

PAPUA NEW GUINEA

1. CONTEXT

1.1 Demographics

Papua New Guinea has an estimated population of around 6.7 million (2010), 38.2% under the age of 15. Around 800 languages are spoken in the country, each language group having a distinct culture, and there are large sociocultural differences between and within provinces. The official languages are English, Pidgin and Motu.

Access to widely scattered rural communities (87.5% of the country's population is living in rural areas) is often difficult, slow and expensive. Only 3% of the roads are paved and many villages can only be reached on foot. Most travel between provinces is by air. The capital, Port Moresby, is not linked by road to the rest of the country.

Papua New Guinea has made some progress in social development over the last 30 years. For example, the literacy rate has risen from 32% to 58%. However, only half of all women aged 15 years and above and two-thirds of all men aged 15 years and older have ever attended school, and enrolment rates vary significantly across provinces. Women have a very high fertility rate of 4.1 births per woman. Life expectancy has risen from 49 to 61 years. In the 2000 population census, the crude death rate was 12.0 per 1000 population. The country's Human Development Index has decreased from 0.5 to 0.4, indicating that progress has slowed in recent years.

1.2 Political situation

Papua New Guinea is divided administratively into four regions: Southern Coastal (Papuan) Region, Northern Coastal (MoMaSe = Morobe, Madang and Sepik provinces) Region, Highlands Region, and New Guinea Islands Region. The governance system is a parliamentary democracy based on the Westminster model. As a member of the Commonwealth, the head of the Independent State of Papua New Guinea is Queen Elizabeth II of the United Kingdom of Great Britain and Northern Ireland, represented by the Governor-General, who is elected by Parliament for a five-year term.

The current single-chamber Parliament has 109 members, comprising one representative from each of the nineteen provinces and the National Capital District, and one representative from each of the 89 open constituencies. Every five years, political leaders are elected to the two tiers of government: national and local. Presently, there is only one woman representative in the national Parliament. There is a decentralized system of government. At the subnational level, there are three levels of administration: provincial, district and local (including several communes, with their villages).

1.3 Socioeconomic situation

During the 1990s, economic performance was mixed, although the economy benefited greatly from major mining and petroleum projects. While there was the potential for economic and social development, the period was largely characterized by negative economic growth and macroeconomic instability. As a result, the economy grew very little in real terms, with growth in the non-mining sector more sluggish than that in the mining sector. The reasons for the economic stagnation were complex. External contributing factors included the worldwide economic depression, the negative development in commodity prices, and unfavourable trade conditions, among others, while internal factors included a series of inappropriate policy regimes and fiscal failures, the catastrophic civil war in Bougainville from 1989 to 1999, and a series of devastating natural disasters.

In recent years, the economic parameters have shown a more stable situation and a slightly more positive trend. However, this has been caused by the rising prices of mining products on the international markets rather than by improved internal performance.

Because of the economic situation, as well as the widespread evidence of deterioration in public services, especially in rural areas, it is a widely held view that living standards for a significant number of Papua New Guineans have declined since 1990. Furthermore, in spite of the increasing cost of living, salaries have changed very little over a long period, contributing to a static or possibly worsening poverty situation, particularly in the urban sector. In 2003, the Government developed a poverty-reduction strategy that was intended to give an added

focus to poverty in the national Medium-Term Development Strategy (MTDS, 2003–2007, not updated since). The country is a signatory to the Millennium Development Declaration, with its first MDG progress report being published in 2005.

1.4 Risks, vulnerabilities and hazards

The country is prone to numerous chronic natural hazards, as well as the occasional acute disaster situation, on a scale greater than any of its Pacific neighbours. The repertoire of hazards that continually hamper the development process in urban and rural remote locations of the country include volcanic eruptions, earthquakes, tsunamis, tropical cyclones, large-scale landslides, flooding, sporadic droughts, frosts in highland areas, the impact of climate change and variability, and rising sea levels. There is also a high risk of technical and human-made disasters, such as oil spills, industrial pollution and unregulated and destructive land-use practices.

Papua New Guinea is situated on the boundary between the Pacific and the Australian tectonic plates. The country has eight active volcanoes and is subject to regular earthquakes every year, with secondary effects of this activity including tsunamis and landslides.

