PAPUA NEW GUINEA
DISTRICT HEALTH MANAGERS’
“GUIDE BOOK”
SEPTEMBER 2016
FOREWORD

In 2001 the National Department of Health adopted “Minimum Standards for District Health Services in Papua New Guinea”. In 2011 these standards were superseded by the National Health Service Standards for Papua New Guinea.

The potential of the district level to contribute to improved health service delivery in PNG is yet to be fully realized. Effective leadership and management skills for district health managers are crucial to the success of District Development Authorities (DDAs) in delivering health services and programs. District health management teams can enhance synergies between the Provincial Health Authority and DDAs in the delivery of quality health services.

This book aims to advance the role of district managers in translating health inputs into quality health services. It strengthens their leadership role, improves supervisory competencies, builds capacity to use health data in decision making and enhances accountability through regular management meetings and monitoring of progress.

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MINISTER for HEALTH AND HIV
ACKNOWLEDGEMENTS

This guide book is largely the result of collaboration between the World Health Organization (WHO) Country Office in PNG, the National Department of Health and Madang Provincial Health Office to strengthen district health services in PNG.

My appreciation goes to the author, Dr. Paulinus Sikosana, the WHO Country Office Coordinator and Team Leader for Health Systems Strengthening and Mr. Ken Wai, Executive Manager, Strategic Policy and Planning in the National Department of Health who reviewed the document for policy consistency.

The guide book is based on results of the Assessment of the Functionality of District Health Systems in Madang Province and remedial actions undertaken to address system weaknesses and lessons learnt from the strengths identified.

I thank the Madang Provincial health team, District Managers, Officers in Charge of Health Centers and WHO Country Office staffs who contributed in one way or the other to this work during the course of their work.

Thank you all.

Mr. Pascoe Kase
SECRETARY FOR HEALTH
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1. INTRODUCTION

Imagine that you have been posted to manage district health services in one of the country’s remotest districts. You are straight from college and perhaps your only exposure to district health services was when you undertook a month’s attachment during your pre-service training as a health worker. Even better still, part of your working life has been working as an officer in charge of a health center. You arrive at your district health office and you are told that there has not been any District Health Manager for the past 5 years. Staff are very enthusiastic that a “messiah” has at last arrived and that the coordination of district health services will once more be the envy of other districts in the province.

The fact of the matter is that you are more comfortable doing clinical work in the confines of a hospital or health center ward. You have never received any training in organizational management, let alone health services management. The situation you are in is such that there is no one to mentor or guide you.

You are probably not alone in such a dilemma as most developing countries suffer from serious shortages of health workers, let alone experienced health managers. Rural areas are particularly hard hit as most health workers prefer to work in urban areas. The shortage of health staff is at times so acute that there is not even time to provide additional training for health workers to prepare them to work as (district) health managers. In most cases there are no prescribed qualifications,
skills or criteria to guide the deployment of staff to work as district health officers or managers. Such situations have often resulted in poorly managed (rural) health services and the delivery of substandard and poorly coordinated health services and public health programs.

An analysis of the functionality of district health services in one province in Papua New Guinea (PNG) revealed a number of weaknesses in the management of district health systems. Weaknesses that could be resolved by simply bringing to the attention of staff a number of issues that only need staff to change the ways they conduct business. Such changes would generally not require a significant injection of additional resources into the system.

As the coordinator and manager in charge of district health services, remember that rural areas require the right number of doctors, nurses, midwives and other supporting health service providers with the necessary skills to work effectively and comfortably in these often neglected areas. The sustainability of rural health services depends on an adequate health service infrastructure, a conducive work environment and the availability of frequent support and supervision of staff.

This publication is meant to be a simple book to guide the novice health worker who is both privileged and unfortunate to have been posted as a district manager with no training, experience or mentorship on such responsibilities. The guide book takes full cognizance of the need for District Health Managers to be trained in the broader aspects of management theory and practice as well as being able to personally address
both the individual and system related issues that affect the performance of health systems at the district level.

It is important therefore that you familiarize yourself with these basic aspects of managing district health services. When the opportunity arises you must grab it and participate in more formal health management courses as part of your personal development plan. Be sure to participate in the “Health Facility Management Training Course” which though targeted at “Officers in Charge” of health facilities, will give you more insight into aspects of managing district health services in Papua New Guinea.
2. ASSESSING THE FUNCTIONALITY OF DISTRICT HEALTH SYSTEMS
LESSONS LEARNED

Let us first of all understand the meaning of the term - “health system”. A “health system” consists of all organizations, people and actions whose primary objective is to promote, restore or maintain health. This includes efforts to influence the factors that promote or determine health as well as the more direct health improving activities. A health system is thus more than a complex pyramid of publicly owned facilities that deliver personal health services. Much of the factors that affect the health and well being of people are beyond the health system itself. Hence the focus on what has often been referred to as the “social determinants of health.

To achieve its goals, the district health system has to perform a number of basic functions, namely: provide services, develop health workers and other key resources, mobilize and allocate resources and ensure effective health system leadership and governance. The World Health Organization (WHO) defines the following “six health system building blocks” which constitute the overarching WHO health systems framework:

- Service delivery
- Health workforce
- Health information System
- Access to essential medicines and health technologies
“Good health services are those that deliver effective, safe, quality personal and non-personal health interventions. A well performing health workforce is one which works in ways that are responsive, fair and efficient to achieve best health outcomes possible given available resources (sufficient staff numbers, mix of skills, fairly distributed, competent, responsive and productive). A well-functioning health information system ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status. The health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost effectiveness, and their scientifically sound and cost effective use. A good health financing system raises adequate funds for
health in a way that ensures that people can use needed services and are protected from financial catastrophe or impoverishment which is associated with having to pay for them.

Health sector leadership and governance ensure that strategy policy frameworks exist and are combined with effective oversight, coalition building, provision of appropriate regulations and incentives, attention to system design and accountability.

Papua New Guinea District Health System Strengths and Weaknesses

The assessment of the “functionality of district health systems” conducted in one province concluded that the district health system faced a number of challenges. There was an evident lack of effective health leadership at the district level which resulted in weak management structures and practices. Support and supervision activities were in most cases, non-existent at both the provincial and district levels.

Staff at both provincial and district levels lacked the capacity to adequately collect, manage and use health information for planning and application in other decision making processes. Often, health information was religiously collected at facility level and passed on to the provincial health office without being discussed at the health facility or district levels. There was no evidence that this information was reviewed by district health managers to ensure that it was accurate. The information was not used for monitoring progress in the implemen-
tation of Annual Activity Plans. Quarterly review meetings were not conducted as required under the National Health Plan Performance Assessment Framework (PAF).

Opportunities for community involvement in the management of health services were not fully exploited. Hospital Boards and/or village/health facility health committees were either no longer in place, and where they existed, it was only in name. Shortages of human, financial and material resources – especially shortages of essential drugs - hampered the delivery of quality health services within the districts.

The majority of District Health Teams had not convened any management meetings for as long they could remember. A situation which had resulted in some districts becoming dysfunctional and riddled with internal conflicts due to ineffective communication and decision making processes. None of the district managers had copies of their job descriptions, let alone job descriptions of staff deployed at health facilities within their districts.

Most of the district health managers demonstrated weak capacity for local planning and budgeting. For example, the planning process for the then current plan period had been conducted in a top-down manner without involving health workers in the district. In one district it was stated that two staff members from the district health office had travelled to the provincial office and developed the district plan assisted by provincial program staffs. At the time of the assessment, half
way in the year, none of the health facility staff had seen the district health plan.

The major contributor to the above state of affairs was the lack of experienced and trained district managers – the majority of whom did not even know their job responsibilities and had not received any in-service training in the many years they had been appointed to their present jobs. Some staff had been in these positions for more than 30 – 40 years and just could not remember what they had exactly been employed to do. Without regular follow up through supervision, some of the staff did not bother to come to work on a regular basis. Nobody could hold them accountable as community participation structures were dysfunctional, a situation compounded by a lack of follow up and supervision.

This guide is meant to assist district managers to effectively fulfil some of their roles and responsibilities as middle managers. It is not a substitute for formal training in leadership and management, but a reference to remind the district manager of local management issues that they should be mindful of at all times.
3. CONTEXT OF HEALTH REFORMS IN PAPUA NEW GUINEA

The policy and operating environment for service delivery in Papua New Guinea has over the years become increasingly difficult and challenging for a number of reasons, which include the unintended effects of the Organic Law on Provincial and Local Level Governments. In order to continue with effective delivery of services, despite these challenges, the National Department of Health has developed and implemented a number of health reforms. These reforms are evidence based changes in existing health and health related policies, the development of new health policies and implementation of institutional arrangements designed to improve the functioning of the health sector – with the ultimate goal of improving the health of the population.

