WHO
COUNTRY COOPERATION STRATEGY

PAPUA NEW GUINEA

2010 – 2015
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This document is the result of extensive consultation between the World Health Organization, the National Department of Health and other government agencies in Papua New Guinea and the international development partners supporting PNG, as well as representatives of civil society organisations and other non-state actors in the field of health. It has been produced by a team of WHO staff from all three levels of the Organization, led by the WHO Representative in PNG.

Under the leadership of the WHO Representative in PNG, Dr Eigil Sorensen, the Country Cooperation Strategy has been prepared by Drs Dale Huntington, Katja Janovsky, Dean Shuey and Geoffrey Clark, representing all three levels of the Organization.
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<th>Full Form</th>
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<tbody>
<tr>
<td>AAP</td>
<td>Annual Activity Plan</td>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<td>AusAID</td>
<td>Australian Aid</td>
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<td>CCS</td>
<td>Country Cooperation Strategy</td>
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<tr>
<td>CDC</td>
<td>Centre for Disease Control</td>
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<td>DAC</td>
<td>Development Assistance Committee of the OECD</td>
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<td>EPI</td>
<td>Expanded Programme of Immunization</td>
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<td>FBO</td>
<td>Faith-Based Organisation</td>
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<td>FTE</td>
<td>Full-time equivalents</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunisation</td>
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<td>GDP</td>
<td>Gross domestic product</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, TB and Malaria (GFATM)</td>
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<td>GoPNG</td>
<td>Government of Papua New Guinea</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HRD</td>
<td>Human Resource Development</td>
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<td>HSIP</td>
<td>Health Sector Improvement Programme</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>IMRG</td>
<td>Independent Monitoring and Review Group</td>
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<tr>
<td>LNG</td>
<td>Liquefied natural gas</td>
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<td>LTDS</td>
<td>Long Term Development Strategy</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MTDP</td>
<td>Medium-Term Development Plans</td>
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<td>NDOH</td>
<td>National Department of Health</td>
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<td>NEFC</td>
<td>National Economic and Fiscal Commission</td>
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<td>NGO</td>
<td>Non-governmental organizations</td>
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<td>NHP</td>
<td>National Health Plan</td>
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<td>NZAid</td>
<td>New Zealand Aid</td>
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<td>ODA</td>
<td>Overseas development assistance</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation’s and Development</td>
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<tr>
<td>PHA</td>
<td>Provincial Health Authority</td>
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<td>PHAAA</td>
<td>Provincial Health Authority Act</td>
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<td>PHC</td>
<td>Primary health care</td>
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<td>PNG</td>
<td>Papua New Guinea</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>US$</td>
<td>United States dollar</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WPRO</td>
<td>WHO Western Pacific Regional Office</td>
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EXECUTIVE SUMMARY

The Background
Papua New Guinea (PNG) is one of the most diverse countries in the world - geographically, biologically, linguistically, and culturally. Its abundant natural resources have not led yet to economic prosperity for the majority of its people. PNG’s relative level of poverty in relation to neighbouring countries is increasing and it now ranks 145th out of 177 countries on the United Nations Development Programme Human Development Index.

PNG’s population is estimated to be 6.5 million and is predicted to reach 9 million by 2020. Currently, 87% of PNG’s people live in rural areas in widely scattered communities that are often not accessible by road. Health indicators are poor, with average life expectancy at 53 years, infant mortality rate at 49 per 1000 live births, and maternal mortality rate at an astounding 733 per 100,000 live births; a figure regarded by some as an underestimate.

After over 30 years of political independence and some early economic and social progress, most of the people remain poor by both regional and international standards. The poor health status is associated with poverty, but it is also widely recognized that a failure of health service delivery is a major contributor to ill-health.

The Issues
The major health problems have remained largely unchanged in the past fifteen years, although there are recent indications of an epidemiologic transition beginning to take effect among some populations. The leading health problems continue to be communicable diseases, with malaria, tuberculosis, diarrhoeal diseases, and acute respiratory disease as major causes of morbidity and mortality. PNG has a generalized HIV epidemic, driven predominantly by heterosexual transmission.

To date, a high level of fragmentation in the institutional and fiscal relationships between national, provincial and lower levels of government has contributed to the poor health outcomes. There is an unclear allocation of responsibilities for service delivery which creates significant barriers to improving access to services and contributes directly to poor health outcomes.

The National Economic and Fiscal Commission has identified that inequitable and insufficient funding of health across provinces is a primary constraint to the ability to deliver needed health services. Provincial health budgets are estimated to provide only 20% of the cost of essential service delivery. However, insufficient funding is a symptom of an underlying weak political support for health. In many provinces health is not seen as a high priority by the local government.

The Government Policy
The Government of PNG (GoPNG) is focusing on a new national development strategy that would take into account the future windfall from the planned liquefied natural gas project. This is projected to double Gross Domestic Product in less than a decade with construction expected to commence in early 2010.

The new National Health Plan 2011-2020, is developed in accordance with this new development strategy, along with a redesign of the sector-wide approach and pledges for a stronger involvement of Central Government Agencies in the health sector. These changes are being enacted within the context of increased emphasis on aid effectiveness, harmonization among development partners and the United Nations reform process. Together, these both compound the challenges and create new opportunities for the WHO country office.
The WHO Strategic Agenda

WHO traditionally has focused on vertical communicable disease programmes, such as tuberculosis, malaria, immunization and HIV. However, since the early 2000s there has been a recognition of the need to focus on health system strengthening initiatives. This represents a realization, both globally and within PNG, of the disparity between the promise of new health interventions and their actual impact; given the inability of the health systems to deliver those interventions, especially to those who most need them which, in PNG, is the rural majority and the urban poor.

Based on a review of the past and current areas of concentration and ways of working, and on extensive consultation with key stakeholders in PNG, the strategic agenda for the next five years features four important strategic priorities as follows:

1. Technical excellence for sustainable health outcomes
2. Technical support for health systems strengthening
3. Universal access to primary health care supporting National Department of Health (NDOH) engagement with provinces and districts
4. Sector overview, partnerships and aid effectiveness.

Importantly, this agenda will bring technical programmes under one umbrella. Also, reproductive health, which previously received insufficient attention, now is featured more prominently.

The emphasis on universal access means a focus of WHO’s support to the NDOH in guiding and supporting provinces and districts to manage and deliver improved health services. WHO will also help the GoPNG to provide constructive oversight of non-state health providers to foster their positive contribution to achieving universal access to quality health services.

WHO will work with government and professional organizations to develop and implement a legal and administrative framework for improved self-regulation with the aim of improving the quality of health services.

WHO will work with the government to monitor progress on human resource development (HRD) reforms and encourage the government to maintain a long-term focus aimed at meeting its HRD needs. In doing so, this will decrease the need for capacity substitution by external partners. WHO will also work to reform the medical supply chain and to develop a coherent national laboratory policy.

The focus on partnerships and aid effectiveness is the first time this important programme of work is given strategic attention and adequate resources. It places WHO in the role of broker and facilitator of policy dialogue and performance monitoring, involving government, development partners and civil society. As part of renewed efforts to achieve a genuine sector-wide approach, WHO will support the development of a coherent health policy with a realistic resource envelope and expenditure plan. This will include global health initiatives and ensure an equitable allocation of resources to reach all segments of the population.

WHO continues to support UN reform in PNG while noting that work within the UN is competing with available time for engagement with a broader range of development partners and civil society in the health sector. It is expected that efforts to streamline UN programming and implementation will pay dividends in the future.
Implications for the WHO Secretariat
These changing ways of working and moving upstream from implementation to informing, influencing and institutional capacity building, has implications for how the Country Office as a whole is conducted, and the support required from Regional Office and HQ.

The new strategic priorities will result in changes in the staff composition and the balance between technical programmes, health systems development and support for harmonization and alignment of development aid. The focus will shift from the integrated management of childhood illnesses to a broader area of work encompassing maternal, adolescent and child health as well as reproductive health.

Health systems work will see staff increase from two to three members. The new area of aid effectiveness and coordination will involve the addition of a new staff member to work alongside the WHO Representative and Programme Management Officer. The total number of professional staff will increase from 13 to 16.

The Country Office will not maintain resident technical capacity for all health problems, but will rather draw upon expertise in the regional and headquarters' offices in response to needs identified in consultation with the NDOH. A recent review of counterpart relations suggests the need for a flexible responsive approach which ensures capacity development for PNG remains at the prime objective.

Strengthening of NDOH financial management systems and realizing a sector-wide approach is expected to channel more donor funds into a common pooled fund for the sector. Instead of managing individual projects, this will mean that WHO staff can focus on technical work, high-quality analysis and institutional capacity building.

Exercising influence and engaging in closer partnerships do not have easily quantifiable indicators but, nevertheless, they are stressed increasingly as desirable WHO core functions. However, no time is allocated for these activities in work plans. Similarly, qualitative indicators of achievements for such tasks are missing and the Country Office needs to include these more abstract and elusive aims and activities into work plans and to reward effort and performance.

