health (NDOH) to policy support, technical and quality standards setting, and monitoring and evaluation. Launched without sufficient preparation for its implementation, it has proved extremely disruptive for the health system, breaking down the vertical integration that is essential to ensure a strong link between policy development and implementation.

In this difficult context, the HSDP has supported and allowed testing of some elements of the sector-wide thinking in the NDOH, at a time of growing dissatisfaction of the government with the increasing difficulty of managing numerous projects, and of donors with the disappointing performance of project-based assistance. Government legislation, systems and regulations have served as the foundation for all public health sector strengthening and HSDP-specific processes. Procurement under the HSDP has been guided by the Public Finance Management Act, and accounting has used the Government's accounting system. The implementation of the HSDP has also contributed to the strengthening of the Department of Finance and other government agencies, which in turn has assisted the reform process in the NDOH and the public health sector. Monitoring and regular standard reporting encouraged, in most instances, an acceptable level of compliance to procedures. A program of performance audits in the provinces has supported the continuous efforts to maintain standards consistent with the government's Public Finances Management Act.

A review of the financial management, accounting, and reporting mechanisms established under HSDP commissioned by the Australian Agency for International Development (AusAID) in early 2000 concluded that the systems and procedures put in place were consistent with AusAID standards. This encouraged AusAID to join the mechanism, followed by the New Zealand Agency for International Development. This was a critical step toward the progressive establishment of a Sector-Wide Approach

(SWAp) in the health sector.

A SWAp is a process in which all funding supports a single sector policy and expenditure program. The government leads the planning and implementation processes, and common—ideally government—management procedures are adopted by donors. A certain degree of consensus has been reached among donors at the end of the 1990s that SWAp offers a better prospect to achieve sustained improvement in health systems than the piecemeal pursuit of separately financed projects. Achieving better health outcomes in Papua New Guinea is a priority for the Government and the donors, and therefore the SWAp is being progressively adopted as a framework for assistance.

While the building blocks of a SWAp are now in place, a number of other mechanisms have to be set in order to progress toward a better integration and coordination of assistance to the sector. Achievements, however, will in time depend on improved economic and political stability in Papua New Guinea.

Chapter 1

Introduction

Background

Imbalances in Papua New Guinea's fiscal performance in the early 1990s resulted in a precipitous halt of government spending on goods and services in 1994. This was followed by an economic rescue effort by the International Monetary Fund (IMF) and the World Bank (WB), assisted by both Australia and Japan, in 1995–1996. The Economic Recovery Program (ERP) provided for government policy to redirect spending to the social sector, particularly in health and education. These events established a framework conducive to a health sector development program loan as part of the overall rescue effort.

The Health Sector Development Program (HSDP)[1] is the first sector-wide assistance program in health in Papua New Guinea. The policy-based loans were designed to support the implementation of the government's National Health Plan 1996–2000 and they reflected the reform process embodied in the *Organic Law on Provincial Governments and Local Level Governments* passed in 1995, adjusting and completing the process of decentralization begun after Independence. Implementation of HSDP coincided with the progressive institution of the National Health Administration Act (1997) and began in 1998.

The reform process initiated under HSDP introduced a framework, which established a working relationship between the National Department of Health (NDOH) and the provinces, in line with the *Organic Law on Provincial Governments and Local Level Governments*, and to which other Departments and government agencies are also party. Management innovations were instituted, creating an environment of greater transpar-

ency and accountability. Issues related to performance began receiving greater attention and public service officials have become increasingly responsive to governance issues. This is of fundamental importance in a country where public spending on health hardly translates into a larger supply of effective health services, due to inefficiency, poor accountability, and lack of transparency in public service provision.

The Land and the People

Papua New Guinea presents a challenging environment, with its rugged terrain, extreme population dispersion, complex land tenure systems, a serious peace-and-order problem, and poor human resource development.

Geography and Climate

The country forms the eastern half of the island of New Guinea, the world's second largest island. The western half of the island is the Indonesian province of Irian Jaya. The northeastern tip of Australia lies just to the south and Solomon Islands is to the east. It has a total land area of 461,691 square km, with the mainland making up 394,765 square km and approximately 600 smaller islands constituting the remaining 66,926 square km. The largest of these islands are New Britain, New Ireland, North Solomons and Manus.

The mainland is dominated by a rugged central mountain range running east to west that rises to 4,509 m at Mt. Wilhelm. Principal rivers include the Fly, Sepik, and Ramu that drain south, north, and east respectively. The Fly River forms a vast swampy delta plain in the southwest. The major islands are mostly volcanic in origin, with rugged relief and enclosed by coral formations. Volcanic and seismic activity is common along the north coast of the mainland and in the islands. Nearly three-quarters of Papua New Guinea is covered by dense tropical rainforests.

The climate is generally hot, humid, and wet the whole year. Temperatures are fairly consistent along coastlines, ranging from 25 to 32 degrees Celsius. In the Highlands, the temperatures are cooler, especially during the dry season. Rainfall averages 2,000 mm to 2,500 mm most of

which falls during the rainy season (December to March in most places). Some extreme rainfall areas (West New Britain, Gulf, Western provinces) receive as much as 9,000 mm. The *El Niño* climatic event can severely disrupt weather patterns in Papua New Guinea. Its 1997–1998 occurrence produced widespread drought that affected the Highlands and many islands and resulted in famine conditions for nearly a quarter of the population.

Language and Religion

PNG is noted for its cultural and linguistic diversity. Approximately 750 indigenous languages are spoken, each a defining characteristic of a clan. The principal lingua franca is Melanesian Pidgin, widely spoken in and around most urban centers in the country. Hiri Motu is spoken along the southern New Guinea coast. English is the language of education, administration, and commerce. It is not uncommon to speak three or four languages: *tok ples*, or one's mother tongue; Pidgin and/or Hiri Motu; and English.

Christian churches, both Protestant and Catholic, are widely represented and found even in remote villages. Indigenous religious beliefs and practices—often based on magic, the atonement of spirits, and the observance of taboos—coexist with western Christian beliefs. While Christian churches and missions have contributed substantially in developing health and education services, traditional values and practices predominate in every day life.

Population and Poverty

Based on final figures from the 2000 census, the total population as of July 2000 was 5,190,786, with males comprising 51.9% and females 48.1%. Forty-two percent of the population is under the age of 15. The average annual growth rate (1980–2000) is 2.7%. The Highlands region is the most populous with 38% of the total population.

A great majority of the population (85%) lives in the rural areas and the remaining 15% is urban-based. However, many urban dwellers return frequently to their villages for long stays and could be considered temporary residents. In an annual cycle of internal migration, a large propor-

tion of urban residents return to their native village during the months of December and January.

Among Pacific countries, Papua New Guinea's Human Development Index (HDI) is the lowest, and the poverty incidence, as measured by the Human Poverty Index (HPI), the highest.

A poverty study in 1996 concluded that:

- approximately 37% of the population lived below a poverty line of US$350 per year (1996 prices);
- 93% of the poor lived in rural areas;
- the Gini coefficient of household expenditure (0.46) was high compared with countries of similar income levels;
- approximately 17% of the population cannot meet the basic requirement of 2,200 calories per day per adult equivalent, even if they spend all their income on food; and
- while overall literacy is assessed at 52%, 31% of males and 49% of females have never completed primary school.

Poverty and low levels of human development have an important gender dimension. Although it has improved over time, the gender-related development index is lower than the overall HDI at the national level and for all provinces. This illustrates that life expectancy, income, and educational achievements of women are universally lower than those of men. Although men and women have equal rights under the constitution, gender inequality remains a severe impediment to development and one of the most visible violations of human rights.[2]

Papua New Guinea Society

The more than 750 languages spoken in Papua New Guinea translate into as many different cultures. The high degree of ethno-linguistic diversity has a profound impact on the country's social and economic performance. It has been shown in particular that cross national variations in either under-5 or infant mortality is influenced negatively by the extent of ethno-linguistic differences within a country, whatever the level of public spending on health.[3] Tribal fights and tensions are common, arising from disputes between clans over the control of resources. Studies[4] have found that the control of public policy is less effective the higher a society's polarization and degree of social conflict, resulting in higher

public spending but a lower supply of public goods.

Civil society in Papua New Guinea is under pressure to change. The country is rapidly adapting to the modern world, but most of the population still live in small villages on subsistence farming. There is a stark contrast in living conditions, cultural attitudes, and the level of development between most rural areas and the western type of environment in the major cities. The speed of change imposed on rural communities in just one or two generations are beyond any comparison with the speed of changes that have occurred in the industrialized countries or even many other developing nations.[5]

Central to Papua New Guinea society is the sense of obligation to and the broad responsibilities for the extended family. Assistance or help is given as a duty but also with the understanding that equal value is owed and will be returned. Contributions, for example, towards bride price, death feast, school fees, and construction—in currency or in kind—are entered into a spoken, unwritten ledger shared among clan members. The intricate web of mutual obligation and the opportunity for some to achieve high standing is the foundation of the *wantok system*.

In most traditional settings, the wantok system provides for an egalitarian sharing of wealth and responsibilities. It provides a safety net not unlike social security but with strong community obligations. While the wantok system procures advantages for the clan, it often does so at the expense of modern social and professional obligations, which go beyond the boundaries of one's extended family or clan. In particular, "the concept of common good does not seem to have taken root in the culture."[6]

In the political arena, the wantok system undermines the democratic process as many candidates run not on the basis of a political platform but rather on the promise of future wealth shared. In the public service, the wantok system leads to much conflict of interest and nepotism. The obligations to the clan frequently supercede the responsibilities of a specific administrative function and the obligations to larger geographic (district/province) or national interests.

Government, Administration, and Infrastructure

The head of state is the British sovereign, represented by a governor-general. The head of government is the prime minister who is assisted

by the National Executive Council (Cabinet). The government is responsible to the National Parliament, a 109-member body (one representative for each of the 89 districts and one for each province and the National Capital District [NCD]) elected for five years by universal adult suffrage. Successive governments have been based on coalition arrangements.

The *Organic Law on Provincial Governments and Local Level Governments* (1995) provides for three levels of government: national, provincial, and local level. The country is divided into 19 provinces and the NCD. All provinces have their own provincial government. Each province is further subdivided into districts, from one to nine in number depending on the province, and of which there are a total of 89. There are, in principle, three local level governments to each district.

Each province has a provincial capital whose population, along with that of the National Capital District, is considered to make up the country's urban-based population (15%). Travel between the provincial capitals and to/from NCD is almost exclusively by air and defines the national airline carrier network. A key strategic road is the Highlands Highway, which links the provinces of the Highlands together, and the entire region to Lae and Madang, both important seaports. Other road infrastructure is predominantly local. Sea travel and freight between coastal provincial capitals and some coastal towns are undertaken by several shipping companies.

Lack of maintenance has resulted in a serious deterioration in the transport infrastructure. Most rural roads have lost their surfacing and many bridges have collapsed. As a result, trips that once took a few hours can now take days, and some roads are only passable in dry weather.[7] The gradual decline of roads, shipping and airlines over the past decade has reduced the delivery of services. This situation has been compounded by declining government budgets.

ADB's Pacific Strategy

The Asian Development Bank (ADB) operates in 12 Pacific developing member countries (PDMCs).[8] The Pacific strategy for the new millennium responds to five key development challenges facing the PDMCs over the medium term: (i) disappointing macroeconomic and growth performance

over the last decade; (ii) increasing poverty, particularly in Papua New Guinea, Solomon Islands, and Vanuatu; (iii) continuing reliance on large government investments due to inadequate private sector response; (iv) increasing environmental degradation; and (v) little progress in strengthening the role of women in political, economic, and social spheres.

To address these challenges, six key variables are: (i) vulnerability of the Pacific island economies, because of their remote locations, narrow resource base, susceptibility to natural disasters, and the influence of the global markets; (ii) political instability and good governance; (iii) limited availability of skilled human resources; (iv) the wide range of sociocultural factors influencing politics and productivity; (v) rising population growth rates; and (vi) inadequacy of physical, technological, and financial infrastructure necessary to underpin sustainable growth.

ADB's Pacific strategy focuses on five broad strategic objectives: (i) continuing support for economic, governance, and public sector reform; (ii) promoting private sector development in the region; (iii) promoting a more active role for women in social, economic, and political spheres; (iv) supporting sustainable environmental management; and (v) supporting poverty reduction as a unifying theme.

Papua New Guinea's fundamental development problem is ensuring that most of the population participates in and shares the benefits of economic growth. The levels of social indicators remain extremely poor, especially for women, due to past under-expenditure on providing essential services and inadequate development management. To reduce poverty, ADB's strategy in Papua New Guinea emphasizes improving the quality and efficiency of public sector management as well as creating an enabling environment for private sector development. Progress in achieving the Millennium Development Goals (MDGs) will require increased and sustained public investment in the education and health sectors. ADB is helping to improve public sector financial management under an ongoing loan project. Program assistance is being provided for public service improvement, encompassing improved management of the public service, strengthened institutions of good governance, and improved delivery of basic services, especially at the provincial and local levels. Further assistance to strengthen provincial and local level government management capacities is being envisaged.

Chapter 2

The Public Health System

The Structure of the Health System

The national health system, based on the primary health care approach, features a network of aid posts (officially 2,400, but 50% are reported closed due to lack of staff, drugs, and supplies), health centers (about 500), provincial hospitals (18) and a national hospital, and urban clinics (45). The government is the largest provider of health services, running all provincial hospitals, almost all urban clinics and aid posts, and about half of the health centers and sub-centers. Churches operate half of the rural health centers and sub-centers. The Churches Medical Council (CMC), which represents 23 different denominations, is the umbrella organization for this sector and is represented permanently in NDOH. Salaries of church health workers are funded by the Government. Mining and other companies also operate a small number of facilities. Company clinics provide possibly the highest quality of services (as judged by facilities, equipment, staffing and utilization). These are mostly situated in remote locations and could be a source of greater cooperation. Some church facilities also have a good reputation, but many government and church facilities in rural areas are now run down and under used.

Between 1996 and 2001, there was a 65% increase in real public sector expenditure on health in Papua New Guinea. When population increases are taken into account, there has been an increase of 42% in the overall availability of resources for the health sector (Table 2.1).

Over this period, per capita domestic resources for health have risen by 4% and this has been brought about by increasing the proportion of the national budget spent on health from 4.8% in 1996 to 6.2% in 1999.[9]

Health expenditure was projected to increase to 8.2% of total expenditure in 2000. Despite this, foreign assistance has provided the bulk of additional resources to the health sector, increasing by nearly 2,000% over the period.[10] To a large extent this growth in external support is an artifact due to the change in modality of Australian aid to Papua New Guinea, shifting from direct budget support to project aid from 1997.

TABLE 2.1
Papua New Guinea Health Expenditure, by Source of Funding, 1996–2001
In '000 Kina

Source	1996	1997	1998	1999	2000	2001
Nominal						
Papua New Guinea Funding	153,062	165,851	181,798	195,573	245,821	278,480
Foreign Assistance	3,424	33,182	57,812	84,789	90,856	109,215
Total	**156,486**	**199,033**	**239,610**	**280,362**	**336,677**	**387,695**
Kina per Capita	34.7	42.8	49.9	56.7	66.0	73.8
Real						
Papua New Guinea Funding	141,071	143,346	136,896	140,498	160,983	170,637
Foreign Assistance	3,156	28,679	43,533	60,912	59,500	66,921
Total	**144,226**	**172,025**	**180,429**	**201,409**	**220,483**	**237,558**
Kina per Capita	31.9	37	37.6	40.7	43.2	45.2
Annual change in real per capita health expenditure		16%	2%	8%	6%	5%

Source: Annual Health Sector Review Team, 2002

In comparison with its Pacific country neighbors, Papua New Guinea spends the lowest proportion of GNP on health and also has the lowest level of health expenditure per capita (Table 2.2).

TABLE 2.2
Comparison of Inputs to the Health Sector by Papua New Guinea and Its Pacific Island Neighbors

Country	GNP 1997 (US$)	% GNP on health	Expenditure per capita (US$)	Doctors per 100,000 population	Nurses per 100,000 population
Fiji Islands	2,460	3.5%	55	37	209
FSM	1,920	9.1%	171	46	329
Tonga	1,810	3.5%	56	46	331
Marshall Islands	1,610	4.6%	85	43	290
Vanuatu	1,340	2.5%	29	10	239
Samoa	1,140	—	—	38	186
Papua New Guinea	930	2.3%	27	7	67
Solomon Islands	870	11.6%	94	11	115

FSM = Federated States of Micronesia
Source: Ministry of Health, National Health Plan 2001–2010

Within this global allocation to health, there are significant variations between provinces on health resources. These variations doubtless reflect past investment decisions as well as current perceived provincial priorities. Table 3 attempts to look at some indications of past investment decisions, in terms of both professional health staffing as well as the number of hospital beds available in each province.

TABLE 2.3
Standardized Staffing (Doctors, HEOs, and Nurses) Levels and Beds Available per 100,000 Population, by Province

Province	Doctors	HEOs	Nurses	Beds
Western	9.0	7.6	99	281
Gulf	1.4	8.2	87	230
Central&NCD	38.3	6.7	162	247
Milne Bay	6.9	6.9	90	377
Oro	4.3	6.1	56	274
Southern Highlands	2.7	3.5	53	180
Enga	1.9	2.9	41	276
Western Highlands	4.2	2.7	52	225
Simbu	1.6	9	56	254
Eastern Highlands	8.1	6.2	48	175
Morobe	12.3	4.7	61	193
Madang	5.1	6.1	62	290
East Sepik	1.8	4.2	64	261
Sandaun	2.4	4.8	59	323
Manus	2.5	22.7	126	464
New Ireland	3.7	12.9	99	583
East New Britain	9.1	4.5	93	312
West New Britain	4.0	10.7	75	398
Bougainville	4.5	6.2	73	389

HEO = health extension officer

Source: Staff numbers – National Health Plan; all health center and hospital beds – National Inventory of Health Facilities, 2000.

Administration Under the Organic Law on Provincial Governments (1977)

The public health system includes the health care services provided by both the government and the churches. Three levels of health care services are provided: primary, secondary and, to a limited extent, tertiary.