A major challenge to improving health is related to perceptions of illness and health among the general population. There is a widespread lack of awareness regarding risk-related and health-promoting behaviour, and little involvement by local communities in health-promoting activities. Key risks include behaviour and environments that increase the risks of communicable disease; risks of noncommunicable disease, such as chewing betel and smoking tobacco; and the risks associated with unsafe sexual behaviour.

2. HEALTH SITUATION AND TREND

2.1 Communicable and noncommunicable diseases, health risk factors and transition

Communicable diseases remain the major causes of morbidity and mortality in all age groups. However, significant progress has been made in some areas. In 2000, the country was declared poliomyelitis-free. In addition, the national leprosy elimination target of less than one case per 10 000 population was reached.

In 2008, malaria was the leading cause of all outpatient visits, the fourth leading cause of hospital admissions and the third leading cause of death. The disease is now endemic in every province, including the Highlands Region, which was once considered malaria-free. An average of 1.5-1.8 million suspected cases of malaria are seen at health care facilities annually, and malaria mortality rates for 2008 were estimated to be 9.7 per 100 000 population. Together, malaria and pneumonia account for one-third of all recorded deaths.

According to WHO estimates, in 2009, Papua New Guinea had an estimated tuberculosis prevalence rate of 337 per 100 000, a TB death rate of 26 per 100 000, and a total of 12 306 new TB cases (all forms). However, it is very likely that these are underestimates because the prevalence and incidence rates are based on case notifications, and cases are generally underreported. Only 14 provinces report and relay their data to the National Health Information System (NHIS). Thus TB remains a major public health problem, particularly in view of the current HIV epidemic, which is posing a serious threat as a double burden (TB-HIV co-infection) and also in the context of multidrug-resistant TB (MDR-TB). In 2010, 4350 TB patients were tested for HIV. An estimated 33% of new and retreatment TB cases had MDR-TB in 2008. According to the 2010 Global MDR-XDR WHO Surveillance Report, there were 530 new and relapsed cases. The Global Stop TB Strategy is reflected in the revised five-year National TB Strategic Plan, with the country able to achieve a case detection rate of 73% and 64% success rate in 2009, meeting the global targets set by WHO. The directly observed treatment, short-course (DOTS) programme has gradually expanded since its inception in 1997, but it was not until 2007 that the DOTS roll-out strategy was implemented and it is currently operational in nine provinces with the roll-out expected to include all 20 provinces by 2012.

The Government is committed to having a TB-Free Papua New Guinea by 2050 and the National TB Programme (NTP) is aligned to the National Health Plan 2011-2020 in that context. The Global Fund has supported the NTP with a five-year grant that began in 2007 and phases out in 2012. Currently the country is in phase two of year four of Global Fund Round 6. The reasons for the slower-than-planned expansion of DOTS include a number of system constraints common to other disease-control programmes: staff migration, weak or no infrastructure, the

geographical layout of the country impeding service delivery, and delays in access to funds, which have led to limited training, supervision and other local-level support.

Papua New Guinea was declared to have a generalized HIV/AIDS epidemic in 2003. While the prevalence rate reached approximately 1.5% in 2007, a consensus meeting held in June 2010 resulted in a revised HIV prevalence rate estimate of 0.9% for 2009. In February 2006, it was estimated that there were 23 000 to 91 000 HIV-positive individuals in the sexually active population aged 15-49 years. HIV prevalence among women attending antenatal clinics was between 0.6% and 3.7% in 2005, and AIDS-related death is the leading cause of death in adult inpatients at the Port Moresby General Hospital. The main mode of HIV transmission is heterosexual. The incidence of other sexually transmitted infections (STI) is also rising, with the high incidence of sexual assaults on women contributing to their risk of contracting an STI.

Filariasis is endemic, although the size of the problem is unknown. Mass drug administration through the Elimination of Lymphatic Filariasis (ELF) programme is ongoing in only a few provinces due to insufficient funding.

Dengue has been reported in the last few years. Two cases were reported by Vamino hospital and confirmed by the Papua New Guinea Institute of Medical Research in March 2011. However, the scope of dengue endemicity is unclear.

The incidence of noncommunicable diseases is rising, creating the double burden observed in most developing countries. Cases of tobacco-related and alcohol-related illness appear to be increasing, while data from Port Moresby General Hospital suggest that diabetes and hypertension are also on the increase. The leading cancer in Papua New Guinea—oral—has a largely preventable cause (betel chewing and tobacco smoking).