In the longer run, WHO's current global results framework will need to be adjusted to ensure incentives are in place to reward greater engagement in policy dialogue, analysis and partnership.
CHAPTER 1  INTRODUCTION


The CCS is based on a systematic review of the nation’s needs and aspirations, and on the priorities articulated in the National Health Plan 2011 – 2020 currently under preparation. It also takes on board the strategic directions in WHO’s 11th General Programme of Work and the Medium Term Strategic Plan, and considers the role and contribution of all national and international development partners in the health sector. The CCS also takes into consideration the ongoing United Nations (UN) reform in PNG.

The strategy has been developed through a highly consultative process involving, not only the National Department of Health (NDOH), but also other national stakeholders, including representatives of central government agencies, non-state health care providers and civil society organisations.

Under the leadership of the WHO Representative, a team representing WHO Country Office, Regional Office and Headquarters carried out an in-depth analysis of key issues to be addressed to improve health in PNG and to strengthen WHO’s performance in providing policy, technical advice and supporting capacity development. Internal consultation within WHO and external discussions with all partners have contributed to articulating a selective strategic approach to WHO’s work in PNG.

Importantly, with harmonization and alignment as key principles, the CCS not only sets out priorities for technical cooperation, but also considers changes required in WHO’s ways of working in response to a rapidly changing environment for global health and development aid. In this context, WHO has a critical role to play, not just as a technical agency, but also as a coordinator, broker and facilitator to address the challenge of implementing a new national health plan and to adopt a harmonized sector-wide approach within a highly decentralized system. The CCS process also serves to review what is WHO’s preferred role and comparative advantage in the current context in PNG.

The document sets out PNG’s health and development challenges. It considers partnerships in health development and coordination and reviews past and current WHO Cooperation. This situation analysis helps define the strategic agenda. The implications for the WHO country office, region and headquarters also are discussed.

The CCS is a dynamic tool for strategic planning. This means that the document will be subject to periodic reviews and will be open to adjustment and adaptation, as may be required.
CHAPTER 2  
HEALTH AND DEVELOPMENT CHALLENGES

The National Setting

PNG is one of the most diverse countries in the world - geographically, biologically, linguistically, and culturally. It has more than 800 languages, over 1,000 dialects and many ethnic groups, sub-ethnicities, clans and sub-clans spread across its 20 provinces. It has abundant natural resources which, so far, have not created economic prosperity for the majority of its people. The relative level of poverty in relation to neighbouring countries is increasing. PNG now ranks 145th out of 177 countries on the United Nations Development Programme (UNDP) Human Development Index\(^1\).

The current population is estimated to be 6.5 million and is predicted to reach 9 million by 2020. 87% of the population in PNG lives in rural areas in widely scattered communities that are often not accessible by road. Health indicators are poor, with average life expectancy at 53 years\(^2\), infant mortality rate at 49 per 1000 live births, and maternal mortality rate at an astounding 733 per 100,000 live births\(^3\); a figure regarded by some as an underestimate.

The country’s major health problems have remained largely unchanged in the past fifteen years, although there are recent indications of an epidemiologic transition beginning to take effect among some populations. The leading health problems continue to be communicable diseases. Malaria, tuberculosis, diarrhoeal diseases, and acute respiratory disease remain the major causes of morbidity and mortality. PNG has a generalized Human immunodeficiency virus (HIV) epidemic, driven predominantly by heterosexual transmission.

The epidemiological profile of PNG, with its heavy burden of communicable diseases, indicates that huge improvement in health outcomes could be achieved with simple and effective interventions using a primary health care approach. While some hospital services (e.g., for maternal complications) are essential, most health problems can be addressed through effective delivery of primary care which is linked to appropriate referral services.

The current poor health status of rural populations points to a weak primary health care system lacking essential services that reach rural communities, even for basic needs, such as immunization and safe delivery. To a large extent, this can be attributed to a flawed decentralization policy where the provinces and districts have been given the responsibility to run rural health services without ensuring commensurate financial resources and managerial capacity.

The incidence of communicable diseases is increased by a combination of: the increased size and mobility of populations; the growth of larger, denser populations in peri-urban communities; and, the relative weakening of health services. Additionally, chronic life-style-related diseases, such as diabetes, heart disease, and cancer, are beginning to emerge as prominent problems in urban areas.

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1 Human Development Report 2007-2008 - Country Fact Sheets - Papua New Guinea
The Economy

Gross domestic product (GDP) grew at an average annual rate of 3.4 percent during the period 1978–1998. This translates to about 1.1% annual growth in per capita terms, although the growth is not well-distributed throughout the population. This growth was led by the mining and petroleum sector. Per capita GDP in the non-mining economy grew at just 0.2% during the same period.

In the late 1990s, economic growth was adversely affected by drought; the Asian economic crisis; macro-economic mismanagement; and, weak governance. Real GDP declined in 1997 and grew in 1998 and 1999 only because of a recovery in mining and petroleum output. Formal employment in the non-mining private sector remained stagnant in the 1990s. In recent years, PNG’s economic growth has improved again, mainly due to high commodity prices, rising to 6.5% in 2007 and 6.6% in 2008. Government’s budgetary and management performance has also experienced improvements.

Nevertheless, after over 30 years of political independence and some early economic and social progress, most of people of PNG remain poor by both regional and international standards. The poor health status is associated with poverty, but it is also widely recognized that a failure of health service delivery is a major contributor to ill-health.

The National Economic and Fiscal Commission (NEFC) has identified that inequitable and insufficient funding of health across provinces is a primary constraint to the ability to deliver needed health services. Provincial health budgets are estimated to provide only 20% of the cost of essential service delivery. However, insufficient funding is a symptom of an underlying weak political support for health and, in many provinces, health is not seen as a high priority by the local government. Some of the lowest rates of service delivery are in those provinces receiving the largest revenues from oil and gas, but these provinces give insufficient priority to health and have weak management of available revenues.

The GoPNG is focusing on a new national development strategy that would take into account the future windfall from the planned Liquefied Natural Gas project (PNG LNG). This is projected to double GDP in less than a decade. The construction on this project is expected to commence in early 2010. There is considerable concern that the expected gains might be squandered on non-sustainable development projects; lost through inefficiency, corruption and capital flight; and, will not contribute necessarily to improved public services for most people’s health and education needs.

National Planning Frameworks and the National Health Plan

A new GoPNG National Strategic Plan 2010-2050 (NSP) will provide the next 40 year vision and framework for long-range planning. In addition to the NSP, a Long Term Development Strategy (LTDS) 2010-2030 is being developed. The LTDS links the principles and focus areas of the NSP and provides policy direction and sectoral interventions with clear objectives, quantitative targets and baseline indicators. The LTDS strives to improve social and economic indicators through: improved economic performance; specific sector interventions; and, developed and implemented public and economic policies. To achieve the intended long-term goal, the LTDS proposes five broad strategies which will be detailed in four Medium-Term Development Plans (MTDP) over the next twenty years.

NEFC (2006) It’s more than numbers - Review of all expenditure in 2006 by provincial governments, Port Moresby
PNG is a signatory to the Millennium Declaration of the UN General Assembly. This sets out objectives for global development over the period 2000-2015. PNG is at risk of not achieving the health-related Millennium Development Goals (MDGs); particularly those related to maternal and child health.

The National Health Administration Act (1997) establishes the National Health Plan (NHP) as national policy. The NHP is the guiding document for the health care system for the government. It also provides the framework within which the development partners, including WHO, are operating. It applies to the entire country, including provincial and local-level governments. The Act provides for the NHP to be approved by the National Executive Council after considering a report and recommendation by the National Health Board.

A National Health Plan for 2011-2020 is currently under development. This will layout the broad goals, strategies and interventions contained within the NSP and the LTDS for the health sector. The goal of the new NHP will be ‘Strengthened primary health care to all and service delivery to the rural majority and urban poor’.

**Health Delivery System and Challenges**

The health care delivery system in Papua New Guinea has struggled to provide universal quality services over several decades with little success. The reasons for this are multiple and include:

- a failed decentralization policy implemented shortly after independence and revised in the 1990s;
- inadequate financial, management and technical resources given to provinces and local level governments to support decentralization; and
- the economic decline of the 1990s coupled with the structural reforms introduced to manage the economic crisis.

While health has received an increasing share of government funds, overall real spending on health has fallen.

Authoritative reports consistently point to a number of operational problems including:

- low standards of patient care;
- unhealthy workplace practices;
- run-down and inadequate facilities and equipment;
- inappropriate distribution of healthcare staff; and,
- education and training which do not always meet the healthcare system needs.

Church-run health services represent an essential part of the total health care system accounting for approximately 50% of health care provision in rural areas. They are considered generally to be of a better standard due to their better supervision, management and additional financial support.

The provincial hospitals managed by the NDOH over the last 15 years have also developed an increased focus on specialised services, with variable quality. In general, the largest failure has been in the delivery of primary health care services to the rural population.

The decline in the delivery of health services is demonstrated through the many problems evident at the district and ward levels such as:
• an increasing number of non-functioning and run down aid posts;
• a serious on-going medical supply problem; and,
• a lack of resources at the health centre and aid post level to deliver the basic services required to improve health outcomes.

Health workforce issues contribute to poor health system performance, in particular, the ageing of the workforce and the inappropriate production, supply and distribution of health care workers across hospitals, provinces and districts. The emphasis of health care worker training has been heavily skewed towards the production of a tertiary curative workforce, rather than one focused on primary health care delivery at the level of the aid post or health centre.

