WHO COUNTRY COOPERATION STRATEGY

PAPUA NEW GUINEA

2005-2009

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Acronyms

ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
AusAID	Australian Agency for International Development
CCA	Common Country Assessment
CCM	Country Coordination Mechanism
CCS	Country Cooperation Strategy
DHS	Department of Health Services
DOTS	Directly Observed Treatment, Short-course
DTP3	Diphtheria-tetanus-pertussis vaccine (3rd dose)
EPI	Expanded Programme on Immunization
FTE	Full-time Equivalent
GDF	Global Drug Facility
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP	Gross National Product
HIV	Human Immunodeficiency Virus
HQ	Headquarters (WHO Headquarters)
HSIP	Health Sector Improvement Programme
IMCI	Integrated Management of Childhood Illness
JICA	Japanese International Cooperation Agency
MDG	Millennium Development Goals
MTEF	Medium Term Expenditure Framework
NACS	National AIDS Council Secretariat
NCD	Noncommunicable Diseases
NDOH	National Department of Health
NGO	Nongovernmental Organization
NZAID	New Zealand Agency for International Development
ODA	Official Development Assistance
OECD	Organization of Economic Co-operation Development
SARS	Severe Acute Respiratory Syndrome
SSA	Special Services Agreement
STI	Sexually Transmitted Infections
SWAp	Sector-wide Approach
TB	Tuberculosis
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNTFHS	United Nations Trust Fund for Human Security
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The World Health Organization (WHO) Country Cooperation Strategy (CCS) for Papua New Guinea outlines the strategic framework within which WHO will collaborate with the Government and people of Papua New Guinea over the period 2005 to 2009. The CCS is based on a systematic assessment of the country's health needs, WHO's strategic policies, and the broader health partnership to improve health in Papua New Guinea.

Papua New Guinea, the largest developing country in the Pacific, is classified as a low middle-income country with a Gross Domestic Product (GDP) per capita of US$ 493 (2001). The country has over 600 islands with a population of 6 million people (2005). Approximately 87% of the population live in rural areas. Around 800 languages are spoken in Papua New Guinea. Administratively, the country has 20 provinces and 89 districts.

In the past, Papua New Guinea has made some progress in social development. Literacy rates have risen from 32% to 65% and life expectancy has risen from 49 to 54 years. Papua New Guinea has a number of important achievements in its socioeconomic development, but many challenges, such as poverty, still remain. Currently, about 40% of the population live within or below the poverty line. About 90% of the poor live in rural areas. Subsistence farmers, fishermen and hunters constitute the poorest segments of the population.

The health status is the lowest in the Pacific Region. Communicable diseases remain the major cause of morbidity and mortality in all age groups. Papua New Guinea now has a generalized epidemic of HIV/AIDS. Maternal and child morbidity and mortality are still high and have not improved significantly in the past. A major challenge to improving health in Papua New Guinea is basically related to perceptions of illness and health in the general population. There is a lack of awareness of both health promoting and risk-related behavior.

Health services in Papua New Guinea are provided by the Government and the Church and primarily financed by public funds. The poor road infrastructure and rugged terrain pose formidable challenges to effective health services delivery nationwide. In recent years, rural health services have deteriorated significantly because of the closing down of many rural health facilities. The shortage and flawed distribution of human resources is a critical issue in Papua New Guinea. There is a shortage of nurses and community health workers in most rural areas. There is a persistent and serious law and order problem. The security situation affects access to health facilities and staff supervision. Local communities rarely participate in health promoting activities.

The current goal of the national government is to improve the health of all Papua New Guineans through the development of a health system that is responsive, effective, affordable, acceptable and accessible to the majority of people. The National Health Plan 2001-2010 and the medium-term expenditure framework 2004-2006 have identified some explicit priorities. These include maternal and child health, immunization, malaria control, HIV/AIDS and water and sanitation programmes.

External agencies provide significant amount of funds and technical assistance to the health sector by supporting health priority issues. A major new source of funds for health from 2004 is the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria (GFATM). The 2001-2010 National Health Plan was developed through extensive consultation with national and international partners. There is now one annual activity plan for the National Department of Health (NDOH) and all donor partners. In the last few years there have been major efforts by the Government and donors to have a more unified approach to health sector development.

The WHO works closely with the Government and its external partners in addressing major health issues and challenges in Papua New Guinea. The current WHO country programme provides continued support to the Government in combating communicable diseases, building healthy communities and populations and development of the health sector.

Through the CCS, WHO aims to be more responsive to country needs by focusing on selective areas of its work and fully taking into account the activities of other development agencies. The following principles have been applied in defining strategic agenda and setting up priorities by which WHO can maximize health gains in Papua New Guinea:

- to reflect national health priorities and commitments made to international health treaties and targets;

- to build on WHO's traditional competencies and activities that will shift the balance of support from routine activities to a more advisory and facilitating role;

- to maintain existing partnerships and commitments and to explore new ways of working with them;

- to be selective and proactive, but to retain sufficient flexibility to respond to unexpected needs and issues;

- to complement the work of other partners and support evidence-based approaches; and

- to balance support for short-term results and long-term health systems development.

- WHO's medium-term strategic agenda in Papua New Guinea emphasizes three main areas.

  – Greater collaboration and support to lessen the impact of the leading causes of morbidity and mortality from malaria, TB and HIV/AIDS, and to also address maternal and child health issues.

  – District health systems development is a major priority of the Government and a focus of support from other donors. WHO's work will concentrate on the systematic analysis of innovative district capacity-building, service delivery and the effectiveness of district health services.

  – Increased support for stewardship and partnerships building. WHO's work in this particular area will bolster efforts to monitor overall health system performance and trends towards Papua New Guinea's stated health goals, with special attention to poverty reduction.

The WHO Corporate Strategy, the global and regional areas of work, Papua New Guinea National Health Policy, and the Health Plan inspired and informed the CCS. It is expected that WHO's work in Papua New Guinea will be revitalized through the medium-term strategic agenda and will contribute to the national goal of combating ill-health and building healthy populations, communities, and strengthening the health systems in the near future.

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1. INTRODUCTION

The World Health Organization (WHO) Country Cooperation Strategy (CCS) for Papua New Guinea outlines the strategic framework within which WHO will collaborate with the people and Government of Papua New Guinea over the period 2005 to 2009. The CCS is based on a systematic assessment of the country's health needs and aspirations; on WHO's own corporate policy and priorities; and on the support and actions of other partners in health within Papua New Guinea. The Strategy aims to achieve a planned and progressive shift towards a more strategic role for WHO in both what it does and how it does it, taking into account the roles and functions of other members of the broader health partnership in Papua New Guinea.

In recent years, the economy of Papua New Guinea has declined and security problems within the country have added to the difficulty of the Government in providing public services. However, the Government of Papua New Guinea is implementing a Structural Adjustment Programme with the objective of steering the national economy back on track and improving effectiveness and accountability in the delivery of public services.

At a time when its national health system is facing many challenges, Papua New Guinea has completed its fifth National Health Plan, which sets the 10-year vision, policy direction, priorities and guidance for both strategic and operational planning at provincial and local level governments. The National Health Plan 2001-2010 builds on an ongoing sector reform programme and the extensive decentralization of responsibility for, and control over, many aspects of health services delivery and financing to provincial and local level governments.

Papua New Guinea and its main partners in health development are implementing a HSIP that is based on the philosophy and principles of a Sector-wide Approach (SWAp). Because of the potential and early success of this mechanism it has been chosen as the vehicle for which funds from the GFATM will go to the health sector.

Given these developments in the country it is an opportune time to conduct a Country Cooperation Strategy in Papua New Guinea.

2. GOVERNMENT AND PEOPLE: HEALTH AND DEVELOPMENT CHALLENGES

2.1 General

Papua New Guinea is the largest developing country in the Pacific. Of Papua New Guinea's main landmass, 85% of its total is located on the eastern half of an island shared between Papua New Guinea and Papua Province of Indonesia. The remaining 15% is spread

over 600 islands. Papua New Guinea is administratively organized into 20 provinces and 89 districts. With a population of 6 million (estimated 2005), the country has a population growth rate of 2.7%. It remains a primarily rural society due to the fact that 87% of the population live in rural areas. Around 800 languages are spoken, and each language group has a distinct culture. There are large sociocultural differences between and within provinces. Official languages are English, Pidgin and Motu. Access to widely scattered rural communities is often difficult, slow, and expensive. Only 3% of the country's roads are paved. Many villages can only be reached on foot. Much of the travel between the provinces is by air.