The Organic Law on Provincial and Local Level Governments has over the years been blamed for negatively impacting on the delivery of basic services—even those beyond the health sector. For example, the Organic Law has been blamed for making it increasingly difficult for the National Department of Health (NDoH) to enforce the implementation of national health policies by provincial governments. National departments are not able to hold provinces accountable for policy implementation because the Organic Law gave them powers of “semi autonomous” institutions. This law, together with the Public Hospitals Act, transferred the management and
financing of public hospitals from provincial governments to the National Department of Health. The management and funding of rural health services – health centers, community health posts, aid posts and operational aspects of public health programs - remained under provincial governments. This created a fragmented health delivery system which has become a challenge to manage. To many, this fragmentation has contributed to the deterioration of health service delivery over the years. Below are some of the health reforms that the National Department of Health embarked on.
The Flow of funds under the Provincial Health Authority System

Provincial Health Authority (PHA)

To mitigate some of the above challenges, the National Department of Health introduced a policy reform through enactment of the Provincial Health Authority Act of 2007. This Act establishes Provincial Health Authorities which are responsible for managing an integrated health service delivery system whereby hospital services and rural health services are managed under a single health authority – the PHA. In its original form the PHA Act provides for Provincial Health Authorities to be established in those provinces whose Governors agree with the Minister of
Health for the Act to take effect in their respective provinces. The adoption of the PHA is a voluntary act for those provinces that choose to do so. Where a PHA operates, its Chief Executive Officer assumes direct management control of all health workers—i.e. those who provide rural health services as well as those working in hospitals.

Within the PHA, the District Health Manager reports directly to the Director of Public Health or in some cases to the District Health Coordinator. The fact that health workers report directly to a health professional potentially improves the accountability of health staffs, especially on professional matters. Where there is no PHA, health workers report to administrators who, in most cases, are considered not to be familiar with health issues.

Once established and running, the Provincial Health Authority receives funds for capital investments, operating costs, and health function grants directly from the Department of the Treasury. The PHA then allocates the funds to hospitals and rural health services. Where there is no PHA, rural health services are funded through Health Function Grants which are allocated directly to provincial administrations and hospitals are funded through the National Department of Health. As more provinces elect to establish Provincial Health Authorities, it is envisaged that legislation will be enacted to regularize or institutionalize these authorities and make them compulsory.
National Health Service Standards
The development of National Health Service Standards (NHSS) in 2011 was a policy reform aimed at establishing a quality assurance framework for curative health care services. The NHSS introduced a new national health service delivery platform consisting of seven levels of health care delivery. The standards provide guidance on minimum staffing levels, minimum package of equipment requirements and standard facility designs for each level of health service delivery.

Under these standards, health facilities are assessed on a regular basis as to the extent to which they meet these standards and implement necessary actions to remedy any shortcomings identified - resources permitting. The National Health Service Standards supersede the “Minimum Standards for District Health Services in Papua New Guinea” of 2001.

Health Financing
A major problem for service delivery is that of inadequate funding to front line service delivery. This is partly the result of health function grants that are allocated by the Department of Treasury to provincial administrations either not being enough or not reaching the health facility level. This often results in health facility staffs providing health services with inadequate operational budgets that are required to keep health facility “doors open”. Operational funds are used for minor repairs of facility infrastructure and equipment, to conduct outreach clinics and patrols, and in some cases to purchase additional essential drugs.
Because funds were not reaching front line health facilities, staffs often resorted to charging user fees to raise the operational funds. Available evidence shows that user fees are an economic barrier which deters the poor and other vulnerable groups from accessing basic health care services.

**Policy on Free Primary Health Care and Subsidized Specialist Services**

Whilst the practice of charging user fees at primary health care facilities in PNG has been in place for many years, technically speaking, the levying of user fees was not legal. Legislation at the time only allowed hospitals to charge user fees. To regularize this situation, in 2014, the government adopted the “Free Primary Health Care and Subsidized Specialist Services” policy. This meant that all government and church primary health care facilities - aid posts, community health posts and health centers would no longer charge user fees for health services they provide.

However, since user fees were a dependable source of operational revenue for primary health care facilities, the abolition of user fees deprived the majority of primary health care facilities of a valuable source of income. To cushion health facilities from this loss of revenue, the government allocated additional funds for all public and church run health facilities affected. These funds were meant to compensate health facilities for the loss of revenue that they previously generated from user fees.
**Direct Health Facility Funding**

In order to address some of the bottlenecks in the flow of health function grants from the provincial level to health facilities, a project was initiated to pilot what was referred to as “Direct Health Facility Funding” (DHFF). This pilot project allowed health centers to open bank accounts into which operational funds were deposited for use by health facility staff. An evaluation of the pilot concluded that Direct Health Facility Funding was a practical way to improve and increase the flow of funds to health facilities and that if rolled out countrywide it has the potential to improve the availability of funds at facility level and contribute to improved service delivery.

**Health Workforce Enhancement Plan (2013-2016)**

In 2011 the National Department of Health conducted a comprehensive review of the Human Resources for Health situation in the country. The review report concluded that Papua New Guinea was facing a Human Resources for Health crisis at the time and into the future. Following this report the National Department of Health adopted a Human Resources for Health policy which was followed by the development and implementation of a Health Workforce Enhancement Plan (2013-2016).

This medium term plan outlines measures to improve the health workforce situation in the country’s public sector. Short term strategies include, amongst others, a proposal to increase the retiring age of health workers to 65 years, the employment of expatriate health workers in the short term, em-
ployment of retired health workers on short term contracts and increasing the intake of health worker training institutions. A program to rehabilitate health worker training institutions and to improve the quality of teaching staff at Community Health Worker and Nurse Training institutions was also initiated. The National Department of Health increased the number of scholarships to support the training of Community Health Workers, nurses and midwives at local training institutions. Previously the majority of these scholarships supported students going for overseas training. In 2016 the duration of this plan was extended to 2019.

**Health Partnership Policy**

In recognition of the potential contribution by private providers of health services to the health of the people of PNG, in 2014 the National Department of Health adopted a Health Sector Partnership Policy. The policy establishes a platform for developing partnership agreements between provincial administrations, Provincial Health Authorities (PHAs), District Development Authorities (DDAs), church health service providers and other non-state providers of health services. The policy also provides a framework for dialogue, negotiations and regulatory parameters and reporting obligations for such partnerships between state and non-state providers of health care services.
Post 2015 Sustainable Development Agenda

You will no doubt be aware that the Millennium Development Goals (MDGs) agreed by governments in 2000 came to an end in 2015. The downside of the story is that a significant number of countries – especially those in the developing world - including PNG, did not achieve most of the MDG targets they had set to achieve by 2015. The 2015 Mid Term Review of the National Health Plan (2011-2020) was an opportunity for the country to assess progress towards the health related Millennium Development Goals. The Demographic and Health Survey (DHS) of 2016 provides additional information on progress achieved.

The post 2015 development agenda succeeds the era of the MDGs and is grounded on Sustainable Development Goals (SDGs) which cover the period 2016 to 2030. As PNG embraces the SDGs, the MDGs remain on the unfinished agenda. The SDGs have 17 goals – of which Goal 3 (Good Health and Well Being) relates specifically to health - “Ensure healthy lives and promote wellbeing for all at all ages”. (See ANNEX 2: Goal 3 Targets)

Universal Health Coverage

The achievement of Universal Health Coverage by countries is a major component of health related SDGs. The concept of Universal Health Coverage (UHC), is about “ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be
effective, while also ensuring that the use of these services does not expose the user to financial hardship”. (WHO).

Under UHC, those who need services should get them, and not only those who can pay for them. Services should be of such quality as to adequately improve the health of those receiving them and the cost of using care should not put people at risk of financial hardship—UHC should guarantee financial risk protection.

Papua New Guinea’s road to UHC initiatives includes adoption of the policy of free primary health care services and subsidized specialist services, which effectively abolished user fees charged at public primary health care facilities. There is enough evidence that user fees are a barrier to populations accessing health services.

Since 2008 the National Department of Health has been implementing medical supplies reforms which aim at improving the availability of essential medicines, vaccines and medical technologies through better estimates of requirements, transparent procurement and improved distribution logistics across the country.