Another ongoing health concern is related to injuries caused by road traffic accidents and all forms of violence (domestic, criminal and tribal).

2.2 Outbreaks of communicable diseases

Outbreaks of communicable disease are common in Papua New Guinea, and are often associated with widespread morbidity and mortality. Since July 2009, the country has been affected by a cholera outbreak that has spread across eight provinces in the country, with approximately 14 000 cases reported in health facilities and communities. Risk factors for cholera outbreaks have included: living in a settlement, poor access to safe water, poor defecation practices, and sharing a house with a case. Contaminated food and water are the major factors contributing to cholera and other disease outbreaks, with only 40% of the population using an improved drinking-water source and poor hygiene conditions resulting in unsafe food-handling practices.

Prior to the first outbreaks of pandemic influenza A(H1N1) 2009, concurrent outbreaks of shigellosis and influenza were associated with high morbidity and mortality across four provinces in zones with health system access limitations. Delayed reporting and response, as well as a lack of access to timely antimicrobial therapies were thought to have contributed to the impact of those outbreaks. The degree to which pandemic influenza impacted on Papua New Guinea is unknown, in part due to limited influenza surveillance capacity. In recent years, internally displaced persons, settlement dwellers, prisoners and other groups have been severely affected by communicable disease outbreaks and can be particularly vulnerable.

The country is strengthening core capacities in line with the International Health Regulations 2005 in order to better prepare for, identify, report, verify, assess and respond to public health events such as communicable disease outbreaks.

2.3 Leading causes of mortality and morbidity

Communicable diseases, including pneumonia, malaria, tuberculosis, diarrhoeal diseases, meningitis and, increasingly, HIV/AIDS, remain the leading causes of morbidity and account for around 50% of mortality. Information on the true impact of HIV on mortality and morbidity in Papua New Guinea is lacking, but AIDS-related death is now the leading cause of death in adult inpatients at the Port Moresby General Hospital.

Perinatal conditions account for over 10% of all recorded deaths and maternal mortality estimates are high and have increased in past years, indicating a decrease in access to quality health services.

The noncommunicable disease epidemic in Papua New Guinea is firmly established and increasing, but remains largely unrecognized in reported data. Tobacco-related and alcohol-related illnesses, diabetes and hypertension are on the increase, as are the three leading cancers (oral, hepatic and cervical), along with breast and lung cancers.

2.4 Maternal, child and infant diseases

Maternal and child morbidity and mortality are not improving. Maternal mortality estimates vary widely, but all are high. The 2006 Demographic and Health Survey established a maternal mortality ratio of 733 per 100 000 live births. The causes of maternal mortality include postpartum haemorrhage, puerperal sepsis, antepartum haemorrhage, eclampsia and anaemia. Almost 53% of pregnant women are cared for by trained health personnel and about 40% of births take place in health facilities. About 35.7% of women are using modern family planning methods.

Perinatal conditions account for over 10% of all recorded deaths. The infant mortality rate was estimated at 56.7 per 1000 live births for 2006, compared with 82 in 1991 and 72 from the 1981 National Census. Overall, 28% of children are considered to be moderately to severely malnourished and 31% of children aged 0–5 are stunted, while wasting is comparatively low. Again, there are marked regional variations.

Child health problems are being addressed through improved immunization, periodic supplementary immunization activities and the joint United Nations Children's Fund (UNICEF)/WHO child survival strategy, with a focus on the integrated management of childhood illness (IMCI) approach.

2.5 Burden of disease

The health status of Papua New Guineans, the lowest in the Pacific region, steadily improved during the 1980s before declining in the 1990s. Life expectancy (2007) is estimated to be 58.7 years for men and 63 years for women, and 15% of a woman's lifetime is estimated to be affected by some form of disability or morbidity. The estimations 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.

3. HEALTH SYSTEM

3.1 National Department of Health's mission, vision and objectives

The overall mission of the National Department of Health is to promote the physical, social, mental and spiritual well-being of people in their communities, and to promote and encourage the maintenance of community health at an acceptable level by planning and delivering preventive and curative medical and other health services.