Prior to independence, government health services were centrally administered by the Department of Public Health in Port Moresby through Regional and Provincial Health Offices. In 1977, in the first attempt at decentralization, the Organic Law on Provincial Governments was introduced. The Organic Law divided government health service functions between the national and provincial governments. Functions were classified into three groups:

- **Transferred Functions to the provinces** included responsibility for rural health facilities (aid posts, health centers, and health sub-centers), health committees and health boards, ambulance services, family health services, and supervision of disease control programs.
- **Nationally Delegated Functions** included other activities delegated to provincial health staff, led by the provincial health officer, but for which NDOH retained ultimate responsibility. These were: the provincial hospital, malaria control, and extension services for disease control (tuberculosis, leprosy, and STDs), dental health services, nutrition work, and health inspector duties.
- **National Functions** were responsibilities retained entirely by NDOH. These included ultimate responsibility for all hospitals and medical, dental, nursing, preventive health, and disease control services; monitoring of standards of health service activities across the country and ensuring satisfactory standards are maintained; pharmaceutical services; mental health, radiotherapy, and special medical services; national health legislation; planning, policy formulation, and evaluation; and medical training.

Responsibility for personnel administration was also transferred along with functions and funding. However, the degree of administrative control by national or provincial authorities depended on whether the health worker was engaged in purely national functions, purely provincial functions, part provincial and part national, or on nationally delegated functions. In addition, provincial health workers who clearly fell under direct control of NDOH still had to maintain constant liaison with provincial authorities. Disciplinary authority was shared.

Following decentralization, a standard organizational and administrative provincial health structure was widely adopted. However, in the early 1980s, provinces began to innovate and modify the administrative

structure of health services. In some provinces, disease control services were divided into vertical programs while in others integration was pursued. Still in others, administrative control was further devolved to the districts, but some provinces preferred to create more centralized structures. As a result, a mosaic of diverse organizational and administrative provincial health structures developed.

The complexity of the arrangements under the Organic Law on Provincial Governments, where authority and responsibility were often seen to be dissociated and the sharing of powers frequently overlapped, created an environment of continuous debate, which undermined performance. The overall performance of many provincial governments began to waver, usually as a result of poor financial management. In the mid to late 1980s, numerous provincial governments were suspended, some of which were later reinstated only to be suspended again. The poor level of performance by these provincial governments appeared entrenched; the delivery of health and education services suffered and rural populations were neglected.

Administration Under the Organic Law on Provincial Governments and Local Level Governments (1995)

An official assessment of the performance of decentralized government led to a review of and changes in the Organic Law of the Constitution. The Organic Law on Provincial Governments and Local Level Governments (New Organic Law), enacted in 1995, provided the framework for a greater devolution of powers to the provinces and local level governments, with clearer definitions of the division of administrative and service functions between the three levels of government.

The National Health Plan 1996–2000 addressed the required changes in the public health system[11] established by the New Organic Law. In brief, it set the following priorities in organization and health care reform:

1. Reorganization and restructuring of NDOH;
2. Standardization of provincial and district health administrative structures; and
3. Passage of the National Health Administration Act.

Introducing specific definitions of administrative functions and details of administrative arrangements across all three levels of government, the National Health Administration Act 1997, passed in December 1997 and certified in April 1998, provides clarification on the roles and responsibilities of governments, administrations, and agencies to facilitate the implementation of national health policy. NDOH went one step further and developed and published a user handbook,[12] which interprets and clarifies the legislation and is used for training purposes and as a reference manual.

In the further decentralization of government and administrative responsibilities under the New Organic Law, the Provincial Health Office (PHO) comes under the Provincial Administration, district-level health facilities answer to the District Administration, and aid posts are the responsibility of local level government. In effect, this arrangement disrupts the vertical integrity of the public health system as each level in the health hierarchy has become answerable to the bureaucracy of the corresponding administrative level, outside of the public health system. There are no longer the requisite, well-defined reference points of responsibility and accountability, and this situation has complicated, and to a significant extent reduced, the performance of the health system.

The National Health Administration Act 1997 attempts to overcome the fragmentation of the public health system through the creation of a parallel health board system. The National Health Board provides advice to the Minister on health policy, sets national health standards, and approves provincial implementation plans. It liaises with Provincial Health Boards and monitors their performance. The Provincial Health Boards provide advice to the provincial governments and coordinate implementation of the national health plan, national health standards, and provincial implementation plans.

By 2001, the National Health Board and 15 Provincial Health Boards had been established. However, the indirect reassertion of central authority over provincial government, restricted to the public health system, has not been successful. Most boards have met infrequently and have not been sufficiently active to mitigate the shortcomings of the New Organic Law. Indeed, to improve health service delivery at the rural health center and aid post levels, the Provincial Health Boards would have to recognize, and remedy, the provincial and district government's poor

support of health services, both in funding and in management.

The National Health Administration Act 1997 also provides for District Health Management Committees. They are responsible, at the district level, for coordinating the implementation of the national health plan, national health standards, and provincial implementation plans in their respective districts. Few District Health Management Committees have been established, as there has been little incentive to recognize Provincial Health Boards and provincial government authority when resources and funding are frequently withheld.

In summary, the implementation of the New Organic Law was not adequately prepared and lacked guidance from the central level. From the onset of implementation in 1995, different interpretations emerged among the provinces, which could not be reconciled by the central government. In addition, the funding levels to provincial, district, and local level governments initially envisioned under the New Organic Law were unrealistic and unattainable. The framework and structure of the Grants to decentralized governments sought to establish both equity and respect for government priorities. Instead, the low and sometimes disparate funding levels served to justify the general non-adherence to the framework and structure of the Grants. As a result, performance was varied and, in the period 1999–2001, one third of the provincial governments were suspended for poor financial management and failure to deliver services. Other provincial governments experienced similar problems and, although not suspended, they were largely inoperative.

The Role of Development Partners

Papua New Guinea and ADB have a shared history of commitment to and investment in the public health sector. Since 1982, ADB has supported a succession of relatively large scale projects.[13] These have focused on establishing and extending rural health infrastructure (health centers, aid posts and staff housing) and rural water supply and the procurement of medical, transport, and radio communication equipment. The most recent of these projects also addressed the maintenance and renovation of health infrastructure and pursued a program of institutional capacity building within NDOH and the PHOs.[14] Technical assistance covered man-

agement and accounting systems within the ADB Project Implementation Unit, defining health worker job descriptions and performance evaluation criteria, establishing and implementing a national health monitoring system, and assistance to improve the budgeting process, expenditure monitoring, and cost containment as well as reestablishing user fees in public hospitals.

AusAID is the biggest donor in the health sector. Australia has provided general budgetary support of approximately A$300 million per year to the government of Papua New Guinea. In a change of policy, budgetary support has been phased out in favor of project aid between 1995 and 2000. Early in this transition, AusAID focused on hospital management and operations as well as providing assistance in the training of health professionals. The Health Sector Support Program, which provides comprehensive assistance to NDOH and targets six provinces, came online in 1998-1999. The Women and Children's Health Project, designed to improve vaccination coverage and women and children's health extension activities nationwide, began implementation in earnest during the same period.

Other development partners have been active in the public health sector. The Japanese International Cooperation Agency undertook the renovation and upgrading of Port Moresby General Hospital and selected provincial hospitals as the centerpiece of its aid program in the health sector from 1988 to 1994. A medical equipment program complemented the hospital upgrading. Under disease control, Japan also provided support to the malaria program.

The United States Agency for International Development targeted rural health services and maternal and child health care under the Child Survival Program from 1990 until their withdrawal from Papua New Guinea in the mid 1990s. Support was also provided to malaria vaccine research from 1987 to 1993.

The European Union provided investment in clean water supply around the country while the World Health Organization (WHO) has made available technical expertise and assistance on a request basis by NDOH. UNICEF and the United Nations Fund for Population Activities have managed a succession of local, mostly community-based projects.

Whereas the level of donor aid, bilateral and multilateral, was moderate in the early to mid 1990s and was relatively constant at about K12

million per year, there was a resurgence beginning in 1997 as a result of the ERP, which engendered HSDP, and the shift from general budget support to project aid by Australia. Another contributing factor was the delay experienced by several projects due to the difficulties resulting from the implementation of the New Organic Law, particularly in 1996. Foreign assistance has provided the bulk of additional resources to the health sector between 1996 and 2001.

The Performance of the Health Sector

Several recent studies[15] have underlined the mixed performance of the health sector in Papua New Guinea. Some indicators are particularly resistant to change, being influenced by factors outside of the health sector (such as women's education and nutritional status) and geographical barriers (such as supervised delivery rate which is influenced by accessibility to health centers). Difficult terrain, combined with poor infrastructure and lack of transport, reduces considerably the physical accessibility of health services. Other indicators have fluctuated according to availability of funds and personnel involved (such as immunization coverage). A review of the National Health Plan 1996–2000 revealed a deterioration in several indicators such as a drop in immunization coverage, a rise in mortality from malaria, an increase in malnutrition, and widespread shortages of medicines (see Box 2.1).

While there have been gains shown in the demographic indicators over the last decade, with an increase in life expectancy from around 52 years in the 1990 census to around 54 years in 1996, which however remains low by regional standards, the infant mortality rate (IMR) had risen from 72 to 77 per 1,000 births over the same period, the only country in the Pacific to record an increase in IMR.[16] There are significant urban and rural differences in IMR, with figures ranging from 33 to 86 per 1,000 lives births respectively. Inter-provincial differences are also very significant: the provinces of West Sepik and Enga had the highest IMR in 1996 at 110 and 109 per 1000 live births, and Manus and the National Capital District the lowest at 37 and 38. Contributing to the IMR are infectious diseases, lack of immunization, lack of safe water supply, unsupervised village births, short birth spacing, and low levels of

BOX 2.1
Summary of Final Review of National Health Plan 1996–2000

Health Promotion. **Health promotion programs for family planning and immunization achieved some success as judged by the rise in family planning acceptors and attendance at national immunization days. However, current efforts require strengthening particularly for safe-motherhood and to increase awareness of risk factors and control strategies for malaria, tuberculosis, and sexually transmitted and other diseases. Health promotion receives low priority in most provincial resource allocations.**

Family Health. **Immunization coverage is below desired levels and there were repeated outbreaks of measles between 1998–2000. The proportion of women receiving antenatal care and supervised delivery did not improve. Malnutrition rates showed no improvement over the plan period and 10% of births are still below 2.5 kg (the cut off for low birth weight). There was no change in school health activities.**

Disease Control. **PNG was declared free of polio in 2000 and has achieved elimination of leprosy according to WHO criteria. AIDS is increasing at alarming levels. Morbidity and mortality rates from malaria remain high. Tuberculosis continues to rise and is now prominent in the highlands. Indeed, malaria and tuberculosis are receiving minimal attention from NDOH, despite the availability of cost effective interventions, the public benefits of infectious disease control, and the new global initiatives in these areas (primarily focused on Africa at present). Similarly, there is no specific program for respiratory illnesses, the leading cause of death. Diarrhea and typhoid remain significant public health problems. Cases of yaws, at one stage virtually eliminated, have escalated.**

Environmental Health. **An improvement in provision of domestic water has been reported, partly assisted by drought relief efforts. However, environmental health activities receive low priority and are usually of small scale and often led by WHO initiatives. The majority of the population still does not have access to safe water or improved sanitation.**

Source: NDOH, 2002.

education. The Maternal Mortality Rate (MMR) is high, at 370 per 100,000 live births. Medical conditions contributing to this high MMR include post-partum hemorrhage, sepsis, eclampsia, and anemia, associated with malaria and malnutrition.

HIV/AIDS is arising as a major public health issue. Cases have been reported from every province, and HIV/AIDS is now a leading cause of adult medical admission and deaths in Port Moresby General Hospital.

Malaria is the leading cause of outpatient mortality and the second leading cause of hospital admission and death.

A recent burden of disease study,[17,18] based on diagnoses in outpatients and on admission to health facilities, provides information on the principal conditions that are brought to the attention of the health services in Papua New Guinea.[19] Table 2.4 shows the proportion of the total burden of disease resulting from three different groupings while Figure 2.1 shows the 10 conditions that account for the most Disability Adjusted Life Years (DALYs).

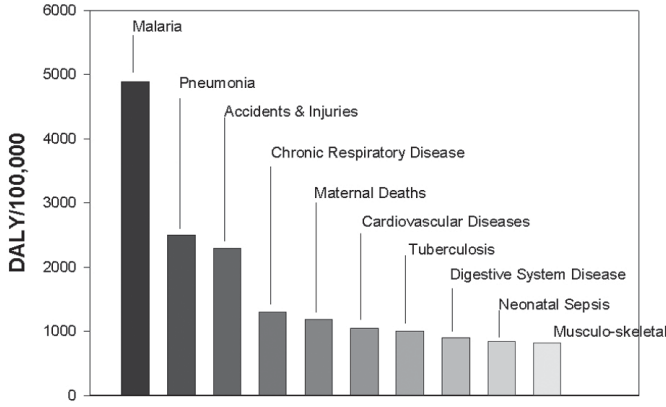
TABLE 2.4
Proportion of Total Burden of Disease Attributable to Three Groupings

Disease Category	DALYs/100,000	%
Communicable, Perinatal, Maternal, and Nutritional	12,301	59%
Non-communicable	6,313	30%
Accidents and Injuries	2,398	11%
TOTAL	**21,013**	**100%**

DALYs = Disability Adjusted Life Years
Source: Burden of Disease Study, 2002.

While inputs (measured by financial resources) to the health sector have increased significantly between 1995 and 2001, output indicators have shown only a marginal increase over the seven years and suffered a significant fall between 1999 and 2000 and further in 2001. The performance for 2001 was, for most indicators, worse than in 1995. Table 2.5 provides the output indicator measurements for five key Mother and Child Health indicators for the beginning and the end of the series.

FIGURE 2.1
The 10 Diseases that Account for the Most DALYs in Papua New Guinea



DALYs = Disability Adjusted Life Years
Source: Burden of Disease Study, 2002.

There is significant variation in the performance of provinces and this is demonstrated in Table 2.6, where the best and worst performing provinces in 2001 are shown. Performance of the provinces is highly dependent on the provincial level management team (both inside and outside the health sector). Milne Bay and Sandaun have shown remarkable improvements, due to strong provincial teams. The best performing provinces are achieving outputs close to national targets set in the National Health Plan. However, in comparison some provinces are performing woefully.

TABLE 2.5
Output Indicators for Five Key Mother and Child Health Activities, 1995 and 2001

Indicator	1995	2001
% of deliveries in health facilities	42%	38%
% of pregnant women receiving Tetanus Toxoid vaccination	62%	63%
% of women getting at least one antenatal visit	68%	58%
% of children, <1 year, receiving 3rd dose Triple Antigen vaccination	61%	55%
% of children getting measles vaccination	42%	47%

Source: Monitoring and Research Branch, NDOH

TABLE 2.6
Performance of the Best and Worst Performing Provinces for Five Key Mother and Child Health Activities, 2001

Indicator	Best	Worst
% of deliveries in health facilities	68%	11%
% of pregnant women receiving Tetanus Toxoid vaccination	77%	39%
% of women getting at least one antenatal visit	108%	37%
% of children, <1 year, receiving 3rd dose Triple Antigen vaccination	107%	40%
% of children getting measles vaccination	79%	30%

Note: The figures of over 100% probably reflect problems with the population figures used as the denominator.

Source: Monitoring and Research Branch, NDOH

Chapter 3

The Health Sector Development Program

Design

A specific technical assistance project to assist NDOH with the development of the 1996–2000 National Health Plan[20] helped to consolidate objectives and strategies across all provinces in a single, comprehensive health plan. In terms of infrastructure and technical assistance to the public health sector, the sequence of ADB projects and the convergence of multiple development projects in the public health sector had set the stage for a sector development program loan. HSDP is composed of two policy-based loans[21] in the total amount of US$50 million and one investment loan[22] targeting human resource development in the amount of US$10 million. The appraisal mission took place in July 1996, ADB's Board of Directors approved the loans in March 1997, HSDP loans were declared effective in October 1997, and the inception mission took place the same month. The first tranche draw down was completed in February 1998. The first release of equivalent funds in Kina to NDOH was in April 1998.

For the purpose of this review, only the "Sector Program" covered by the two policy-based loans will be considered. The investment component of HSDP, commonly referred to as the Human Resource Development Project, was structured and managed independently as a project and thus falls outside the scope of this review.

Core Design Features

The design of HSDP took place in the wake of the political process establishing a framework for the decentralization of political authority, responsibility, budgeting, and spending, all embodied in the New Organic Law. However, the implementation and practical considerations necessary to achieve effective decentralization were given insufficient attention. In particular, NDOH lost authority over the decentralized public health infrastructure in the provinces and districts. Provincial and district governments assumed complete responsibility and authority over local health services.

The only exceptions to relinquished authority were found in the Department of Finance (DOF) and the Department of Provincial Affairs and Local Level Government (DPALLG). The national government retained some measure of authority over the decentralized budget and expenditure process by keeping the Provincial Treasuries under the authority of DOF, while DPALLG was mandated to ensure that standards for decentralization would be developed and implemented in all provinces, districts and local level governments.

Design Strengths

The National Health Policy, developed in a broad consultative process in 1995, was approved by the National Executive Council (cabinet) on 29 May 1996 and officially launched by the Prime Minister during the National Health Conference on 3 June 1996. The policy focuses on improving health services to the rural majority and the need to adopt health promotion and preventive health strategies to ensure improved health status. It also addresses issues of management reform in all areas and all levels of the public health hierarchy.

The policy gave shape to the National Health Plan, a cohesive document that presented a comprehensive set of objectives and strategies in the public health sector to be pursued over five years. The objectives and strategies described under HSDP, consolidated as benchmarks for the purpose of evaluating performance especially with regard to qualifying for the second tranche release, are drawn from the government's National Health Plan 1996–2000.

Because HSDP was a program loan, DOF was made its Executing Agency while NDOH was made its Implementing Agency. This arrangement had the added advantage of ensuring that responsibility and authority were not dissociated under the then largely untested New Organic Law. The primary rationale was to ensure that DOF would indeed make the Kina equivalent of the loan proceeds available to NDOH. In practice, it produced the added benefit of providing the basis for close consultation between the two departments and facilitated the development of improvements in accounting, monitoring, and reporting in both of them, leading to greater transparency and a growing willingness to address issues of governance.

An important design feature was the creation of a management committee, the Program Coordination Committee (PCC), the membership of which was drawn from many key government agencies. This was to ensure broad awareness of and participation in HSDP, its endeavors and progress. Participation in the PCC was further broadened to include the senior health representative in all 20 provinces (Provincial Health Advisors) and all interested stakeholders in the public health sector.

A technical assistance project[23] was attached to HSDP. The terms of reference were to assist in the implementation of HSDP, which by extension implied achieving objectives consistent with the National Health Plan and the key benchmarks required for the release of the second tranche of the loan. Monitoring and demonstrating conclusively that the benchmarks were indeed achieved was also an essential task.