The National Department of Health proposed the establishment of a social health insurance in line with a National Executive Council (NEC) decision of 2005. However, in 2014 the World Bank published a policy brief which suggested that a social health insurance scheme would not be a viable health financing option for PNG.
The Mid Term Review of the National Health Plan provided an opportunity for the National Department of Health to have a fresh look at the National Health Plan (2011-2020). This resulted in the development of a more focused document, Health Sector Strategic Directions (2016-2020).
4. TAKING CHARGE OF DISTRICT HEALTH SERVICES

Papua New Guinea defines District Health Services in line with the World Health Organization concept of the district health system. “District Health Services, based on the primary health care approach, are more or less a self-contained segment of the national health services. District Health services serve a well-defined population, living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, church, private or traditional. District health services consist of a large variety of interrelated elements that contribute to health in homes, schools, workplace, and communities, through the health and other sectors, and incorporating the Healthy Islands Concept approach. It includes self-care and all health workers and facilities, up to and including the hospital at first referral level and appropriate laboratory, other diagnostic and logistic support services. It focusses on a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities, clearly developed to provide maximum effect at the different levels within the services.” (National Department of Health, 2001)

The rationale behind the district health system concept is to decentralize the management of human and financial re-
sources, to establish decentralized planning processes based on the district level and to promote inter-sectoral action, develop leadership in Primary Health Care (PHC), mobilize action and redefine the role and function of the district hospital. The district health system concept divides the country into smaller geographical areas – districts – that are more manageable. This concept applies to both urban and rural geographic boundaries. According to the concept, each local health system has its own hierarchy of patient referral which ensures some degree of continuity in patient care within each health district.

Your deployment to manage district health services means that you have to hold your district health staff accountable – deal with the problem of UNFINISHED TASKS – the small things that make a BIG difference to the experiences and survival of patients and communities. Your overall responsibility is to co-ordinate the delivery of health services within your assigned district. In Papua New Guinea, rural health services are defined as, “Any promotive, preventive, curative and rehabilitation health services that are provided outside of a gazetted public hospital, to the peripheral population within a legally specified provincial and district boundary in the country”. (National Department of Health, 2001)

In this context you are required to ensure that the delivery of health services is seamless across district boundaries to en-

The various levels of service delivery must cooperate, work in harmony, avoid duplication, conflict and competition
sure that no communities are left without access to health services. This means looking after all the health facilities within the district administrative boundary. Such facilities include the district hospital, which is the first level referral hospital, also classified as level 4 according to the National Health Service Standards. The Health Center, (Rural or Urban) is classified as level 3, the Community Health Post is level 2 and the Aid Post is level 1. This classification is irrespective of whether the facilities belong to the public sector, church or the private for profit sectors (agricultural and mining industries).

According to role delineations in the National Health Service Standards (NHSS), the District Health Center and the Rural Hospital no longer feature in the classification of levels of health service delivery in Papua New Guinea. Level 5 is the provincial hospital, level 6, the Regional Hospital and level 7, the national referral hospital – Port Moresby General Hospital.

**Health leadership and management**

Your role is both that of a leader and a manager for district health services. As a leader you must establish an enabling work environment for health workers, create a vision and strategic direction for your district team, inspire, motivate and align stakeholders to achieve a common district health vision. As a manager you will undertake a set of task-orientated processes which include planning, budgeting, organizing, staffing, controlling, monitoring and problem solving.
As a health manager you will spend a substantial proportion of your time managing (i) the volume and coverage of services (planning, implementation and evaluation) (ii) resources (e.g. staff, budgets, drugs, equipment, buildings, information) and (iii) external relations with partners, who include service users.

Familiarize yourself with the service delivery functions of all levels of health facilities within the district health system (refer to National Health Service Standards). Make sure you at least have a copy of the health standards document in your possession.

Know your health district

It is important that you are aware of the district (health) situation - know the health profile of the health district in terms of:

- The district map—always display it in your office
- Geographic boundaries of the district and immediately neighboring districts
- Total population and its structure
- Find out population catchment areas for health facilities as well as populations that are outside the catchment areas and need to be covered through outreach patrols
- Social and economic activities
- Local topography and climatology
- Transport and communications infrastructure
- Language and literacy levels
- Distribution of other amenities such as schools, grocery shops, mines, police stations etc.
4. Taking Charge of District Health Services

- The number and distribution of health facilities by type, size, ownership, health service and program coverage, state of infrastructure, and staffing levels.

- Community leadership – meet some of them as soon as possible

To find out how the district has been or is being managed on a day to day basis – review minutes of previous health and district administration management meetings - if they are available. These may give you hints as to how business was conducted and how decisions were/are made in the district. If you do not find any minutes – this maybe a sign that all is/was not well regarding management and communication within the health district.

Find out if the district health office has any copies of the current National Health Plan and Health Sector Strategic Directions (2016-2020) document. Review the quality of current and previous Annual Activity Plans (AIPs) and the type of health activities that were/are being implemented. You may find that district staffs do not have any of these plans. Find out if there are any quarterly or annual performance review reports on file. These will assist you to assess the extent to which health information is used for decision making in the district.

Find out if district staffs use any checklist to guide supervision activities. If so, review the supervision checklist, supervision schedules, supervision site reports and supervision feedback reports that may be on file. If such reports are not
available, consider this to be an opportunity for you to be a real change agent and improve the quality of supervision in the district.

Find out if there is a database for all staffs employed in the district. Look for job descriptions of each and every category of health worker – starting with those that are part of the District Health Team. Ascertain if staffs in the district use work schedules/plans to manage their work? When you meet staff at health facilities, ask them when they last received a supervision visit or when they last participated in staff development activities. Ask if there is a staff leave register.

**Conduct a Rapid Assessment of the District Health System**

The starting point in knowing the state of district health services is by conducting a rapid assessment of the district health system. If you do not have the skills to undertake this task, ask for assistance from the PHA, Provincial Government or National Department of Health. (see Table 1)

**Address weaknesses identified from the assessment**

From the assessment, identify determinants of health needs of communities in your district. Assess the social, cultural, economic, political and ecological factors prevailing in the district. Once these have been identified, community health needs should form the basis upon which district health plans and programs are developed. Assess the local health needs and rank them in order of priority. Take into account objective community health needs identified through collection and analysis of
### Table 1  Rapid Assessment of the District Health System

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<th>Health System Component</th>
<th>Parameters to Assess</th>
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| Adequacy of Human Resources within the district  | Proportion of facilities with the required human resources  
Number of doctors per capita  
Number of nurses per capita  
Number of midwives per 1000 pregnant mothers |                                                                                                                                                      |
| Health Financing                                | Ease of flow of resources  
Per capita expenditure or allocation at district level  
Expenditure patterns |                                                                                                                                                      |
| Adequacy of health infrastructure               | Proportion of facilities with adequate building infrastructure  
Proportion of aid posts/health centers that are operational  
Proportion of facilities with electricity or other source of reliable energy  
Proportion of facilities with access to safe water and sanitation  
Percentage of facilities with adequate communication infrastructure |                                                                                                                                                      |
| Health Services Management                      | The composition of the District Health Team – are all the expected members in place?  
How frequently are they supervised from the province?  
How well are basic management tasks fulfilled (team meetings, performance reviews, supervision of facilities, submission of monthly reports on time, annual implementation plans completed?  
Availability of standard treatment books |                                                                                                                                                      |
| Availability of health services                 | Proportion of population within 5km radius of a health facility  
Percentage of facilities with no stock out of medicines  
Proportion of facilities offering the defined minimum package of services for the health care level  
Proportion of facilities with a functional cold chain for vaccines  
Use of integrated management of childhood illnesses strategy  
Provision of HIV screening and antiretroviral therapy  
Availability of artemisinin based combination therapy (ACTS) and Rapid Diagnostic Tests for malaria  
Provision of insecticide treated nets (ITNs)  
Provision of obstetric services (EDC), Sexual and Reproductive health services  
Provision of directly observed therapy (DOTS) for tuberculosis |                                                                                                                                                      |
| Access to health services                        | Consultations per capita  
Antenatal care coverage  
Proportion of births supervised by skilled health personnel at health facility  
Proportion of births by caesarian sections (CS)  
District Family Planning coverage  
Measles immunization (EPI) coverage  
Pentavalent vaccination coverage |                                                                                                                                                      |
health statistics as well as through subjective health needs expressed by the community.

For the district health system to be acceptable and responsive to community needs, you must allow for community participation through – where possible – direct involvement in the planning and implementation of local health service activities.

Ensure there are systems which enable communities and individuals to express their views, complaints and concerns about the local health system so that improvements can be made. These could include suggestion boxes at outpatient departments and through health staffs engaging with community leaders and civil society organizations on a regular basis. District and facility committees can be established for active community participation.

On the supply side of the health equation, develop effective and efficient management and support systems for health services and program delivery. Pay attention to infrastructure such as physical facilities (water facilities, buildings, vehicles), other material resources (drugs, medical and other supplies), human resources (trained and motivated staff) and financial resources for salaries, maintaining and repairing equipment, conducting outreach clinics, and patrols, patient referrals and medical evacuations and/or patient referrals.

The health system must be seen to result in positive changes in the health of both individuals and communities. Remember that there are other sectors which impact on the health status of communities. To achieve your district health goals,
you must promote inter-sectoral action. You can achieve this by collaborating with sectors such as education, agriculture and local government, to mention only a few. Pay particular attention to community based health workers, village birth attendants and volunteers in your district.