The vision of the Department is of a nation of healthy individuals, families and communities where self-reliance prepares all for healthy living in a healthy island environment, with the ultimate goal of improving 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 Government is focusing its efforts on improving child health and reducing malaria, tuberculosis and HIV/AIDS through specific programmes. To be a nation of healthy individuals, families and communities, and in the spirit of the National Goals and Directive Principles, as enshrined in the National Constitution, Papua New Guineans strive for a future in which:

- fewer infants and children die before they have had a chance to experience life;
- fewer mothers die in childbirth from preventable causes;
- all Papua New Guineans have access to basic health care and good nutrition;
- fewer Papua New Guineans die from preventable and treatable diseases including malaria, pneumonia, tuberculosis, diarrhoea and HIV/AIDS;
- women and men live healthier, longer, productive lives and age with dignity;
- villages have safe drinking water and a clean environment; and
- individuals make informed choices as regards health behaviour.

3.2 Organization of health services and delivery systems

Health services are provided by government and church providers (both of which are financed primarily from public sector funds); enterprise-based services (e.g. the mines); a small, modern private sector; and traditional healers (undocumented amount). Within the public sector, management responsibility for hospitals and rural health services within provinces is divided. The National Department of Health manages the provincial hospitals, while provincial and local governments are responsible for all other services (health centres and subcentres, rural hospitals and aid posts), known collectively as 'rural health services'.

The National Health Conference 2001 supported a proposal to create a unified provincial health system. The proposal envisaged a single provincial health authority responsible for both hospital and rural health services, headed by a provincial director of health who would report to both the national and provincial governments. Thus far, this system has only been implemented in four provinces.

Strategies to ease managerial difficulties include: amendment of selected public finance and management procedures; 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 alignment of treasury warrants to provincial budgets. Stronger monitoring mechanisms are being developed. A review of functions has recommended that provincial health budgets should make provision for each rural health facility individually, which may have implications for the current budget structure if all resources going to facilities from several different programme heads are to be captured comprehensively. This too still needs to be actually put in place.

3.3 Health policy, planning and regulatory framework

The National Health Plan 2001-2010 and the Medium-Term Expenditure Framework 2005-2007, with its 2007-2009 update, identify some explicit priorities. These include maternal and child health, immunization, malaria control, TB DOTS, HIV/AIDS, and water and sanitation programmes. Work on the development of the next National Health Plan 2011-2020 has started.

3.4 Health care financing

Overall health spending is falling despite receiving a high share of government funds. Total health expenditure as a share of GDP rose steadily from 3.2% to 4.4% between 1997 and 2001. In 2009, however, it decreased back down to 3.1%, while total health expenditure per capita increased to US\$ 39, from US\$ 32 in 1997. Over 80% of recurrent provincial health budgets were allocated to salaries in 2006. Increased income from the mining sector in the same year provided for an additional US\$ 60 million for the health sector, which allowed the undertaking of long-awaited renovation work in hospitals and the addressing of human resource issues, such as staff housing.

Papua New Guinea receives significant levels of official development assistance (ODA), estimated to have amounted to US\$ 203 million, or 7.2% of GNP, in 2001. Over recent years, ODA for health has fluctuated, but has been around 24% (2004) of total health spending.

A major new source of funds for health was opened up in 2005 with the signing for a US\$ 30 million grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) for the country's HIV/AIDS programme. In 2004, the Global Fund committed US\$ 20 million for malaria over five years. A further proposal of US\$ 21 million for TB was accepted in 2006 and, in 2008, a malaria proposal of over US\$ 152.2 million.

Papua New Guinea does not have any form of private health insurance, although there is an initiative to introduce mandatory staff health insurance in the formal sector. In principle, health services are free. In most provinces, however, a fee is charged for outpatient visits. It is not clear in how much this acts as a deterrent to people accessing health services.

3.5 Human resources for health

The nurse-to-population ratio is estimated at 1:2271 population. An additional 600 nurses, 600 community health workers and 100 midwives are estimated to be needed to fill vacant posts, but current production rates are insufficient to fill the gaps. The doctor-to-population ratio is estimated at 1:19 399 population, the majority of doctors being in Port Moresby.

Churches are important providers of care, especially in rural areas, where they provide up to 80% of 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 and the churches run five of the seven nursing schools and all the community health worker training schools.