Design Weaknesses

The non-prescriptive nature of and the diversity of settings and objectives ascribed to sector development program loans make them poorly understood, or at least susceptible to multiple interpretations. This was, and to a certain extent continues to be, the case for HSDP.

Since HSDP was widely seen as ADB's participation in the ERP, there was a not uncommon belief that the sector development program loans were intended to be budgetary support, albeit to the health sector, similar to the assistance from the other contributors to the ERP. At different times during the life of HSDP, often coinciding with changes in DOF's top management, the preferred interpretation was that the Kina equivalent

of the loan proceeds could be transferred to consolidated revenue and simply used to cover NDOH's recurrent budget without the increase in funding necessary to implement the National Health Plan. While this was identified by ADB as the principal risk to a successful outcome, the issue was frequently couched in ambiguity, allowing for differing interpretations of the sector development program loans.

The relatively large size of the loans, totaling US$50 million, released in two equal tranches, created some discomfort within NDOH in relation to the proportionate responsibility the loans carried. Within DOF, early on, there was a near certainty that HSDP could only be budgetary support. This was evidenced by the non-inclusion of HSDP in the initial 1998 budget, ostensibly because a vote number had not been created in the budget to accommodate HSDP. Once it was agreed that the funds would be appropriated in the annual budget cycle, HSDP became one of the largest, and frequently one of the first, targets for budget reduction measures. Both the continual need for overall budgetary discipline and the frequent changes in DOF's top management ensured that, at each budget cycle, a protracted and intense battle to defend appropriations under HSDP was inevitable.

Contributing to DOF's position that the sector development program loans should be treated as budgetary support were the loan agreements, which focused on policy embodied in the policy matrix. Notably absent were familiar project-like management structures, large dedicated staff numbers commensurate with the size of the loans, and prescribed inputs with a schedule of outputs to be measured against objectives. DOF was not convinced that NDOH should have access to, and discretion over, a large pool of funds outside of the government's accounting system. By allowing the transfer of HSDP funds to an NDOH-controlled trust account, DOF was relinquishing authority and discretion to regulate cash flow and to influence expenditure patterns. DOF was not, at that time, suitably prepared to accept a sector development program.

Laying the Foundation for Implementation

The year 1997 was a troubled one for Papua New Guinea, which saw many reversals in government, frequent changes in department heads,

and the onset of a serious drought. NDOH and DOF struggled for ascendancy in their respective interpretation of HSDP loans. This created delays on the part of the government to open imprest and trust accounts and establish a vote in the budget. Delays were also experienced by ADB as Asian Development Funds were not available for Loan 1517-PNG (SF) and loan effectiveness had to be postponed.

The delays allowed for a concerted lobby effort by NDOH of most DOF division managers, many middle managers, and consultants. With time, this established a favorable environment within DOF, which then became receptive to the interpretation that HSDP was intended not for budgetary support but rather for supplementary funding to implement the objectives of the National Health Plan.

With the understanding that NDOH and DOF had a shared responsibility in ensuring the success of HSDP, a period of consultations and negotiations between the two departments resulted in accepted definitions of the roles, responsibilities, and authority of both parties, at the national and provincial government levels.

Among the key agreements were:

- The Trust Instrument, which defines the operation of HSDP parent and all provincial subsidiary trust accounts;
- The level of accounting responsibility acceptable to DOF for the Provincial Treasuries;
- Acceptance by both NDOH and DOF of accounting and reporting requirements to be the responsibility of Provincial Health Advisors (PHAs);
- The creation of the HSDP Secretariat and its functions and its location in DOF;
- The appearance of HSDP appropriation in NDOH Vote 240, making NDOH responsible for all expenditure;
- The use of the Papua New Guinea Government Accounting System (PGAS) for all accounting of HSDP expenditure; and
- The Procedures Manual for Provincial Health Advisors and Provincial Treasurers.

All agreed definitions were presented in detail to the PCC for review and debate before being endorsed for implementation. Detailed minutes of all PCC meetings as well as HSDP quarterly reports establish a record of the agreed definitions.

Procedures Manual for Provincial Health Advisors and Provincial Treasurers

The contents of the Procedures Manual, which establishes the necessary references and internal controls to ensure that implementation of HSDP activities would proceed efficiently and in a timely and transparent manner, were negotiated between NDOH and DOF over a nearly one year period. The Loans and Revenue Division was chosen to represent DOF with respect to overall responsibility as Executing Agency. The Public Accounts Division helped to define DOF accounting requirements and acknowledge limitations. The Budgets Division worked with NDOH in defining and officially recognizing the standard health program categories. The Information Technology Division assisted with establishing codes on the PGAS and provided technical support to the HSDP Secretariat. Direct discussions were held with many Provincial Treasurers to evaluate their propensity to participate in HSDP. Senior financial managers in NDOH assisted with the accounting procedures. Lastly, the Procedures Manual was reviewed by an independent accounting firm and found to be responsive to the needs of HSDP and compliant with government standards. At the PCC meeting held on 13 May 1998, the Secretary for Finance and the PCC made the final endorsement.

The following are the essential features of the Procedures Manual:

- An overview of HSDP, which responds to commonly asked questions;
- A statement of priorities drawn from the National Health Plan along with advice on how to obtain the best value for money;
- A description of the roles and responsibilities of the key participants and organizations, including the PCC, the HSDP Secretariat, and the Benefit Monitoring Unit;
- A description of the trust account system—including the division of authority, NDOH-initiated expenditure, province-initiated expenditure, and operating conditions and procedures—and progressive trust account ceiling levels which reflect performance levels;
- Accounting and monitoring procedures and requirements specific to HSDP and compliant with government standards, filing, and the paper trail and bank reconciliation;

- Reporting requirements, monthly and quarterly (expanded upon in later documents); and
- References including the HSDP Secretariat functions, the HSDP Trust Instrument, accounting forms, standard health budget, expenditure code structure, and coding for provinces and districts and items of expenditure (chart of accounts).

The procedures for undertaking expenditure of HSDP funds are largely drawn from the government's own procedures found in the Public Finances (Management) Act (1995). In the case of HSDP, they are presented in a more forthright manner and with greater practical context. In addition, modifications related to the data requirements on HSDP accounting forms provide for greater exploitable information potential in line with the monitoring requirements established under HSDP.

Financial Management Performance Requirements

Of paramount importance to the success of HSDP was the introduction of measures, which established minimum management performance levels (essentially, strict adherence to the procurement and financial management rules) in the provinces as a prerequisite to qualify for continued HSDP funding. This was possible as HSDP funding was appropriated at the NDOH level. As such, NDOH was under no obligation to provide funds to a given province although, clearly, the objectives of the National Health Plan can be met only through the active support of provinces, which in turn implement their annual health activity plans.

NDOH found itself in a position of authority (officially relinquished under the New Organic Law) as it could regulate the flow of resources, through HSDP funding, and do so conditionally. The Procedures Manual precisely sets out the conditions, restrictions and requirements, which establish the ground rules for provinces to receive funding under HSDP.

To qualify for continued HSDP funding, systematic supervisory reviews determine compliance with the following minimum requirements:

- Expenditure undertaken is identified in the Annual Health Activity Plan and/or is in respect of national priorities;
- Only expenditure authorized at the decentralized level, as defined in the procedures manual, has been undertaken;
- Value for money has been obtained on the basis of a competitive

pricing process;
- All original supporting documentation is present and filed for all expenditure;
- Monthly cashbook and bank reconciliation is provided to the HSDP Secretariat;
- A minimum 80% of expenditure is acquitted (balance carried over to next review); and
- Previously identified issues are resolved.

However well designed and presented, the validity of a Procedures Manual is tested in its application and the enforcement of procedures in a fair and equitable manner. This implies an active management entity which ensures front line supervision and management and which reports to a higher authority on matters and issues necessitating high-level decisions.

The HSDP Secretariat

Based on the principal design feature of HSDP, the establishment of the HSDP Secretariat in DOF lent credibility to that department's designation as the Executing Agency as well as creating a permanent liaison entity between NDOH and DOF.

The functions of the HSDP Secretariat are described in detail in the Procedures Manual for Health Advisors and Provincial Treasurers (see Appendix A). In summary, the HSDP Secretariat provides support to the PCC, ensuring that it is kept informed of progress and all pertinent issues. The HSDP Secretariat also organizes, prepares, and takes the minutes in all PCC meetings and is responsible for all record keeping.

The HSDP Secretariat provides an important liaison function with relevant DOF divisions, between DOF and NDOH, and with other Departments and government agencies including the DPALLG, the Department of Personnel Management (DPM), and the Auditor General's Office (AGO). It provides close support to all PHOs and, to a lesser extent, the Provincial Treasuries. It assists NDOH planning/budgeting initiatives and assistance in the provinces and districts. The Secretariat also fulfills an important liaison function for the development partners, keeping ADB, AusAID, New Zealand Agency for International Development (NZAID), WHO, and

other interested parties informed of progress and issues.

An essential function of the HSDP Secretariat is to provide comprehensive accounting support to the PHOs and, more recently, to the project section of NDOH. The Secretariat maintains a stand-alone PGAS station used to record all expenditure under HSDP. Standard HSDP expenditure reports are produced and special analysis is available upon request. In an independent financial review of the Trust Account conducted on behalf of AusAID,[24] it was found that the Secretariat, its operations and procedures, satisfy the accountability requirements for contributions made by AusAID, thereby allowing AusAID's participation in the mechanism (See Developing Partners Finding Common Ground, Chapter 5).

In addition to accounting support, the HSDP Secretariat has an important supervisory function. *Field Visits* and reviews in the provinces cover procurement processes, an evaluation of performance both with respect to public health activities and to procedural requirements, and provide assistance in the resolution of local management issues. This function has led to considerable progress in some PHOs, facilitating them to improve upon their overall management skills and to be more effective in their role as a coordinating entity of provincial health services.

The HSDP Secretariat also serves the important function of providing an effective internal review of NDOH expenditure of HSDP funds, which covers approximately two thirds of all HSDP expenditure. As established under the HSDP Trust Instrument, both NDOH and DOF are obligated signatories to all fund transactions. The independent situation of the Secretariat, situated in DOF, allows for the critical review of HSDP expenditure initiated by NDOH. The Secretariat is then able to advise DOF on the nature of HSDP expenditure ensuring a high degree of transparency.

Program Coordination Committee

As head of the Executing Agency, the Secretary for Finance was the PCC chairperson. However, the Secretary for Health most often chaired PCC meetings in the absence of the Secretary for Finance. DOF representation was good and usually included the Budgets Division, Public Accounts Division and Information Technology Division. The Department of Na-

tional Planning and Monitoring (DNPM), closely associated with DOF, was also usually well represented. Meeting on average three times a year, the PCC brought together senior NDOH staff, PHAs, CMC and non-government organization (NGO) representatives, and other public health stakeholders in a unique forum with key DOF and DNPM representatives and, on occasion, representatives of the DPM, DPALLG, and the National Monitoring Authority.

Under the steady leadership of the Secretary for Health, issues of importance not only in the context of HSDP but to health services delivery overall were discussed openly and constructively. Indeed, PCC meetings offered a rare opportunity for DOF and DNPM managers, among others, to hear directly from key representatives in the health sector.

The issues debated, which the PCC influenced, included the official recognition by DOF and its Budgets Division of the standard program categories establishing a uniform budget structure in health for all three levels of government. The PCC also served as an important forum to discuss annual appropriations in health, at both the national and provincial levels. A recurring theme was the weak budgetary support to health services in many provinces as well as the unstable appropriation of HSDP funding from year to year.

The poor performance of many provinces in passing along the payment of wages and operational support for church-run health services received much attention and airing of views. The resolution saw NDOH, DOF and CMC agree to withdraw church health funding from provincial governments and instead channel the funds through NDOH, which then ensures that the funds are transferred to CMC and the various church health services around the nation.

The PCC was the ideal forum to table financial reports on health expenditure, which although up-to-date and informative were not initially well received by DOF and DNPM. These reports were essentially Technical Assistance (TA)-driven but strongly supported by NDOH as an internal requirement for proactive management. Opinions changed and positive attitudes developed as the reports were produced year-after-year, and the information was widely shared and used in a constructive manner.

An important function of the PCC was to provide a forum for PHAs to report on their successes and difficulties to the extensive PCC membership. This allowed for an informal peer review process on the one hand,

and a de facto recognition of NDOH's hierarchical position, especially in the person of the Secretary for Health, on the other. Provinces, which could demonstrate improvements, were openly commended. As for those which were deemed to be non-performing, the Secretary for Health would demand improvement, stipulating requirements and a time schedule. Only some PHAs, however, were responsive. Changes in NDOH, with the appointment of a new Secretary and the transformations brought by the participation of other donors in the Trust Account mechanism (see Developing Partners Finding Common Ground, Chapter 5), led to the interruption of the PCC, which finally was revived as part of the Sector-Wide Approach preparation process.

Implementation Support to Provincial Health Offices

Training

The difficulties encountered in apprising DOF senior staff and managers of the nature and operation of HSDP underscored the importance of adequately training provincial health staff and provincial treasurers and of informing the decentralized public health staff and the provincial and district level governments as broadly as possible. To this end, formal training was organized for all signatories to the provincial trust accounts and the successful completion of the training was made a prerequisite for the first disbursement of funds. This required both the Provincial Health Advisor and the Provincial Treasurer to work side-by-side in the training sessions. Practice situations and examples were selected based on their high probability of creating disagreement and, possibly, conflict between the two principal signatories. This provided the opportunity to resolve many issues before they actually occurred in the provinces. It also gave both parties the opportunity to develop a working relationship where frequently none had existed. The Secretaries of both NDOH and DOF expressly endorsed this strategy.

Supervision

The initial release of funds to a PHO was contingent on the success-

ful completion of the training. The next release of funds depended on the outcome of a review of the use of the initial advance of funds. The required review would take place in the province, conducted by the HSDP Secretariat under the heading Field Visit, in order to better address the difficulties encountered. As it turned out, all manner of interpretations of HSDP procedures as well as of strategies in implementing health plans and priorities generally revealed a less than optimal use of HSDP funds at the start. The prevalence of this initial finding covered nearly all provinces.

It became necessary to negotiate the resolution of problematic items of expenditure on a case-by-case basis. This allowed for practical, on-the-job training with frank discussions addressing both public health issues and governance issues. In the process and in most provinces, a working relationship was forged between the HSDP Secretariat and the PHO, sometimes extending to the provincial administrator and elected representatives. It became evident that active, constructive supervision based on a detailed review process was necessary to effect the changes sought to ultimately improve health status.

It gradually emerged that while PHAs and many of their staff would respond positively to the Field Visits and the detailed review process, many of the district-level and facility-based staff would not recognize the PHA's authority or HSDP procedures. In effect, there were few "trickle-down" benefits from the review process and on-the-job training. More frequently found was an attitude of challenge and non-compliance shaped by the fragmentation of the public health system hierarchy engendered by the New Organic Law.

Mediation

To respond to the poor performance of the decentralized public health staff in some provinces, opportunities were sought to include greater numbers of public health staff in organized management meetings and consensus-building sessions during Field Visits. The meetings often revealed that the PHO would have a poor record of communication with health staff and local public health stakeholders. The resulting low levels of trust and isolation, both willed and physical, meant little cooperation could be found, a situation far from desirable when success largely de-

pends on organization and functioning systems. In some cases, conflicts within or simply a lack of support from the provincial government would negatively influence the respect for hierarchy and contribute to broad-based poor performance by public health staff.

Some PHAs have taken the initiative to improve relations with district-level staff and facility-based health staff. However, to establish a dialogue and to engage in a management process to encourage and coordinate public health activities usually requires much confidence building. In these instances, mediation by the HSDP Secretariat and the ADB Technical Assistance to facilitate dialogue and to actively support the PHAs proved to have a positive influence on future performance.

Discord has also not been uncommon between the PHA and the chief executive officer of the provincial hospital and between the PHA and the church health secretaries and representatives of NGOs. Competition for scarce resources and, occasionally, land disputes have made cooperation between these province-based public health agencies difficult. As each has a recognized role in the delivery of public health services, all are eligible for HSDP funding. Mediation on a case-by-case basis by the HSDP Secretariat has proven useful in improving relations and access to HSDP funds. Frequent follow-up has usually been required to prevent backsliding.

Monitoring and Reporting

A hallmark of HSDP was monitoring and reporting. Each Field Visit or review would be written-up in a standard format covering issues and recommendations. Selected examples are provided in Appendix B. They illustrate the range of issues addressed in the context of HSDP monitoring, which are not limited to the Program but also encompass broader issues within the public health system. Usually only a page or two in length, the Field Visit report would be shared within a week of the review with the PHA and NDOH senior management. Over time, the reports were circulated more widely, especially when some issues proved impervious to resolution and greater awareness to generate greater peer pressure to conform seemed to be required. While the reports were frequently critical, they were constructive in nature and always proposed solutions to the shortcomings discussed.

The Field Visit reports were often shared, through the HSDP Secretariat, with other provinces. This proved beneficial particularly in frequently encountered issues as these were more easily discussed and resolved if it were established that other provinces were experiencing the same issues.

Short financial reports were produced and widely circulated, especially in the course of Field Visits and speaking invitations to various seminars and workshops. Annual HSDP expenditure reports by province and program category and by province and item category (type of input), limited to just two pages, allowed easy comparison between provinces and helped establish whether expenditure mirrored stated priorities.[25]

Monthly tracking sheets which monitored, by province, trust account balances and fund transfers and a summary progress report on expenditure and availability of funds were reproduced in large quantities and circulated widely within NDOH, DOF, and all the provinces and among development partner agencies.[26] This type of constant feedback helped to minimize misrepresentations as to the availability of funds, especially in the provinces, and to ensure a high level of transparency to guard against the misuse of funds.

Transparency

A conscious effort to be as transparent as possible not only helped to define HSDP but also helped to guarantee its survival. The combined effect of the Procedures Manual, written Field Visit reports and Secretariat reviews, various monthly tracking sheets, comprehensive quarterly reports, annual public health sector expenditure reports, and an independent audit program covering the use of HSDP funds (see Reforms and Innovations, Chapter 4) was to stave off any serious threat of large scale abuse.

Chapter 4

Successes and Challenges

Achievements

Increased Financial Allocations to Rural Health Services and Collaboration with Information Technology Division, DOF

Under the first policy reform area "Shift Emphasis from Urban to Rural Health Services," the first of the benchmarks reflecting the government's priorities was to increase financial allocations for rural health services by not less than 10% every year in 1997, 1998, and 1999 over the 1996 level of expenditure. Annual health expenditure undertaken at the national level was made available by DOF's Public Accounts Division in April or May of the following year. The difficulty was with decentralized health expenditure, which—although recorded by the Provincial Treasuries—was not reported. A result of the New Organic Law and the difficulties associated with its implementation, the situation continues to persist.