There is a persistent and serious law and order problem, which involves a combination of "conventional" crime, public disorder and tribal warfare. This, together with the poor road infrastructure and rugged terrain, pose formidable challenges to effective health services delivery nationwide.

2.2 The economy

Papua New Guinea is a low-income, moderately indebted country with a Gross Domestic Product (GDP) per capita of US$ 847 (2004). It has many natural resources. Mining, forestry and oil dominate the economy. The formal sector is small and there is a large informal sector—over 75% of the labour force still engages in subsistence farming. The public sector is the largest formal employer. In 2001, total external aid amounted to US$ 24 per capita.

GDP growth has long been low and unstable and GDP per capita has dropped by 40% in the past 10 years (The Economist Intelligence Unit). The annual average change in GDP between 1997 and 2001 was –1.1%. Since 1997, the currency (Kina) has depreciated by 45% against the US dollar. Estimates show 37% of people live below the national poverty line (World Bank), 1999). Papua New Guinea's economic problems have been attributed by many analysts to a combination of factors such as limited infrastructure, the inadequate supply and high cost of skilled labour, natural disasters and a weak institutional environment. In the late 1990s Papua New Guinea's economic problems were compounded by drought and the Asian economic crisis. An economic reform programme, started in 1994 with International Monetary Fund and World Bank support, continues with an emphasis on public sector reform, governance and privatization.

2.3 The political and administrative system

Papua New Guinea became independent in 1975. A key feature of the political and administrative structure is the decentralization of responsibility for essential services to provincial, and more recently, to local level governments. In 1983, the management of public services—including hospital and rural health services—were transferred to provincial governments. In 1995, the New Organic Law on Provincial and Local Level Governments extended the decentralization, creating 300 local level governments within 89 districts. The capacity and quality of public sector management at all levels, but especially at district level, has long been a cause of concern.

A public sector reform programme began in 1998 and involved extensive retrenchment of peripheral public sector staff. It was halted in 1999, but many problems remain in filling existing public sector vacancies.

2.4 Poverty and development

Papua New Guinea has made some progress in social development over the last 30 years. Literacy rates have risen from 32% to 65%. However, only half of all women aged 15 and over and two thirds of men over 15 have ever attended school, and enrolment rates vary significantly across provinces. Life expectancy has risen from 49 to 54 years, and Papua New Guinea's Human Development Index has risen from 0.43 to 0.55. However, in recent years progress has slowed.

Table 1. Comparisons of selected health indicators

Indicator	Papua New Guinea	Lower middle income countries	East Asia and Pacific Region
Infant mortality rate/ 1000 live births	64	38	57
Child mortality (M/F)	88 (2004)	10/11*	10/11*
Life expectancy at birth	53 yrs (2000)	68	69
Primary school enrolment (gross)	85% (2000)	93%	97%
Access to safe water in rural community	32% (2002)	58%	29%

Sources: Papua New Guinea 2000 census report; NHP 2001-2010, The World Health Report 2003;

* World Development Indicators 2002, World Bank

Poverty in Papua New Guinea is often viewed in terms of access, for example, access to basic services such as education, health, and in terms of income. Many rural dwellers do not earn cash income. The 1996 National Household Survey estimated that 37.5% of the population was living at or below the poverty line, with 93% of the poor living in rural areas. Real per capita consumption of the wealthiest quartile is eight times that of the poorest quartile, one of the widest differentials within countries at a similar stage of development. Subsistence farmers, fishermen and hunters constitute the poorest segments of the population. There appears to be no significant gender bias to poverty in Papua New Guinea, but households with uneducated or elderly heads suffer disproportionately from poverty. Access to health care is one of the highest priorities for the poor.

Papua New Guinea has an extensive informal safety net system, called *wantok*. A *wantok* is an informal association based on kinship, ethnicity, language and/or friendship. Members of a *wantok* support one another in a variety of ways and transfer income to needy members. However, reports suggest that these traditional coping mechanisms do not make a significant impact on the depth or extent of rural poverty.

Papua New Guinea has developed a poverty reduction strategy which is intended to give increased focus to poverty in the existing national Medium Term Development Strategy (2005-2010). Papua New Guinea is a signatory to the United Nations Millennium Development Declaration. Achieving the targets contained in the Millennium Development Goals (MDG) poses a real challenge.

2.5 Current health challenges and trends

Health status, the lowest in the Pacific region, steadily improved during the 1980s but has declined over the last decade. Life expectancy (2000) is estimated to be 52.5 for men, and 53.6 years for women, with healthy life expectancy of 45.5 years (*The World Health Report 2000*). It is estimated that about 15% of a woman's life span is affected by some form of

disability or morbidity. Infant mortality rate is estimated to be 64 per 1000 live births (2000 census) compared to 82 in 1991 Department of Health Services and 72 from the 1981 National Census. Estimates of mortality and morbidity patterns in the population are very approximate, as data are almost entirely facility-based and laboratory confirmation of clinical diagnoses is rare.

(a) Communicable diseases remain the major cause of morbidity and mortality. Papua New Guinea has made significant progress in some areas. In 2000 Papua New Guinea was declared polio free. In addition, Papua New Guinea reached the national leprosy elimination target of less than one case per 10 000 population. However, around 50% of all mortality is still due to communicable diseases. Malaria is the leading cause of all outpatient visits and the second cause of hospital admissions and deaths. An average of 1.5 million cases of suspected malaria cases are seen at health facilities annually. Malaria is now endemic in every province including those which were once malaria free. Malaria death rates for 2002 are reported to be 11.8 per 100 000. Together, malaria and pneumonia account for one third of all recorded deaths. The estimated incidence of TB is 104/100 000 year (smear positive cases) (2005). TB remains a major public health problem in PNG, in particular with the current HIV epidemic Serious measles outbreaks continue—there were an estimated 17 620 cases in 2002. Intestinal infectious diseases including diarrhoeal diseases and typhoid are major causes of morbidity with an estimated combined incidence of 434/100 000 year. Contaminated food and water are major contributors to these illnesses. Only 30% of the population has access to safe water and poor hygienic conditions result in unsafe food handling practices.

(b) Papua New Guinea now has a generalized epidemic of HIV/AIDS. Papua New Guinea was declared to have a generalized epidemic of HIV/AIDS in 2003. HIV prevalence among antenatal attendees is over 1.3% in Port Moresby and 3.7% in some other areas. AIDS is the leading cause of death in adult inpatients at the Port Moresby Hospital. A consensus workshop in February 2006 estimated 23 000 to 91 000 HIV-positive individuals in the sexually active population of 15-49 years. The number of reported cases shows a hyperbolic increase. Prevalence is rising in low risk groups such as blood donors and women attending antenatal clinics. The main mode of transmission is heterosexual. Sexually transmitted infections are rising, especially among sex workers, but the sexual assault of women in the rest of the population is also high, which increases their risk.

(c) Maternal and child morbidity and mortality are not improving. Maternal mortality estimates vary widely, but all are high. The official NDOH figure is 370 per 100 000 live births (1996) with marked variations among provinces. Causes of maternal mortality include postpartum haemorrhage, puerperal sepsis, antepartum haemorrhage, eclampsia and anaemia. About 80% of pregnant women attend antenatal clinic at least once, but only 45% of the births are supervised by skilled health workers. Only 12% of women use modern family planning methods (National Health Plan 2001-2010). Perinatal conditions account for over 10% of all recorded deaths. Chronic malnutrition is a problem, particularly among rural women and children, and is closely related to poverty. Overall, 27% of children are considered malnourished with 43% of children aged 0-5 stunted although wasting is comparatively low. Again there are marked regional variations.

(d) High rates of injury from accidents and violence. Accidents and violence are the fourth leading cause of hospital admissions, representing 8% of total admissions. Of all hospital deaths, 4% are due to accidents and violence.

(e) Disasters and emergencies. Papua New Guinea is a country prone to natural disasters (intense volcanic activities, earthquake, tsunami and cyclone) and outbreaks of infectious diseases. To improve response capacity, the Department of Health and WHO initiated a programme to improve disaster preparedness and response (2004). The programme needs to be strengthened as the response capacity is still very basic.