Significant change in health systems and their management is required to address the health needs of the population. Administrative reforms to strengthen local government at the district and provincial level are being implemented and these show promise. An example is the Provincial Health Authority Act which integrates the management of hospital and public health services at provincial level. Potentially this would decrease fragmentation and improve service delivery.

Investments in health by private sector entities, such as the extractive industry and plantations, have opened up opportunities for improved health service delivery. These new types of partnerships have great potential, but will need to be managed through better government stewardship.

Civil society involvement in health service delivery has emerged rapidly, mainly as part of the response to the HIV/Acquired immune deficiency syndrome (AIDS) epidemic. Global Health Initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI) have made substantial resources available. However, they are also contributing to increased transaction costs as government and development partners struggle with the administrative burden that comes with these large flows of additional resources. Furthermore, they may also have contributed to a skewed distribution of resources among competing health priorities. The development of a new National Health Plan in 2009/10 will provide an opportunity to move the strategic agenda of health forward in a unified manner.

**Governance and Institutional Context**

A high level of fragmentation exists in the institutional and fiscal relationships between national, provincial and lower levels of government. There is an unclear allocation of responsibilities for service delivery. This creates significant barriers to improving access to services and contributes directly to poor health outcomes.

Significant bottlenecks exist in the flow of funds from the health sector’s diverse financing sources to the multiple levels of providers (government and church run hospitals, rural health services). Spending on non-salary goods and services has been affected in particular. Most provinces have accorded a low priority to quality enhancing, non-salary budget allocations. Poorer provinces, with limited ability to generate their own revenues, are even more constrained in their capacity to finance operational costs. This leads to large inequities in health service financing as well as in the distribution of health resources between provinces. The NEFC has found that less than 40% of provinces have the resources to pay for the recurrent, non-wage goods and services needed to maintain a basic level of service delivery.\(^6\)\(^7\).

\(^6\) NEFC (2006) It’s more than numbers - Review of all expenditure in 2006 by provincial governments, Port Moresby
Fragmented government relationships and multiple 'buckets' of resources have prevented a holistic approach to planning and budgeting and weakened accountability. This is obvious in the current annual activity planning. For example, district managers, who are responsible for preparing annual activity plans, do not have a consistent and accurate picture of the total amount of resources potentially available. Meanwhile, different reporting formats for expenditures have made it difficult to track actual expenditure by function and provider, both within and across provinces. The problem of planning at the district or provincial level is further complicated by the lack of planning and coordination between the public sector actors and the non-state actors. For example, the relationship between the NDOH and the Faith-Based Organisations (FBOs), which functions fairly well at the central level, is not translated into operational partnerships at the local levels.

Health managers have little control over the health workforce. Separate establishment-based salary budgets under the Department of Personnel Management are not responsive to the costs and needs of service delivery institutions. Costs of long-term casual employees divert recurrent budgets to programme administration, rather than operational inputs.

The absence of mechanisms to ensure accountability and to provide adequate incentives for health workers has weakened rural health services. Faced with budget constraints, facilities have increasingly resorted to user fees and other forms of cost recovery to support their recurrent/operating budgets. In many rural areas, the poor availability of staff and other inputs have forced patients to bypass lower level services in favour of hospitals and church health services. Many aid posts, meant to be first line providers, have been shut down. These issues have combined to increase financial and physical barriers to access in a context where there was already significant underutilization of services.

To address service delivery constraints, the NDOH has prioritized evidence-based budgeting to align funding to health priorities. A re-energised multi-agency Health Sector Steering Committee involving national and provincial agencies and development partners has established four working groups to tackle four key issues: financing of health service delivery; medical supplies; quality of and access to health care; and, partnerships for health. However, progress made by these groups has been slow so far.

The NEFC has undertaken a critical analysis of the health services looking at costing; the service delivery network; and government fiscal space, in order to clarify responsibilities for service delivery roles across the system. Reforms are being initiated to increase essential health service delivery funding through a new inter-governmental financing system and show promise. This new system will replace the previous per capita based provincial block grants with functional grants that are based on health need. Grants are to be sectorally quarantined so that funds cannot be diverted to other sectors, with budget and expenditure Instructions requiring implementation and reporting on three minimum priority activities of: drug distribution; medical patrols; and, health facility maintenance.

Several initiatives are addressing provincial level management constraints to service delivery. Strengthening of provincial government systems remains a priority. Such

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7 NEFC (2005) Cost capacity performance - Review of all expenditure in 2005 by provincial government, Port Moresby
8 Ibid
10 NEFC (2006) It’s more than numbers - Review of all expenditure in 2006 by provincial governments, Port Moresby
initiatives have tended to focus on provinces which have indicated significant demand for reform and which have demonstrated management capacity to improve service delivery. This may exacerbate inequality of services. NDOH has expressed its interest to replace the common ‘pilot’ approach in a few provinces with a national rollout of key reforms within the implementation of the NDOH Corporate Plan.

The Provincial Health Authority (PHA) reform is an initiative led by the NDOH Health Sector Reform Unit to combine provincial health management in a distinct entity, empowering provincial managers to improve service delivery. Within the PHA reform, the development of a Single Financing Framework at provincial level aims to offer provincial health authorities holistic and predictable management of financing sources and mechanisms.

The PHA concept has been defined by the NDOH and provinces, but questions remain about organizational structure, financing mechanisms and solutions to current budget management challenges. Agreements need to be reached with central agencies, provinces and the NDOH on funding flows to PHAs to be consistent with existing laws, including the enabling act for the revised function grant arrangements. Greater capacity will have to be built if the new PHAs are to succeed in improving services.

The difficulty of transferring funds to districts, local level government and health facilities charged with service delivery has led to proposals for direct national funding to these lower levels to ensure service delivery. The Department of Provincial and Local Government is piloting direct funding to district treasuries for health facilities based on the National Department of Education’s model of funding schools. It is hoped this will address the issue of reliance on user fees for operational costs as this is an obstacle to universal coverage.
CHAPTER 3  PARTNERSHIP IN HEALTH DEVELOPMENT AND COORDINATION

The NHP 2011-2020 redesign around a sector-wide approach and pledges for a stronger involvement of Central Government Agencies in the health sector provide an opportunity for significant improvements. These changes are being enacted within the context of increased emphasis on aid effectiveness, harmonization among development partners and the UN reform process. This both compounds the challenges and creates new opportunities for the WHO country office.

Aid Environment in Papua New Guinea

Foreign development assistance provided approximately 60% of the total development budget for PNG in 2008, showing the effects of recent trends in increase government resource allocations to the Medium-Term Development Strategy. Overall development aid to PNG in 2006 was equivalent to 5.5% of gross national income according to the Organisation for Economic Co-operation’s Development Assistance Committee (OECD DAC). Development partner spending on health in 2008 was estimated to be Kina 284 million (US$ 113 million), about Kina 47 (US$ 19) per capita.

Table 1 gives an overview of development partners (DP) assistance to PNG from 2001 to 2006, including Australian Aid’s (AusAID) share.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Net Overseas Development Assistance (ODA) to PNG and to the Health Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>2001</td>
</tr>
<tr>
<td>Net ODA to PNG (US$ million)</td>
<td>363.4</td>
</tr>
<tr>
<td>AusAID share in total net ODA</td>
<td>72%</td>
</tr>
<tr>
<td>Health share in total aid</td>
<td>15%</td>
</tr>
<tr>
<td>Health ODA to PNG (US$ million)</td>
<td>39.9</td>
</tr>
<tr>
<td>Real DP health spend, 2008 US$/Head</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Australia remains the largest bilateral donor even though a recent evaluation of Australian aid to health service delivery suggests that total Australian aid to the health sector has fallen since 2002. New Zealand, Japan and the European Union are also significant bilateral donors. Activities related to prevention, care and treatment of HIV have attracted substantial external funding in recent years amounting to US$ 57.4 million in 2007 and US$ 52.2 million in 2008. The HIV epidemic has brought in new donors, such as the United States, and an increasing number of international NGOs. The GFATM has made a big impact with the first grant to PNG in 2004 for the malaria programme. Since then, three other grants have been approved for HIV, TB and Malaria programs in 2005, 2006 and 2008 respectively for a total of US$205.2 million.

The large resource envelope for HIV, TB and malaria has raised concerns within the NDOH and among development partners about the skewed distribution of funding and the heavy

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burden this puts on the health care system. Other priority areas, such as maternal and child health, receive far fewer resources.

Although efforts are being made to ensure that funds from global health initiatives are managed to contribute to the strengthening of health systems and a broader set of priorities in the health sector. Yet it is too early to know whether these efforts will be effective. For example, funding from Global Health Initiatives, such as GFATM and GAVI, has used global procurement mechanisms for the purchase of impregnated bed nets, Rapid Diagnostic Tests, antiretroviral, TB and malaria medicines. These procurement mechanisms have replaced government procedures given the weak regulatory and procurement capacity of NDOH. Although this has resulted in improved availability of essential medicines and commodities at low cost with in-built quality control, it has not assisted in the development of a reliable national procurement and supply management systems for the health sector.

The GAVI is providing support of US$ 9 million over 5 years from 2007 - 2012 to introduce new vaccines to the Expanded Programme of Immunization (EPI) program in PNG. This enabled PNG to introduce Haemophilus influenza b (Hib) vaccine in 2008. It is anticipated that GAVI will support the introduction of pneumococcal vaccine from 2012. The UN Foundation has supported the Supplementary Immunization Activity (SIA) for measles vaccination.