In collaboration with the DOF's Information Technology Division, it was determined that the data were recorded on PGAS and available on backup tapes kept by all Provincial Treasuries. The data, however, were not routinely shared by all provinces with the DOF. Using HSDP resources and the argument that DOF, NDOH and ADB all required public health expenditure monitoring to evaluate performance under the policy matrix, the backup tapes were obtained from all Provincial Treasuries.

Information Technology Division staff and technical assistants collaborated with NDOH, through the ADB TA, to define a standard health expenditure report with as much useful information as the available data

would allow. Data were reviewed for integrity and some data sets required cleaning. A series of software programs were developed to produce the required information, in particular provincial health expenditure under the grants (200 series), provincial health expenditure from self-generated provincial revenues (700 series), and the treasury payroll for public servants employed in the public health sector. This information completed the data necessary to produce annual provincial health expenditure and annual public health sector expenditure reports.[27] The information has been produced for all years between 1996 and 2001, in standard format. Dissemination of the annual Public Health Expenditure Report averages 600 to 800 copies each year.

Analysis of the annual public health sector expenditure revealed rural health services expenditure increased by more than 10% for each of the years 1997–1999 over the 1996 level of expenditure, specifically: (1997) 44.1%, (1998) 22.4%, and (1999) 16.2%. The large increase in 1997 is due to the inclusion of AusAID project aid for the first time. The increase in 1999 drops to 1.9% when HSDP contribution is factored-out.

Increased Medical Supplies to Rural Health Services

Appearing under both the first policy reform area "Shift Emphasis from Urban to Rural Health Services" and the third policy reform area "Undertake Financial Reforms in the Health Sector," benchmarks were exceeded in both cases. The first benchmark was to "increase the value of drug supplies to health centers and aid posts to K3.0 per capita in the area served." In 1998, the value was K4.29 per capita; in 1999, it was K6.00 per capita. The second benchmark was to "increase the allocation for drugs and medical supplies to 25% of NDOH's budgetary allocation for 1998." In 1998, the allocation of drugs and supplies as a percentage of total NDOH expenditure was 28%. In 1999, the value increased to 31.8%.

In terms of the contribution made by HSDP to the total expenditure on drugs and medical supplies, in 1998 the contribution was 34.7% and in 1999 it was 26.6%. More importantly, the nature of the contribution has resolved the persistent problem of inadequate drug supplies reaching the lowest level of the public health system, the aid posts. A standard aid post medicine kit was designed with three rounds shipped annually. The kits are delivered directly to the PHOs, bypassing NDOH's area medi-

cal store network. The PHOs use HSDP-supplied trucks and funds to distribute the kits to all functioning aid posts. Because the kits are assembled in-country, health promotion materials from various sources (WHO, NDOH, National AIDS Council) have frequently been added to the kits for broad rural dissemination.

The aid post medicine kit system is widely viewed by NDOH, other central agencies, and provincial governments as a successful initiative. Responsibility for procurement and distribution rests entirely with NDOH, PHOs, and rural health facilities. The ADB TA provided minimal supervision, monitoring, and reporting. While the aid post medicine kit system needs to be reviewed and refined, it should be maintained as a permanent feature in NDOH's provision of medicines nationwide.

Management Processes

While the fourth policy reform area "Enhance the Efficiency of Health Service Delivery" has as its principal benchmark the establishment of national and provincial health boards (see Administration Under the Organic Law on Provincial Governments and Local Level Governments, Chapter 2), the underlying objective was to improve the management of the delivery of public health services. As presented in this section, the management structures and processes developed and implemented under HSDP have served as an overall management strengthening process extending beyond the HSDP policy matrix. This success is to a great extent based on the ownership developed through the wide consultation and participation in their establishment, and the investment in capacity building in the provinces through regular supervision and the performance review process.

Many of the PHOs and their respective provincial governments have responded well to the continuous process of management strengthening. The process has served to highlight the principal governance issues, creating a more transparent environment in which these issues receive greater attention and often become the subject of local discussion and remedial action. While all provinces receive the same oversight, their problems and recognized weakness are given individual attention, in a manner and at a pace that are acceptable, most often, to their respective provincial governments. A frequently updated tracking sheet, Health Sec-

tor Improvement Program: Status of the Provincial Trust Accounts, allows the PHOs to assess their management performance at a given point in time and in relation to other provinces. This information is widely distributed throughout the public health system and to all stakeholders. A recent example can be found in Appendix F.

Reforms and Innovation

The implementation of HSDP raised numerous issues both within NDOH and in the provinces, and across other central government agencies. Building on initial good will and perceived success, the resolution of issues relating to the performance of NDOH and provincial public health officials became crucial to the continued success of HSDP. Concomitantly, the performance of other key government agencies including the DOF, DPM, DPALLG, and AGO became accepted as inextricably linked to the performance of the public health sector.

Provincial Performance Audits

Early in 2000, it was recognized that the pattern of performance in the provinces with respect to HSDP was not dissimilar to the pattern found among provincial governments. The absence of authority over the PHOs by NDOH and the HSDP Secretariat meant there was no recourse for failure to comply with advice and assistance other than to withhold future funding, even though this would compromise the overall health status.

In order to resolve the stalemate and to lend greater credibility to NDOH's leadership and the functions of the HSDP Secretariat, an independent audit firm was contracted to conduct performance audits on the use of HSDP funds by PHOs. The audits reviewed their conduct of business against HSDP procedures, expenditure statements, and supporting documentation. Assets procured under HSDP were physically verified and a determination made as to whether value for money was obtained and if the assets were used for their declared and intended purpose. Four provincial performance audits were conducted in 2000, eight in 2001, and seven in 2002.

The audit reports were discussed internally by NDOH senior management and the concerned PHA was given the opportunity to respond to the findings. Several PHAs were found to be severely deficient in their management of HSDP funds. In these cases, the Secretary for Health initiated dialogues with the concerned provincial administrators, in their capacity as chairpersons of the Provincial Health Board, to seek corrective action.

These independent performance audits and the resulting situation wherein NDOH enjoined a provincial government to undertake remedial action with regard to its senior manager for health was an uncharted administrative process. Most cases were politicized, and it sometimes took from one to two years before an acceptable resolution could be found. In some cases the DOF, DPALLG, and AGO were informed and requested to intercede in an official capacity. However, while these national agencies have some degree of responsibility with regard to the provincial governments and the concomitant authority to act on behalf of the State, the principal issue is one of personnel management within a provincial government, the independence of which is defined in the New Organic Law. Nonetheless, there is some evidence that this recourse has assisted in breaking the stalemate situation.

Department of Health Performance Audit and Reform Process

The undertaking of independent performance audits in the provinces served to underscore the need for a similar review process in NDOH. This situation was made clear by the Secretary for Health and ADB was requested to assist in establishing an independent review of NDOH's financial management and procurement process.

Terms of references were prepared by NDOH and the AGO was approached for assistance in undertaking the selection process for an accounting firm. The AGO approved NDOH's request to initiate a performance audit not normally provided for under government regulations. It was also agreed that AGO would undertake the selection process and only international accounting firms would be invited to participate. The audit costs were covered with HSDP funds.

The performance audit[28] covering financial management and procurement[29] was carried out over a two-month period and the findings

were presented by the accounting firm to NDOH senior executive management in mid 2001. The report established that controls over procurement and expenditure within NDOH were ineffective and were not conducive to efficient operation. In particular, there was an inadequate managerial control framework, inadequate operational procedures and controls that do not ensure compliance with the Public Finance and Management Act, and the inability or unwillingness of management to take appropriate action in the event of suspected breach of statutory requirements or ethical business practice. Subsequent senior executive management meetings were held to review the performance audit findings, which resulted in a decision to proceed with the implementation of the recommended corrective measures. More importantly, senior executive management recognized that NDOH could not undertake the proposed reforms alone and the consulting branch of the accounting firm, which conducted the performance audit, was contracted to assist in the implementation of the reform measures.

Among the tasks carried out in the first eight months were:

- Assistance in bringing up-to-date the bank reconciliation of NDOH, 18 months out-of-date, required by DOF;
- Reforming the internal audit section of NDOH which had become dysfunctional, providing both purpose and on-the-job supervised training, and using the section to assist in the implementation of subsequent reforms (e.g., review of all NDOH rental agreements and establishment of an NDOH rental policy);
- Review of the accounts division and the proposal of a new structure, revised procedures, and a training program for staff;
- Re-engineering the procurement function to limit the number and nature of procurement centers and formulation of written procedures for the capital expenditure procurement center and for the human resource management procurement center;
- Assistance in the recruitment of private sector accounting staff; and
- Assistance in developing regular expenditure reporting by NDOH senior executive management for management purposes.

The process of bringing about change has been slow. Only incremental progress has been achieved thus far, but with the potential to positively influence public service culture. The exercise has polarized public

servants within NDOH into those supporting the reform process and those opposed. The internal debate generated has created undercurrents, which frequently influence the outcome of individual initiatives making up the process. Setbacks are not uncommon and, occasionally, progress attained appears inexplicable. Participation in the reform process is extensive; the slow pace of progress a necessary trade-off for broad consultation and consensus building.

The reform process should be expected to require several years to take hold within NDOH and perhaps longer, depending on the pace of reform processes undertaken in other national departments and central agencies. Many of the weaknesses identified within NDOH are present to varying degrees in all government agencies. Progress in NDOH will have to be matched with progress in other agencies to ensure sustainable public service reform.

Perhaps one of the greatest constraints to progress in the reform process is the inability or unwillingness of senior management to exercise personnel management options in relation to non-performance or breach of ethical business practices. NDOH's ineffectiveness in this area of management responsibility is entrenched, supported by non-responsive central government agencies, in particular DPM and DOF. Public service reforms addressing personnel management issues will have to reach across all government agencies and all levels of government in order to have a permanent impact on public service culture.

Department of Finance and Public Health Sector Expenditure

The production of a standard report on public health expenditure for six consecutive years has established that required information can be produced given sufficient persistence and collaboration between DOF, NDOH, and development partner agencies. Many government departments and development partners alike have positively received the broad dissemination of the annual report. The standard reports have helped to create a growing body of information users, especially among decision-makers. This is a slow process and one in which an interruption of even a single year would result in a serious setback in the sustainability of the information cycle.

The added value of having standard information over a six-year pe-

riod is highlighted by the inclusion of the public health sector expenditure trends, particularly in the provinces, in the ongoing debate on the strengths and weaknesses of the New Organic Law. The difficulties encountered in the information production process also underscore systemic weaknesses in DOF, both at the national and decentralized levels, and in the government payroll system. NDOH, like every government department, has a vested interest in seeing DOF address and resolve these weaknesses. For NDOH, to actively subscribe to DOF's strengthening process is to contribute to the DOF's fundamental mission to support other government departments and agencies.

The Financial Management Improvement Program (FMIP)[30] established in the DOF is undertaking fundamental reforms to correct recognized weaknesses. NDOH maintains a policy of liaising with DOF and the FMIP in order to provide inputs to their reform process, which reflects the needs experienced by the public health sector. NDOH has successfully influenced the budget structure and the re-centralization of the appropriation for both hospital funding and church health services funding to overcome the dilution suffered at the level of provincial governments. In working with the FMIP, NDOH seeks to participate in the DOF reform process as it applies to NDOH and, eventually, at the decentralized levels. This developing working relationship is increasingly seen as being beneficial to all parties.

Opportunities in Managing Cash flow

An unexpected outcome was the flexibility offered by the HSDP trust account to manage cash flow in a decentralized way. NDOH's managing of cash flow to allow for the "unexpected" instead of the standard DOF manner has enabled rapid crisis resolution including clearing shipments of medicines off the wharf because DOF was experiencing a cash flow crisis, reopening NDOH offices following lockout due to non-payment of electric bills, avoiding NDOH phone disconnections by covering final requests for payment, making up a shortfall in the cost of travel arrangements for essential purposes, and many other instances. The result is that NDOH has been allowed to function relatively smoothly, with fewer disruptions to core activities, in a period of fiscal uncertainty. HSDP has also had a similar stabilizing effect in most PHOs.

Managing cash flow guided by a minimum comfort safety margin has also allowed for opportunities to be seized. In the case of the independent audits of PHOs as well as the independent review and one-year consultancy to reestablish internal controls and management systems within NDOH, although not budgeted, both NDOH and DOF agreed to cover the associated costs with HSDP funds.

Managing cash flow from one fiscal year to the next and across different fiscal years for bilateral development partners has also provided for much needed stability. In a well-established cycle of profligate government spending in the fourth quarter and very tight availability of funds in the first quarter, HSDP has consciously managed its own cash flow to compensate for the less than regular government spending patterns. Also, important bilateral development partners have fiscal years six months out of synchrony with Papua New Guinea's fiscal year and the HSDP trust account has served to facilitate bilateral assistance across the fiscal years of these development partners.

Challenges

HSDP included 34 policy actions in four policy areas: (i) shift emphasis from urban to rural health services, (ii) shift orientation from curative to promotive and preventive health services, (iii) undertake financial reforms in the health sector, and (iv) enhance the efficiency of health service delivery. The release of the second tranche was subject to the fulfillment by the Government of eight specific conditions,[31] of which six were complied with at the time of the midterm review. While substantial progress has been made in financial reforms in the health sector and the allocation of drugs and funds to the rural health facilities has benefited from HSDP and AusAID input, other targets have not been attained. Little has happened with regard to the planning and management of human resources. The on-site training of health center staff is not systematically developed and supervision is very weak at all levels. Mother-and-child health patrols have increased only marginally and only in some provinces, and immunization rates are falling. In brief, HSDP did not succeed in preventing the slow and steady collapse of the health system in rural areas.

The causes for these failures are complex, including cultural and social issues in personnel management, but many are rooted in the breakdown of the vertical integration of health services brought by the New Organic Law. Decentralization can alleviate overloading of central government and improve access to decision-making and participation by more people. However, decentralization can also lead to deterioration in the use and control of resources if the administrative capacity is lacking, which is the case in Papua New Guinea. Of major importance, too, is the continuous degradation of the economic situation in the country and the deterioration in the transport infrastructure. Other factors identified by the Health Sector Review[32] are:

- The *management culture of the Papua New Guinea public sector is not performance based* with few rewards available for officials who perform well and few sanctions available to deal with those that perform badly. Budgeted funds are not always available to enable implementation of sector activity plans.
- *Many provincial authorities have not prioritized health services* through budget support. Provincial governors have all agreed to allocate 15% of provincial revenue to health. None have yet done so. Peripheral health services have been damaged by disproportionate retrenchments of key health staff when savings have been required.
- *Health policy is generally sound.* However, a number of *significant gaps* were noted with respect to: (i) AIDS/HIV, where there appears to be confusion over roles and responsibility; (ii) family planning, where this effective mechanism for reducing maternal and infant mortality appears to be under-prioritized; (iii) human resource development, where there appears to be little enthusiasm to address the multiple issues that face the management of this key resource; and (iv) poverty, where there appears to be little recognition of the need to specifically address the problems of providing services to the disadvantaged.
- *Supportive supervision*, a basic management tool for achieving and maintaining performance, is absent or weak at all levels of the health system.
- While policy is sound, *implementation of the policies has been weak* or non-existent reflecting both the lack of vertical integration in

the health sector and management weaknesses.

- Focus has been on developing high quality studies, policy papers, and guidelines and a lot of effort has been invested in planning rather than in *service delivery*.

Confronted with these difficulties, the Government and donors involved in the health sector began to explore mechanisms that would permit a broader framework for policy dialogue and action, within an integrated, strategic approach. This development took place while there was increasing frustration and dissatisfaction in NDOH with the proliferation of projects, which were overwhelming NDOH's management capacities and distracting attention from overall sector management, and the dissatisfaction of donors with disappointing performance of project-based assistance. The search for new forms of partnership and a review of international initiatives resulted in the adoption of a Sector-Wide Approach (SWAp) as a medium-term collaborative program of work.

Chapter 5

Moving Toward a Sector-Wide Approach

Defining a SWAp

The SWAp defines a method of working between government and development partners, a mechanism for coordinating support to public expenditure programs and for improving the efficiency and effectiveness with which resources are used in the sector (see Box 5.1).

The defining characteristics of a functioning SWAp are:

- All significant funding for the sector supports a single policy and expenditure program;
- Government provides leadership for the program; and
- Common implementation and management approaches are applied across the sector by all partners.

Over time, the program progresses towards relying on government procedures to disburse and account for all funds, and the ad hoc parallel reporting and management systems setup for projects disappear.

Six SWAp principles, which underpin the defining characteristics, are:

1. The SWAp is "sector-wide" in scope and covers both current and capital expenditures;
2. The SWAp is based on a clear sector strategy and policy framework;
3. Local stakeholders (government, direct beneficiaries, and private sector representatives) are fully in charge of the SWAp process;
4. All main donors sign on to the approach and participate in financing the SWAp, ideally in a process led by government;

BOX 5.1
The Sector Wide Approach

The sector wide approach (SWAp) is a method of working that brings together governments, donors, and other stakeholders within any sector. It is characterized by a set of operating principles rather than a specific package of policies or activities. The approach involves movement over time under government leadership towards: broadening policy dialogue; developing a single sector policy (that addresses private and public sector issues) and a common, realistic expenditure program; common monitoring arrangements; and more coordinated procedures for funding and procurement. Being engaged in a SWAp implies commitment to this direction of change, rather than the comprehensive attainment of all these different elements from the start. It implies changes to the ways in which both governments and donor agencies operate, and in their required staff skills and systems.[33]

Source: World Health Report 2000 – Health Systems: Improving Performance

5. As far as possible, common implementation arrangements are established for all donors participating in the SWAp; and
6. Local capacity, rather than long-term technical assistance, should be relied upon as much as possible to design, manage, and implement the SWAp.

Principal advantages of a SWAp

The principal advantage of a SWAp is increased government leadership and control and the strengthening of systems and capacities. The test over time will be improvement in terms of real efficiencies in resource use and improvements in health service delivery and in the satisfaction of consumers of these services. A SWAp —

1. Increases predictability of government and donor funding, when embedded in a public expenditure framework;
2. Places government squarely as sector leader, guided by policy and planned with knowledge of available resources;

3. Identifies priorities for action and service delivery and improves the financing base for delivery of these priorities;
4. Reduces transaction costs between donors and government and increases coordination of programs thereby reducing inefficiencies in implementation;
5. Applies health sector interventions and improvements equitably across the nation, avoiding geographic disparities;
6. Unifies financing from all sources, increases transparency of resource use, and improves accountability;
7. Applies a uniform "code of conduct" for all health sector development partners; and
8. Employs performance monitoring and uses an evidence-based approach.