**Staffing levels**

You have a responsibility to ensure that each facility is staffed, at least, according to the minimum prescribed standards and that there is appropriate relief for leave of absence. This will ensure that health facilities are always staffed and functional at all times. The number and skills mix of staff must be such that the health facility can deliver the prescribed minimum package of services. Staffing levels should be at a level which allows shift work, call arrangements and relief for leave and other extended staff absences.

It is your duty to ensure that all health facilities in your district have the necessary staff to fulfill health service requirements for the particular level of the system.

Where necessary, take the management initiative to move staff within the district to ensure service delivery is not interrupted and to match the number of health staffs with health facility workload. Develop mechanisms to monitor staff punctuality and attendance and ensure that every health facility in your district maintains an up to date duty roster and that staff adhere to it.
Tips:

- National Health Service Standards prescribe the minimum staffing levels which take into account workload levels for each type of health facility.
- Job descriptions are a useful basis for evaluating staff performance. Make sure that every staff member in your district has his/her job description at their workstation. Keep copies of job descriptions of all health cadres at the district offices for reference, induction of new staff and to assist in staff performance appraisals. Job descriptions should assist you to determine the suitability of candidates for positions in the district.
- Familiarize yourself with the National Human Resources for Health Policy of 2014.
- The Public Service General Orders will guide you in staff recruitment, placement and transfers.
- Prepare an induction package for all new district health (medical and non-medical) staffs. Work closely with the Human Resources Division of the Province or Provincial Health Authority and the District Administrator (or Chief Executive Officer in the case of a District Development Authority (DDA)).
- Ensure that all health professional staffs employed in your district are registered with the relevant professional board—e.g. the Medical Board, Nursing Coun-
cil or indeed any other relevant authority or body. Ensure that their registration status is up to date at all times. Refer staff professional behavior issues to these professional registration bodies.

- Ensure that all health staffs have equal opportunities for in-service training and education. Avoid the practice where the same individuals continue to receive training whilst others do not receive any at all. Be fair and keep an up to date in-service training plan and register for your district staffs.

- Ensure that all staffs are regularly appraised in line with Public Service General Orders. Refer to relevant job descriptions and agreed annual personal work plans.

- Allow your Officers in Charge to employ drivers/operators where they have a vehicle/boat/dingy. Cleaners are an essential part of health facility staff as they ensure cleanliness and upkeep of the health facility and its grounds. Where there are security problems it is important that health facilities are allowed to employ security guards.

**Deliver the appropriate Health Service Package**

Refer to National Health Service Standards on details of minimum packages of services for each level of the health delivery system. Within this hierarchy, a level 1 health facility (the Aid Post) provides the least complex package of health services.
The district package of health services increases in complexity through to levels 2, 3 and 4. The ascending hierarchy of services is more in terms of content and complexity of the package than the quality of services.

Ensure that all district office and health facility staffs have copies of the most up to date standard treatment books and National Treatment Guidelines. Treatment guidelines are also designed to assist staffs to decide when to refer patients for higher levels of patient care and management.

**Adhere to Health Facility Design Standards**

Health infrastructure is an indispensable part of health service delivery. It contributes to the quality of health services and the safety of both patients and staffs. In most cases, communities in rural areas do not have access to quality and safe health care services. This is mainly due to health infrastructure that has deteriorated over the years due to poor maintenance. Volume 3 of the National Health Service Standards outlines design standards for the various types of health facility infrastructure.

Whenever your Member of Parliament, donor or Non Government Organization plan to build a health facility in your district, ensure that the proposed facility is part of an approved
Provincial Health Services and/or District Development plan and that the designs conform to the National Health Service Standards. Ensure that all proposed (new) health facilities always include the construction of staff accommodation as part of the plan/project. Keep a copy of the Community Health Post Policy and share it with the local Member of Parliament. Whenever a new health facility is established, ensure that there are enough funds for health staffs to be employed in line with the minimum staffing levels for the particular type of facility—refer to National Health Service Standards.

**Ensure functional Medical and Non-Medical Equipment**

Essential medical and non-medical equipment are necessary tools for health staff to deliver the desired quantity and quality of health services for a particular level of the health delivery system. Each level of service delivery requires a particular set of essential basic medical equipment, cold chain equipment, non-medical equipment, essential drugs, vaccines and other medical supplies. It is your responsibility to ensure that these inputs are available at all times and in line with section seven of the medical catalogue.

In order to do so, it is important to assign a designated officer who will be called to account for the availability (or unavailability) of these inputs. Ensure that these supplies and equipment are not only available but are in a functional state. Make sure that discussions on the availability of medical
equipment remain a standing agenda item in all your district management and review meetings.

**Manage the availability of Essential Drugs**

Familiarize yourself with the National Medicines Policy as revised and updated in 2014. The policy emphasizes drug availability, safety, efficacy, affordability, rational use and the need for designated human resources to manage medical and related supplies. The National Policy on Immunization and the National Policy on Cold Chain and Logistics provide guidance on the procurement and management of vaccines. These documents are available on demand from the National Department of Health. Provide copies to district staff and ensure that they are familiar with relevant Standard Operating Procedures.

To ensure the rational use of drugs, provide health facility staffs with the most up to date versions of National Treatment Guidelines/Protocols. Train all health staffs on the standard treatment guidelines. Regular and proper use of these guidelines will ensure that not too many drugs are unnecessarily used on one patient, that drugs are used only after a proper diagnosis has been made and that only the right doses are prescribed and used.

It is recommended that, at any time, health facilities should have at least 3 months minimum stock levels of each item of essential medicines. All Officers in Charge of health facilities must be trained on how to calculate minimum stock levels for their respective facilities based on patient/client...
workload and consumption. Adhering to these principles will reduce overstocking, prevent drugs expiring on shelf and drug stock outs. Assist staffs to redistribute near expiring drugs and

overstocked items to facilities that are able to utilize such items before they expire. Such problems can be identified and resolved through regular supervision. (See ANNEX 1: Management of Essential Drugs Supplies at facility level). All drugs nearing their expiration date should be sent to the district or provincial hospital.

**Coordinate the delivery of Public Health Programs**

Public Health Programs range from the Healthy Islands concept which aims to develop healthy communities and populations in healthy environments to fully fledged public health programs. Public Health programs include the prevention and control of communicable and non-communicable diseases; provision of sexual and reproductive health, maternal, neonatal, child and adolescent health; the provision of safe water supply, sanitation and waste disposal; safe nutrition, food supply and food security programs; enforcement of policies or rules for the protection and promotion of health; and programs on freedom from tobacco use, alcohol and substance abuse.
All these program areas each develop national strategic plans (usually covering a five year period) which are implemented through Annual Implementation Plans (AIPs) at various levels of the health delivery system. Provincial program managers should always have copies of national and provincial strategic plans for their respective program areas. These will guide them in developing provincial and district Annual Implementation Plans.

**Partner with non-state health service providers**
The District Health Manager coordinates planning of health service and program delivery in the district – including health activities of non-state providers of health services. In coordinating the development of district Annual Implementation Plans, the district manager must bring together all health service providers operating in the district – be they public, private or non-state. This ensures that all providers’ planned activities are aligned to the National Health Plan, Provincial Health (Development) Plan, District Health (Development) plan, government policies and priorities, and National Health Service Standards.

Under the guidance of the PHA, the Provincial Administration or DDA, you can enter into partnership arrangements with other providers of health services. These partnership agreements include working with the PHA, DDA (as the case may be), public hospitals, Churches, Non Governmental Organizations, private for profit enterprises, international development...
partners and indeed any other non-state provider of health services. Ensure that non-state providers of health services fulfill their obligations under the National Health Administration Act, the Medical Registration Act, including providing the district health authorities with the necessary health information in line with Public Health Act reporting obligations.
## DISTRICT HEALTH MANAGER’S CHECKLIST