There has been a large increase in the number and size of civil society organisations and FBOs in health, in part due to support from the GFATM, AusAID and others. These organisations have contributed to a greater acceptance of non-state providers’ involvement in health care and a stronger national human resource base in particular for community-based approaches in prevention, care and treatment. The increase in aid has also been accompanied by an increase in the amount of international technical assistance. This increased volume of work by development partners is stretching government oversight capacity, particularly in the area of HIV/AIDS.

The Asian Development Bank is currently supporting a Rural Enclave HIV Prevention Project, as well as studies related to costing of health facilities and public-private partnerships. There may be increasing involvement of the Asian Development Bank (ADB) in the health sector. The World Bank (WB) has not been directly involved in the last few years, but may become active again in the sector, particularly in providing technical support in areas such as human resource planning and costing.

While the size of UN organisations’ financial contributions is less significant for development activities in PNG than other donors, the UN and its agencies play an important part in supporting the coordination of aid and sector support. WHO is the lead agency in health, whilst United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA) have been focused on reproductive and child health. All UN agencies are working on HIV prevention, care and treatment, with WHO and UNAIDS as lead agencies.

**National Ownership and Aid Effectiveness**

The National Department of Planning and Monitoring is the main government agency engaged in developing a national aid effectiveness agenda. A dialogue between the Government and development partners led to the signing of the PNG Commitment on Aid Effectiveness in July 2008.

The purpose of this joint commitment was to give meaning to the principles in the Paris Declaration actions to improve aid effectiveness, including specifying targets that could be monitored. The shared goal is to work together towards the achievement of PNG’s Medium
Term Development Strategy and the MDGs. The country strategies, programmes and use of resources by development partners are assessed according to an aid effectiveness performance assessment framework. To date progress has been limited. WHO, as the lead health agency, has a responsibility to support the aid effectiveness agenda.

Alignment of Technical Assistance with the National Development Agenda

Technical assistance is quite common in all development assistance in PNG, including in the health sector. The Medium Term Expenditure Framework predicted a reduction of expenditures on technical assistance by all donors from approximately 20% of total goods, services and capital works funding in 2003 to approximately 8% in 2006. Expenditures on technical assistance fluctuate, and experienced a decline after 2003/04 followed by an increase from 2005-2007. In 2008, the expenditures on technical assistance were estimated to be Kina 39.6 Million, and do not appear to be reducing.

The role of technical assistance remains highly problematic in the PNG. Evaluations and reviews consistently judge it to be substitutive and gap filling; problems that are compounded by an "internal brain-drain".

The general conclusion, widely acknowledged both by development partners and the government, is that technical assistance does not sufficiently promote national capacity building. For example, the Independent Monitoring and Review Group of the Health Sector Improvement Programme (IMRG) mission in November 2007, concluded that there was a need to review the processes by which technical assistance requirements are identified and managed. Specifically, they called for more strategic approaches which tackle systemic constraints, increase support to front line service delivery, and place greater emphasis on making better use of existing PNG capacity. In recognition of this issue, the PNG Commitment on aid effectiveness called for the government and development partners to develop a joint protocol for technical assistance to promote local capacity. A protocol for mobilizing and managing technical assistance in Papua New Guinea has been developed that emphasizes GoPNG leadership, ensuring that technical assistance is aligned to PNG development priorities, and that there is a progressive increase in the use of GoPNG processes to manage such assistance.

Recent actions indicate that the situation may be changing. For example, the 2009 cadetship programme on international development (in which WHO participates) is an example of an initiative to build stronger national capacity in managing development programmes.

Other steps taken still have operational aspects that need to be worked through, such as the recent protocol on technical assistance. This describes how the GoPNG and Development Partners will carry out joint processes in identifying technical assistance expertise and in assessing technical assistance performance. This latter point indicates the complexities associated with revising procedures, as the joint processes may contradict the policies and guidelines of WHO and other UN agencies with respect to hiring.

The resolution of the issues surrounding technical assistance remains problematic.
Harmonisation of International Cooperation

In 1996, a trust fund known as the Health Sector Improvement Programme (HSIP) was created by the ADB, initially to handle its own loan. In the late 1990s, in an effort to decrease the transaction costs, the Government asked development partners to move from project-oriented funding towards a sector-wide approach. In 2000, the governments of PNG and Australia signed an agreement establishing the HSIP trust account as the means of channelling funds to a sector-wide approach to support the health sector plan and the medium-term expenditure framework. New Zealand Aid (NZAid) joined the HSIP pool in 2003. In 2004 the GFATM began funneling its resources through the HSIP, although the funds were project-specific and earmarked, rather than pooled and flexible.

HSIP has never become a fully pooled, un-earmarked, sector-wide approach since substantial development assistance to the health sector continues to be channelled through parallel projects and other funding channels. Although HSIP has achieved a high level of accountability within the PNG context, its requirements for disbursement and liquidation of funds has been a barrier for fiscal transfers to sub-national levels.

HSIP was never designed to manage more than about Kina 30 million per year. With the increased funding level after the GFATM grants, the management of HSIP has become increasingly difficult. As a result, the implementation rates of HSIP have been low with only 30%, 39% and 46% of funds disbursed in 2006, 2007 and 2008 respectively.

HSIP disbursement is typically delayed at the beginning of the year because of uncompleted Annual Activity Plans (AAPs). The demanding financial and planning procedures are one of the reasons for the delays, although there are also problems with inadequate staffing for the task and poor communication with the periphery. In principle, a sector-wide approach should simplify reporting and follow national planning frameworks. However, some funders, such as the GFATM, have rigorous reporting requirements outside of national planning frameworks as part of performance-based disbursement. Even so, the HSIP is perceived as a step towards greater control by the government of development assistance and better alignment to national planning processes and it deserves further strengthening.

A redesign of the health sector-wide approach is planned for 2010. It is anticipated that the HSIP will work to overcome current shortcomings and move towards a better implementation of sector-wide modalities with stronger involvement of non-state service providers and central agencies and more focus on the sub-national level.

The evaluation of Australian aid to health services in PNG indicates that less than 30% of Australian aid is managed through the pooled fund trust account. Two thirds of the expenditure being financed by AusAID is outside the AAPs and the level and pattern of Australian expenditure did not reflect the priorities set out by the NDOH and AusAID. Australian aid is felt to be dominated by technical assistance and capital expenditure managed by Australian contractors. The evaluation suggests that increased support for operating costs at provincial and district level would have created a more balanced pattern of spending in which services could have expanded. However, operating at sub-national levels has its own problems which have to be managed.

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Joint Monitoring and Oversight

The PNG Commitment on aid effectiveness emphasizes the importance of joint monitoring and oversight by government and development partners. Programme and Finance Committees have been established to oversee HSIP implementation, and regular monitoring of HSIP progress is done through the IMRG in which WHO has regularly participated.

Twice yearly Health Summits between GoPNG and development partners are organized; one being in conjunction with the National Health Conference. The Health Summit brings in development partner representatives from abroad (Canberra, Wellington, WB), as well as local partners. This has become an increasingly useful forum for dialogue; despite the weak representation from the Central Agencies of the government. In addition to the Health Summit, the development partners have a monthly Health Group meeting where WHO is actively engaged, having previously served as Chair and currently as Co-Chair. Similar development partner groups for other sectors also exist, including for HIV.

A Health Sector Steering Committee with high-level government representation was formed in 2008 with the aim to have a strategic oversight of the health sector and to increase Central Agency involvement in health. WHO has a seat on this committee together with the Chair of the DP Health Group and AusAID. However, the Health Sector Steering Committee has so far proved to be ineffective, not least due to the lack of commitment from Central Agencies to participate.

In recent years, WHO has become a key player in supporting and pursuing reform initiatives within the health sector in PNG. This has included medical supply reform; contractual mechanisms for collaboration with non-state health care providers; and, the development of the National Health Plan 2011-2020. WHO has also had a critical role in coordinating and consolidating the work of development partners working within health and HIV. WHO is seen as an honest broker and well-placed to have even a greater role in the policy dialogue with the government and development partners. Enabling factors include a close working relationship with NDOH as well as being located within the same premises; the in-country technical expertise; and, reliable backstopping from WHO Regional Office and Headquarters.
CHAPTER 4  PAST AND CURRENT WHO COOPERATION

Brief Historical Perspective
The World Health Organization has had a continuous presence in Papua New Guinea since it established an office shortly after independence in 1975. During this period, WHO staff have been located within the NDOH in Port Moresby and since 2008 in the UNDP office in Buka (Autonomous Region of Bougainville) with the presence of a WHO UN Volunteer.

Areas of Work and Ways of Working
WHO has focused traditionally on vertical communicable disease programmes, such as Tuberculosis, malaria, immunization and HIV. Since the early 2000s, however, there has been a recognition of the need to focus on health system strengthening initiatives. This represents a realization, both globally and within PNG, of the disparity between the promise of new health interventions and their actual impact given to the inability of health systems to deliver those interventions, especially to those that most need them which, in PNG, is the rural majority and the urban poor.