(f) Noncommunicable diseases are rising. Tobacco and alcohol related illnesses appear to be on the increase. Data from Port Moresby Hospital suggest that diabetes and hypertension are on the increase. The three leading cancers in Papua New Guinea—oral, hepatic and cervical—have largely preventable causes. Cancers of the breast and lung appear to be on the increase. The noncommunicable diseases (NCD) epidemic in Papua New Guinea is firmly established but largely unrecognized in policy-making. This is partly due to the wide disparity that exists in the indices. Diabetes has been documented at levels that range from below 1% of rural *Kalo* adults to between 30%-50% of among urban *Koku*, *Wanigela* people. Similar variations are found in obesity, hypertension and hypercholesterolemia. There is firm evidence that Papua New Guinea, even as it faces major communicable disease challenges, is undergoing a health transition and an early response to NCD prevention could prevent much larger burdens on the health services in the future.

Based on recent apparent trends, Papua New Guinea faces a real challenge in reaching many of the health-related MDG targets.

2.6 Challenge for the health system

(a) Perceptions of illness and health. A major challenge to improving health in Papua New Guinea is related to perceptions of illness and health in the general population. There is widespread lack of awareness of risk-related and health-promoting behaviour. There is little involvement by local communities in health-promoting activities. Key factors include behaviours and environments that increase the risks of communicable diseases, noncommunicable diseases such as tobacco consumption and risks associated with unsafe sexual behaviour.

(b) Health systems development achievements. Health services are provided by government and church providers which are financed primarily from public sector funds, by enterprise-based services like mining, through small, modern private for profit sector and an undocumented amount from traditional healers. Within the public sector, management responsibility for hospitals and for rural health services within a province is divided. The NDOH manages the 19 provincial hospitals, while provincial and local governments are responsible for all other services (health centres and sub-centres, rural hospitals and aid posts) known collectively as “rural health services”.

(c) Churches as providers of care. Churches provide approximately 60% of rural health services. They share many of the problems of public facilities but appear to perform better in a number of areas. Papua New Guinea trains most of its health workforce. The

churches run five of the eight nursing schools and all of the community health worker training schools.

(d) Rural health services. A Functional and Expenditure Review in 2001 described the health system in rural areas in a state of, "slow breakdown and collapse, but currently being saved from complete collapse by donors". The review stated, "About 600 rural facilities are closed or not functioning effectively. Where services remain, the breadth and quality of services is diminishing." Reliable data on service availability and coverage are limited, but all sources suggest low coverage. The current official coverage estimates are as follows.

Table 2 Indicators for DPT3 coverage, measles vaccine coverage and antenatal care

Intervention %	1990	1998	2000	2001	2002	2003 WHO/UNICEF estimate	2004
DPT3 coverage	67	58	57	48	49	56	46
Measles vaccine coverage	66	59	68	49	56	58	44
Antenatal care (1st visit)		59	59	55	56	78[b]	40
Attended delivery	33[a]	53[a]				53[b]	42

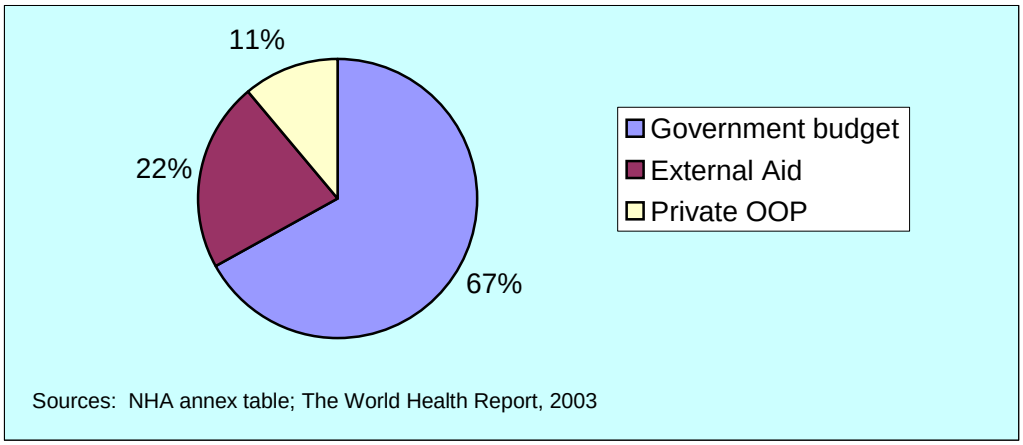
[a] Source: Asian Development Bank [b] Source: UNICEF

Most national averages have not been changed appreciably since 1995 (Functional Review). Averages also conceal considerable interprovincial variation. Multiple factors are thought to contribute to low coverage. At district level these include: absolute lack of services; limited use of services that do exist; limited clinical and managerial capacity of district health workers in a very decentralized health system; limited and poorly coordinated training efforts and other approaches to capacity-building. Many district problems are due to constraints higher up the system, which also need to be addressed if district services are to improve: lack of district supervision and support; the existence of parallel systems for provincial hospitals and district health services; the scarcity and maldistribution of financial and human resources; and the lack of timely and reliable information for decision-making.

(e) Overall health spending. Total health expenditure as a share of GDP has risen from 3.2% to 4.4% between 1997 and 2001. The Government has demonstrated its own commitment to health by maintaining a relatively high allocation of the total government budget to health—around 10% over the same period. Despite this, total health expenditure per capita (measured in US dollars) has fallen steadily over the last five years, from US$ 32 to US$ 24 (1997–2001, average exchange rate, Medium Term Expenditure Framework).

The major sources of funds are provincial government taxes and external aid, which account for about 90% of total health expenditure, with the remainder coming from direct out-of-pocket spending. User fees have long existed in both government and church facilities, but raise only small amounts of revenue and appear to be poorly managed. Private insurance is very limited.

Fig. 1 Distribution of total health expenditure in 2001



Given constrained resources, a Medium Term Expenditure Framework (MTEF) has been developed to help prioritize health sector activities and resources for 2004-2006 (extended – 2008).

(f) Low allocations by local administrations. Public funds for rural health services are transferred from the Treasury to provinces within block grants. Funds for health services are not earmarked, and in practice allocations to health by provinces are often lower than those suggested by Treasury. In 2000, on average, 10% of provincial budgets were allocated to health, but has dropped since. Provinces also raise some revenue from local taxation. There is considerable variation in health spending between provinces: data for 2000 suggest a four-fold variation in kina spent on health per person across the provinces. Salaries consume the bulk of recurrent health spending, leaving little for goods, services and maintenance. About 80% of recurrent provincial health budgets were allocated to salaries in 2004.

(g) Weak financial management at all levels. As part of efforts to improve financial management, the NDOH introduced a programme-based standard budget structure in 1996, and now produces annual provincial health expenditure reports.

(h) Structural problems. The 1995 Provincial and Local Level Government Decentralization Law ("Organic Law") appears to have contributed to current problems. This was not a health sector specific law, but it had significant sector-specific effects. The 1995 law gave greater autonomy to districts and local level governments in service planning and management. It had major effects on planning and budgeting processes and human resources management. Initially, all hospitals were transferred to provincial governments, but provincial hospitals were transferred back to the NDOH in 1996/7. They now operate largely independently of rural health services within the same province.

The Organic Law led to an increase in the number of actors involved in planning, budgeting and management, without clear definition of roles and responsibilities. It gave provincial and district administrations almost total freedom to allocate funds from central government to health or other sectors. The 1997 National Health Administration Act tried to address some of the difficulties that arose. It created provincial health boards and district

committees to "assist the implementation of national health policy" and set out responsibilities at different levels.

2.7 Key constraints

(a) Human resources: shortage and maldistribution. Nurses and community health workers form the backbone of primary health care services in the rural areas, and both are considered to be in short supply. Accurate information is limited but all reports suggest that the 1998 Public Service Reform programme dramatically reduced the number of community health workers in aid posts in rural areas, one reason many rural health facilities closed. The nurse to population ratio is 150 per 100 000. An additional 1000 nurses and community health workers and 100 midwives are estimated to be needed to fill vacant posts although current production rates are insufficient to fill this gap. These shortages constitute a serious hurdle for implementing the National Health Plan, but it is unclear how they can be resolved in the short term given the funds and time required. The doctor to population ratio is 13 per 100 000, with the majority in Port Moresby. Some provinces and many districts have no doctors.