<table>
<thead>
<tr>
<th>DOCUMENT</th>
<th>AVAILABLE</th>
<th>MANAGER’S TASKS</th>
<th>DONE</th>
</tr>
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<tbody>
<tr>
<td>National Health Plan</td>
<td></td>
<td>Convened District Health Management Meeting (monthly)</td>
<td></td>
</tr>
<tr>
<td>District Annual Activity Plan (current)</td>
<td></td>
<td>Attended District Health Management Committee Meetings</td>
<td></td>
</tr>
<tr>
<td>District Map (with health facilities)</td>
<td></td>
<td>Convened District Quarterly Review Meetings (at least 2)</td>
<td></td>
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<tr>
<td>Demographic Profile (district)</td>
<td></td>
<td>Attended Health Facility Committee Meetings (quarterly)</td>
<td></td>
</tr>
<tr>
<td>Staff Job Descriptions</td>
<td></td>
<td>Performed Staff Appraisals</td>
<td></td>
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<tr>
<td>In Service Training Register</td>
<td></td>
<td>Conducted Supervision visits to Health facilities</td>
<td></td>
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<tr>
<td>Community Health Post Policy</td>
<td></td>
<td>Met with Local Member of Parliament</td>
<td></td>
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<tr>
<td>Health Partnership Policy</td>
<td></td>
<td>Reviewed NHIS Data from facilities</td>
<td></td>
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<tr>
<td>Treatment Guidelines (Adult)</td>
<td></td>
<td>Provided Feedback Reports on NHIS (to facilities)</td>
<td></td>
</tr>
<tr>
<td>Free Primary Health Care and Subsidized Specialist Care</td>
<td></td>
<td>Participated in Provincial Quarterly Performance Reviews</td>
<td></td>
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<tr>
<td>Treatment Guidelines (Children)</td>
<td></td>
<td>Updated District Finances/Budget</td>
<td></td>
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<tr>
<td>Supervision Checklist</td>
<td></td>
<td>Updated catchment Population of Health facilities</td>
<td></td>
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<tr>
<td>Supervision Manual</td>
<td></td>
<td>Checked availability of Essential Medicines at facilities</td>
<td></td>
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<tr>
<td>Facility Supervision File</td>
<td></td>
<td>Checked the state of Cold Chain equipment</td>
<td></td>
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<tr>
<td>Sector Performance Annual Report (SPAR)</td>
<td></td>
<td>NHIS from Private Providers of health services in the District</td>
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<tr>
<td>District Disaster (Mitigation) Plan</td>
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<tr>
<td>Public Service General Orders</td>
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<td>Stock Cards for Health Facility Dispensaries</td>
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<tr>
<td>Modules for the Rural Health facility Management Training Course for Officers in Charge</td>
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<tr>
<td>National Health Service Standards</td>
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</table>

### 4. Taking Charge of District Health Services

- Convened District Health Management Meeting (monthly)
- Attended District Health Management Committee Meetings
- Convened District Quarterly Review Meetings (at least 2)
- Attended Health Facility Committee Meetings (quarterly)
- Performed Staff Appraisals
- Conducted Supervision visits to Health facilities
- Met with Local Member of Parliament
- Reviewed NHIS Data from facilities
- Provided Feedback Reports on NHIS (to facilities)
- Participated in Provincial Quarterly Performance Reviews
- Updated District Finances/Budget
- Updated catchment Population of Health facilities
- Checked availability of Essential Medicines at facilities
- Checked the state of Cold Chain equipment
- NHIS from Private Providers of health services in the District
5. DISTRICT GOVERNANCE STRUCTURES

The District Health Manager is part of a broader service delivery structure of the Department of Provincial and Local Level Government Affairs. For more details refer to the document entitled, “The Determination, Assigning Service Delivery Functions and Responsibilities to Provincial and Local Level Governments.” This document explains what each level of government is responsible for in terms of service delivery. The determination aims to eliminate vertical overlap between National Departments, Provincial Governments (Provincial Health Authorities), and District Development Authorities and Local-level governments (LLGs).

The District Development Authority (DDA) reform gives more administrative powers and “autonomy” to districts in the implementation of development programs and service delivery. The DDA Act abolishes the Joint District Planning and Budget Priorities Committee and takes over its responsibilities. These include overseeing, coordinating and making recommendations regarding planning and budget priorities. Under the Act all provincial administration staffs in the district are assigned to the DDA.

As a District Health Manager you must develop district health plans and budgets which are good enough to convince the Chief Executive Officer for the DDA to allocate you adequate resources to satisfy the health development needs of your district. Take advantage of your membership of the Dis-
trict Health Management Committee team which is chaired by the District Administrator/Chief Executive of the DDA.

District Health Services are the next level of health service delivery below the Provincial Health Department, PHA or Provincial Hospital. In those provinces that are yet to adopt the Provincial Health Authority, the District Health Manager reports to the Provincial Health Advisor (or Provincial Health Director) on technical issues related to health service delivery.

On general administrative issues, the District Health Manager reports to the District Administrator or Chief Executive Officer of the DDA. Where there is a PHA, the District Health Manager is an integral part of the PHA structure and reports to the Director of Public Health (Services) and in some PHAs the District Health Manager reports to a District Health Coordinator. Familiarize yourself with the PHA Act, the user manual for the PHA and the functions and responsibilities of District Development Authorities.

In terms of professional/technical accountability, Officers in Charge of Health Centers – public and private – report to you as the District Health Manager. Current arrangements (where there is no PHA) dictate that all civil servants within the district fall under the District Administrator or DDA Chief Executive Officer. Where there is a PHA all health workers report to the Chief Executive Officer of the PHA. It is important to note that staff management arrangements which are based on dual accountability tend to bring with them challenges of
staff discipline and accountability – especially from a professional point of view.

The District Health Manager is expected to work from the District Health Office. Where practical – this office is located within the district hospital grounds.

**THE DISTRICT HEALTH OFFICE**
This office manages and coordinates district health services, public and private, and is the link between the district and higher levels of health service administration – provincial and national. This office is managed by the District Health Management team under the leadership of the District Health Manager. The primary responsibility of the office is to translate national health policies into annual district health plans.

Remember that it is not possible for an individual to have all the necessary skills, or to have enough time at hand to do everything that must be done in the district. As a District Health Manager, you are part of a management structure referred to as the **District Health Team** – of which you are the chairperson.

This team assists you to coordinate the management of district health services. According to the now obsolete Minimum Standards for District Health Services (2001), the composition of the District Health Team varied depending on the availability of staff. Under ideal staffing conditions, to be effective, the District Health Team should consist of at least the following minimum staff categories:

- The District Health Manager – chair
- District Disease Control Officer
Depending on the local epidemiology and availability of funds, a District Tuberculosis Control Officer, Malaria Control Officer, Expanded Program on Immunization Officer, etc. can be part of this team.

In broad terms, the main function of the District Health Team is to provide day-to-day management of district health services - planning, organization/coordination of health service delivery, resource mobilization and utilization, and monitoring and supervision:

- Convening District Health Management Team meetings
- Planning and budgeting for district health services, programs, staffing, facilities, drugs and medical supplies
- Coordinating the development of district Annual Implementation Plans (AIPs)
- Coordinating the implementation of district AIPs
- Disease surveillance and disaster preparedness
- Regular (quarterly) integrated supervision of staffs at all health facilities within the district
- Participation in Quarterly District Health Management Committee meetings – chaired by the District Administrator/District Development Authority Chief Executive Officer
- Monitoring resource (human, material and financial) availability and use
- Conducting regular (quarterly) performance reviews of the implementation of AIPs.
• Planning and conducting District in-service Training programs for staffs

The **District Health Management Committee** advises and supports the District Health Team. Considering its composition, the District Health Management Committee plays a crucial role in health advocacy, inter-sectoral coordination, and galvanizing community participation in service delivery. The Committee meets at least every quarter and previously reported to the Provincial Health Board (where such a Board exists). The composition of the District Health Management Committee includes:

- District Administrator—Chair (CEO of DDA)
- District Health Manager
- District Education Officer
- Representative of Community Health Workers
- Representative of Church Health Services
- Community Representative (Local Level Government President)
- Women’s Representative
- Representative of Youth Groups

The specific functions of the **District Health Management Committee** are detailed in the relevant sections of the *National Health Administration Act (1997)*.

Where there is a Provincial Health Authority, the functions of District Health Management Committees are likely to be replaced by Health Facility Committees at Health Center and District Hospital levels. It is proposed that these facility Committees report to the PHA Board. The PHAs are likely to pass bylaws to provide for the establishment and functions of such Health Facility Committees.
Health Facility Committees play a role in mobilizing community involvement in the planning, management and provision of local health services. These roles include working with health facility staffs to prioritize community health needs and to ensure that these needs are part of health facility and district health plans; to support local community based health volunteers and to mobilize community resources. The involvement of local community leaders, including the local Member of Parliament is important.

It is crucial that all your staffs work closely with community and/or health facility committees as these are links between health facility staffs and communities or beneficiaries of health services. They provide opportunities for communities to actively participate in and influence health related activities. In such cases communities can, for example, arrange community transport for the referral of patients, collect community based health data, promote community hygiene and sanitation programs, and mobilize other local resources to promote healthy lifestyles.
6. **OVERVIEW OF DISTRICT HEALTH SERVICES**

According to the Minimum Standards for District Health Services (2001), now superseded by the National Health Service Standards (NHSS), there were 4 levels of hospitals which were identified as follows: level 1: National (Port Moresby General Hospital); level 2: Three Regional Referral Hospitals (Mount Hagen, Angau and Nonga); level 3: Six Provincial Hospitals (providing specialist services which include Surgery, Obstetrics, & Gynaecology, Paediatrics, Internal Medicine and Anaesthetics); level 4: Eight Provincial Hospitals (with no specialist services and needing upgrading).