The 2008-09 WHO PNG biennial work plan was structured around three broad themes. These reflect the challenges faced by the health system in PNG as follows:

- communicable disease control – addressing HIV/aids, malaria, Tuberculosis and disease surveillance (including avian influenza) and disaster support
- child, adolescent and maternal health and immunization
- health systems strengthening – addressing human resources workforce planning and national level planning.

WHO provides technical cooperation to support the NDOH primarily through its international staff. The WHO PNG office also provides considerable direct implementation assistance for the NDOH (e.g. procurement, project management, direct funding of NDOH activities and technical oversight). These additional functions have evolved in response to pressing needs to directly support the NDOH. These have become difficult to break away from once started, as mentioned previously in Chapter 3.

UN Reform Status and Process
The UN Country Team (in consultation with the GoPNG agreed to develop a ‘One UN Country Programme’, instead of an United Nations Development Assistance Framework (UNDAF) in March 2005. Prior to this, the UN Country Team actively participated in the consultations that led to the GoPNG’s Medium Term Development Strategy (2005-2010).

A base document for analysis was completed in May 2006 as part of this process and replaced the traditional Common Country Assessment of the UN. It relied on the assessment done for the first National MDG Report in 2004 in Papua New Guinea. Subsequently, a joint UN/Government Process Steering Committee meeting was organized to prioritize the objectives for the next UN programme cycle.
The overarching theme is ‘A Partnership for Nation Building’ with five main outcome areas as follows:

- Governance and crisis management
- Foundations for human development
- Sustainable livelihoods and population
- Gender
- HIV and AIDS.

A One UN Country Programme Action Plan 2008 – 2012 was then prepared. Unfortunately the plan does not adequately articulate the priority of health service delivery or public health and, when health is mentioned, the reference is overly focused on reproductive and child health and does not incorporate other aspects of the WHO country programme.

Although WHO supports harmonization and alignment of programmes, as in other countries, it has constraints for full participation in “One UN Programme” given its status as a specialized agency with its own governing bodies and structures. These issues affect all of the UN specialized agencies. The “One UN” concept was modified into that of ‘Delivering as One’ which is more in line with the WHO approach to UN reform.

In April 2007, the Executive Boards of UNDP, UNICEF and UNFPA approved the suggestion to forego an UNDAF and develop a common UN Country Programme. As the Boards of the ExCom Agencies had requested each agency to develop its Country Programme, the individual Country Programme documents were produced so as to reflect each Agency’s direct input into the common UN Country Programme. This allowed the UN Country Programme to remain the overarching guiding document. The WHO Country Work Plan was reflected also in the UN Country Programme, recognizing the mandatory two-year planning cycle of WHO, as opposed to the 5-year cycle of the ExCom agencies.

In general, UN reform and the development of the Joint UN Country Programme Action Plan has been a time-consuming process. More staff time made available for the UN reform process could have given a stronger WHO flavour and involvement in ‘Delivering as One’. However, WHO work within the UN is competing with time available for engagement in the health sector with a broader range of development partners and civil society. Over time, streamlining of implementation and monitoring of programme outcome may justify the efforts. The synergies of joint UN programming may become more obvious in the future. WHO in PNG has increasingly tried to support the ‘Delivering as One’ process through interventions such as the alignment of job descriptions and signing up to the ‘One UN Fund’.

Sources of Funding and Allocation of Financial Resources

Financial resources available to the WHO PNG country office have expanded significantly over the last three biennial funding cycles (2004-5, 2006-7 and 2008-9). The majority of new funding has come from global partnerships, such as the GFATM, and through direct support from AusAID.

Assessed contributions or core funding for the WHO PNG office has increased marginally and essentially stagnated over this period. The amounts were US$ 2,250,000 in 2004/5, US$2,580,000 in 2006/7, and US$ 2,709,000 in 2008/9. After exchange rate variations between the US dollar and the PNG Kina and inflation during this period are taken into account, this represents an overall real decline in core funding for the office.

Figure 1 below shows the allocation of financial resources in 2008-09. They illustrate that most of the financial resources are allocated to communicable disease control initiatives.
which have a project focus. External funding increasingly threatens to define the programme focus which is not necessarily in complete alignment with the health priorities of the Government. In particular, the large level of support available from the GFATM risks dominating other WHO country programmes. It is important that wider cross-cutting health system issues are not neglected in the WHO office so that a broad range of activities, including communicable disease control, can be more efficiently delivered within PNG.

**Figure 1** % Share of the 2008-09 Operating Budget

![Pie chart showing the breakdown of the 2008/09 Operating Budget of the WHO Office in PNG. The largest share is Comm Dis (56%), followed by Family Hlth (28%), Hlth systems (7%), Other (2%), and WR office (7%).](chart.png)

External funding supports most WHO operations in PNG. In the 2008/9 biennium, the WHO PNG country office received approximately US$ 7.8 million of support from external partners. Key contributors were Australia; the United Nations Foundation; the United Nations Human Trust Fund; Global Fund for HIV/AIDs, TB and Malaria; Japan; and, the United States of America. The Country Office’s willingness and ability to work closely with other development agencies in a partnership environment has been important for mobilizing resources. While most of the external funding has been mobilized at country level, the Regional Office has also played a significant role in raising additional funds for technical programmes.

Resource mobilization has focused on filling funding gaps in existing work plans and providing more predictability in funding of staff positions. The emphasis has been on supporting fixed-term posts rather than short-term advisers. The funding from AusAID has been instrumental to recruit and sustain experienced technical staff in the country office. However, concerns have been raised about the possibility of conditionalities that may be associated with external funding.

**Staffing of the WHO Country Office**

Professional staff numbers in the WHO PNG office have expanded from 4.5 full-time equivalents (FTE) in 2002-3 to 13 FTE in 2009. Most new staff support the communicable disease control programmes as demonstrated by Figure 2 below.

A key achievement in recent years is the increased number of professional staff on fixed term contracts, as opposed to temporary appointments. This has brought improved stability.
and continuity to WHO engagement with the NDOH. Increased numbers of fixed term positions has come as a result of specific funding from external partners. AusAID in 2007-2009 funded four fixed-term positions in TB, Maternal and Child Health, Disease Surveillance and Human Resource Planning. The Global Fund currently finances two positions in HIV, and the Centre for Disease Control (CDC) USA is sponsoring one in EPI. The ability of the PNG WHO Office to offer more fixed term positions has also helped overcome difficulties in recruiting well qualified staff by making placements in PNG more attractive. However, the overall staffing pattern remains skewed towards communicable diseases.

**Figure 2  Staff Allocation (in full-time equivalents)**

![Staff Allocation Chart]

Despite the large increase in professional staff numbers, general service staff numbers have remained static since 2005. General service staff in PNG support both WHO operations and provide significant administrative assistance to the NDOH for their internal operations.

**Partnerships, Development and Aid Effectiveness**

WHO is a signatory to the HSIP framework agreement, yet it has continued traditional financial mechanisms for supporting government activities, rather than pooling. It is likely that WHO in the future will use HSIP and, already, has begun to channel some funds for specific activities through HSIP (e.g. supplemental immunization activities in 2008). The ExCom UN agencies have been working on a harmonized approach for the transfer of funds to the government, and will start using this from 1 January 2010. WHO will build on their experiences, whilst recognizing the specific organizational requirements of WHO as a specialized UN agency.

Disasters and major disease outbreaks require sufficient capacity and flexibility within WHO to fulfil its role as the lead agency of the Health Cluster. The main task is supporting the government’s coordination and response. The effectiveness of WHO response in emergencies, including in PNG have been improved by better preparedness and experience among WHO staff and more effective collaboration and redeployment of staff between the country offices, regional office and HQ.
WHO’s participation in the IMRG has solidified WHO’s position among the development partners and increased the knowledge about PNG in the regional office. WHO has funded and provided a team member to the IMRG missions. WHO has played a similar role within the Independent Review Group for the national response to HIV. Numerous joint technical missions (e.g. medical supply; preventing mother-to-child transmission of HIV; malaria programme review; and, TB programme review) have also been conducted, often with the support of WHO Western Pacific Regional Office (WPRO). This has strengthened the perception that WHO is able to actively engage in a partnership environment and provide upstream policy advice.

Support from Regional Office and Headquarters

Whenever possible, expertise is sought from within the organization, rather than hiring external consultants. Thus, the first source of technical expertise for a country should be the WHO country office. However, WHO country officers do not work in isolation. They are supported by a wider network of specialized WHO staff in other country offices, in the WPRO and at WHO Headquarters. HQ and regional office staff also provide inputs when the required technical expertise is outside the WHO country office staff core competencies. There have been an increased collaboration and exchange between country offices in the region and even between other WHO regions.

Organizational collaboration is maintained through regular contact using WHO’s Global Private Network with teleconferences, e-mails and country visits of WHO HQ and Regional staff. Where technical expertise is not available within WHO short-term consultants are engaged, often from the substantive network of WHO Collaborating Centres.

Within WHO sub-regional groupings, support to PNG is programme-specific. This is not always ideal. There is significant collaboration between PNG and other Pacific Island nations under initiatives for disease surveillance, HIV, essential medicines and health systems. For other programmes, like immunization, PNG is grouped with Asian countries.
CHAPTER 5  THE STRATEGIC AGENDA

Based on a review of the past and current areas of concentration and ways of working, and on extensive consultation with key stakeholders in the Papua New Guinea, the strategic agenda for the next five years features four important strategic priorities as follows:

1. Technical excellence for sustainable health outcomes
2. Technical support for health systems strengthening
3. Universal access to primary health care (PHC) supporting NDOH engagement with provinces and districts
4. Sector overview, partnerships and aid effectiveness.