Principal risks of a SWAp

1. *Reduction in or static government spending on health:* even if an adequate sector policy environment is achieved, deterioration in macroeconomic performance resulting in government being unable to keep up its financial commitments to the SWAp can undermine the sector budget.
2. *Weak government capacity to implement and manage the program:* Often capacity to lead the SWAp process has been shown to be weak, and optimistic donors tend to overestimate the implementation and absorption capacity of governments.
3. *Inadequate ownership and participation of wider stakeholder group:* Strong leadership and policy capacity are essential to the long-term success of a SWAp. SWAps can falter due to weak ownership of the process, leading to confusion about roles and responsibilities of partners (especially government), and inadequate participation of key powerful groups (particularly civil servants and decision makers).
4. *Weak accountability environment:* In a bilateral project, accountability is ensured through dedicated financial management systems because donors lack confidence in Government systems. Government's own financial management systems are, however, the backbone of common financial arrangements in most SWAps,

and internal and external audit mechanisms may be weak. Government systems are often in need of considerable strengthening to ensure transparent, accurate, and timely financial and progress reporting

5. *Loss of attribution:* In joint financing, donors lose the ability to attribute their funds to the attainment of specific objectives.
6. *Increased demands on government performance:* Often the pace of a SWAp must be linked to an achievable pace of a decentralization or other reform program. Systems and capacity strengthening are normally part of the SWAp process.

These advantages and risks have to be thoroughly weighed against the potential benefit of the proposed approach. Certainly, where there is no clear government policy or where policy is inconsistent, there is little to gain from the adoption of a SWAp. However, in these circumstances, the rationale for project aid is also weak.

An Established Foundation to Build a SWAp in the Health Sector

The Founding Mechanisms

The general framework of HSDP, now the Health Sector Improvement Program (HSIP), including budget support, earmarked for the health sector but focused on agreed priorities within the National Health Plan, and its financing mechanisms are building blocks of a SWAp to health, based on the existence of a single, accountable Government-managed mechanism to hold and disburse pooled donor funds. At a conceptual level, Papua New Guinea's HSIP trust account is highly consistent with international best practice in pooled funding arrangements. It closely resembles the Government financial system in its expenditure procedures and accounting and, in theory, is integrated with national and provincial planning and budgeting. There are very few restrictions on eligible expenditure items. In terms of accountability, it has been independently assessed as being of high quality. Substantial experience with these mechanisms has already been acquired in Papua New Guinea over the past five years,

which allows moving toward a real SWAp.

Under HSDP, NDOH and DOF established essential management systems, which provided the opportunity to all provinces to achieve improved health services delivery within the framework of the National Health Plan and the respective provincial health activity plans. The budget support provided through HSDP was available for most requirements but within a context of transparency and accountability.

The trust account mechanism, the supervision and oversight provided by the HSDP Secretariat in the provinces, the frequent and regular monitoring and reporting—all helped to strengthen the leadership position of NDOH. In turn, this provided NDOH sufficient leverage to adopt a position of influence with many provincial governments. Because NDOH, as a central government agency, engaged the provinces in a dialogue on commitment, performance and funding levels for health services, it is widely viewed as an innovator in the implementation of the New Organic Law.

Development Partners Finding Common Ground

In 2000, AusAID began discussions with NDOH and DNPM to examine the feasibility of shifting a portion of its assistance in the health sector toward a SWAp mechanism using the systems developed under HSDP as the foundation. The government's position was favorable as the implications suggested fewer projects and a more involved role for existing public health sector officers and staff. In fact, fragmented and relatively uncoordinated donor assistance created a significant managerial and administrative cost for national managers and staff. At the same time, some of NDOH's top management team were introduced to the concept and practice of sector-based assistance.

AusAID's bid to merge with HSDP, thereby establishing the HSIP, was welcomed by ADB and the HSDP Secretariat as both increasing the profile of and lending stability to the management systems and strengthening the relationship between the Government and the public health sector's two biggest development partners. The potential for complementary and supportive roles, improved efficiencies, and a strengthening of the public health sector, both centrally and at the decentralized levels, were featured prominently in conferences, workshops and PCC

meetings.

AusAID and ADB were not entirely in synchrony as the former was substantially increasing project aid to the health sector in 2000 and 2001 while ADB was winding down its project-based assistance. Financial contributions by AusAID and NZAID to the HSIP trust account in 2001 were linked to existing project-based assistance. The concept of unified assistance and support to the public health sector was not entirely implemented as different management and reporting requirements began to emerge between the untied aid provided by ADB and the tied aid from the bilateral partners. These are for the most part transitional issues that can be readily resolved through improved coordination mechanisms.

The difficulties in reconciling fundamental differences between multilateral and bilateral development partners notwithstanding, the potential the HSIP offers as a developing SWAp, to work towards the resolution of core health issues recognized by the Government and all development partners, holds promise. Indeed, a SWAp framework can facilitate both the development of leadership in key positions within the sector as well as improve upon development partner coordination and cooperation. The parallels of improving the management of health services at the decentralized levels involving multiple stakeholders should not be overlooked.

Other Mechanisms To Be Developed

While common financial management procedures are now in place, clearly the SWAp has implications for all the other elements of the aid management process.[34] In particular, sector-specific developments in health need to be tied into more general work on aid instruments, macroeconomic development, public expenditure management, and poverty reduction. Estimates of the resources available to the sector need to be as comprehensive as possible, and ideally the SWAp should follow an annual planning cycle synchronized with the budget, within a medium-term frame synchronized with the Medium Term Expenditure Framework (MTEF).[35] While Papua New Guinea does not yet have an MTEF, the Medium Term and Fiscal Outlook 2002–2007 is available and an MTEF is under development as part of the FMIP and Public Sector Reform.

The comprehensive approach also requires a change of focus in moni-

toring and evaluation, as donors have to consider the efficiency and effectiveness of the assistance to the sector. One of the key monitoring instruments in this context is the public expenditure review. A public expenditure review is currently being undertaken (March 2003) with the assistance of the WB. In addition, aggregate assessments of sectoral performance will have to be refined. Typically, performance monitoring looks at health sector performance (process, outcome and output indicators, health status and quality of life—disease burden in terms of morbidity, mortality, QUALYs/DALYs) and SWAp performance (achievement of milestones, management performance, donor and government performance). In Papua New Guinea, performance monitoring and evaluation is a core function of NDOH but in-house capacity needs strengthening. Monitoring is mainly limited to the 19 core indicators set by the National Health Plan and the routine Health Management Information System data, which are mainly disease and activity oriented (see Box 5.2). Sector performance would need to go beyond the monitoring of the 19 core indicators, to include systems analysis and a comprehensive assessment of all resources.

BOX 5.2
National Health Core Indicators, by Program

To monitor the overall performance of the National Health Plan, 19 Core Indicators have been identified. These form the basis of the Performance Monitoring Framework, which is a subsystem of the overall monitoring system and is integrated into the planning and management process at all levels.

Program	Core Indicators
1. General Administration	1. Proportion of total provincial expenditure on health 2. Proportion of provinces using the Standard 10 Health Program Budget
2. Urban Health	3. Total hospital expenditure as a proportion of total health expenditure 4. Proportion of public hospitals that meet key hospital standards
3. Rural Health	5. Proportion of total aid posts that are functional
4. Family Health	6. Proportion of deliveries in health facilities 7. Proportion of pregnant women receiving Tetanus Toxoid booster 8. Proportion of pregnant women who have attended the first antenatal care visit 9. Proportion of children under 1 year of age receiving third dose of Triple Antigen 10. Proportion of children under 1 year of age receiving measles vaccination 11. Proportion of children under 5 years with moderate malnutrition
5. Disease Control	12. Malaria case fatality rate for children under 5 years admitted to hospitals or health centers. 13. Pneumonia case fatality rate for children under 5 years admitted to hospital and health centers 14. Proportion of tuberculosis patients completing treatment.
6. Environmental Health	15. Proportion of health facilities with internal water supply
7. Health Promotion	16. Proportion of provincial implementation plans that include a health promotion component
8. Medical Supplies	17. Proportion of health centers recording shortages of essential drugs in more than two consecutive months
9. Human Resource Dev't	18. Proportion of health centers receiving at least one supervisory visit per year 19. Proportion of health facility staff receiving at least one competency based in-service training session each year

Source: Ministry of Health National Health Plan 2001–2010

Chapter 6

Conclusion

Moving Forward

The Government and nearly all its development partners are actively engaged in a process to define and implement a Papua New Guinea specific SWAp in the health sector. Special attention is devoted to ensuring that NDOH and other government officials retain the essential leadership role in moving forward. Efforts are made to ensure a broad participation of central government agencies including DNPM, DOF, DPALLG, and DPM in the process. The SWAp framework and principles presented above provide guidance accepted by all parties and allow for steady progress.

In laying the foundation to develop a SWAp in the health sector, HSDP undertook initiatives in key support areas, which contributed to the success of the overall program. Continued attention to these important support functions should remain an essential feature of the developing SWAp and HSIP. Some of these areas are covered below.

Governance Issues

The program of external audits has contributed much to broadening public sector recognition that governance issues are at the heart of poor performance levels in the health sector. This process, and the debate it fuels, should be maintained and supported.

The reform process underway in NDOH with the assistance of an international accounting firm also needs to be sustained. The progress to date is substantial, but a change in public service culture will require continued

assistance and the progressive and active involvement of the relevant government support agencies including DOF, DPM, AGO, Department of Intergovernment Relations, and others. A change in public service culture cannot occur, in a sustainable manner, in one government department alone.

There are growing influences which hinder and may oppose initiatives to improve upon governance and management. Opposing pressures include the rising consumer price index and weakening purchasing power of public servants' salaries, coupled with the poor management established by weak government leadership over the years. Cultural parameters such as clan affiliation and extended family are also, in the face of harsher economic times, creating greater and often conflicting demands on public servants, in health as in other sectors. For these reasons, it is important for NDOH and DOF managerial staff to travel to the provinces and provide a strong show of support for those PHAs and managers who are struggling to build up and sustain health systems based on sound planning and budgeting procedures.

Supervision and Continuous Support in the Provinces

Supervision and support by the HSDP/HSIP Secretariat of the PHOs and the PHAs have been very beneficial in most cases. However, there is a need to take this process further down the public health infrastructure pyramid to the districts and health facilities. Indeed, experience has revealed that the basic principles upon which functioning organizations and management are grounded are frequently lacking. These principles and their practical applications are best taught in an on-the-job, hands-on environment. While the HSDP/HSIP Secretariat endeavors to provide this type of support, a staffing level of six limits the coverage and time spent in each province. NDOH, which has a vested interest in improving performance at the decentralized level, should itself devote greater human resources and time to this function. The institutionalization of the Secretariat's function within NDOH is a prerequisite for moving toward a SWAp.

Transparency

HSDP established early on a policy of producing and disseminating information on as broad a basis as possible. This went counter to the not uncommon practice of producing information of limited scope for use in selective situations for purposes that might not entirely qualify as beneficial to the public health sector. In fact, HSDP helped place information in a new light, one where the discomfort of having one's performance rated and revealed began to be replaced by the understanding that this was a necessary step in identifying weaknesses in order to address them to improve performance. The information produced was standardized with regular periodic updates, and maximum exposure was given to guarantee HSDP was viewed as impartial and non-partisan.

With few exceptions, monitoring and information dissemination under HSDP served to create an environment of trust. The attention given to transparency and to resolving issues raised through the monitoring process also served to underscore the importance of the monitoring and information process. The useful application of information in the management process is acquired through practice. Only when managers have acquired this skill is the costly exercise of producing information justified.

Equilibrium, Unity, and Active Reform

HSDP has provided opportunities, which, during an unstable period of Papua New Guinea's history, contributed not only to the public health sector's steadiness but also to the ability to undertake a reform agenda. The challenges of the New Organic Law and decentralization were matched by the dynamic and consistent leadership of the Secretary for Health. Bringing together the provinces under NDOH leadership, HSDP provided not only much needed resources, but also management tools and supervision and monitoring and information sharing.

Both NDOH and the PHOs have improved their stature within their respective governments. The constructive dialogue undertaken with DOF, DNPM, DPMALLG, and AGO, among others at the national level, and with provincial governments at the decentralized level, has extended the list of stakeholders in public health.

Endnotes

1 Loans No. 1516-PNG / 1517-PNG (SF): Health Sector Development Program, for a total of US$50 million equivalent, approved on 20 March 1997.

2 UN, 2001.

3 Filmer, 1997.

4 Svensson, 1997.

5 HERA, 2002.

6 Archbishop Hans Schwemmer, in Sullivan, 2002.

7 Hanson et al., 2001.

8 The term PDMCs refers to the Cook Islands, Fiji Islands, Kiribati, Federated States of Micronesia, Republic of the Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tuvalu, Tonga, and Vanuatu.

9 ADB Country Economic Review – Papua New Guinea, June 2000.

10 Apparently a number of changes occurred in the National accounts for investment expenditures in 1996, which resulted in much lower recorded expenditure. This may explain, to some extent, the apparent dramatic rise in donor funding between 1996 and 1997. It may be appropriate therefore to take 1997 as the base year. This still shows a 22% increase in per capita health expenditure over the 5 years (or an average 4.5% increase annually), mainly due to increased expenditure from donor support. Government support has remained more or less stable in real terms over the same period.

11 National Health Plan 1996–2000.

12 National Health Administration Act.

13 First Rural Health Services Project, Loan No. 586-PNG, 1982–1986; Second Rural Health Services Project, Loan Nos. 746-PNG (SF) and 747-PNG, 1987–1991; Special Intervention Project – SIP, Loan No. 1054-PNG (SF), 1991–1993; Third Rural Health Services Project, Loan No. 1097-PNG (SF), 1992–2000; Population and Family Planning Project, Loan No. 1225-PNG, 1994–2001.

14 Loan No. 1097-PNG: Papua New Guinea Third Rural Health Services Project.

15 Annual Sector Review funded by AusAID in 2002, Health Sector Review conducted under ADB TA 3762-PNG.

16 National Health Plan, 2001–2010. Volume 2.

17 "Burden of Disease" is a method of calculating the impact of disease on a population that takes into account morbidity as well as mortality. Burden of Disease is measured in years of healthy life lost. The measure is known as Disability Adjusted Life Years (DALY).

18 Hiawalyer, G. and Spohr, M. 2002.

19 Some conditions, such as neuropsychiatric illnesses, constitute an unusually low proportion of the Burden of Disease, probably as a result of people suffering with these conditions not attending health facilities. The Burden of Disease reflects the actual reasons for attendance at health facilities rather than the societal burden of disease.

20 TA No. 2103-PNG: National Health Plan 1996–2000, approved June 1994.

21 Loans No. 1516-PNG / 1517-PNG (SF): Health Sector Development Program, for a total of US$50 million equivalent, approved on 20 March 1997.

22 Loan No. 1518-PNG for US$10 million, commonly called the HRD Project.

23 TA No. 2772-PNG: Strengthening Financial Management of the Health Sector.

24 Health Sector Monitoring and Review Group (HSMRG), 2002.

25 PNG Health Sector Improvement Program 2001 Expenditure, Appendix C.

26 HSDP Summary Progress Report: Expenditure and Availability of Funds, Appendix D.

27 PNG Public Health Sector 2001 Expenditure, Appendix E.

28 Department of Health, Procurement and Expenditure Review, 2001.

29 The review covered recurrent expenditure by NDOH under votes 240 and 241.

30 Supported by ADB (Loan 1703-PNG: Financial Management Project).

31 Increase financial allocation for rural health centers and aid posts by no less than 10% every year, increase drug supply to health centers and aid posts to K3 per capita, increase revenue from hospital user fees to 8% of operating costs, increase allocation for drugs and supplies to 25% of NDOH budgetary allocation, establish national and provincial health boards, establish local health committee for at least 50% of health centers, establish HRD branch within NDOH, privatize distribution of drugs.

32 HERA, 2002.

33 WHO, 2000.

34 A. Fozzard and M. Foster: Changing Approaches to Public Expenditure Management in Low-Income Aid Dependent Countries; A. Cassels: A Guide to Sector-Wide Approach for Health Development, World Health Organization, 1997.

35 See A. Fozzard and M. Foster (op.cit.).

Appendixes

Appendix A

Functions of the HSDP Secretariat

THE Department of Finance (DOF) is the Executing Agency (EA) of the Health Sector Development Program (HSDP), and the National Department of Health (NDOH) is the Implementing Agency (IA). In this capacity, DOF is responsible for carrying out the HSDP as specified in the Loan Agreement.

While the responsibilities of the EA are with DOF, many of the functions necessary to fulfill those responsibilities will be delegated to the HSDP Secretariat. The principal functions and associated tasks and activities are:

PCC Support

- Develop issues and provide recommendations based on monitoring activities to the Program Coordination Committee (PCC)
- Provide regular progress reports
- Undertake the organization/preparation of PCC meetings
- Keep minutes of all meetings
- Undertake all filing and record-keeping activities

Liaison

- Maintain close liaison with relevant sections of DOF (Budgets Division, Public Accounts Division, Information Technology Division, etc.) in the management and accounting of Program funds
- Support Provincial Treasuries in HSDP related matters
- Support and assist the NDOH in training and workshops

- Facilitate mutual assistance with the Asian Development Bank (ADB) Project Implementation Unit and NDOH
- Assist both the EA and the IA in policy discussions with the ADB
- Assist and respond to ADB queries
- Facilitate information sharing with the Benefit Monitoring & Evaluation Unit, DOH
- Facilitate information sharing with the National Monitoring Authority

Accounting Responsibilities

- Establish standard accounting forms and procedures
- Provide training and support in HSDP accounting
- Manage the imprest account and parent trust account
- Provide quality control to all provincial accounting
- Ensure all journal entries are correct and complete

Monitoring and Reporting to PCC and ADB

- Undertake the monitoring of all indicators relative to the policy matrix benchmarks
- Prepare the quarterly financial report on expenditure under the HSDP
- Prepare the quarterly activity report on overall progress
- Undertake comprehensive information dissemination
- Provide feedback to the Provinces and NDOH
- Coordinate the preparation of the Program Completion Report

Appendix B

Field Visit Reports: Selected Examples

Appendix B-1

HSIP Field Visit: Western Highlands

Review Dates : 14–15 March 2001

Team Members : Mr. W, Mr. Y

Meetings : Provincial Health Advisor
Provincial Health Administration Officer
Co-ordinator Health Extension Services
Ela Motors Service Manager
Highlands Regional Hardware Manager

Brief

This was a follow-up review related to earlier ones, the most recent on 18–19 December, 2000. We reviewed the outstanding problem expenditures which were still not corrected after two other reviews conducted. During this review, the PHO managed to bring down the unacquitted amount to less than 20 percent. They now qualify to get further funding under HSIP. The problem items of expenditure still not resolved are given below for further corrective actions.