According to National Health Service Standards (2011), the role delineation for service delivery defines a hierarchy of 7 service delivery levels. The standards describe packages of health services (core service groups) to be delivered at each of the seven levels and minimum staffing requirements calculated based on productivity levels (Full Time Equivalents). Health service delivery levels are defined as follows:

- Level 1 (*Aid Post*) — curative services and public health programs, including community based health services
- Level 2 (*Community Health Post*) - curative services and public health (community) programs
- Level 3 (*Rural Health Centre/Urban Clinics*) – curative services and public health (community) programs
• Level 4 (District Hospital)— first referral hospital, provides curative (inpatient and outpatient) and support services for public health (community) programs
• Level 5 (Provincial Hospital) - selected specialist curative services (inpatient and outpatient) and support for public health programs, support visits to levels three and four and training of health workers
• Level 6 (Regional Hospital) - specialist curative services (inpatient and outpatient), referral support for levels five and four, and support to public health programs and training of health workers
• Level 7 (National Referral Hospital) - super specialties, specialist services and support to public health programs and training of health workers

**Hours of operation**

By their nature, hospital services operate 24 hours a day and 7 days a week on a shift basis. Whilst rural health facilities are supposed to operate in this manner, staff constraints have over the years made it difficult for them to do so. Aid posts are staffed by one person, making it difficult to operate 24 hours a day and 7 days a week. A number of aid posts are closed, mainly because of staff shortages and, in some cases, law and order problems. The district manager has the responsibility to ensure that all health facilities in the district operate as required at all times.
**Patient Referral**

The patient referral system is an integral part of well functioning district health services. The main objective is to guarantee continuum of care and referral back of patients. Within the district health system, the referral hierarchy ideally starts at the Aid Post (level 1), through to the Community Health Post (level 2), Health Centre (level 3) to the district hospital (level 4). Referrals may occur horizontally across health facilities at the same level. Treatment guidelines provide criteria and guidance on patient referrals.

In some (urban) areas, where there are no primary health care or gate keeping institutions, patients seek health care directly from referral hospitals without being referred. In some cases this is because lower level facilities do not have adequate staff, medicines or equipment. Treatment of minor ailments at referral facilities is very expensive, inefficient and wasteful of scarce resources.

**Communication between levels of care**

Road and telecommunications infrastructures within and across districts are generally under developed. In the past most rural health facilities in PNG were linked through a sophisticated radio network which facilitated patient transfer; provided a communication platform for discussing clinical cases and the transmission of health information and disease surveillance data. Due to a lack of adequate maintenance, this radio network has gradually become dysfunctional and is being replaced.
by cell phone technology — where cell phone connectivity is available.

Medical doctors from provincial hospitals are required to visit district hospitals and health centres every six months to support patient management and conduct in-service training. Due to logistic problems these visits are however not as regular as expected. As district health manager you could mobilise the necessary resources to enable this type of clinical support to continue.

**Role of non-state providers of health services**
The National Department of Health developed a Health Sector Partnership Policy which came into effect in 2014. The policy defines mechanisms for collaboration between state and non-state providers of health services. Church health services provide upwards of fifty percent of outpatient (ambulatory) services in the country—mainly in rural areas. In addition to providing health care services, churches collaborate with the state in training nurses and community health workers.

The private for profit sector (mining companies, agricultural concerns and private for profit hospitals) is gradually increasing its presence, especially in urban areas. The same applies in areas where mining companies and agricultural enterprises provide health services to communities as part of their social responsibilities. There are also a number of local and international Non-Governmental Organizations (NGOs) who
provide health services and programs. The state also partners with private universities in the training of health workers.

You must encourage referral of patients and sharing of staff between NGOs, churches and government facilities within your district. The starting point is to bring these organizations together when you develop your district health plan.

The District Health Manager has the responsibility to coordinate planning, implementation and monitoring all health service providers in the district - both public and private. In other words, health service and program delivery plans for public and private providers must be an integral part of the district health plan. Remember that non-state providers of health services in your district have a legal obligation to collect health program and service delivery information through the National Health Information System and submit it to the district health office.

Linkages with local communities

Facility based health care can only make an impact if the services provided are actually utilised and patients adhere to treatment instructions. The approach to district service delivery must emphasize community outreach and community participation so as to build demand and expand access to health care. You must aim to empower communities and give them a greater voice in the planning and management of local health services – e.g. through health facility committees or similar local bodies. Offer communities opportunities to express their
views on how health facilities should function, hours of operation and types of services to be offered, where applicable.

Community based health workers have the potential to strengthen local health promotion actions. They occupy a vantage position in their communities where they can encourage and motivate household members to, for example, increase the use of health facilities and participate in outreach activities. A community based health worker can promote childhood immunization and thereby build demand for these and other health services. In addition, a community based health worker can assist with follow up and retention of patients in care. They can bring services directly to the household and thereby reduce some barriers to access – e.g. cultural, racial and sex discrimination. Community based health workers contribute to a comprehensive continuum of care and provide a link between patients’ homes, local health facilities and eventually, patient referral services.
7. PLANNING AND IMPLEMENTING DISTRICT HEALTH SERVICES

PLANNING DISTRICT HEALTH SERVICES AND PROGRAMS

Major responsibilities of a District Health Manager and his/her team include (i) Planning (ii) Coordinating (iii) Implementing and (iv) Monitoring and Evaluating the delivery of district health services and programs. Planning is about deciding now what you are going to do in the future. Plans answer a number of questions which include (i) What will we do? (ii) When will we do it? (iii) Who will do it? (iv) How will we do it? and (v) How much will it cost? Planning is about setting (short and long term) goals and performance objectives, developing multiyear plans, allocating adequate resources (money, people and materials) and anticipating and reducing risks.

At the top of PNG’s planning hierarchy is “Vision 2050”, the Medium Term Development Plan, the National Health Plan (sector plans), Health Sector Strategic Directions (2016-2020), Provincial Plans and Annual Implementation Plans (rolling plans). Provinces develop their own respective medium term development plans which are products of various sector plans. Health Sector Annual Implementation Plans are developed at national, provincial, district and facility levels. The health sector has committed to implementing facility based planning and budgeting - focusing on costing inputs and activities at health facility level. Within this framework, facility based plans and
budgets are consolidated into detailed district annual implementation plans.

The District Health Manager leads and coordinates the planning and budgeting process for health service and program delivery in the district. He/she is at the forefront of coordinating this process across public and non-state providers of health services within the district. The district health plan is a building block for the Provincial Health Plan.

Define where you want to end up at the end of the plan period by setting the main objectives. Determine the range of inputs (health staff, vehicles, equipment, essential drugs and funds) required to achieve the goals, objectives and targets of the district plan.

- Analyze current services, resources and health trends in the district
- Prioritize and plan activities that form the best option to improve district health services
- Quantify inputs required to carry out each of the proposed activities
- Cost the amount of money required to pay for these inputs
- Prepare the budget
- Refine the plan and prepare the final budget.
- Negotiate with the District Administrator (District Development Authority Chief Executive Officer) / Provincial Government or Provincial Health Authority for an appropriate district allocation to implement the plan. Do not forget to mobilize funds from the local Member of Parliament through the DSIP.
Set district targets for the entire range of prevention, treatment and care and rehabilitation services in line with national and local priorities. A good planning process engages all relevant key stakeholders within your district – all Officers in Charge of health centers, NGOs, churches, Civil Society Organizations, the private-for-profit sector, the District Administrator or Chief Executive Officer of the DDA. Work closely with the relevant program officers in the provincial health office or PHA.

Refer to current health planning guidelines which should be aligned to the National Health Plan (Key Result Areas) and the relevant strategies. Make sure that every health service provider in the district participates in the planning process. It is important that you work with your Officers in Charge of Health Centers to develop health facility plans which should inform the development of the overall district health plan. The national government planning cycle provides guidance on when to start the planning process and when to submit final versions of the plan to the District Administrator, Provincial Government or PHA.