The first strategic priority builds on previous work in communicable diseases and maternal and child health. Importantly, under this component, technical programmes are brought together under one umbrella, and reproductive health which has previously received insufficient attention is now featured more prominently.

The second and third strategic priorities are about health systems development and strengthening and about access to primary health care. In particular, the emphasis on universal access is on supporting the NDOH in guiding and supporting provinces and districts in the management and delivery of health services.

Finally, the fourth strategic priority is about partnerships and aid effectiveness. Although widely acknowledged as an area of work of vastly increasing importance, this is the first time that it is actually defined as a distinct programme of work which requires strategic attention and adequate resources. It places WHO in the role of broker and facilitator of policy dialogue and performance monitoring, involving government, development partners and civil society.

The following provides an overview of each of the strategic priorities and outlines a series of specific focus areas where the strategy is to be targeted.

STRATEGIC PRIORITY 1: Technical Excellence for Sustainable Health Outcomes

Promoting technical excellence in disease and public health programmes involves:

- the dissemination of new and up-to-date scientific evidence;
- unbiased and credible information on new medical products; and,
- programmatic approaches to scaling-up innovation and increasing coverage.

WHO will work for the dissemination of lessons learned, best practices and other types of new information within the context of building competencies to promote technical excellence in public health programmes.

Key principles that guide the work of the WHO Country Office in PNG relate to promoting conditions of national health and gender equity. The strategic positioning of WHO Country Office resources (human and financial), vis-a-vis support provided by other Development Partners, will be a paramount consideration.
Technical support will target interventions that:

- strengthen the health system;
- avoid the creation of parallel procedures; and,
- develop national capacity to govern a decentralized and pluralistic health care delivery structure.

**Focus Area 1a: Communicable diseases**

WHO will continue its long-standing work in communicable diseases to support approaches that reduce the burden of diseases, such as HIV/AIDS, TB, malaria, dengue and lymphatic filariasis. Linkages between HIV/AIDS and reproductive health (particularly sexually transmitted infections) will be emphasized as the WHO Country Office seeks to promote integrated service delivery at the primary care level.

National capacity for surveillance and response capacity of emerging diseases (including field epidemiological assessments) remains uneven and generally weak in PNG. As a consequence, WHO will expand its role in supporting:

- the development of epidemiology services dedicated to collecting, analysing and communicating data to monitor and improve the health of PNG citizens;
- the application of the International Health Regulations;
- the implementation of the Asian Pacific Strategy on Emerging Diseases; and,
- increased attention to building national epidemiology and communicable disease control capacity in a coordinated manner with other development partners with the aim of establishing a new national CDC structure. A variety of approaches will be undertaken, including short-term and post-graduate training courses abroad.

**Focus Area 1b: Reproductive, maternal, newborn, child and adolescent health**

Maternal health is not improving and PNG’s maternal mortality ratio of 733 per 100,000 is in the highest tier worldwide. This far exceeds rates from other countries in the region. There is a strong consensus that past strategies have been ineffective in reducing the burden of maternal morbidity and mortality, despite the difficulties in obtaining timely and accurate MMR estimates.

The National Strategy for Reducing Maternal Mortality will establish the directions for reinvigorating NDOH work in this area and serving as a key reference for all development partner support related to maternal and newborn health. WHO will take a lead among the development partners in addressing the maternal mortality issues. The increased focus by the Regional Director on MDGs and highlighting the needs of PNG emphasizes the commitment of the regional and country office to assisting the GoPNG in addressing maternal health.

Family planning is a key intervention area for reducing maternal mortality and promoting conditions favourable to reducing poverty. Although some progress has been made in increasing in the use of modern contraceptive methods, overall, their use remains low and uneven. More work is needed to increase access to family planning services.

WHO will increase its support to national efforts aimed at improving maternal and newborn health (including family planning), and reducing gender-based violence. This will be achieved by enacting a transition in the Country Office’s programmatic support, shifting its focus from the Integrated Management of Childhood Illnesses (IMCI) strategy towards a broader set of interventions that target maternal and newborn care services. This shift in
technical support will be done within the context of ‘One United Nations’, in a manner highly coordinated with UNFPA and UNICEF that ensures comprehensive technical support is provided across the programme areas of reproductive, maternal, newborn, child and adolescent health - including IMCI by the different UN agencies.

The goal of a single, unified technical support team working together across the three UN agencies is foreseen as the ultimate outcome of this process. The management of this transition will work through a developmental process that focuses, in the first instance, on technical harmonization across the different agencies and repositioning of the WHO Country Office staff capacities.

Overall, work in this Focus Area will strive to achieve an integrated package of primary care services for reproductive, maternal, newborn, child and adolescent health, including nutrition, that is linked through referral to higher levels of care for delivery services. Hence actions will be taken to support the development of both primary and referral level care settings. This will be undertaken within a health systems perspective and coordinated broadly with other related actions. e.g. Human Resource Development (HRD).

WHO will continue to provide support to the EPI, sustaining its engagement with the national programme to increase coverage and strengthen health systems. Thereby, it will create opportunities for expanding access to other primary health care services.

**Focus Area 1c: Other areas of concern for guidance and technical support**

WHO will continue to respond to national requests for technical support in the following areas: non-communicable diseases; mental health; food safety; tobacco; alcohol; violence and injuries; and, environmental health.

The Country Office will not maintain on-site / resident technical capacity, but will rather draw upon expertise in the regional and headquarters' offices and short-term technical experts in response to needs identified in consultation with the NDOH.

Particular attention will be given to the nature and frequency of the requests, and need for technical support to the treatment of non-communicable diseases and mental health. Should the need for a more sustained, in-country technical capacity in the Country Office become apparent, then the strategy for relying upon support from regional and headquarters will be re-evaluated.

**STRATEGIC PRIORITY 2: Technical Support to Health Systems Strengthening**

Robust health systems serve as the platform for providing the health sector's contribution to improved health outcomes through universal access to quality health services.

Globally, there has been a large increase in development assistance in health in the period 2000-05. Much of this increase has been focused on disease control programmes, particularly communicable diseases, rather than on the broader health system. While much has been accomplished, there is increasing concern that weak health systems are an obstacle to achieving the maximum improvement in health outcomes possible with the resources available. This inefficiency harms health and puts achieving the MDGs at risk.

This global situation is mirrored in PNG. To a large extent, the health system has become increasingly dysfunctional and unable to cope with routine tasks\(^\text{15}\). Because of this

\(^{15}\) e.g. procurement and logistics management; supervision; human resource development, in all of its aspects; efficient and effective financing; and, equipment and facility maintenance; to name only a few.
weakness, many programmes and projects bypass the government health system in order to achieve their objectives. While this may yield results in the short-term, it places the sustainability of any improvements at great risk and leads to an even more fragmented health sector.

At a policy level, primary health care has been advocated as the organizing principle for health services. At an implementation level, however, this approach has not been consistently followed with a large majority of funding going to provincial hospitals. Very little investment has been made to increase capacities at the provincial or district level for monitoring and supervising rural health service provision. A low level of focus on the training of Primary Health Care workers has exacerbated this counter-productive approach to funding.

Strategic Area 2 will focus on providing technical assistance in the area of health systems to strengthen implementation of the primary health care policy and help deliver universal access to quality health services, thereby leading to improved health outcomes.

Current government reforms in improving service delivery and financing provide new opportunities for health systems strengthening. In cooperation with partners, WHO will provide technical support for strengthening capacities and expertise in the development of a sustainable health financing system.

It is recognized that managing health systems requires a holistic approach. WHO is not the only partner in this area and cannot, and should not, work alone. Therefore, strategic choices have been made in line with WHO’s capacity and the needs of the health sector.

Government reforms in improving service delivery and financing provide opportunities for health systems strengthening.

**Focus Area 2a: Private and non-state health providers: supporting core capacities and developing government oversight**

Non-state providers of various types are of great importance in the health sector in PNG. FBOs are estimated to provide almost 50% of health services and as much as 80% of primary health care services in rural areas. The relationship of the government with FBOs is close, as the government provides the majority of their funding. However, there are gaps in the contractual and planning relationships with them. This contributes to gaps in health service provision. Strengthening of this relationship at national, provincial and district level has the potential to improve health service provision to the rural majority significantly.

Enterprises, such as plantations, factories, and mines, are also significant providers of health services for their employees and families and, in many cases, for the surrounding population. More clear definition of roles and responsibilities for these enterprise-provided health services could contribute also to universal access. Enterprise health activities should be implemented within the framework of the national health plan. Their activities need to be fully integrated into the health plans of provinces and local government units in a sustainable fashion.

Non-governmental organizations (NGOs), both national and international, are also significant providers of health services, particularly for marginalized and at risk populations.

Private practitioners of medicine or health service provision make up a final category of non-state providers, particularly in certain urban settings.
Even when the role of non-state providers is large, the state remains responsible for leadership and governance of the health sector; a role that is sometimes referred to as stewardship.