(b) Decentralization: Staff supervision and performance. About 30% of provincial government staff are health workers. The Organic Law exacerbated existing problems with health staff supervision. Provincial health advisors lost much authority to supervise and discipline district health staff. These functions were transferred to provincial administrators and to district and local governments, but there is widespread belief that it is, "near impossible to discipline, let alone dismiss" staff. The transfer of senior personnel, including doctors, from rural health centres as well as the withdrawal of vehicles made outreach services and supervision almost defunct as hospitals became less involved in district supervision. Other factors cited as contributing to low staff morale and motivation are the lack of incentives such as housing and hardship allowances and long periods of isolation in remote areas.

Central NDOH oversight of provincial staff is also limited. Reasons include limited capacity of programme units at central level, lack of funds for travel, lack of economies of scale through joint training and supervision across programmes and delayed disbursement of funds.

(c) Funding: distribution, management and use of drugs and other supplies. Efforts to improve drug availability, including a National Drug Policy, privatization of distribution, kits for aid posts, and more warehouse staff training, have likely contributed to fewer drug stock outs, but significant shortages remain. The devaluation of the kina has reduced purchasing power. Public spending on drugs is US$ 5 per capita, but there is very inequitable distribution, with highland provinces receiving much less than the national average. Only two hospitals have qualified pharmacists. Prescribing practices are also a cause of concern. Information on equipment is limited and the most recent inventory of equipment did not include rural facilities.

(d) Information and monitoring: weak but improving information for decision-making. Information for clinical decisions and for public health management and planning is incomplete and uneven. Diagnostic services in hospital and public health laboratories are limited and disease surveillance is primarily based on signs and symptoms

only. There are long-standing efforts to improve facility-based service data, with variable success. Routine reporting of a standard set of information from health facilities appears to be relatively complete, but analysis suggests reporting inaccuracies. There is no effective overall disease surveillance system, though individual programmes such as malaria and TB, are improving their own surveillance systems, and the National Aids Council (NACS) collects AIDS statistics. The vital registration system covers only 2% of the population. Household surveys are infrequent. Health expenditure data is improving through the regular budget reports and the current national health accounts exercise. Health system research capacity is limited. One problem is that, apart from the annual National Health Conference, there is little feedback to local planners and managers from the central level, and little local capacity to analyse data. There are moves to help hospitals analyse their own activity data.

2.8 Coordination and stewardship

(a) Coordinating various groups. The NDOH is the government department with lead responsibility for ensuring improved health of the population in Papua New Guinea. Within a pluralistic and extremely decentralized health system the country has many national partners in health system development such as other government departments, churches, provincial and district health authorities and new ones such as mining companies and local chapters of Rotary. External agencies provide significant amounts of funds and technical assistance. In particular, there is a real need for greater coordination. Some new mechanisms for better coordination at national level are now being established.

Health system stewardship involves influencing the behaviour of various groups so that population health improves by maintaining oversight to detect trends, and reacting to problems promptly. The NDOH has to do this with few direct command and control tools at its disposal. It has a number of important achievements, but many challenges remain. Besides national leadership and stewardship there is also need for effective stewardship at provincial and district levels. In particular, there is a real need for greater coordination.

(b) Law and order problems. In some provinces access to health facilities is reduced because of tribal fighting with hospitals periodically closing because of risks to staff safety. The security situation also affects staff supervision.

2.9 Key elements in the Government's current response

(a) Explicit priorities. The goal of the NDOH of Papua New Guinea is to improve the health of all Papua New Guineans through the development of a health system that is responsive, effective, affordable, acceptable and accessible to the majority of people. The National Health Plan 2001-2010 and MTEF 2004-2006 have identified some explicit priorities. These include maternal and child health, immunization, malaria control, HIV/AIDS and water and sanitation programmes.

(b) Improved services through selected programme support. The Government is focusing its efforts to improve child health and to reduce malaria, TB and AIDS through specific programmes. Its malaria control strategy will have a major injection of funds from GFATM beginning in 2004. For TB, the directly observed treatment, short-course (DOTS) programme is gradually expanding and is currently operational in 38 districts (of 89). Reasons for a somewhat slower than planned expansion include a number of system constraints

common to other disease control programmes – central level staffing, weak infrastructure and support services, and delays in access to funds which limits training, supervision and other local level support. Child health is being tackled through improved immunization and through the Integrated Management of Childhood Illness (IMCI) approach. Both DOTS and IMCI are seen as entry points for strengthening district health services more generally. For example, the two districts where IMCI has been introduced are now being assisted to meet the more general minimum standards developed by the NDOH.

(c) Further organizational reform: moving towards a unified provincial health system. The National Health Conference 2001 supported a proposal to create a unified provincial health system. If implemented, there will be a single provincial health authority responsible for both hospital and rural health services, headed by a provincial director of health, which would report to both national and provincial governments.

(d) Changes to selected financial and staff management procedures. Strategies to ease managerial difficulties that do not require changes to the Organic Law include the amendment of selected public finance and management procedures: the quarantining (earmarking) of health funds in provincial grants, delegation of powers over district health staff from the provincial administrator to the provincial health adviser and the alignment of treasury warrants to provincial budgets.

Stronger monitoring mechanisms are being developed. The Functional Review recommended that provincial health budgets should make provision for each rural health facility. This may have implications for the current budget structure if all resources going to facilities from several different programme heads are to be comprehensively captured.

Box 1

Responsibilities of national, provincial and local level governments in Papua New Guinea

The National Government is responsible for:

- development of policy and standards and legislation
- provision of technical advice
- human resources planning and development
- provision of technical services, specialist medical equipment and pharmaceutical supplies to help provisional governments deliver rural health services
- maintenance of a national health information system and a national health planning and data system

The Provincial Government is required to:

- provide a reasonable level of funding
- direct and supervise staff to carry out those functions
- ensure national health standards are met
- provide and maintain equipment and facilities to carry out the functions
- ensure provincial health services are consistent with the National Health Plan

Local level governments are:

- responsible for providing funding for health services, programmes, and facilities in their area and
- should participate in planning activities to help direct health services delivery to the highest priority areas

(e) A sector-wide approach: the HSIP. In the last few years there have been major efforts by the Government and donors to form a more unified approach to health sector development. The 2001-2010 National Health Plan was developed with extensive consultation. There is now an annual activity plan for the NDOH and all donor partners. A

MTEF has been developed for 2004-2006. There are formal annual reviews of achievements, most importantly the National Health Conference, attended by the NDOH, donor partners, church and provincial government staff.

3. DEVELOPMENT ASSISTANCE: AID FLOWS, INSTRUMENTS AND COORDINATION

3.1 Past and future trends in official development assistance

Papua New Guinea receives significant levels of official development assistance, estimated to amount to US$ 203 million or 7.2% of Gross National Product (GNP) in 2001.

The health sector receives around 15% of total ODA. Over the last five years, ODA for health has fluctuated, but has been approximately 20% of total health spending.

3.2 Sources of external assistance

Papua New Guinea is unusual in having relatively few development partners. According to The Organisation for Economic Co-operation and Development (OECD) statistics, 96% of ODA for health in 1998-2000 was from Australia—by far the most significant donor in volume of aid and breadth of support. This has changed over the last years. Other major external agencies providing loans or grants are the Asian Development Bank (ADB), New Zealand Agency for International Development (NZAID), WHO, Japan International Cooperation Agency JICA), and until recently the World Bank. The World Bank has not contributed to the health sector since 2001 but is currently considering a loan for HIV/AIDS. There are smaller contributions from United States Agency for International Development (USAID), the European Union and United Nations agencies.

Table 2. ODA commitments (2006)

	Health	
	PGK (millions)	% all donors
All donors – total	184.8	100
AusAID	105.8	57.3
NZAID	11.1	6.0
JICA	4.5	2.4
WHO	10.3	5.6
GFATM	33.3	18.0
UNICEF	1.9	1.0
UNFPA	0.4	0.2
ADB	12.5	6.8
Sustainable development	5.0	2.7

Source: HSIP Management Branch

A major new source of funds for health from 2004 is the GFATM, which has committed US$ 20 million for the malaria programme over the next five years and is

considering a grant of US$ 30 million for HIV/AIDS. A fifth round proposal to GFATM related to the supervisory system for TB and HIV has been declined but the NDOH has been requested to resubmit after some adaptations to the proposals.