Whilst the current National Health Plan (NHP) is divided into 8 Key Result Areas (KRAs), future plans may be formatted differently. The District Annual Implementation Plan is one way of translating the National Health Plan into locally implementable activities. For each Key Result Area or strategic objective,
the district Annual Implementation Plan must detail locally relevant activities, implementation timelines, costs, sources of funding and responsibilities for implementation at the various levels of service and program delivery. (see Table 2)

Table 2: Possible Activities for a Health Facility Plan

<table>
<thead>
<tr>
<th>Activity/Cost</th>
<th>Activity/Cost</th>
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<tbody>
<tr>
<td>Integrated Patrols/Outreach (KRA 1)</td>
<td>Cell-phone costs, internet, etc. (KRA 1)</td>
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<tr>
<td>Supervision visits (KRA 3)</td>
<td>Health Committee Meetings (KRA 3)</td>
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<tr>
<td>Distribution of medicines and supplies (KRA 1)</td>
<td>Casual Workers’ Salaries (KRA 3)</td>
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<tr>
<td>Fuel, per diems and air fares (KRA 4-8)</td>
<td>Clinical/Maternal death audits (KRA 5)</td>
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<tr>
<td>Medical referrals and evacuations (KRA 4-8)</td>
<td>Utilities (KRA 1)</td>
</tr>
<tr>
<td>Epidemic control/contingency funds (KRA 8)</td>
<td>Other administrative costs (stationery, security, etc. (KRA 1)</td>
</tr>
<tr>
<td>Minor Repairs/maintenance (equipment, facility, staff accommodation, etc.)</td>
<td>Program costs – relevant to each level of the health system—school health programs, community participation activities, patient follow-up and community visits, oral health programs</td>
</tr>
<tr>
<td>District Performance Reviews (KRA 3)</td>
<td>Commemoration of special events</td>
</tr>
<tr>
<td>Management meetings (KRA 3)</td>
<td>Healthy Island/village projects</td>
</tr>
<tr>
<td>In-Service training, in country study tours, attachments</td>
<td>Health promotion activities—</td>
</tr>
<tr>
<td>Water reticulation at health facilities</td>
<td>Other hardware – e.g. lawn mowers, etc.</td>
</tr>
<tr>
<td>Incinerators</td>
<td>Replacement/repair of cold chain equipment</td>
</tr>
<tr>
<td>Power supply – solar power, generators</td>
<td>Expanding storage space at health facilities, etc.</td>
</tr>
</tbody>
</table>
## 2016 Annual Implementation Plan

**Division/Branch/Unit:** 0

<table>
<thead>
<tr>
<th>Activity</th>
<th>Budget &amp; Expenditure Summary</th>
<th>Activity Selection Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Division/Branch/Unit:</strong> 0</td>
<td><strong>Division/Branch/Unit:</strong> 0</td>
<td><strong>Division/Branch/Unit:</strong> 0</td>
</tr>
<tr>
<td><strong>Budget Program Linkage:</strong> NHP</td>
<td><strong>NHP Key Result Area:</strong> Expanding partnerships with resource developers, private healthcare providers, church and NGOs in rural and remote areas.</td>
<td><strong>Key Focus Sectors/Activities:</strong> National Public Private Partnership Policy is implemented, and innovative and cost-effective options for delivering services is selected.</td>
</tr>
<tr>
<td><strong>Planning and Implementation District Health Services</strong></td>
<td></td>
<td><strong>NHP Key Result Area:</strong> Health sector coordinates and monitors the implementation of the National Health Policy.</td>
</tr>
</tbody>
</table>

### Priority Strategies 2015

<table>
<thead>
<tr>
<th>OPMS Number</th>
<th>2015 Activities Related to Strategies (Must be Measurable)</th>
<th>Time Frame</th>
<th>Planning &amp; Budget Drivers</th>
<th>Funding Source</th>
<th>Other</th>
<th>Full Implementation % Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Improve patient-provider relationship with non-clinical providers of health services.</td>
<td>Q1 Q2 Q3 Q4</td>
<td>Key</td>
<td>Key</td>
<td>Key</td>
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<tr>
<td>1.2</td>
<td>Ensure all stakeholders develop services delivery infrastructure in line with National Health Standards.</td>
<td>Q1 Q2 Q3 Q4</td>
<td>Key</td>
<td>Key</td>
<td>Key</td>
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</tr>
<tr>
<td>1.3</td>
<td>Increase the use of community clinics/health centers as a means of increasing public access to health services.</td>
<td>Q1 Q2 Q3 Q4</td>
<td>Key</td>
<td>Key</td>
<td>Key</td>
<td>0</td>
</tr>
</tbody>
</table>

### Routine Operational Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time Frame</th>
<th>Planning &amp; Budget Drivers</th>
<th>Funding Source</th>
<th>Other</th>
<th>Full Implementation % Complete</th>
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<tbody>
<tr>
<td>2.1</td>
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<td>2.2</td>
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<td>2.3</td>
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### Activity Summary

<table>
<thead>
<tr>
<th>Activity</th>
<th>Budget &amp; Expenditure Summary</th>
<th>Activity Selection Criteria</th>
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</table>

**Note:** This table provides a summary of the annual implementation plan for the National Department of Health, focusing on priority strategies and routine operational activities, with specific details on budget and expenditure, as well as activity selection criteria.
IMPLEMENTING DISTRICT HEALTH SERVICES AND PROGRAMS

Organizing is about ensuring that resources are available at the right time, in the right place and in the right amounts to get the work done. Implementation requires decisions to be made, problems to be resolved, activities coordinated, negotiations undertaken, effective communications achieved and activities implemented and effectively monitored.

As the District Health Manager you must make decisions about possible courses of action. Good decisions require accurate “information”. To be useful, decisions must be made in a timely manner so as to meet the needs of the moment. Once you have made a decision, it must be communicated to those staffs who must act on it. This means that implementers of decisions should be part of the decision making process. One way of making decisions and involving your staff in decision making is through convening regular meetings.

Convening (District Health Team) Meetings

We have referred to the fact that you are the chairperson of the District Health Team. You thus have a responsibility to convene and chair regular management meetings of the District Health Team. Meetings enable you to communicate with your staff, share information, solve problems, resolve disputes, improve performance and build teamwork. Staff meetings enable you to keep staff informed of new developments and new policies. You can also convene “one-to-one” meetings to appraise the performance of your staffs.
Meetings are an important part of a manager’s work. They can be large or small, held in open air or closed spaces, with colleagues, communities, targeted groups such as patients or clients for purposes of health education. Some meetings are regular and meant to make decisions; whilst others are educational meetings or discussion groups. Committee meetings are a special type of meeting which consist of a group of persons appointed to fulfil special functions. They have strict rules and procedures on how business will be conducted, powers and duties, membership, and voting rights. (WHO, 1992)

When you prepare for a meeting there are a number of issues to consider:

- The purpose of the meeting and the subject to be discussed
- The type of meeting—information sharing, review of progress in implementation, problem solving, etc.
- The number of people expected to attend
- The venue, time and duration of the meeting
- Announcing the meeting to those expected to attend

Do not forget to designate a “secretary” to record the deliberations of the meeting. Together with the meeting invitation, make sure to circulate minutes of the previous meeting and an agenda for the meeting you are calling. As chairperson you must ensure that the meeting starts and ends on time, give everyone a fair chance to contribute or speak and keep order. Manage the discussions, rule out irrelevant remarks and bring proceedings to a stop if necessary. Encourage those who
Resourcing the District Health Plan

Central government is the main source of funding for health services in Papua New Guinea through the Health Function Grants. The national government allocates specific funding to provincial governments to meet salaries for public servants. Churches manage their own salary budget which comes as a grant from central government and is currently disbursed through the National Department of Health. The District Health Office is not responsible for salaries of health staffs but must ensure that all persons on the district salary sheet are physically in place and that they actually provide health services at their designated places of work.

There are a number of funding streams that support health service delivery at the subnational level. Provincial hospital grants are allocated through the National Department of Health or PHA. Where these are established, PHAs receive grants for recurrent funding directly from the Treasury or through the provincial Treasury.

Health function grants are allocated directly from Treasury to provincial administrations to fund health related goods and services — particularly for the delivery of rural health services.
Box 1 Typical Agenda for a District Health Meeting

1. Opening Prayer
2. Welcome and announcements
3. Apologies – from those that are not able to attend the meeting
4. Minutes – of the previous meeting: these would have been circulated well before this meeting and participants given an opportunity to submit their comments. Before you proceed with formally adopting the minutes, check if there are any corrections that need to be made. When corrections have been identified and made, the minutes can then be adopted as a correct record of what was discussed and agreed at the last meeting. The procedure is for the chair to call for one person to propose a motion that the minutes are indeed a true record of the previous meeting. Once this has been done the chair then calls for another person to second the motion – and the minutes are then adopted.
5. Matters Arising — After the minutes have been adopted, the meeting can then discuss matters arising – this would normally be a follow up on actions agreed to be undertaken as a result of decisions of that meeting
6. Agenda for the day – the chair will direct the meeting to start discussions on the agenda items for the day’s meeting (e.g. a typical Quarterly Review Meeting will have the following standing agenda items – 1 to 2 days meeting)
   - **Overview of District Performance** - presentation of overall district progress report against indicators and targets – District Manager/Health Information Officer (15 min)
   - **Brief Reports by district program managers** - (15 min each)
   - Brief progress reports by health facility Officers in Charge (10 min each)
   - **National Health Information System** – issues, concerns etc. (15 min) Discussions – 45 min
   - **Budget /Expenditures** – District Health Manager (15 min) Discussion – 20 min
   - **Administration** – logistics, transport and staffing etc. (20 min)
   - **Availability of essential drugs** – (15 min) Discussions – (20 min)
   - **Overview of District Supervision reports** (15 min)
     Challenges for the quarter
7. **Resolutions/Decisions** – on the way forward
8. Date of Next meeting
Health related goods and services include the delivery of health programs, the distribution of medical supplies, outreach services, disease prevention and control, safe motherhood, patient referral, immunizations, school health programs, water supply and sanitation and health service monitoring, and performance reviews and supervision. In this context the National Department of Health is responsible for national procurement of medical supplies and distributing these to area medical stores. Provincial administrations have the responsibility to distribute medical supplies to all health facilities within the province.