WHO recognizes the importance of the non-state health sector in PNG and encourages further developments in creating and upholding strategic partnerships between the state and non-state providers. Clearer policy directives on the part of the GoPNG with respect to non-state providers would help move away from the current often *ad hoc* arrangements with non-state providers.

WHO will concentrate on strengthening the capacity of the government to provide constructive oversight of the non-state health sector. This might be through, for example:

- fostering non-state provider organizations
- improved methods for contracting with non-state providers, and
- more transparent sharing of information.

The aim is to create conditions which foster a positive contribution of the non-state sector to achieving universal access to quality health services. In addition, in selected circumstances, WHO will work directly with non-state providers to increase their capacities to deliver services more efficiently and effectively.

Further strategic interventions might include assistance such as:

- improvements in regulation
- contracting arrangements
- monitoring
- supervision systems
- information flows
- training
- human resource development; and
- comprehensive service delivery planning aimed at universal coverage.

**Focus Area 2b: Strengthening regulation and voluntary self-regulation**

Improvement in the quality of health services has great potential for improving health outcomes. Universal access to low quality services is not sufficient. There are many methods of improving quality. Some are mandatory, such as licensing or registration with professional councils. Others are quasi-voluntary or entirely voluntary, such as accreditation, self-regulation through professional associations, and the formation of local quality committees within institutions. All of these mechanisms are more likely to succeed if there is a legal framework to support their activity.

WHO will work with the government primarily, but also with professional councils and institutions, in developing and implementing a legal and administrative framework for improved self-regulation with the aim of improving the quality of health services.

**Focus Area 2c: Evidence-based health policy and planning**

National health plans are a pre-condition, but not a guarantee of a well-planned and managed health sector. Health planning in PNG has been extensive. Meanwhile, implementation of the plans has lagged. Robust national health plans, which include strategies for institutional capacity development, are taking on increasing importance. They are the basis for sector-wide approaches in the health sector. There is an increasing movement to use them as a foundation for funding from various global health initiatives.
PNG is beginning its next cycle of development of a national health plan. WHO will provide technical support to this process with an emphasis on widespread participation, feasibility of implementation, and national ownership.

WHO technical assistance has been primarily focused on gap filling and on hands-on implementation of programmes and projects. Less time and effort has been dedicated to upstream analytic work. As capacity for programme implementation increases within PNG WHO technical staff in all technical areas will concentrate more on analytic work in their area of expertise. This will include initiatives such as situation analyses, policy briefs or options for decision makers, and reviews of relevant research and surveys for presentation to decision makers. This will be included as part of the terms of reference for technical staff.

**Focus Area 2d: Human resource development**

WHO has been involved in many aspects of HRD through provision of technical assistance. HRD involves working with a multiplicity of partners, both internal and external. WHO will engage with all of them in issues of planning, curriculum development, training, standards, quality improvement, and legal frameworks. The government will need to maintain commitment to the HRD reform process if it is to succeed.

WHO will work with the government to monitor progress on HRD reform and encourage the government to maintain a long-term focus aimed at meeting its HR needs. In doing so, this will decrease the need for capacity substitution by external partners.

**Focus Area 2e: Medical supply reform**

The management of the procurement and supply chain for pharmaceuticals and other medical supplies has been problematic. WHO has facilitated the initiation of a process of medical supply reform by working closely with the government and other partners. It is anticipated that this support will continue, probably for a limited period of 1-2 years, until more robust procurement and supply chain mechanisms are in place and functioning.

**Focus Area 2f: Health technology**

Health technology is a major driver of health quality improvement and health care expense. WHO will provide technical assistance in developing sound policies in selected areas of health technology. An initial area of interest is in developing a coherent national laboratory policy.

**STRATEGIC PRIORITY 3: Universal Access to Primary Health Care: Supporting National Department of Health Engagement with Provinces and Districts**

The national government has limited responsibility for the actual delivery of health services. The NDOH is responsible for provincial hospitals, while the provinces and local government units are responsible for primary health care services at lower levels. This is complicated by the fact that non-state providers, some of whom receive funding from the government, are also significant providers of both hospital and primary care services. The recently passed Provincial Health Authority Act (PHAA) seeks to unify health services in provinces by creating a single authority to manage both hospitals and primary health care services in a province. The PHAA is currently being rolled out.

The most important aspects of service provision occur at district level and below. It is also at this level where the compromises to service delivery are most severe. Unless interventions
have an effect at this level improvements in health outcomes are unlikely. PNG has a large body of health policy and health frameworks which, if implemented, could lead to improved health outcomes. However, implementation has been almost completely delinked from the policy process. Therefore, policy has had little influence on service delivery. The difficult issue is how WHO can have a positive effect on service delivery at lower levels that is sustainable and which contributes to universal coverage.

Recognizing the difficulties and challenges, there is also a convergence of reforms at lower levels of government that make this an opportune time for WHO to seek to influence service provision in the provinces and districts. Many of these changes deal with an improved framework for provincial, district and local government unit administration. Although this effort has been facilitated by ministries other than health and by other development partners, it may provide a real opportunity for the NDOH to catalyze health service delivery improvement. WHO will have two strategic foci as follows:

- supporting the NDOH monitoring (e.g. PHA act) and implementation role; and,
- developing and assessing improved service delivery models.

In order to do so, it is anticipated that the tasks revolving around support to provinces and districts would require an additional team member.

**Focus Area 3a: Supporting and monitoring policy implementation from NDOH to province to district**

Although the role of the NDOH is not service delivery, their support and monitoring role remains important. The NDOH is studying various ways of improving their ability to provide support and monitoring, such as the development of regional support teams. WHO's role will be to provide targeted technical assistance to the NDOH in carrying out its role in a manner that will complement other initiatives to improve provincial and local level governance. WHO will not plan to develop a large presence at provincial and lower levels. However, a limited presence of WHO staff, particularly as part of a UN team at provincial and lower levels, could be beneficial to the programme.

**Focus Area 3b: Supporting the development and assessment of integrated service delivery approaches**

In addition to their supporting and monitoring role, the NDOH is responsible for setting standards and developing feasible and realistic service delivery models for each of the settings in which services must be delivered. Innovative service delivery models are being proposed, such as the community health post. More integrated or linked service delivery models are felt to be desirable and seen as the only feasible method that could lead to universal access. These models must also address the management of services and finances at district and provincial level.

Linkages between different levels of service need improving. Linkages between different programmes within the health sector need strengthening at an operational level, perhaps based on EPI micro-planning method extended to a wider range of PHC services. Linkages between partners, particularly the FBOs, enterprises, and government services need to be improved so that a comprehensive and universal service delivery model is designed and implemented in each geographic location. The work on improving arrangements with non-state providers in Strategic Priority 2 is complementary to these activities.

Innovative methods require careful design, costing and monitoring of their effectiveness. The increased emphasis on analytic work from Strategic Priority 2 will be of significance if WHO is to support this function within the NDOH.
STRATEGIC PRIORITY 4: Sector Overview, Partnerships and Aid Effectiveness

The global landscape for health development continues to change. The number of partners is still on the rise, ranging from huge and powerful international funds to small national NGOs. In this situation, coherence and aid effectiveness are formidable challenges.

PNG is committed to the Paris Principles of Harmonization and Alignment\(^\text{16}\), and has made some progress toward putting a sector-wide approach into practice. However, much remains to be done. Apart from improving the flow of funds through the HSIP Trust Account/pooled fund, the policy dialogue between government, development partners and non-state actors needs strengthening, as do agreed mechanisms for monitoring resource distribution; policy action on key technical and institutional issues; and, assessing results on the ground. The proposed work is building on the role already performed by the WHO Representative and his office in the coordination and oversight of various partnerships. It will add additional strength to the Office to deal with increasing demands for development cooperation.

WHO’s traditional role as broker/facilitator provides a suitable platform to work with government and development partners to achieve greater aid effectiveness across the sector. The GFATM grants and the work of the Country Coordinating Mechanism remain key challenges in ensuring sound planning and use of resources for disease-specific programs, whilst also contributing to strengthening of the health system. The role of the GFATM in a sector-wide approach is an area of great confusion in PNG, as elsewhere.

Focus Area 4a: Ensuring a fit between policy and resource allocation

A key role for WHO is to support the development of a coherent health policy and link this to a plan with a realistic resource envelope and a comprehensive expenditure plan. This needs to include contributions from global health initiatives to ensure that the health sector does not experience major distortions and that all partners contribute to an equitable allocation of resources to reach all segments of the population.

Focus Area 4b: Supporting sector overview: engaging in policy dialogue and tracking resource allocation, policy action and results

WHO is actively involved in various efforts to monitor implementation and results. Given the multitude of mechanisms for monitoring, including the annual health sector performance review and the work of the IMRG, WHO’s role is to help NDOH manage work in this area, for example, by avoiding duplication and overload and ensuring that results are used.

Whereas approaches to monitoring of health status and service indicators are relatively well-developed, less attention has been given to tracking progress in policy action and reviewing bottlenecks and constraints impeding progress. As part of PNG’s review of its current strategies for harmonisation and alignment and its track record in implementing a sector-wide approach, renewed attention will need to be given to improving the performance of existing partnership forums and committees in policy dialogue and monitoring.

WHO will also work with government and development partners to support constructive engagement with non-state actors: churches, private sector and civil society. Where needed, WHO will help support effective umbrella organizations for social accountability and voice.