ECF #	Date	Cheque	Amount	Remarks
00-057	05.07.00	400389	5,883.40	No completion report
00-067	11.07.00	655702	9,845.00	No x 3 quotations, no receipt, explanation of costs for preferring the camera at CHM
00-069	11.07.00	655704	1,533.62	No alternate quotation & distribution list, no receipt
00-070	27.07.00	655705	858.54	No invoice and receipts, invoice for K258.20
00-074	27.07.00	655709	2,961.24	No receipts from Ela Motors & no copy of cheque
00-079	27.07.00	655714	2,951.58	No receipt, scope of work & completion certificate
00-088	27.07.00	655723	1,890.52	No quotes, invoice, receipt, delivery docket and completion certificate
00-108	13.09.00	655743	2,148.83	Payment is questionable; no report of workshop. How was the money cashed from the shop?
00-111	25.09.00	655746	5,400.00	No health promotion report; acquittals not acceptable
Total amount not acquitted			**33,472.73**	

After the review, several suppliers and firms were visited to find out why they are unable to provide the necessary supporting documents to establish payment and delivery of goods. We visited:

1. Ela Motors for not producing a receipt. We met the Service Manager and he advised us that a receipt is usually issued for payments made and he doesn't understand why a receipt wasn't issued for this payment. He said he would find out and necessary actions will be taken after he finds out the problem.
2. We went to Jaya Office Supplies for not producing an invoice and receipt. One of the senior officers advised us that he will

inform the officer responsible to issue them when he comes back. The officer was not there when we went to enquire about the documents.

3. Thirdly we went to Steamships Hardware. The regional manager was approached and we enquired why documents were not supplied for purchases made from them. The regional manager is aware of the HSDP/HSIP and does make sure documents are given to the officers who come to collect the purchased items. He reiterated that the fault lies with the officers who pick up the materials in misplacing the documents.

We also went to one of the nearby Hagen town community SDA-run schools for a site inspection of the toilet block built with HSIP funds. The project was completed although from observation, the materials used in construction were of poor quality and the amount spent was not worth the end result, i.e., poor value for money.

On Thursday morning, we site inspected the renovation and maintenance work at Anga Aidpost which is about 10 to 20 kilometers out of Hagen town. The work was progressing well and we were told by the carpenter that the job will be completed within a week's time. We were told that the aid post was closed about 10 years ago but now they were reopening it, mainly because the position of the CHW is funded under this year's Provincial Government budget.

Principal Issues

The Provincial Health Office is still having a lot of problems trying to follow up on invoices and receipts from suppliers to which they have made payments. According to our observations, we feel they are not persistent or aggressive enough in following up with outstanding matters highlighted in our review reports. As a result, the PHO did not have access to new HSIP funds for six months.

We insisted that we would like to visit the Provincial Transit Store but were informed the officer who had the store keys to the building was not available. As a result, we could not established whether all the aid post kits were sent out or not. We were informed by the PAO that some aid post kits were sent out and some are still in the transit store yet to be sent out. The actual number of kits could not be established.

Appendix B-2

HSIP Review by the Secretariat: North Solomons

Review Dates : 20–21 March 2001

Team Members : Mr. S

Meetings : Provincial Health Advisor
Provincial Health Administration Officer
Assistant HSDP Accounts

Brief

The review was carried out following a request by the PHA. The period covered by the review was from August 2000 to February 2001 (ECF# 00-160 through ECF # 01-66).

Follow-up on the problem items listed in our last review dated 31 August 2000 could not be made as the required papers were not available with the PHA and his team.

Progress achieved on the principal issues listed in the last review was also checked.

The following problem item of expenditures remain unresolved:

ECF #	Date	Cheque	Amount	Remarks
01-66	28-02-01	730632	4,000.00	Renovation & important maintenance of PHO building. No alternative quotations. Contact: John Karai, PT
01-48	28-02-01	730614	5,100.00	Fuel supplies for immunization work. No report of actual immunization work done. No alternative quotes.
01-47	28-02-01	730613	9,328.00	Two (very expensive) lawn mowers purchased. No alternative quotes, no invoice and no proof of delivery.
01-40	27-02-01	730605	4,095.00	Fuel purchase for boat, vehicle & generator. No invoice.
01-32	22-02-01	131697	900.00	Reimbursement to J. Galo for 9 travels to Buka from Manetai HC @ K 100 per trip. No report on the work done during trips.
01-27	22-02-01	131692	3,000.00	Timber purchased for Manetai HC. No proof of delivery.
Total of problem items			26,423.00	

The total being lower than the 20% threshold allowed, further transfer of funds may be made to the HSIP trust account. Improvements noted in all the areas listed under principal issues at the last review.

Principal Issues

- The coding of expenditure items needs improvement. The PHA and the PHAO have been given a short training on the use of the correct item codes.
- The problem items of expenditure, as noted above, need to be resolved.

Appendix B-3

HSIP Field Visit: Madang Province

Review Date : 2 May 2001

Team Members : Mr. I

Meetings : Provincial Health Advisor
Provincial Health Administration Officer
Health Promotion Officer
CEO Madang General Hospital
OIC Area Medical Store

Brief

The primary purpose of the field visit was to re-establish contact with the Provincial Health Office and to begin to resolve the many issues raised in the independent audit of the use of HSDP funds carried out in October 2000. Correspondence between the PHO and the NDOH was reviewed, documents collected and the following determined:

- The exceptional items of expenditure revealed in the *Field Visit* report of October 2000 received additional attention and some work from Mr. Z. However, the PHA had not reviewed the work and could not provide an indication of the state of advancement.
- Mr. Z and Mr. H are no longer assigned to work on HSIP/HSDP. Currently Mr. Z is unattached. However, he retains in his pos-

session all files and documents pertaining to HSDP expenditure and exceptional items.
- Mr. X, confirmed in the position of Provincial Health Administration Officer, does not have adequate knowledge of the HSDP audit and the many exceptional items which need to be resolved. Mr. X did indicate his willingness to assume the responsibility of taking over from Mr. Z.
- The Provincial Health Office is largely inoperative because of lack of funds, all phone lines disconnected, and office equipment removed by the previous Provincial Health Advisor.

Open and frank discussions led to the following decisions:
- All HSDP files will be handed over from Mr. Z to Mr. X. All Cash Books, all bank reconciliations and all ECFs (including supporting documentation) will be stamped "Received from Mr. Z", *dated and signed*.
- An HSIP *Field Visit* will be undertaken in the next two weeks to review and help resolve all outstanding items of expenditure identified in October 2000 totalling over Kina 220,000.
- The Department of Health will assist to make the Provincial Health Office functional again by 1) replacing office equipment removed by the previous Provincial Health Advisor, 2) procuring necessary office supplies, 3) paying the overdue HSDP phone bills.
- The PHA agreed to have his staff organize all records and files, and to clean all offices including floors, walls, bathrooms, and other areas. Very old records will also be examined for possible disposal.

Aid Post Medicine Kits were also covered during the visit. The PHA reported the PHO received one container in January and another in March, each one holding about 148 kits. The January shipment was said to be completely distributed and for the March shipment, 60 kits were registered as picked-up whilst 67 kits remained in the Provincial Transit Store (PTS). The recently built PTS is dry, cool and clean. The Aid Post Kit register is made up of loose pages. The register should preferably be a hard bound book. The distribution of kits is mostly

passive in nature with Aidposts and Health Centres picking up kits from the PTS. The PHO is not actively distributing kits due to lack of funds.

Health Promotion Materials were received in March in the same shipment as the Aid Post Kits. According to the Health Promotion Office, the following materials were received in March:

- *Mi Gat Banis* posters – x 1000 each Coast and Highlands version (total x 2000 posters)
- *Specim?* FP posters – x 300 posters
- *Dakglascaman* comic book – x 250 books
- *Olgeta Samting Mi Bin Laik Save Long Pasin Bilong Spesim Pikinini* – x 1200 books
- *Asua Bilong Husat* comic book – x 1200 books
- Your questions answered on HIV/AIDS (WHO) – x 200 books
- *Laif Bilong Mi Toktok Bodi* (meri) poster – x 50 posters
- *Laif Bilong Mi Toktok Bodi* – x 45 books
- 2001 Calendar Rausim Birua Malaria – x 100 posters

The HPO noted that the materials received were not the materials requested in December 2000, and that the request form had not been answered. He indicated he needed more copies of "Your questions answered on HIV/AIDS" (WHO), more *Laif Bilong Mi Toktok Bodi* books and *Bodi Bilong Mi* (man) posters. He would also like to receive some order/request forms from the NDOH.

Area Medical Store – A brief meeting with the OIC AMS Madang, was held during which he confirmed the 3-ton truck supplied by HSDP last year had suffered two accidents and was currently parked at the OIC's residence. Both accidents had occurred with the OIC at the wheel and both occurred after business hours. The OIC was requested to obtain professional advice from Ela Motors on whether the vehicle could be salvaged and at what cost.

Modilon Hospital – A meeting was held with the CEO Modilon Hospital, who indicated that the hospital wished to support the Provincial Health Office in becoming functional again so that both the Hospital and PHO could work together on initiatives of mutual benefit. The

CEO advised that he was trying to ready the X-ray facility for the new X-ray machine being procured through HSIP. However, the CEO has not had a response from the Director of Health Facilities, on the necessary renovation work.

The CEO also noted that the Hospital no longer had a functioning photocopier so that both the PHO and the Hospital had to seek assistance elsewhere whenever photocopy services were needed. It was suggested that since the PHO might receive a photocopier through HSIP, it would be a good idea for the Hospital to receive the same machine. It was generally agreed that this made sense and the request would be taken up at the Department of Health.

Principal Issues

One issue predominates and that is the rehabilitation of the Madang Provincial Health Office to once again be eligible for HSIP funding. On this, both the PHA and the PHAO expressed their unequivocal readiness to undertake whatever actions are required to correct the extensive weaknesses revealed in the audit and the field visit reviews.

The HSIP Secretariat will begin to work closely with the Madang PHO to undertake corrective measures and to become functional. The PHA was advised that the Department of Health will soon approach the Provincial Administrator and the Provincial Health Board with proposed actions to remedy the current situation.

Appendix B-4

HSIP Field Visit: West New Britain

Review Dates : 14–16 February, 2002

Team Members : Mr. K, Mr. I, ADB consultants

Meetings : Provincial Administrator
Deputy Provincial Administrator
Provincial Health Advisor
Provincial Health Administration Officer
A/DHO Talasea
CEO, Kimbe Hospital
A/OIC, Buvussi Health Center
CHW, Hoskins Aid Post
OIC, Malalia (sub) Health Center
OIC, Callan Health in Service College, Valoka

Brief

This field visit had two main objectives: 1) to resolve the situation concerning the large unacquitted expenditure for some 25 water tanks which were never delivered and 2) to provide the two ADB consultants reviewing the HSIP an opportunity to evaluate its implementation and the issues the SWAp raises. The problem items of expenditure that require further explanation and acquittals are given below:

ECF #	Date	Cheque	Amount	Remarks
00-025	14.02.00	79475	21,028.37	No proof of delivery of two tanks after physical verification of 8 tanks on site.
00-053	17.07.00	126403	2,000.00	No progressive status report/ completion report
00-054	17.07.00	126404	1,000.00	No progressive status report/ completion report
00-062	17.07.00	126412	62,100.00	No invoice, receipt, distribution list, no proof of delivery of 23x tanks, whereabouts unknown
00-093	22.08.00	126445	1,452.00	No ticket butts for two officers (unused tickets must be reimbursed)
Total unacquitted expenditure			**87,580.37**	**... linked to Mr. L's administration.**
01-010	03.09.01	94811	540.00	Cash advance to Yatao to do MCH, no report on patrol and acquittal
01-011	03.09.01	94812	510.00	Cash advance to Mageo to do health improvement assessment, need refund of K150 fuel used for funeral cost, not eligible item of expenditure
01-014	03.09.01	94815	280.00	Cash advance to Mangurei to do MCH, no receipts, acquittals and report on patrol
01-017	03.09.01	94818	790.00	Cash advance to Kause to do MCH, no report on patrol
01-024	03.09.01	94825	470.00	Cash advance to Tiga for immunization, no acquittals and report on patrol

(continued)

ECF #	Date	Cheque	Amount	Remarks
01-028	03.09.01	94829	400.00	Cash advance to Kasate for immunization, no acquittals and full receipts
01-056	08.10.01	94857	1,095.00	Cash advance to Pakilio for Village Health Patrol, no report on patrol
01-059	08.10.01	94860	460.87	Purchase of premix fuel for Village Health Patrol, no report on Patrol
01-060	08.10.01	94861	280.00	Cash advance to Pakilio for Village Health Patrol, no report on patrol
Total problem items of expenditure			**4,825.87**	

Principal Issues

A meeting was held attended by the Provincial Administrator, Deputy Provincial Administrator, Provincial Health Advisor, Kimbe Hospital CEO, the Director of Policy & Planning DOH and the ADB Technical Advisor, to resolve the issue of missing water tanks (see field visit reports for August and December 2001) and the Department of Health's position on further transfers of HSIP funds to the WNB Health Office.

The Provincial Administrator informed the meeting that Mr. L had recently been suspended and that Mr. T had been nominated as acting Provincial Health Advisor. The Provincial Administrator expressed confidence and trust in T's abilities and commitment to public health and indicated he expected none of the problems that were experienced under the previous Health Advisor.

The ADB Technical Advisor noted that under HSIP procedures, new funds could not be transferred to the WNB Health Office until a solution was found regarding the 25 missing water tanks. After some discussion, it was agreed that problem items of expenditure would be temporarily set aside pending the Provincial Government's efforts to recover the tanks or reimburse the funds, resorting to the police / judi-

ciary to accomplish this. Given this course of action, new HSIP funds could be made available to the Provincial Health Office.

The unacquitted expenditure appearing in the box above in the amount of Kina 87,580.37 is linked to Mr. L's administration and will be temporarily set aside pending investigation into the 25 missing water tanks. A satisfactory outcome will be necessary in order to have this unacquitted expenditure permanently removed.

The PHO may receive new HSIP funds to the level of the current ceiling of Kina 50,000.

Several health facilities were inspected during the field visit. **Buvussi Health Center** was found to be in an advanced state of decay. Maintenance work paid for under HSDP had barely begun before being abandoned. As the facility is used by many employees of New Britain Palm Oil Ltd., it was suggested they become involved in the renovation and maintenance of the facility whilst HSIP funds could still be used to cover costs.

The **Hoskins Aid Post** appeared well managed and required only minor repairs and new paint. The water tank was said to be too small causing water interruptions during the dry season. A larger tank could be installed.

The **Malalia Health (sub) Center** also requires important maintenance work including the replacement of beams supporting the overhang and roof drainage gutters and pipes. Louvers and new mosquito screens are needed along with inside and outside painting. The nearly finished and unoccupied ward could serve as a temporary facility whilst maintenance work is carried-out on the principal building.

An extensive tour of the **Callan Health in Service College, Valoka**, was provided by the OIC. The facility is very well organized, well-maintained and clean. Patients are said to come from all over WNB, and beyond, to take advantage of the high quality of services. The contrast with the other facilities visited is extreme.

Appendix B-5

HSIP Field Visit: Manus Province

Review Dates : 25–27 March 2002

Team Members : Mr. I, Mr. S

Meetings : Provincial Administrator
A/Provincial Health Advisor
Coordinator Implementation & Monitoring
Project Officer
Provincial Treasurer

Brief

The *Field Visit* was undertaken with three principal objectives: 1) to resolve issues related to the non-performance of the Provincial Health Office in relation to managing HSIP funds, 2) to participate in the workshop on the *Implementation of Minimum Standards*, and 3) to follow up on the status of the problem items of expenditure noted in our review dated 7 February 2002. Expenditure Control Forms and supporting documentation for problem items identified in the last review were examined. Problem items of expenditure are listed below:

ECF #	Date	Cheque	Amount	Remarks
01-17	14-03-01	143138	5,400.00	Paid to M Salvage for salvage of MV Hian. No alternative quote as service provider is said to be the only supplier of the kind. Boat no longer functional; Said to be on tender for sale; Estimated sale value of K300,000 appears excessive on visual inspection. Not a qualifying item of expenditure under HSIP and should be reimbursed.
01-22	16-03-01	143143	2,549.80	Airfare for travel of B Avue, M Pahun amd Mr Bomai to POM and Madang. No ticket butts to substantiate travel; No report.
01-24	14-03-01	143145	1,890.00	Compensation payment to Simon Ndrepolon for chain wire lost in 1999 in boat mishap while on PHO's work. Not a qualifying item of expenditure under HSIP. Needs reimbursement.
Total of problem items			**9,839.80**	

The total being lower than the 20% threshold allowed, a new transfer of funds can be made to the Manus Province HSIP Trust Account.

A ***PGAS daily backup tape*** was obtained from the PT's office and handed over to ITD for inclusion in the analysis of provincial health sector expenditure for 2001.

Principal Isues

- The Provincial Administrator advised the Team of the reorganization of the health office, in particular the appointment of a new Provincial Health Advisor. Appropriate changes to the A21

and a new signature card are needed and will be initiated by the HSIP Secretariat.