3.3 SWAp: the HSIP

Papua New Guinea currently receives aid in different forms: as loans and grants, in the form of project aid, and as more sector-based assistance. Funds are channelled through project trust accounts. There is also a move towards greater pooling of external assistance to the health sector through a sectoral trust fund. In 1996, a trust fund known as the HSIP was created by ADB, initially to handle its own loan. The Australian Agency for International Development (AusAID) now channels a proportion of their aid through this trust fund. NZAID, which previously operated primarily through church and nongovernmental organizations (NGOs), will also contribute. The GFATM is channelling funding through the HSIP. Funds channelled through the HSIP amounted to 27.8 million kina or 7% of total public expenditure in 2005. Other bilateral and United Nations agencies manage funds with their traditional arrangements.

3.4 Subsectoral breakdown of aid

In 1998-2000, 35% of aid to the health sector went to basic health care, 28% to STI control, including HIV/AIDS, and 18% to health policy and administration management (OECD statistics). AusAID and ADB provide the bulk of support for health sector institutional policy development, and specific aspects of service delivery. AusAID projects cover many aspects of health sector development, and to some degree, every province and facility in the country. There are currently projects related to health policy and planning, health services management, medical and public health training, women and children's health (including the expanded programme on immunization, HIV/AIDS, malaria research, pharmaceuticals and medical equipment supply and management. Loans and smaller technical assistance grants for health have been provided by ADB since 1983. ADB has shifted its focus over the last 30 years from expanding infrastructure to greater emphasis on quality and efficiency of service provision. The most recent US$ 60 million Health Sector Development Programmes loan finished in 2002 and had policy and investment components, with a focus on provincial hospitals, essential drugs and equipment, planning and management capacity (especially financial management). AusAID and ADB are also working to strengthen governance in general—especially public expenditure management and law and order issues, which affect health sector performance.

Other agencies do not have the same scope of activities. The focus of future Japanese assistance is shifting from health infrastructure building and support to strengthening primary health care, disease control activities, particularly for TB and malaria, provision of safe water supply systems, and health workforce development through a health friendship exchange programme. In addition to this, the United Nations Trust Fund for Human Security (UNTFHS) funded by Japan will be providing financial assistance to a project for displaced women as a result of HIV, displaced communities and for laboratory support. The European Union and the World Bank are supporting, or considering supporting, projects in HIV/AIDS.

3.5 Work of the United Nations

Various United Nations agencies work within their mandates. The United Nations Children's Fund (UNICEF) is active in maternal and child health and nutrition, with activities in selected provinces. United Nations Population Fund (UNFPA), with WHO as the executing agency, has a project to strengthen health workers skills in reproductive health in four provinces that is extended to other provinces with AusAID and ADB support.

The Common Country Assessment [CCA] is a country-based process, whereby the United Nations system reviews and analyses the national development situation, and identifies key issues and challenges based on its common experience in the country. The country's first CCA was prepared in 2001 in consultation with the Government and other stakeholders. It forms the basis for the development of a single United Nations Development Assistance Framework (UNDAF). The CCA is considered to be a working document that is refined continuously and it has been used by the wider community of development partners both inside and outside Papua New Guinea.

3.6 Issues and challenges

(a) HSIP. All development partners have signaled their support for the priorities specified in the National Health Development Plan. However, translation of that convergence of support for policy into coherent support in practice is not yet streamlined.

The ability of the NDOH to coordinate through the SWAp needs to be strengthened. The harmonization and alignment of activities and support can be addressed to the SWAp. The majority of the partners have signed an agreement with the department in order to be SWAp compliant.

(b) Human resources. Human resources in the country are limited. The Ministry of Finance has put restrictions on growth in personnel due to lack of funds, the result of budget restraints and mismanagement of some salaries. Most of the Government’s health budget is allocated to salaries, investment and programmes. A general mapping and a programme-linked mapping of human resources have to be completed.

All provinces are considered based on their annual activity plans. However, continuation of funding depends on the capacity to absorb, disburse and reconcile funds allocated. The Global Fund to Fight AIDS, Tuberculosis and Malaria’s (GFATM) provision of a significant amount of new funds for malaria is a great opportunity, but needs to be carefully managed to avoid diverting efforts from other priority conditions.

(c) Implementation level. The provincial and mainly the district level must be directly supported. The decentralization shifted responsibility to provinces and districts. WHO needs to get more national staff to support this level.

4. WHO: Current Country Programme

WHO closely works with the Government and its external partners in addressing major health issues and challenges in Papua New Guinea. The current WHO country programme provides continued support to the Government in the areas of combating communicable diseases, building healthy communities and populations and health sector development. The main programme focuses under each of the three main areas of work during the 2002-2003 biennium were as follows:

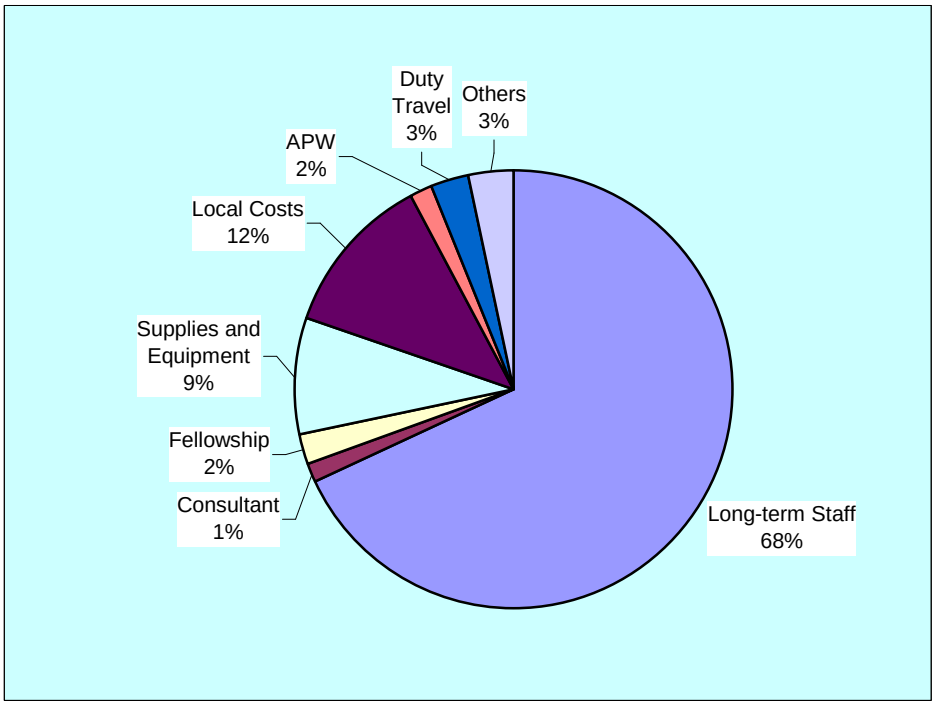
- Combating communicable diseases
  - TB, malaria, expanded programme on immunization, STI/HIV/AIDS, disease surveillance
- Building healthy communities and populations
  - health promotion, environmental health, child health, reproductive health, tobacco-free initiative
- Health sector development
  - health planning and management, health financing, essential medicines, public health laboratories and human resource management, health emergency and disaster preparedness, health information systems and operational research

The WHO country office in Papua New Guinea is one of the largest in the WHO Western Pacific Region. The availability of a wide range of WHO technical experts in-country is a major strength that needs to be fully utilized not only for the delivery of programmes, but also for the systematic transfer of knowledge and skills to national counterparts.

4.1 WHO financial resources

The WHO country programme is funded from three main sources, the regular budget, the intercountry budget, and the extrabudgetary funds. Some resources are shared by other donors like ADB and GFATM at the country level. The regular budget is US$ 2 580 000 for 2006-2007 and the voluntary contributions from donors is likely to be more than the regular budget.

Fig. 2 Composition of the WHO regular budget by component, 2004-2005



In June 2005, the Country Office count was 12 international staff (long and short-term) eight local staff and eight general-service staff (secretaries and drivers). For 2006, the cost of the staff is 41% of the regular budget (around 20% of total budget).

Another large regular budget component (12%) is local costs, which covers in-country workshops and seminars for national health staff. During the period 2004-2005 WHO - supported workshops and seminars were organized at national, provincial and district levels.

Smaller portions of expenditure go to funding fellowships and special services agreements, which have long been a feature of WHO's support in Papua New Guinea.

In terms of regular budget allocation by content of work, the analysis showed that 27% went toward combating communicable diseases, 35% on building healthy communities and 38% on health sector development.

4.2 WHO human resources

During the period 2002-2003, about 4.5 full-time equivalent (FTE) staff time or nearly half of all WHO professional staff time was spent on communicable diseases control. Less than two FTE support was provided on health system-related aspects. Administrative support staff constitute an important part of WHO's total staff presence in Papua New Guinea.