3.6 Partnerships

Papua New Guinea has relatively few development partners. According to statistics provided by the Organisation for Economic Co-operation and Development (OECD), 96% of ODA for health in 1998-2000 came from Australia. Since then, other major external agencies providing loans or grants have included: the Asian Development Bank (ADB); United Nations agencies, including WHO; and the governments of Japan (JICA) and New Zealand (NZAID). Smaller contributions have been made by the United States Agency for International Development (USAID), the European Union and the World Bank.

In the last few years, there have been major government and partner efforts to ensure a more unified approach to health sector development. The 2001-2010 National Health Plan was developed after extensive consultation. There is now one annual activity plan for the National Department of Health and all donor partners. A Medium-Term Expenditure Framework was developed for 2004-2006, and was further refined to become a rolling plan. There are formal annual reviews of achievements, most importantly by the National Health Conference, attended by the National Department of Health, donor partners, churches and provincial government staff. In 2004, two bilateral (AusAID, NZAID) and three multilateral partners (UNICEF, UNFPA and WHO) signed a 'partnership arrangement' with the National Department of Health, formally entering into a sectorwide approach called the Health Sector Improvement Programme (HSIP), which ADB joined in 2006. This arrangement, through its management structure, has clearly strengthened day-to-day operations and coordination among development partners and with the National Department of Health. A jointly managed and financed Independent Monitoring and Review Group, which spends a couple of weeks in-country twice a year, is a key instrument in assessing the performance of the health sector in general and interactions between development partners and the Government, mainly the National Department of Health. This group provides recommendations on lessons learnt and best practices and guides the discussion on strategy development for the health sector.

The Country Coordination Mechanism (CCM), a requirement of the Global Fund to execute programme activities, has had a further impact on overall cooperation between the different stakeholders in Papua New Guinea's health sector.

In 2006, under the leadership of the Resident Representative of the United Nations to Papua New Guinea, the EXCOM agencies (UNDP, UNICEF and UNFPA), as well as the other in-country and non-resident United Nations agencies (WHO, UNHCR, OCHA, UNIFEM, UNESCO and FAO), agreed to pilot a 'Delivering as one UN' approach in the country. Although Papua New Guinea (referred to as a 'self-starter') has not been formally included in the first eight pilot countries, there are indications that the Common United Nations Country Programme is more advanced in the process. The bearing of this on the health sector remains to be seen. Partners in the 'Delivering as one UN' approach are currently revising their four-year strategic plan (2012-2015), which includes the activities of the various agencies under three sub-task teams: maternal and child health, communicable diseases and health system strengthening.

3.7 Challenges to health system strengthening

Under the Organic Law on Provincial Governments and Local Level Governments, district and local governments are given responsibility to manage and support their health services, each level of government having different powers and functions in relation to health. The National Department of Health is responsible for policy, standards, training, medical supplies, specialist services, public hospitals and monitoring, while the provincial and local governments are responsible for implementation of health policies, standards and funding programmes. However, due to other district and local government priorities, almost all rural health services in the country are underfunded.

Nurses and community health workers form the backbone of primary health care services in rural areas, and both are considered to be in short supply and dramatically reduced. These shortages constitute a serious constraint in implementing the National Health Plan, including the priority programmes. Some provinces and many districts have no doctor.

The passing of the Organic Law exacerbated existing problems in health staff supervision and support. Provincial health advisers lost much of their authority to supervise and discipline district health staff. National Department of Health oversight of provincial staff is also limited. Reasons include the limited capacity of programme units at the central level; the lack of funds for travel; the lack of economies of scale through joint training and supervision across programmes; and delayed disbursement of funds. As a result, rural health services are poor and deteriorating.

A function and expenditure review in 2001 described the health system in rural areas as being in a state of “slow breakdown and collapse, 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 the services are diminishing.” This dire situation has worsened since then, and more facilities have closed down. In spite of the problem being acknowledged for some time, little has been done yet to seek redress. The scarcity and maldistribution of human resources for health has not been addressed effectively, and there have only been limited and not very coordinated efforts in training and other approaches to capacity-building. Recommendations from the Human Resources for Health Forum, conducted in 2008, included the urgent need to upscale health care worker training and to develop a human resource development plan. Action on these recommendations is still pending.

There has been no proper assessment of the national health information and surveillance system for many years, resulting in a lack of timely and reliable information for decision-making. The surveillance system is weak and there is a lack of capacity for conducting proper surveillance. Consequently, most information on communicable disease outbreaks comes from the media.