- The remaining problem items noted above need to be resolved.
- The PHO explained that Shell is the only wholesale supplier, and principal retail supplier, of fuel on Manus and it is therefore difficult to obtain three quotes. The Field Team requested an explanatory letter from the PHO and emphasized the need for control over fuel usage to ensure use is for health purposes only.
- Health vehicle maintenance and repairs as per HSIP procedures is proving difficult to adhere to by the PHO. They suggest an agreement/arrangement/contract be established with the Ela Motors agent on Manus through Ela Motors in POM. The Field Team suggested that a list of authorized health vehicles be prepared with details of the local agent for taking the matter up with Ela Motors. It was also explained to the PHA that no past/outstanding commitments will be paid out of new HSIP funds.
- The issue of patient evacuation/referral was brought up and it was explained that this is a recurrent item of expenditure for which the Provincial Government is responsible. It was further noted that it is a long-standing Program Coordination Committee (PCC) decision that patient evacuation/referral costs are not an eligible item of expenditure under HSIP.
- On the matter of integration into the National Health Radio Network, it was explained that HSIP can be used to cover maintenance costs and new radios but that HSSP are providing technical guidance in the matter. Thus it was agreed that the PHO will contact HSSP and TE to take the necessary steps to integrate Manus into the National Health Radio Network.
- The Field Team explained to the PHO that no expenditure is permitted at this point in time towards the construction of new staff housing. However, HSIP will cover maintenance/renovation costs of health facilities and existing staff housing. Work should be completed first on the health facility before maintaining staff housing.
- It was agreed that the outstanding telephone bill relating to the HSDP/HSIP telephone ***only*** will be paid off by HSIP. However, in future better control will be exercised over the use of the HSIP

telephone. (The PHO was reminded that the monthly HSIP Secretariat phone bill averages Kina 700 and that provincial HSIP phone bills were expected to be below the Secretariat's.)

- Regarding the use of the Certificate of Inexpediency, it is normally applied for, approved, and issued ***before*** purchase or expenditure is incurred in a situation where there is only one supplier.
- All boats/OBM will be purchased centrally. The request to replace the PHO's Health Boat destroyed by a falling tree in 2001 will be considered. The Provincial Health Advisor made a strong appeal to purchase 23' banana boats equipped with 40 hp OBM for Health Centers. It will be considered on a trial basis for the three facilities given by the PHA as the highest priority: Pehpowai HC, Lako HC, and Panuselu HC.
- DPM's circular on travel allowance dated 1 September 2000 must be followed in every respect. In particular, camping allowance is set at Kina 20 per night. Rates in excess of those provided under DPM regulations will not be accepted under any circumstance.
- The Field Team requested a cash plan for the first K50,000 be prepared by the Provincial Health Advisor and faxed over to the HSIP Secretariat. Once a plan is agreed upon and funds transferred, a member of the HSIP Secretariat will travel to Lorengau and work with the PHO to carry out the plan whilst following HSIP procedures. This exercise is intended to be on-the-job training for all PHO staff.
- A presentation was given at the workshop on the *Implementation of Minimum Standards*. Approximately 30 health staff, including the OICs of all the major Health Centers and Health sub-Centers in Manus Province were in attendance. HSIP expenditure for 2001 was presented and included discussion on anomalies in spending patterns. Also presented and discussed was the tracking sheet on the performance and status of all provincial HSIP trust accounts. Issues relating to governance, transparency, and obtaining value for money were discussed in the public health sector context as well as in relation to HSIP.

Appendix B-6

HSIP Field Visit: West New Britain

Review Dates : 31 October–2 November 2002

Team Members : Mr. W, Ms. K

Meetings : Provincial Health Advisor
Provincial Health Administration Officer
Provincial Health Enviornmental Officer

Brief

The review was requested by the PHA to cover HSIP expenditure under ECF 02/31– 02/142. The items of expenditure were reviewed to ensure HSIP accounting procedures and guidelines were adhered to in expending HSIP funds given to the Provincial Health Office. The problem items of expenditure as of date are stated below:

ECF #	Date	Cheque	Amount	Remarks
00-025	14.02.00	79475	21,028.37	No proof of delivery of two tanks after physical verification of 8 tanks on site.
00-053	17.07.00	126403	2,000.00	No progress report/completion report.
00-054	17.07.00	126404	1,000.00	No progress report/completion report.
00-062	17.07.00	126412	62,100.00	No invoice, receipt, distribution list or proof of delivery of 23 tanks; whereabouts unknown.
00-093	22.08.00	126445	1,452.00	No ticket butts for two officers (unused tickets must be reimbursed).
Total unacquitted expenditure			**87,580.37**	**... linked to Mr. L's administration.**
02-015	18.04.02	94888	3,234.32	Paid to Genaka Construction for final payment on repairs contract for Marapu aid post. Job still incomplete. Contractor must complete unfinished job.
02-077	17.07.02	115551	780.00	No receipt for accommodation for Yakabus Waia of K300 for doing dental visits.
02-094	19.07.02	115569	680.00	No report of response workshop conducted at PHO.
02-110	29.07.02	115585	1,100.00	No report of supervisory visit conducted by the Health Information Officer at Gloucester area.

(continued)

ECF #	Date	Cheque	Amount	Remarks
02-117	29.07.02	115589	3,750.00	No report for TOT cap training workshop & require reimbursement of balance unspent of K367.80
02-118	05.08.02	115590	145.80	No alternate quote for stationaries bought for PHO.
02-124	05.08.02	115598	1,890.00	No acquittal from Julie Mitchel for the TOT training workshop on TOT training for 6 days.
02-136	05.09.02	187610	2,593.70	No receipt for materials purchased & invoices do not agree to the value of cheque amount.
Total of problem items			**14,173.82**	

The above total being less than the 20% threshold, a new transfer of funds can be made at this point in time.

Aid Post Kits: We visited the medical transit store which was found to be clean and dry. All the aid post kits were sent out immediately as soon as they were received. We found 10 boxes, both A and B, which were designated for Gloucester, Talasea and Mosa. We told them to send them out to the respective sites as soon as possible. Their Dyna truck designated to drop off medical supplies is in the workshop and will be taken out of the workshop as soon as they get the next transfer of HSIP funds.

Principal Issues

- The PHO has demonstrated much improvement in the management and accounting of HSIP funds since the last field visit. Cash books were found to be updated together with the bank reconciliation. This is commendable and must be maintained.

- The last HSIP funds transferred were evenly expended over the 10 health programs. Much emphasis was given to family health services apart from the spending on the other health programs. The PHA was advised to do the same with the next transfer of HSIP funds.
- The PHA was told to complete all outstanding capital works not completed by the former PHA, ensuring that they are not duplicate payments and must be the final payment to complete the unfinished jobs. The current PHA said he would look into it and complete the two projects referred to above.

This Review

Total items reviewed	:	111	
Total items acceptable	:	103	92.8%
Total problem items	:	8	7.2%

Appendix C

Health Sector Improvement Program: 2001 Expenditure

TABLE C-1
Health Sector Improvement Program: 2001 Expenditure By Standard Program Category through 31 December

	Expenditure Entity	Prg 1 General Administration	Prg 2 Urban Facilities	Prg 3 Rural Facilities	Prg 4 Family Services	Prg 5 Disease Control
	DOH/HSIP Secretariat	**2,481,042**	**926,802**	**1,351,565**	**674,674**	**73,927**
1	Western	94,767	0	60,012	0	4,484
2	Gulf	43,386	0	0	40,064	1,714
3	Central	208,290	0	62,625	56,981	20,889
4	NCD – uses Parent Acct.					
5	Milne Bay	207,004	12,843	64,404	123,123	11,463
6	Oro	4,385	0	800	0	0
7	Southern Highlands	116,550	5,255	13,911	44,863	0
8	Enga	103,725	60,990	334,376	14,331	1,054
9	Western Highlands	154,895	1,597	116,421	13,515	0
10	Simbu	109,161	240	87,653	6,154	32,695
11	Eastern Highlands	153,127	41,901	72,670	14,515	11,071
12	Morobe	222,940	781	104,785	30,235	22,570
13	Madang	0	0	0	0	0
14	East Sepik	6,542	0	9,191	6,532	8,475
15	Sandaun	102,545	2,598	9,457	2,016	2,004
16	Manus	51,229	4,596	33,728	1,975	0
17	New Ireland	77,999	3,000	16,781	18,818	11,117
18	East New Britain	(419)	0	0	0	0
19	West New Britain	13,776	0	0	23,580	2,790
20	Bougainville	137,810	3,775	81,299	23,105	15,266
	Provincial Total	**1,807,712**	**137,577**	**1,068,115**	**419,808**	**145,592**
	TOTAL	**4,288,754**	**1,064,379**	**2,419,680**	**1,094,482**	**219,519**
	Program Distribution	**16.4%**	**4.1%**	**9.3%**	**4.2%**	**0.8%**

NOTES

1 Prg 1 - General Administration, Prg 2 - Urban Health Facilities, Prg 3 - Rural Health Facilities, Prg 4 - Family Health Services, Prg 5 - Disease Control, Prg 6 - Environmental Health & Water Supply, Prg 7 - Health Promotion & Education, Prg 8 - Medical Supplies & Equipment, Prg 9 - Human Resource Development, Prg 10 - Support Services.

2 All amounts are in Kina.

3 Contributors to the Health Sector Improvement Program include the Government of Papua New Guinea, ADB, AusAID, NZODA, WHO and SPC.

Source: HSIP Secretariat, Financial Evaluation Division, Department of Treasury. Update: 28 February 2002.

Prg 6 Environment & Water	**Prg 7** Promotion & Education	**Prg 8** Supplies & Equipment	**Prg 9** HRD	**Prg 10** Support Services	**TOTAL**	% **Share**
506,630	**318,716**	**12,717,892**	**2,173,763**	**131,609**	**21,356,619**	**n/a**
6,490	4,728	29,195	2,317	500	202,492	4.3%
3,234	181	9,243	6,984	2,354	107,160	2.3%
74,427	0	27,088	10,855	0	461,157	9.7%
37,469	5,140	92,104	65,060	5,389	623,999	13.1%
0	0	0	0	0	5,185	0.1%
3,749	0	8,304	5,935	0	198,567	4.2%
191,035	100	1,310	12,015	0	718,937	15.1%
2,729	0	1,431	16,303	0	306,891	6.4%
29,945	0	1,466	6,500	0	273,814	5.8%
103,453	5,200	26,525	9,346	23,593	461,401	9.7%
6,280	10,979	39,462	11,325	0	449,358	9.4%
0	0	0	0	0	0	0.0%
4,877	0	12,377	0	0	47,994	1.0%
50,514	0	18,187	11,651	0	198,971	4.2%
1,985	0	963	0	4,180	98,655	2.1%
72,239	520	4,998	7,533	6,561	219,566	4.6%
0	0	0	0	0	(419)	0.0%
3,160	0	3,881	0	0	47,187	1.0%
59,805	0	16,526	0	0	337,588	7.1%
651,391	**26,847**	**293,060**	**165,823**	**42,577**	**4,758,503**	**100.0%**
1,158,021	**345,563**	**13,010,952**	**2,339,586**	**174,186**	**26,115,122**	
4.4%	**1.3%**	**49.8%**	**9.0%**	**0.7%**	**100.0%**	

TABLE C-2
Health Sector Improvement Program: 2001 Expenditure By Item Category through 31 December

	Expenditure Entity	Personnel Emoluments Items 110	Goods & Services Items 120	Other Operation Expenses Item 135
	DOH / HSIP Secretariat	**0**	**15,321,371**	**24,807**
1	Western	0	140,955	7,022
2	Gulf	0	101,112	4,921
3	Central	0	306,656	-2,911
4	NCD - uses Parent Acct.			
5	Milne Bay	0	501,580	9,315
6	Oro	0	7,198	-2,013
7	Southern Highlands	0	151,228	10,533
8	Enga	0	136,572	9,546
9	Western Highlands	0	219,465	6,064
10	Simbu	0	147,141	20,057
11	Eastern Highlands	0	175,818	28,346
12	Morobe	0	324,307	18,447
13	Madang	0	0	0
14	East Sepik	0	47,984	11
15	Sandaun	0	102,464	13
16	Manus	0	76,688	12,555
17	New Ireland	0	119,968	8,942
18	East New Britain	0	(44)	(376)
19	West New Britain	0	46,730	120
20	Bougainville	0	247,764	12,135
	PROVINCIAL TOTAL	**0**	**2,853,586**	**142,727**
	ITEM DISTRIBUTION	0.0%	60.0%	3.0%
	GRAND TOTAL	**0**	**18,174,957**	**167,533**
	ITEM DISTRIBUTION	0.0%	69.6%	0.6%

NOTES

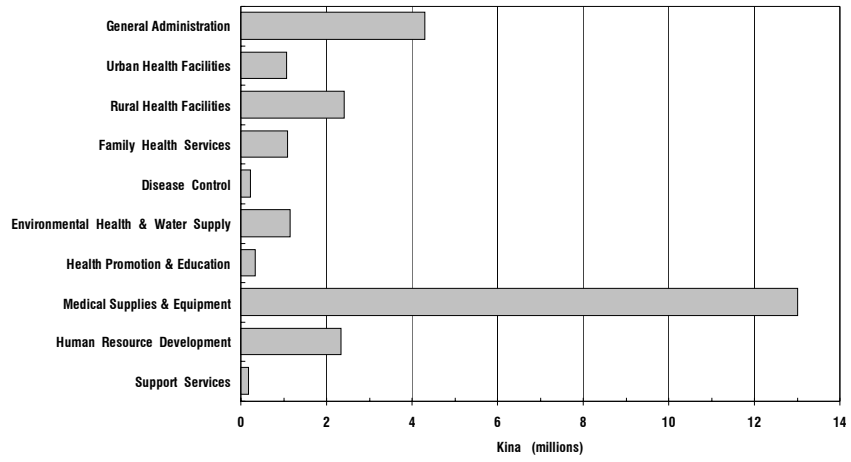
1 All amounts are in Kina.

2 Contributors to the Health Sector Improvement Program include the Government of Papua New Guinea, ADB, AusAID, NZODA, WHO and SPC.

Source: HSIP Secretariat, Financial Evaluation Division, Department of Treasury. Update: 28 February 2002.

	Capital Formation Items 220	Transfers + All Other	TOTAL
	5,295,471	**714,970**	**21,356,619**
	54,515	0	202,492
	1,127	0	107,160
	157,412	(0)	461,157
	113,103	0	623,999
	0	0	5,185
	36,806	0	198,567
	572,819	0	718,937
	81,363	0	306,891
	106,617	0	273,814
	257,236	0	461,401
	106,604	0	449,358
	0	0	0
	0	0	47,994
	96,494	0	198,971
	9,412	0	98,655
	90,656	0	219,566
	0	0	(419)
	337	0	47,187
	77,689	0	337,588
	1,762,191	**0**	**4,758,503**
	37.0%	0.0%	100.0%
	7,057,662	**714,970**	**26,115,122**
	27.0%	2.7%	100.0%

FIGURE C
Health Sector Improvement Program: 2001 Expenditure By Standard Program Category through 31 December



Source: HSIP Secretariat, Financial Evaluation Division, Department of Treasury. Update: 28 February 2002.

Appendix D

HSDP Summary Progress Report: Expenditure and Availability of Funds 2001

Table D
HSDP Summary Progress Report: Expenditure and Availability of Funds 2001

	January	February	March
Bank of Papua New Guinea (BPNG) // WPA			
HSDP ADB 1516 PNG Imprest Acct. (# 03900)	1,279,106	1,279,106	1,279,106
HSDP ADB 1517 (SF) PNG Imprest Acct. (# 03898)	0	0	0
TOTAL ADB Imprest Accounts with BPNG	1,279,106	1,279,106	1,279,106
Waigani Public Accounts (WPA)	43,660,960	43,660,960	30,660,960
TOTAL BPNG // WPA	**44,940,066**	**44,940,066**	**31,940,066**
Papua New Guinea Banking Corporation (PNGBC)			
HSDP GoPNG Trust Acct. (# 202-006-51910) + IBDs	10,196,569	8,716,386	20,159,433
HSDP GoPNG Trust Acct. – Provinces	802,208	461,702	939,343
Interest on IBDs	71,540	71,540	53,655
TOTAL PNGBC	**11,070,316**	**9,249,628**	**21,152,431**
HEALTH EXPENDITURE under HSDP			
NDOH initiated expenditure	315,527	1,551,722	817,493
Total provincial expenditure	346,496	340,506	333,358
TOTAL Monthly Health Expenditure under HSDP	**662,024**	**1,892,228**	**1,150,851**
CUMULATIVE HEALTH EXPENDITURE under HSDP	**59,784,446**	**61,676,674**	**62,827,525**
AVAILABLE/REMAINING FUNDS under HSDP	**56,010,382**	**54,189,693**	**53,092,497**

NOTES

1 The Health Sector Development Program (HSDP) loans became effective 23 October 1997. The accounts at BPNG were opened 18 November 1997. The initial advance of US$5 million was received 8 December 1997. The first tranche of US$24.88 million was received mid-February 1998.

2 The HSDP was appropriated K30 million for 1998 by Parliament in mid-March 1998. These funds were released 23 April 1998. The HSDP was appropriated K12 million for 1999. These funds were released 11 May 1999.

3 The second tranche of US$24.91 million was released in December 1999 and generated K68.66 million deposited to the HSDP accounts held at BPNG and later moved to Waigani Public Accounts (16-20 December).

4 The Year 2000 appropriation of K15 million was released in February 2000. Additional appropriation of K10 million was released 15 December 2000.

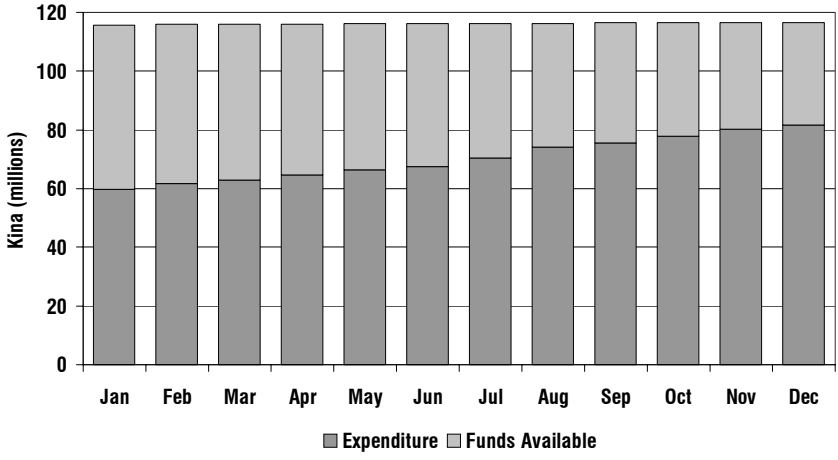
5 The Year 2001 appropriation was revised to K24 million. All funds were released in 2001.

6 All figures for balances are from monthly bank statements. The main account has been adjusted for non-HSDP funds.

Source: HSDP Secretariat, Department of Finance. Update: 31 December 2001.