Special Services Agreements (SSA) can play a useful role in increasing capacity in the country office and in supporting government-implemented programmes at provincial and district levels. WHO presence at a peripheral level is crucial for clear input at the implementation level. This was clearly demonstrated during the Supplementary Immunization Programme and was crucial to its success.

High turnover of national counterparts and provincial health advisors have contributed to the delay in implementation of programme activities, and complicate efforts to develop institutional capacity. SSA have provided a practical short-term solution to the very real staffing and funding shortages experienced by the NDOH. However, there is no clear evidence that SSA are contributing to greater longer-term capacity in Papua New Guinea. There is a problem of retention because many nationals employed on an SSA contract with WHO have subsequently left government service, and there is no mechanism to monitor and supervise SSA-contracted experts, especially those working in the field. There is also a need for greater accountability of SSA to WHO and for closer supervision to be undertaken by WHO of their activities.

4.3 Achievements

The WHO country programme has contributed to important national policy developments in the past. The Government has endorsed the DOTS strategy as the most effective strategy to address the high burden of TB in Papua New Guinea. The Integrated Management of Childhood Illness (IMCI) strategy was advocated and the WHO IMCI training manual was adopted and applied in selected districts with high child morbidity and mortality. Through collaboration with the Department of Education, a health-promoting school programme has been introduced in 300 of 6000 schools in all 19 provinces. A national drug policy and legislation on medicine and cosmetics have been developed with WHO's technical support. WHO was an important element in fund raising and was responsible for successfully securing and implementing the malaria programme of the GFATM (US$ 20 million) and for the introduction of the HIV component (US$ 30 million). WHO was strongly involved in the supplementary immunization activities (2004-2005) with follow-up of activities in the field to maximize the technical quality and ensure accountability with use of resources. WHO, in collaboration with ADB, initiated and supervised the first pilot project for HIV therapy which is now integrated in the "3 by 5 Initiative" activities.

Along with these achievements, a number of issues and challenges need to be considered and addressed in order to strengthen WHO's support of health development in Papua New Guinea:

- securing long-term staff for EPI, epidemiology, IMCI, emergency preparedness, health systems and information;

- strengthen our presence in peripheries: special services agreements and national programme officers to be increased significantly;

- greater ability to manage extrabudgetary funds at country level;

- interchange of experience with staff of other countries; and

- strengthened involvement in coordination with partners and closer collaboration through their contribution to budget or through the secondment of personnel to WHO office.

5. WHO's CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTION

5.1 WHO Corporate policy framework

A WHO Country Cooperation Strategy needs to reflect the Organization's corporate policy framework and regional strategies as well as the health needs of the country and activities of other development partners.

WHO's mission, as set out in its Constitution, remains the attainment, for all people, of the highest possible level of health. A number of challenges have emerged from the significant changes in international health in the last decade, including a new understanding of the causes and consequences of ill health; the greater complexity of health systems; increasing prominence for "safeguarding health" as a component of humanitarian action; and a world increasingly looking to the United Nations system for leadership. WHO has developed a corporate policy framework to guide its response to this changing global environment and to enable WHO to make the greatest possible contribution to world health.

The policy framework continues to reflect the values and principles articulated in the global Health-for-All policy, which was reaffirmed by the World Health Assembly in 1998 with new emphasis on:

- adopting a broader approach to health within the context of human development, humanitarian action and human rights, in particular focusing on the links between health and poverty reduction;

- playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;

- triggering more effective action to improve health and to decrease inequalities in health outcomes by carefully negotiating partnerships and catalyzing action on the part of others;

- creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

5.2 WHO's goals and priorities

WHO aims to build healthy populations and communities and to combat ill-health. The following four interrelated strategic directions have been set for WHO's areas of work:

- reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;
- promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes;
- developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair;
- developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

In addition to these strategic directions, WHO has also defined limited specific priorities, based on criteria which include the potential for a significant reduction in the burden of diseases using existing cost-effective technologies (particularly where the health of the poor will demonstrate benefit), and the urgent need for new information, technical strategies, or products to reduce a high burden of disease. The specific priorities are malaria, HIV/AIDS, TB, maternal health, mental health, tobacco, non-communicable diseases, food safety, safe blood, health systems and investing in change in WHO.

Strengthening corporate action at country level is one of the key objectives of WHO. The Country Cooperation Strategy is a key instrument of the organization-wide country focus initiative, which aims to optimize WHO's work at the country level and provide effective support to countries in addressing their health problems. Along with the Country Cooperation Strategy, the strengthening of competencies and capacities, enabling effective functioning of country teams, providing coherent support, information, in-country intelligence and working with partners, have been defined as the major components of the Country Focus Initiatives.

The WHO policy framework guides the Organization as a whole to collaborate effectively with United Nations agencies and all other partners to bring health into the agenda of socio-economic development. Recent international health developments such as MDG, Poverty Reduction Strategy Papers, the Commission on Macroeconomics and Health, Global Alliance for Vaccines and Immunization and the Global Fund to Fight AIDS, Tuberculosis and Malaria's have broadened such opportunities and established new mechanisms for increased internal and external investments in health.

5.3 Regional emphasis

Within the WHO corporate strategy and in the light of emerging health challenges in the Region, the WHO Regional Office for the Western Pacific has tailored its own supporting framework for action around four outcome-oriented themes:

- combating communicable diseases;

- building healthy communities and populations;
- developing a strong health sector; and
- reaching out (which encompasses information technology, external relations and communication).

In recent years, emerging and re-emerging diseases have been a major public health issue in several countries and areas of the Region. Te outbreak of severe acute respiratory syndrome (SARS) has taught many important lessons, which have resulted in increased commitments to address the weaknesses in public health systems and strengthen disease prevention and control measures. HIV/AIDS, malaria and TB are serious health issues for many countries and areas in the Region. The regional policy to fight HIV/AIDS has been revitalized by the WHO's new statement to ensure access to HIV/AIDS drugs for 3 million HIV-infected patients in developing countries by 2005, known as the "3 by 5 Initiative".

Health sector development is another important issue in the Region. Health systems in many countries need to be adequately developed and funded in order to deliver a minimum level of essential health services. Consequently, most health system reforms undertaken in the Region aim to improve health system functioning, management and financing at all levels. Increasing cost of health services and application of user fees often push low-income families into poverty. Therefore, the issue of removing undue financial burden on individual households and ensuring appropriate financial protection for the entire population through prepayment is recognized as one of the most important health system reforms in the Region.

6. WHO'S MEDIUM-TERM STRATEGIC AGENDA IN PAPUA NEW GUINEA

6.1 Objectives, principles and outlook

WHO's overall objective is to support the Government in achieving its goal of improving the health of Papua New Guineans, as envisioned in the national health plan 2001-2010. WHO's main areas of work within the four outcome-oriented regional themes will be maintained in Papua New Guinea with newly defined principles and strategic directions which are discussed below.

The overarching principles of WHO's work in Papua New Guinea are to:

- be guided by Papua New Guinea's national health priorities, and commitments to international health treaties and targets;
- continue to provide technical and logistical assistance to Papua New Guinea in order to facilitate the full and effective implementation of the International Health Regulations (2005);
- build on WHO's traditional competencies and activities, and aim to gradually shift the balance of support as national, provincial and district capacities increase away from active support for routine programme delivery towards a more advisory and facilitating role;

- maintain existing partnerships and commitments, including those within the United Nations family, but respond to an increasing number of actors in health-public, private and external-by exploring new ways of working with them;

- emphasize the need to be selective in its work and to be proactive, but to retain sufficient flexibility to respond to the unexpected;

- complement the work of other partners and support evidence-based approaches;

- balance support for short-term results and long-term health systems development.

6.2 Strategic directions

(a) Intensified collaboration to reduce the main causes of morbidity and mortality.

This will continue to be WHO's main area of work. WHO will intensify its support to reduce mortality and morbidity from malaria, HIV/AIDS and TB, and to reduce child and maternal mortality. At present WHO provides intensive support to the NDOH in the design and implementation of its national programmes, from central to district level. WHO will continue to provide the full spectrum of support including technical policy development, guidelines, selected logistics, training at different levels, supervision, and monitoring. WHO will support the following Government priorities through a mix of interventions, but focused and cross-cutting:

- Malaria. The Government strategy consists of scaling up the use of insecticide-treated bednets, improved diagnosis and effective treatment. Papua New Guinea has recently received additional funds for this strategy from the GFATM, which has pledged $20 million over the next five years, with $6 million for 2004-2005. GFATM resources are additional to the current health budget, and their timely and effective use poses both an opportunity and a challenge. In addition to continued technical advice on effective malaria control, WHO will support the Government and the Country Cooperation Mechanism (CCM) in the use these funds, especially in developing greater linkages with nongovernmental organizations and the private sector, to monitor the effects on malaria prevention and care, and on other aspects of service delivery.