At all levels, there are very limited capacities for outbreak response, and current central government policy of putting a ceiling on staff numbers does not allow for recruitment of more staff for the health system, especially in the peripheral areas. The National Department of Health is making an effort to strengthen communicable disease surveillance and to build outbreak response capacities by re-establishing its Disease Control Branch and recruiting staff for communicable disease surveillance and outbreak response, but the process is still ongoing.

There is some laboratory capacity and a laboratory network in Papua New Guinea, but laboratory services are generally weak. The Central Public Health Laboratory (CPHL) in Port Moresby is responsible for overall coordination of operations for communicable disease diagnosis and surveillance, while the regional and provincial hospital laboratories form the backbone of the country’s laboratory network. Some health centres also have some limited laboratory diagnostic capacities.

The Blood Transfusion Service has just been recognized as a specialized service in the health service and is now functioning under the guidance and direction of Curative Health, National Department of Health. The Blood Transfusion Service remains fragmented and hospital-based, and the network is very weak. However, there are about 34 blood centres in the country that cover all provincial hospitals and some other church-run semi-urban or district hospitals.

Medical supply and drug procurement and distribution face many challenges and ‘stock-outs’ are common occurrences. The distribution system is often dependent on ad hoc solutions. A 2006 survey showed a high level of susceptibility to corruption in the pharmaceutical sector. Although the necessary regulations are in place, they are not being enforced and there seems to be collusion between the approving and procuring authorities. There is anecdotal evidence that the prices paid for drugs may be up to several times higher than those available on international markets. In 2008, on the advice of an independent drug procurement mission, procurement was separated from the regulatory side in medical supply.

4. LISTING OF MAJOR INFORMATION SOURCES AND DATABASES

<i>Title 1</i>	:	2000 National Census
<i>Operator</i>	:	National Statistical Office (NSO)
<i>Title 2</i>	:	Papua New Guinea Demographic and Health Survey, 2006
<i>Operator</i>	:	National Statistical Office
<i>Features</i>	:	Includes information on health outcomes, family planning etc.

Title 3	:	<i>Millennium Development Goals progress report for Papua New Guinea 2004.</i>
Operator	:	Government of Papua New Guinea, United Nations in Papua New Guinea
Features	:	Tables, graphs and maps on MDG indicators by province
Title 4	:	Papua New Guinea National Department of Health Information System,
Operator	:	Monitoring and Research Branch
Features	:	Yearly compiled tables of all collected and compiled data by province
Title 5	:	<i>Papua New Guinea National Health Plan 2001-2010 (volume III)</i>
Features	:	Tables, graphs and maps of major health indicators by districts 1995 – 1999
Title 6	:	<i>Discharge reports 2004</i>
Operator	:	Monitoring and Research Branch National Department of Health
Features	:	Survey of compiled data drawn from health facility discharge reports
Title 7	:	<i>Annual Health Sector Review</i>
Operator	:	National Department of Health, Monitoring and Research Branch
Specification	:	Compiled Provincial Reports with tables and graphs on regularly collected indicators
Title 8	:	<i>National inventory of health facilities 2003</i>
Operator	:	National Department of Health
Features	:	Tables (& graphs) on staff and equipment of all health facilities as foreseen by the health coverage plan (gazetteer)
Title 9	:	<i>Medium Term Development Strategy 2005 - 2010, (November 2004)</i>
Operator	:	Department of National Planning and Rural development
Features	:	Financial information of all sectors, including health (Annex 1)
Title 10	:	<i>Report of the 2004 National Consensus Workshop of Papua New Guinea</i>
Operator	:	National AIDS Council / National Department of Health
Features	:	Tables and graphs on the HIV/AIDS situation in PNG
Title 11	:	<i>Strategic Plan 2006 – 2008, (formerly Medium Term Expenditure Framework)</i>
Operator	:	National Department of Health
Features	:	Outlines current situation and the way forward in priority areas in health
Title 12	:	Reports of the Independent Review Group, reports (Nov. 2005, May 2006 & Nov. 2006, May 2007 & November 2007)
Operator	:	National Department of Health with all Development Partners united under the Sector Wide Approach (Health Service Improvement Programme)
Features	:	Narratives on Health Sector Situation

5. ADDRESSES

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6. ORGANIZATIONAL CHART: National Department of Health