April	May	June	July	August	September	October	November	December
1,279,106	1,279,106	1,279,106	1,279,106	1,279,106	1,279,106	1,279,106	1,279,106	1,279,106
0	0	0	0	0	0	0	0	0
1,279,106	1,279,106	1,279,106	1,279,106	1,279,106	1,279,106	1,279,106	1,279,106	1,279,106
30,660,960	30,660,960	30,660,960	30,660,960	30,660,960	30,660,960	24,660,960	24,660,960	19,660,960
31,940,066	**31,940,066**	**31,940,066**	**31,940,066**	**31,940,066**	**31,940,066**	**25,940,066**	**25,940,066**	**20,940,066**
18,215,779	16,773,962	15,896,219	13,169,196	9,363,877	8,126,415	12,166,533	9,840,441	12,844,873
1,069,335	933,760	778,467	661,179	913,766	694,018	403,827	595,605	1,004,585
130,644	99,625	75,452	73,632	73,356	47,507	20,959	20,214	18,164
19,415,758	**17,807,347**	**16,750,139**	**13,904,007**	**10,351,000**	**8,867,940**	**12,591,319**	**10,456,259**	**13,867,622**
1,381,308	1,198,461	696,368	2,640,475	3,149,951	1,022,818	2,007,389	1,719,050	1,295,782
486,008	509,575	436,293	279,289	476,412	507,748	290,191	436,223	311,020
1,867,317	**1,708,036**	**1,132,661**	**2,919,764**	**3,626,363**	**1,530,567**	**2,297,580**	**2,155,273**	**1,606,802**
64,694,842	**66,402,878**	**67,535,538**	**70,455,302**	**74,081,666**	**75,612,232**	**77,909,812**	**80,065,085**	**81,671,887**
51,355,824	**49,747,413**	**48,690,205**	**45,844,073**	**42,291,066**	**40,808,006**	**38,531,385**	**36,396,325**	**34,807,688**

FIGURE D
HSDP Funds Expended and Available
As of 31 December 2001



Source: HSDP Secretariat, Department of Finance. Update: 31 December 2001.

Appendix E

PNG Public Health Sector 2001 Expenditure

TABLE E-1
PNG Public Health Sector 2001 Expenditure by Standard Program Category

Vote	Expenditure Entity	Prg 1 General Administration	Prg 2 Urban Facilities	Prg 3 Rural Facilities	Prg 4 Family Services	Prg 5 Disease Control
240	DOH - Recurrent	7,788,311	12,739,212	0	990,899	2,699,069
240	DOH - PIP (excl. HDSP)	0	12,508,645	22,021,496	28,033,693	344,398
	DOH - HSIP/HDSP	2,481,042	926,802	1,351,565	674,674	73,927
240	**Sub-total DOH**	**10,269,353**	**26,174,659**	**23,373,061**	**29,699,266**	**3,117,394**
241	**Hospital Mgt. Services**		**85,646,694**			
	Provincial Health Expenditure					
240	HSIP/HDSP in provinces	1,807,712	137,577	1,068,115	419,808	145,592
241	Church HS - Wages			23,647,735		
2xx	Nat'l PGAS Expenditure	4,034,922	910,991	4,880,661	152,680	178,020
7xx	Prov'l PGAS Expenditure			17,649,606		
	Treas. Payroll Expenditure			57,326,751		
	Sub-total Provinces	**5,842,634**	**1,048,568**	**104,572,868**	**572,488**	**323,612**
	TOTAL	**16,111,987**	**112,869,921**	**127,945,929**	**30,271,754**	**3,441,006**
	PROGRAM DISTRIBUTION	**4.2%**	**29.1%**	**33.0%**	**7.8%**	**0.9%**

NOTES

1 Prg 1 - General Administration, Prg 2 - Urban Health Facilities, Prg 3 - Rural Health Facilities, Prg 4 - Family Health Services, Prg 5 - Disease Control, Prg 6 - Environmental Health & Water Supply, Prg 7 - Health Promotion & Education, Prg 8 - Medical Supplies & Equipment, Prg 9 - Human Resource Development, Prg 10 - Support Services.

2 All amounts are in Kina.

3 While the new expenditure code structure is operational on the PNG Government Accounting System (PGAS), allowing for the recording of health expenditure using the Standard Health Budget, in fact it is not yet implemented by some Provincial Treasuries. Provincial health expenditure under National PGAS expenditure is reported by Standard Program Category for the first time in recognition of progress achieved. Provincial health expenditure under Provincial PGAS is assigned to Prg 3, rural Health Facilities.

4 National AIDS Council expenditure, both recurrent and project related, is not reported under the PNG Public Health Sector.

Sources: DOH-Recurrent, PB expenditure statement for period 13 year 2001; DOH-PIP, run date 18 April 2002, TMS 330; HSIP/HSDP; DTP, L&RD, HSIP/HSDP Secretariat, 28 February 2002; Hospital Management Services, run date 18 April 2002, TMS 330; Provincial Health Expenditure (National PGAS Expenditure, Provincial PGAS Expenditure, Treasury Payroll Expenditure), Information Technology Division, Department of Finance.

Prg 6 Environment & Water	Prg 7 Promotion & Education	Prg 8 Supplies & Equipment	Prg 9 HRD	Prg 10 Support Services	TOTAL	% Share
766,247	1,013,922	35,292,838	11,254,723	3,015,441	75,560,662	19.5%
0	0	10,473,971	6,607,412	3,110,193	83,099,808	21.4%
506,630	318,716	12,717,892	2,173,763	131,609	21,356,620	5.5%
1,272,877	**1,332,638**	**58,484,701**	**20,035,898**	**6,257,243**	**180,017,090**	**46.4%**
					85,646,694	**22.1%**
651,391	26,847	293,060	165,823	42,577	4,758,502	1.2%
					23,647,735	6.1%
170,807	182,395	296,100	7,000	7,835,222	18,648,798	4.8%
					17,649,606	4.6%
					57,326,751	14.8%
822,198	**209,242**	**589,160**	**172,823**	**7,877,799**	**122,031,392**	**31.5%**
2,095,075	**1,541,880**	**59,073,861**	**20,208,721**	**14,135,042**	**387,695,176**	**100.0%**
0.5%	**0.4%**	**15.2%**	**5.2%**	**3.6%**	**100.0%**	

FIGURE E-1
PNG Public Health Sector 2001 Expenditure by Standard Program Category

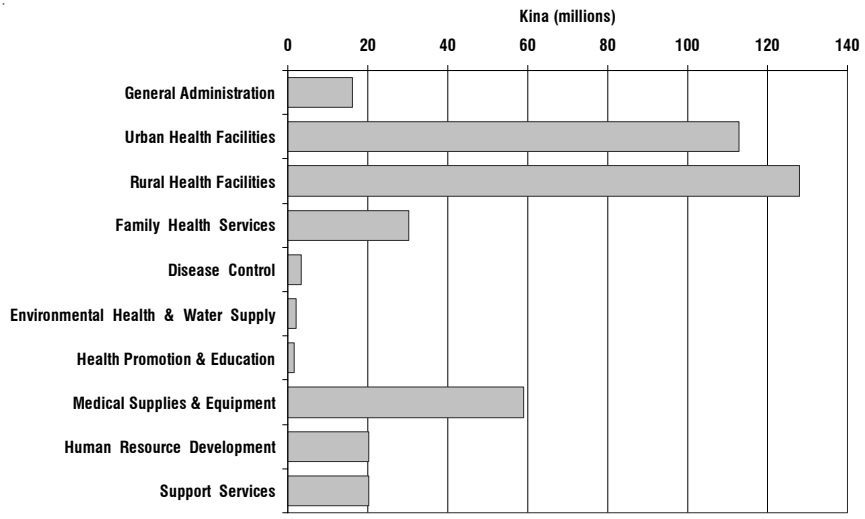


TABLE E-2
PNG Public Health Sector 2001 Expenditure by Item Category

		Personnel Emoluments	Goods & Services	Other Operation Expenses	Capital Formation
240	DOH - Recurrent	25,359,913	41,586,248	2,702,110	1,519,116
240	DOH - PIP (excl. HDSP)	0	38,440,494	16,343,376	26,839,805
	DOH - HSIP/HDSP	0	15,321,371	24,807	5,295,471
240	**Sub-total DOH**	**25,359,913**	**95,348,113**	**19,070,293**	**33,654,392**
241	**Hospital Management Services**	66,224,924	14,269,689	2,409,697	577,500
	Provincial Health Expenditure				
240	HSIP/HDSP in provinces	0	2,853,586	142,727	1,762,191
241	Church Health Services - Wages	23,647,735			
2xx	National PGAS Expenditure	5,515,052	2,705,751	1,360,141	1,081,677
7xx	Provincial PGAS Expenditure	6,751,053	2,311,229	6,243,852	656,350
	Treasury Payroll Expenditure	57,326,751			
	Sub-total Provinces	**93,240,591**	**7,870,566**	**7,746,720**	**3,500,218**
	TOTAL	**184,825,428**	**117,488,368**	**29,226,710**	**37,732,110**
	PROGRAM DISTRIBUTION	**47.7%**	**30.3%**	**7.5%**	**9.7%**

NOTES

1 All amounts are in Kina.

2 ADB and AusAID health projects are included under Vote 240, DOH-PIP. The HSIP/HSDP, because it is a program and covers nearly all activities, has been broken out and separated between expenditure undertaken by the NDOH and expenditure in the Provinces.

3 NCD's contribution to health services is not included as they did not use PGAS prior to 2000 and most recurrent and investment expenditure is covered under NDOH, Vote 240.

4 Treasury Payroll for Central and Enga Provinces are 1999 figures as both provinces escape the system.

5 Transfer + All Other contain the following important elements: some of the K9.8 million expenditure under Provincial Health Expenditure are grants to Church Health Services for goods and service, and transfers to LLGs; about K3.6 million under DOH-Recurrent went to NGOs such as St. Johns Ambulance Service and pre-service training schools; about K1.3 million under DOH-PIP went to research (malaria vaccine).

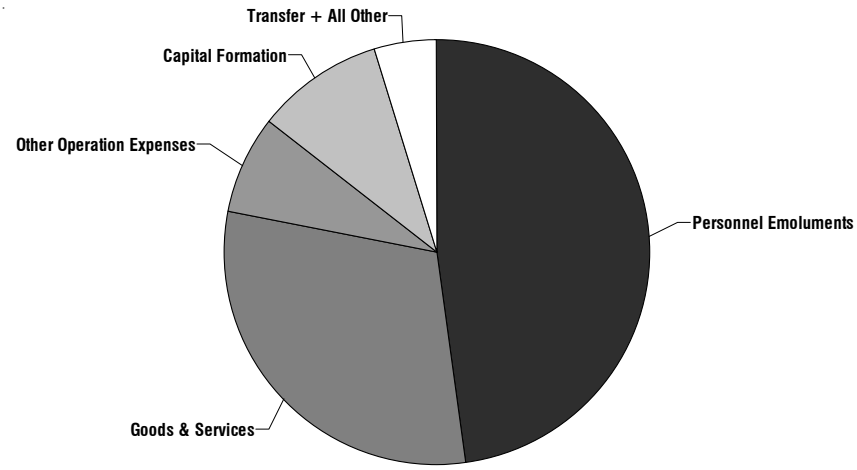
6 All wages (item 112) for church and mission health facilities transited through Vote 241, i.e., they were paid through the NDOH.

7 All Base/Provincial Hospitals and Laloki Psychiatric Hospital were included under Vote 241 in 2001.

Sources: DOH-Recurrent, PB expenditure statement for period 13 year 2001; DOH-PIP, run date 18 April 2002, TMS 330; HSIP/HSDP; DTP, L&RD, HSIP/HSDP Secretariat, 28 February 2002; Hospital Management Services, run date 18 April 2002, TMS 330; Provincial Health Expenditure (National PGAS Expenditure, Provincial PGAS Expenditure, Treasury Payroll Expenditure), Information Technology Division, Department of Finance.

Transfer + All Other	Total Expenditure	% Share
4,393,275	75,560,662	19.5%
1,476,133	83,099,808	21.4%
714,970	21,356,619	5.5%
6,584,378	**180,017,089**	**46.4%**
2,164,884	85,646,694	22.1%
0	4,758,504	1.2%
	23,647,735	6.1%
7,986,177	18,648,798	4.8%
1,687,122	17,649,606	4.6%
	57,326,751	14.8%
9,673,299	**122,031,394**	**31.5%**
18,422,561	**387,695,177**	**100.0%**
4.8%	**100.0%**	

FIGURE E-2
PNG Public Health Sector 2001 Expenditure by Item Category



Appendix F

Health Sector Improvement Program: Status of the Provincial Trust Accounts

Table F-1
Health Sector Improvement Program
Status of the Provincial Trust Accounts

PROVINCE	HEALTH ADVISOR	Health Board Established	HSIP Agreement Signed	BSP A21 Current
1 Western	Mr. Naweda Gageya	May 2000	May 2002	06/06
2 Gulf	Mr. Peter Siliwen	Feb. 2000	Apr. 2002	22/03
3 Central	Mr. Michael Uaiz	Pending	Nov. 2002	24/04
4 NCD - (main acct.)	Mr. Samson Kove	May 2002		
5 Milne Bay	Dr. Festus Pawa	Oct. 2001	May 2002	22/03
6 Oro	Mr. Thompson Manuda	Oct. 1999	Oct. 2001 #	No
7 Southern Highlands	Mr. Thomas Anda	Pending	May 2002	06/04
8 Enga	Mr John Tondop	May 2000	May 2002	No
9 Western Highlands	Mr Bernard Bal	Oct. 1999	July 2002	27/03
10 Simbu	Mr William Asue	July 2000	May 2002	Apr 02
11 Eastern Highlands	Mr Ben Haili	April 2000	Apr. 2002	06/04
12 Morobe	Dr. Likei Theo	Pending	Nov. 2002	27/09
13 Madang	Mr. Markus Kachau	Jun 2000	hold #	No
14 East Sepik	Mr. Francis Anjang	Jan 2000	Oct. 2002	Aug. 02
15 Sandaun	Mr. Desak Drorit	Oct 1999	Apr. 2002	16/05
16 Manus	Mr. Oka Nungu	Feb 2000	May 2001 #	Apr.02
17 New Ireland	Dr. Joachim Taulo	Mar 2000	May 2002	24/04
18 East New Britain	Mr. Bernard Lukara	Feb 2000	May 2002	Jun 02
19 West New Britain	Mr. Joshua Giru	Sep 1999	June 2002	Apr 02
20 Bougainville	Mr. Lawrence Disin	Pending	Oct. 2002	04/09

NOTES

1 The new HSIP trust instrument replaces the HSDP trust instrument. The new HSIP trust instrument was signed 24 November 2000 by Hon. Sir Mekere Morauta Kt, MP, Prime Minister.

2 All cheques and accounting documents must bear TWO signatures: one from the National Department of Health and one from the Department of Finance.

3 All amounts are in Kina.

4 # = HSIP Agreement NOT current; PHO not eligible for new funds.

Source: HSIP Secretariat, Department of Finance. Update: 15 November 2002.

	Last Audit	Current Ceiling	Last Transfer	Current Balance end Sept
	Nov 2001	100,000	Jun 02	836
	Oct 2002	100,000	Sep 02	79,080
	Nov 2001	100,000	Jun 02	16,882
	Jul 2001	200,000	Jul 02	1,295
	Oct 2001	50,000	Mar 00	2,521
	Oct 2001	100,000	Dec 01	14,094
	May 2000	200,000	Sep 02	1,318
		200,000	Aug 02	103,250
	Apr 2002	50,000	Nov 02	2,318
	Aug 2002	200,000	Oct 02	3,847
	Mar 2001	100,000	Oct 02	6,880
	Oct 2000	50,000	Jun 00	closed
	Nov 2001	50,000	Oct 02	7,649
		100,000	May 02	34,960
	Jan 2001	50,000	Apr 02	470
	Apr 2002	100,000	Nov 02	2,108
	Dec 2000	50,000	Sep 02	50,885
	Jul 2000	100,000	Nov 02	3,258
	Aug 2002	200,000	Oct 02	5,688

Table F-2
Health Sector Improvement Program
Status of the Provincial Trust Accounts
As of Last Field Visit or Review

	PROVINCE	HEALTH ADVISOR	Date	Expenses Not Acquitted
1	Western	Mr. Naweda Gageya	03-05-02	28,742
2	Gulf	Mr. Peter Siliwen	06-09-02	16,424
3	Central	Mr. Michael Uaiz	14-06-02	Nil
4	NCD - (main acct.)	Mr. Samson Kove		
5	Milne Bay	Dr. Festus Pawa	29-10-02	98,602
6	Oro	Mr. Thompson Manuda	11-09-01	12,925
7	Southern Highlands	Mr. Thomas Anda	05-12-01	16,083
8	Enga	Mr John Tondop	11-09-02	38,837
9	Western Highlands	Mr Bernard Bal	13-09-02	151,597
10	Simbu	Mr William Asue	18-10-02	<10,000
11	Eastern Highlands	Mr Ben Haili	19-10-02	32,174
12	Morobe	Dr. Likei Theo	15-10-02	16,845
13	Madang	Mr. Markus Kachau	25-10-02	
14	East Sepik	Mr. Francis Anjang	04-10-02	8,654
15	Sandaun	Mr. Desak Drorit	26-03-02	<20,000
16	Manus	Mr. Oka Nungu	07-08-02	19,366
17	New Ireland	Dr. Joachim Taulo	18-10-02	16,324
18	East New Britain	Mr. Bernard Lukara		
19	West New Britain	Mr. Joshua Giru	02-11-02	14,174
20	Bougainville	Mr. Lawrence Disin	17-08-02	<40,000

NOTES

1 All amounts are in Kina.

2 **Performance Appraisal** reflects adherence to HSIP procedures and demonstrated management capability: Excellent-★★★★★, Good-★★★★, Average-★★★, Poor-★★, Very Poor-★.

3 **Trend**: Improving performance - ↗, No change either way - —, Declining performance - ↘.

Source: HSIP Secretariat, Department of Finance. Update: 15 November 2002.

REMARKS	Performance Appraisal	Trend
OK - operational	★★	—
OK - operational	★★	—
OK - operational	★★★	—
OK - operational	★★	—
Not eligible for new funds	★★★★	↘
PT, A 21 issues	★	—
OK - ceiling lowered	★★	↘
OK - operational	★★★★	↘
Not eligible for new funds	★★	—
OK - operational	★★	—
OK - operational	★★★	—
OK - operational	★★★	—
Temporarily suspended	★	—
OK - operational	★	—
OK - operational	★★	—
No HSIP agreement / NE	★★	—
OK - operational	★★	—
OK - operational	★★	—
OK - operational	★★	—
OK - operational	★★★	—

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