- HIV/AIDS. WHO supports the comprehensive response by the Government that includes prevention, counselling, and treatment. WHO will particularly continue efforts to decrease stigma and raise awareness of HIVAIDS through advocacy to the wide range of concerned parties. It will also work to increase access to antiretroviral drugs through the mobilization of seed funds and through helping develop competencies in a small number of treatment centres that are then expected to act as "path-finders" for larger and longer term implementation. Exploring ways to maintain long-term compliance, to successfully scale up services, and analyses of costs and options for longer term funding are part of that "path-finding" role. Furthermore, WHO will support surveillance of HIV, strengthening the control of STI and provide support for laboratories for STI and HIV. WHO will work with other partners and especially the United Nations theme group to provide leadership.

- Tuberculosis. WHO will continue to play a key role in providing technical expertise in implementing the TB programme in Papua New Guinea. Specific emphasis will be given to the expansion of the DOTS strategy to all provinces by 2007.

- Childhood illness. WHO will continue to support the Integrated Management of Childhood Illness Strategy (IMCI) in Papua New Guinea and its expansion, based on lessons learnt from the two pilot districts.

- Maternal mortality. WHO will increase its inputs into the "Making Pregnancy Safer" programme and Reproductive Health in general including Family Planning/Birth Spacing, based on lessons learnt from its implementation in four provinces.

- Immunization. WHO will support and strengthen the national Expanded Programme of Immunization to achieve >80% coverage for the third dose of diphtheria tetanus and pertussis vaccine (DTP3), polio and measles within five years. Supplementary immunization activities will be supported as needed.

- Noncommunicable diseases and injuries. WHO will help the NDOH anticipate the emerging noncommunicable diseases (NCD) agenda, by supporting the assessment of trends in mortality and morbidity of heart disease, diabetes and preventable cancers such as oral, hepatic and cervical cancers. The unrecognized burden of NCD needs to be qualified in the short term and assessed for its impact especially on the urban poor. A national response for dealing with the double burden of disease should be developed.

- Mental health and violence. WHO will raise awareness of mental illnesses and all forms of violence and support the NDOH to promote good mental health among the population and to plan responses to mitigate its negative impacts.

- Food safety. WHO will continue to support and strengthen the national regulatory environment to enhance the safety of imported and domestically produced food and increase consumer awareness of safe food handling practices to reduce the burden of diarrhoeal diseases.

- Essential health technology. WHO will continue to support and provide technical expertise to strengthen public health and clinical laboratories and of the Blood Transfusion Service to ensure blood safety.

- Emergency and disaster preparedness. WHO will strengthen national capacity to plan and coordinate a timely response to mitigate health consequences during emergencies and disasters.

- Health promotion activities related to priority diseases. WHO will continue to support the Ministry of Health's Healthy Islands approach to stimulating community involvement in health, which uses schools and other community-based structures as key entry points. WHO will: focus on the priority health conditions in Papua New Guinea; encourage greater synergies in prevention and treatment activities within specific programmes; promote greater consistency in health

promotion messages across the many agencies involved; and undertake systematic evaluations of the effectiveness of health promotion activities in changing behaviours in Papua New Guinea.

- Strengthening human resources capacity. In order to facilitate the achievement of the strategic directions, WHO will continue to support and provide technical assistance for the continued development of human resources capacity in the health care workforce.

Selected activities and ways of working

To support the implementation of the above programmes WHO will maintain a district peripheral focus (provinces and districts).

- Capacity-building. For a programme to be effective, service delivery at the district level needs to occur. WHO will focus on supporting the development of capacity at the district level supported by a management and supervisory system at provincial and national levels and appropriate national policies and guidelines.

- Best practices and lessons learnt. Currently, the implementation of many programmes is limited to selected districts or provinces. There is limited information and documentation of successes and failures across the various programmes. Therefore, WHO will support exchange of information on best practices and lessons learnt across programmes.

- Encouraging programme integration. To minimize duplication, waste, and multiple demands on local staff, WHO will support efforts at district level to integrate programmes where appropriate. This should include integrated approaches to training.

- Scaling up. WHO will encourage the early development of a long-term strategy for scaling up programmes to achieve national coverage to other areas and will avoid only supporting programmes that cover a limited number of districts and do not have a plan for scaling up.

(b) Health systems development within a decentralized system

Main directions of WHO medium-term support. The decline in district services means these are a major priority for the Government, and a focus of support from other donors. Decentralization has resulted in districts having many responsibilities but often little capacity. WHO will build on its existing activities at both central and district levels to improve the effectiveness of district health services. It has to adapt to the current configuration with its decentralization and split in provincial health services. WHO and its partners will work together to improve communication, supervision, effective referral, and interaction between health centres and hospitals. It will also encourage systematic analyses of innovative district capacity-building and service delivery strategies. Specifically it will support the NDOH in:

Human resources development

- WHO support for human resources development will be coordinated with other development partners and ideally within an overall government framework or plan. However, urgent actions need to be taken when appropriate, especially in view of the influx of large donor funds such as GFATM.

- The ongoing public sector reform, including administrative and financial decentralization, require a more strategic focus on human resources development including skill mix, clear terms and conditions of employment and disciplinary procedures. Therefore, WHO will support the NDOH in the development of a health workforce capacity-building strategy, particularly at a district level that could guide capacity-building activities of all partners.

- WHO will facilitate access to international knowledge and experience on different aspects of health workforce development, such as strategies to improve distribution, skill mix, and supervision to create incentives and improve accountability.

Capacity-building

- WHO-supported workshops more often addressed national rather than provincial or district health needs and problems. Management skills and knowledge of district health administrators are not addressed. For international workshops, some people are frequently selected, while provincial and district staffs rarely attend. There is no systematic mechanism to support the translation of new skills and knowledge into practice. Therefore, WHO will pay special attention to the issue of investing resources in training, including overseas studies. WHO in collaboration with the NDOH will develop appropriate selection criteria and accountability mechanism to improve the training benefits and quality of workshops.

- WHO will ensure that its workshops and courses will reach district service providers and managers and the course content is relevant and of good quality through better coordination with other agencies and proper follow up.

Standards and guidelines development

- WHO will continue to support strategies to strengthen the district's operating environment through the implementation of "Minimum Standards for District Health Services", a strategy developed and adopted in 2001 which further enhances support services the foremost and strengthens public health laboratories.

Supervision and monitoring

- Given that the bulk of the NDOH budget is going towards salaries and benefits, only a small amount remains to operate the system, which is the underlying cause of poor monitoring and supervision. WHO, with other development partners, will support innovative ways to strengthen an integrated supervisory and monitoring system central to province and province to district levels.

Health information systems and use of data for management

- It is a known fact that "lower levels" are requested to collect and collate data, but are often not given regular feedback of the compiled and analysed data. WHO will support the health information systems and data management, ensuring that information exchange goes in both ways, which should enable provinces and districts to make their own analysis and use gained information as a management tool for decision-making.

Drug supply and management

- Drug procurement and supply is surrounded by sensitive issues, which often results in unacceptable shortages and stock-outs. WHO will continue to provide support for the Medical Supply and Equipment branch to improve drug management, with special attention to provincial and district levels. When necessary, and on an exceptional ad hoc basis, WHO will procure drugs to mitigate serious health impacts of affected populations.

Health systems and financing

- WHO will support the analysis of alternative financing options, such as community insurance. This will draw on local and international experience, and link up with broader debates on health financing options in Papua New Guinea.

(c) Support the National Department of Health in good governance and partnership building

Main directions of WHO support. The NDOH faces many challenges in guiding the development, implementation and monitoring of the national health policies in a decentralized and increasingly pluralistic health system. WHO will support the NDOH in:

Good governance and leadership

- The key duty of WHO's country office is to strengthen the National Department of Health's leadership role in every aspect at a national level.

- At provincial and district levels WHO will strengthen governance and stewardship capacity to ensure that provincial and district health services meet the minimum standard and other performance criteria as defined in its strategic framework.