\(^\text{16}\) The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators. The Accra Agenda for Action was drawn up in 2008 and builds on the commitments agreed in the Paris Declaration.
This activity links with the health systems strengthening work already referred to and with the newly created Partnership Unit at NDOH

**Focus Area 4c: Supporting the rationalisation of technical assistance**

There is a need to streamline donor inputs, not only in terms of finance, but also for goods and services. The supply of technical assistance is particularly important to manage. WHO is prepared to play its traditional role of broker and facilitator to ensure that there is a good fit between demand, need and what is being supplied. This entails tracking commitments and actions by development partners through mapping and guiding inputs. The Capacity Building Service Centre has been performing part of this role. With its phasing out, there will be a need to review how technical assistance inputs will be managed in future and what approaches to capacity building will be adopted. This issue is closely linked to ways of working discussed in Chapter 6.
CHAPTER 6  IMPLICATIONS FOR THE WHO SECRETARIAT

The proposed shift in programmatic focus set out above has clear implications for the mix of professional staff required in the Country Office, and for the support needed from the Regional Office and HQ. Even more significantly, new ways of working were discussed extensively during the CCS mission. Key points are presented in this section.

Staffing Implications of the Proposed Shift in Programmatic Focus

The new strategic priorities will result in changes in the staff composition and the balance between technical programmes, health systems development and support for harmonization and alignment of development aid. Although the number of posts allocated to family health will remain the same, the focus of these posts will shift from a concentration on IMCI to a much broader area of work that will encompass maternal and child health, as well as reproductive health. A full-time post for supporting immunization will remain.

For health systems work, there will be an increase from two to three staff members, and the new area of aid effectiveness and coordination will be substantially strengthened with the addition of a new staff member, working alongside the WHO Representative and Programme Management Officer. The total number of staff is expected to increase from 13 to 16 as indicated in Table 2.

Table 2  Current and Future Allocations of Staff

<table>
<thead>
<tr>
<th>Area of Work/Focus</th>
<th>Current Level</th>
<th>Future Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. FTE</td>
<td>%</td>
</tr>
<tr>
<td>Communicable Diseases</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Family Health</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Other Diseases and Risk Factors</td>
<td>.5</td>
<td>4</td>
</tr>
<tr>
<td>Health Systems</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>WRO/Aid Coordination</td>
<td>1.5</td>
<td>12</td>
</tr>
<tr>
<td>Total Country Office staff</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

NB. FTE = Full-time equivalent

Funding the WHO Programme

It is important to recall that 70% of the WHO budget is funded from voluntary contributions. This proportion is expected to increase even further. Although the aim is to obtain un-earmarked contributions to the cost of implementing the strategic agenda set out in this document, the reality is that most voluntary contributions continue to be quite tightly earmarked, and not all play to the strength of WHO as a technical agency.

The recent funding from AusAID to WHO in PNG for 2009-2011 has provided a better modality as the funding is targeting WHO’s strategic priorities in PNG, rather than being earmarked to specific posts and activities. This approach avoids overfunding already relatively well-funded activities, such as AIDS, tuberculosis and malaria, whilst leaving other areas of work severely underfunded, such as health systems strengthening, maternal and child health and broad-based sector development.

The predictability and flexibility of future funding - within the framework of the CCS and with a strong focus on analysis, advice and coordination, rather than implementation and substitution - is critical for the country office’s ability to maintain quality technical staff. In view of the limited number of funding sources available in PNG, the collaboration with, and
financial support from, key partners, such as AusAID, NZAID and US CDC, is vital. The potential impact of the One UN Fund remains uncertain. Depending on the approach to funding long-term in-country staff, it may provide an opportunity but also a considerable challenge for WHO.

Engaging with NDOH Staff
There is a general consensus that the current fairly hands-on direct support to NDOH staff\(^\text{17}\) needs to give way to a more appropriate and effective capacity building approach that engages, not just with individual counterparts, but also with groups and teams. Providing an extra pair of hands – albeit often needed – does not contribute to sustained capacity development. On the contrary, it sometimes actively prevents it. Capacity building approaches need to include the development, not just of skills, but also of systems. They also need to consider explicitly the political and social context in which work takes place.

The issue of pace also enters into the equation. WHO staff often have work plans with targets which, if not achieved, can lead to a negative individual performance assessment. As a consequence and in some cases, WHO staff may impose their own time scale on NDOH staff.

The debate regarding ‘doing’ versus ‘advising’ is a long-standing one. It represents a burning issue for all development partners. A recent review of counterpart relations in PNG suggests that there is a need for a flexible approach which is responsive and keeps capacity development at the heart of the matter. Such an approach would appear to be in line with directives from the Secretary of Health. However, it will be important that this is understood throughout the Department. The question whether WHO staff sharing office space with counterparts exacerbates the tendency for ‘implementation and substitution’ needs to be further explored.

Balance between Technical Work and Administration
At present, WHO staff are devoting considerable time and effort to manage financial and administrative business which, ideally, should be done through NDOH systems. Although the PNG sector-wide approach planning is still work in progress, and there continue to be problems with the HSIP Trust Account, operating funds for the NDOH should primarily flow directly from donors through the trust account/pooled fund.

Given that WHO is not a donor or funding agency, and that its comparative advantage is the quality of its technical support and advice, WHO staff should increasingly be freed up from administrative work so they can focus on technical work, high quality analysis and institutional capacity building. To make this possible, further strengthening of financial management systems within the NDOH is required whilst realizing a sector-wide approach can effectively channel the majority of donor funds into a common pooled fund.

Joined-Up Ways of Working within the WHO Country Team
Working in silos in the WHO Country Offices is much commented upon, but very little has been done to change this. The approaches outlined in Strategic Priority 1 and Strategic Priority 3 offer new opportunities for working in a more collaborative way. More time spent together in the same office will help, as will undertaking joint field work and organizing internal discussions that focus on substantive issues and present up-to-date analyses of different aspects of the health sector.

\(^{17}\) sometimes referred to as substitution or gap filling
Implementing ‘Strategic Selectivity’

Despite good intentions to be more focused and selective, the demand for WHO to be involved in anything and everything continues. This is a common problem for WHO Country Offices and is perceived by many to dilute the effectiveness of WHO’s work. A judicious approach is required to decide to which requests WHO should respond to and how. The response repertoire should include: provision of information; technical back-up from the Region and HQ by electronic communication; and, through country visits, short-term consultants and study visits. WHO staff are inundated with ad-hoc requests to attend meetings. More strategic choices will have to be made regarding attendance.

Supporting National Professional Development

A number of mechanisms for grooming young PNG staff for international and national health leadership positions through training and mentoring are being considered. National Programme Officers are one possibility, but have the distinct disadvantage. Worldwide the evidence shows that these officers tend not to return to service in their national government. Creating a cadre of Young Professionals with time-limited attachment is another possibility, as is the concept of scouts as used in the UN system.

Other models should be explored as well, including WHO support for the creation of national resource institutions which has been successfully tried in other Regions. The provision of fellowships for formal training is an essential element of enhancing national professional development. WHO’s fellowship allocation is relatively small, but with funds provided from other sources, WHO is in a good position to manage an expanded and intensified fellowship programme.

Ensuring more demand-driven, and less supply-driven, support from the WHO Regional Office WHO functions at three levels; global, regional and national. WHO is the leading global public health agency with normative public health functions that are generated, potentially, from all three levels of the agency, but mainly from the global and regional levels. An example would be the International Health Regulation Regulations or the Framework Convention on Tobacco Control. WHO is also a development agency. Most development directions are generated and implemented at national level. However, there are also global initiatives, such as polio eradication, which are driven by global and not national policy.

The strands of work that arise from each of the three levels of WHO are usually complementary. However, there are occasional problems. The volume of requests and initiatives from higher levels of the organization may overstretch the capacity of the relatively small country office to respond, taking time away from tasks that are more directly-related to country priorities. More seriously, there may be times when initiatives generated from outside the country may contradict or duplicate in-country work. An example might be when the country is focusing on integrated or linked programmes, when outside initiatives are organized vertically and separately.

These differences of approach are inevitable in a large and diverse organization. Goodwill is required in all parts of the organization to harmonize approaches. The fundamental principle is that WHO should align with national policy wherever possible. The country office is the level of WHO most likely to reflect national priorities the closest. Therefore, country office initiatives should take usually take precedence. This will require flexibility on the part of all involved.
Assessing Performance

Changing ways of working and moving upstream from implementation to informing, influencing and institutional capacity building has implications for the way in which the performance of professionals and of the Country Office as a whole is conducted. Exercising influence and engaging in closer partnerships do not have easily quantifiable indicators but, nevertheless, they are stressed increasingly as WHO core functions.

Analytic work and operational research are seen to be a desirable part of everyone’s job, but for most professional officers, no time is allocated for these activities in work plans. As such, qualitative indicators of achievements for such tasks are missing.

The Country Office needs to make a start in including these more abstract and elusive aims and activities into work plans and to reward effort and performance. In the longer run, WHO’s current global results framework will need to be adjusted to ensure incentives are in place to reward greater engagement in policy dialogue, analysis and partnership. Finally, because these ways of working have not been explicitly assessed so far, it is difficult to establish a baseline against which to measure progress.
ANNEX 1  LIST OF DOCUMENTS REVIEWED