- WHO will collaborate in strengthening of efforts to monitor the overall health system performance and trends towards Papua New Guinea's stated health system goals, with special attention to the treatment of vulnerable groups. It will promote better and more timely feedback of information to decision-makers and encourage its use.

Policy support

- WHO will continue to provide technical support for technical and institutional health policy development, including independent, expert advice when requested, and will facilitate access to policy options from international experience in collaboration with other partners.

Coordination

- Efforts to improve policy coherence and greater coordination of partners and in greater technical cooperation around specific health priorities at national level has been a challenging issue in the health sector. In recent years, WHO has made progress and works closely with the United Nations country team on matters of common interest. Especially, WHO will intensify the work with the NDOH and other partners in further development of Health Sector Improvement Program (HSIP), and encourage the gradual harmonization of procedures and systems. Further, it assists in the GFATM's Country Coordination Mechanism (CCM) to tackle malaria, HIV/AIDS and TB.

Monitoring health-related Millennium Development Goals

- WHO will support monitoring of the health-related Millennium Development Goals in ways that give a system wide perspective and allow data to be disaggregated to see whether access by the most vulnerable groups is being improved. It will facilitate access to international experience in monitoring health systems performance, and to relevant new methods and instruments, for example, through the Health Metrics Network.

Health and the poverty agenda

- WHO will also work to enhance understanding of the contribution of health to human development and poverty reduction and vice versa, in Papua New Guinea.

- WHO will address the international dimensions of Papua New Guinea's health agenda. For example, WHO will facilitate access to reduced prices for pharmaceuticals for priority conditions, through innovative mechanisms such as the Global Drug Facility (GDF).

Selected activities and ways of working

Papua New Guinea is a country in transition with a large communicable diseases agenda, but also with an increase in new lifestyle ailments, which is not matched by its fragile health system. There is a substantial range of ongoing health policy reforms and other developments to address the challenge. Therefore, WHO will provide expertise in broader health systems development and pay special attention to increased generation of data and information. It will further insure that the health agenda is seen outside the immediate health sector to foster overall development.

- Knowledge generation. WHO will support key institutions such as the Institute of Medical Research at Goroka and the Central Public Health Laboratory to

strengthen their capacity to carry out operational research on diseases such as measles, acute respiratory infections, and HIV.

- Intersectoral action. WHO will support the NDOH to maintain links with other partners such as the Department of Education and the Department of Community Development in order to keep health promoting interventions that fall within the mandate of these departments on their agenda.

- Health and development. WHO will help "translate" the messages on Health and Development from the Commission on Macroeconomics and Health to Papua New Guinea's own context, and explore ways these could be used to stimulate action by politicians and administrators at all levels of the system in mobilizing and allocating resources for health.

7. IMPLICATIONS FOR THE COUNTRY OFFICE

The Country Cooperation Strategy calls for new ways of working at the country level and it will have major implications on WHO's country collaboration in Papua New Guinea. These will be in the areas of programme management, resource mobilization, human resources, partnership building, and advocacy.

7.1 The role of the country office

The country office has played an important role not only in supporting the NDOH in providing technical assistance but also in supporting the management of programmes and providing back-up in other areas. This has resulted in a high proportion of the regular budget being allocated for staff. This role is expected to continue for the next several years as WHO supports priority programmes to scale up their coverage. However, where programmes have the capacity, WHO would try to step back and take a more advisory role.

7.2 Programme management

Given the five-year time frame of the Country Cooperation Strategy (CCS), it provides a bridge between the biennial cycle of WHO and the general programme cycle of five years that is common for the Government and other United Nations partners. The CCS also clearly demonstrates the need for long-term support in terms of technical assistance and resources. It will assure that the country plans of action developed every two years are in-line with the global and regional planning cycles. The NDOH has adopted a SWAp and has called for harmonization of programme cycles among development partners in health to support the medium-term expenditure framework and its national health plan.

In terms of budget allocation, the SWAp calls for pooled funding to support annual activity plans. To facilitate this, a trust account mechanism has been put in operation. Increasingly, the NDOH and donor partners including the GFATM are utilizing this trust fund. WHO plays an important and critical role in ensuring good management of this trust account and providing technical support for programme development and implementation. The funds WHO provides for activities are limited, but where possible, funds will be placed in the trust account as earmarked funds.

With the move towards decentralization in WHO and development of a "one country plan and budget" for the contribution of all levels of the Organization to work in a country, the WHO Representative will be delegated increased responsibility for all WHO resources spent in Papua New Guinea. There will be a greater emphasis on integrated programme budgeting with the coordinated planning, implementation, monitoring, and evaluation of both regular budget and extra-budgetary resources. Not only will there be close monitoring of funds from all levels of the Organization spent in-country, but also the routine six-monthly monitoring of implementation of the Programme Budget will analyse the combined contribution of all sources of funds to achieve the expected results under the Programme Budget.

7.3 Resource mobilization

Besides regular and inter-country budget the country office has been successful in mobilizing resources from other sources to support country programmes. In the past, funds have been mobilized from bilateral donors and financial institutions to support implementation of the DOTS Strategy, implementation of essential drugs policy, conduct supplementary immunization activities and for starting the "3 by 5 Initiative" to promote the care and treatment of HIV/AIDS patients. Although the country budget is limited, support has been provided to many essential country initiatives through better extra-budgetary resource mobilization. In the future, the country office should play an even bigger role to attract funding to support implementation of activities at the peripheral level especially during health emergency disease outbreaks. New avenues to mobilize funds at the country level should be explored. More efficient systems for managing and monitoring these funds in coordination with the regular budget and the NDOH budget, should be developed.

7.4 Staffing of the country office

Currently, the country office is composed of five fixed-term staff including the WHO Representative. Other positions are filled with short-term professionals supported by nine general-services staff. Due to difficult working conditions especially the deteriorating law and order situation and increasing violence against women, it is difficult to achieve a gender balance within country staff. Poor security also makes it difficult to recruit international staff. This is unlikely to change unless there is a drastic improvement.

Communicable diseases prevention and control, including the expanded programme on immunization, will remain priority programmes in the future. Thus, there is a growing need to create long-term positions for epidemiological surveillance and health information; for reproductive health; for human resources (nursing) capacity; and for HIV/AIDS. Due to the burgeoning infant and child mortality rates, there is also a clearly identified need to provide technical support in the area of child health. These human resources needs could be met in several ways:

- Increase the number of fixed term professional staff (including United Nations Volunteers and Associate Professional Officers)

- Funding of additional post by donor partners

- Recruitment of National Programme Officers (possibly also Special Services Agreements)

Based on experience, it is emphasized that once the decision is taken to create a position, all efforts are needed for timely recruitment of good quality international staff.

It is also important that all personnel be involved with an integrated supervision system and have the ability to observe and report on activities from other programmes outside their own.

In the past, an emphasis has been placed on developing national policies and guidelines. Many such policies and guidelines are now in place with little evidence of effective implementation at the local level. As the CCS will have a focus on strengthening district health systems, it will be important to have staff on the country team with experience on programme development, implementation, monitoring and evaluation at provincial and district levels. While WHO is experienced in working with national counterparts, there will be a need to develop further ways of working with counterparts at local levels. For example, SSAs could play an important role in implementing the district focus strategy.

Appropriate continuing education and training of in-country staff is essential if staff is to keep abreast of current knowledge and scientific advances in their respective fields. To achieve this, resources will be required for continuing staff development and training. WHO will also have an important role to play in supporting the Government and civil society on periodic reporting on progress towards achieving the health-related Millennium Development Goals. This will necessitate the strengthening, through training, of the capacity of technical staff, including the WHO Representative, to provide technical support to governments and other agencies on MDG monitoring and reporting.

7.5 Building partnerships and advocacy

WHO is seen as the leader in the health field and is frequently called upon by the Government, nongovernmental organizations, and other developmental partners to give technical advice on various matters related to public health. The country office needs to be strengthened and equipped with modern information technology so that timely and up to date information is available for wider dissemination, advocacy, and sharing with partners.

The core responsibility of WHO is, and will continue to be, to facilitate and assist the NDOH to produce the best health outcomes for the country. The strategic directions outlined in the CCS call for also building partnerships with other sectors of government as well as with nongovernmental organizations and the private sector. For successful implementation of the suggested strategies, new ways of working with different partners beyond the NDOH have to be developed and strengthened.