The Health Function Grant (HFG) is meant to support – first and foremost - implementation of the three health Minimum Priority Activities (MPA). These are (i) outreach patrols, (ii) drug distribution and (iii) health facility operations. Provincial administrations must allocate HFGs to district/local level governments or PHAs (where applicable) to support service delivery. The Health Function Grant is not meant to be used for infrastructure development projects—except for minor preventive maintenance of facilities. Provincial Administrations are required to supplement the HFG with locally generated revenue which can be used for both health infrastructure development and/or health service and program delivery.

With the establishment of DDAs, the pathway for the allocation of HFGs is likely to change. DDAs have a responsibility to support recurrent costs for assigned service delivery
functions – including health. As earlier indicated, the DDA replaces the Joint District Planning and Budget Priorities Committees (JDPBC) and assumes their responsibilities. For more details, refer to the assignment of responsibilities to DDAs (as and when this is made available).

The “development budget” is meant for infrastructure development and is allocated to provinces through the Public Sector Investment Program and in some provinces, through Special Support Grants. These funds are managed by the provincial administration. Where there is a PHA, some funds meant for the development of health infrastructure are channeled directly to the PHA. Funding for district and local level infrastructure development becomes the responsibility of the DDA.

The local Member of Parliament is the custodian of District Service Improvement Program (DSIP) funds. In order to mobilize these funds for district health development, it is important that you develop close working relationships with your local Member of Parliament. Take every opportunity to share and/or discuss the district health plan with him or her. To the extent possible, involve the Member of Parliament in district health planning—e.g. this includes inviting him/her to your district health planning workshop!

You are likely to experience challenges regarding the flow of health funds to your district. The Department of Treasury almost always fails to release funds to provinces on time. This will inevitably result in the first release of funds for
the year, for example, reaching front line service delivery during the second quarter of the year. When the provincial administration receives the funds, there are often additional delays in disbursing these to district health service providers. It is important that you develop appropriate strategies to follow up and prompt the timely release of these funds.

Insufficient funding to front line service delivery results from delays at the different stages of formulation and execution of the health budget, (i) allocation, (ii) budgeting, (iii) disbursement and (iv) accountability for funds. Provincial governments control health function grants with some tending to give priority to administration costs at the expense of investing in service delivery.

Key disbursement problems include: (i) delays in funds being made available; (ii) delays in approving expenditures and (iii) delays in accessing cash. It is important that as the manager you produce financial and other reports on time as these have a bearing on the timing of disbursements of funds. If you do not acquit funds that you have been allocated, you will certainly not get the next allocation.

It is important to note that, “The payment of salaries and wages for rural health staffs, including community health workers, is a national government responsibility. When provincial administrations meet the costs for staff salaries using health function grants, they are in fact misapplying funds meant for goods and services. These funds would otherwise have been spent on fuel to enable health patrols, childhood immunizations, training of village birth attendants, helping women during child birth and assisting with the transfer of
immunizations, training of village birth attendants, helping women during child birth and assisting with the transfer of patients from health centers to provincial hospitals for treatment and/or the distribution of medical supplies.

**Implementing the District Health Plan**

Planned activities include those for curative (facility based) health interventions, program interventions – which are both facility and community based. For each activity, local targets to be achieved must be specified. Development (project) activities (e.g. infrastructure and purchase of major equipment), capacity development (training) and other support activities must also be included.

The District Health Manager coordinates implementation of the district plan by staffs through:

- Ensuring that the collective action of staffs is coordinated – through meetings and other means of communication to synchronize and resolve issues that may arise and are likely to adversely affect implementation.
- Providing continuous training for staffs through in-service training programs to keep their knowledge and skills up to date.
- Providing staffs with the necessary incentives to encourage them to perform.
- Providing logistics such as transportation to facilitate movement – out reach patrols, supervision, transportation of supplies and referral of patients.
• Ensuring that there is adequate functioning equipment – medical and non-medical.
• Ensuring that essential medicines are available at all health facilities at all times.
• Conducting regular support supervision.

**Accounting for district health funds**

Familiarize yourself with delegated responsibilities under the provisions of the Public Finances (Management) Act (1995). Pay particular attention to the relevant procedures and processes and adhere to the basic guidelines for delegated officers:

• Use **approved financial procedures** to conduct and record all transactions.
• Check that money is **lawfully available** for payment of an expense (invoice).
• Make sure that all expenditures or transfers of money are **correctly recorded** and **coded** in the accounts ledger.
• Ensure that payment of any account is **checked** by the officer responsible for the expense.
• Comply with any other agreed **requirements** relating to the payment of the account.
• Meet all **legal** and **ethical obligations** under legislation for transparency and accountability.
• For procurement ensure that you source 3 quotations or provide proper and credible explanations for any deviation from required procedures
• Make sure that details of the payments are recorded clearly, so that the calculations can be easily checked or audited.
• Make sure that all entries of financial transactions are written in ink and are legible (can be read), and if a mistake is made this is crossed through, but never erased (Source: "Rural Health Facility Management Training Course for Officers in Charge. Version 2.1. National Department of Health and Department of Foreign Trade, Australia. October 2013).

MONITORING HEALTH SERVICE DELIVERY

Support and Supervision of health staffs
Supervision is one way of keeping one’s finger on the pulse of what is happening in health service and program delivery in your district. Supervision should be undertaken as a team effort. It is very important that supervision visits are planned and budgeted for well in advance, at the beginning of the plan period and as part of the Annual Implementation Plan. This means that there will be a schedule of planned supervision visits kept at the district office and at all the facilities that are supervised by your team or by Officers in Charge of Health Centers. There will also be a dedicated budget allocated for supervision in the Annual Implementation Plan.
In 2014, the National Department of Health adopted an Integrated Supervision Manual and Check list. This is available in both electronic and hard copy formats. Familiarize yourself with the tool and train your Officers In Charge of Health Centers on using the Integrated Supervision tool.

It is through regular supervision that you can (i) ensure that the objectives and priorities in your district plan are implemented in line with national objectives and that these are locally relevant; (ii) determine what is being done well and encourage staffs to continue the good work; (iii) observe if your staffs are following service delivery and program implementation guidelines; (iv) help staff identify and solve problems, and give them feedback in person and through supervision reports and follow-up.

Support Supervision - is supportive, creative and not a strategy to maintain discipline. The best supervisor has substantial working experience in the relevant area of work and has both managerial and training skills.

Ensure that all your District Health Team members and Officers in Charge of Health Centers have a copy of the Supervision Manual and Integrated Checklist and that they are trained on how to use it. Ensure that findings and follow-up actions are discussed with staff at the time of supervision and that a supervision report is compiled and one copy left at the site of supervision and another copy filed at the district health office. It is important to keep a supervision file for each of the facilities that your office is responsible for supervising. Any
member of your staff who decides to visit a health facility should review the file of that particular facility before the proposed visit. Where possible the staff can follow up on some of the actions agreed to during the last supervision visit.

It is crucial to ensure that health system performance gaps (clinical and management/administrative) identified during supervision are addressed through appropriate capacity building and quality improvement interventions. (see ANNEXES 4 and 5: Conducting a Supervision visit and the Reporting Template, respectively). Where considered necessary, unannounced visits to health facilities may be conducted.

**Utilizing Health Information and Evidence**

You must have a clear and in depth understanding of the function and relevance of the National Health Information System (NHIS) in health service delivery. You must be familiar with the various data collection instruments/forms currently in use and ensure that all your staffs are familiar with these as well. If not, make the necessary arrangements for you and your staff to be trained on the NHIS, data collection, compilation, analysis and use in decision making.

Make sure you are familiar with the 29 core indicators (as may be revised from time to time) that are in the Performance Assessment Framework (PAF) of the National Health Plan. These indicators are defined in the NHIS System Monitoring and Evaluation Strategy and Plan and monitored through Sector Performance Annual Reports. The Sector Performance An-
Annual Report details the various aspects of health sector performance at national, provincial and district levels. Make sure that the District Health Team and Officers in Charge of health facilities have copies of these reports as and when they are published. The report has health profiles for every district in the country – thus making it easy for your district to compare its performance against that of other districts in the country.

Ensure that district population figures and health facility catchment populations are always up to date and based on the most recent population census figures. The catchment population for health facilities must be updated every year. Accurate catchment populations will contribute to improved accuracy in calculating coverage statistics for health programs. Work with the Provincial Health Information Officer to get the latest population figures for your district or health facility catchment population.

Ensure staffs at all health facilities in the district abide by prescribed monthly deadlines for the submission of National Health Information reports. Remember the discharge data from the district hospital if there is one. **Follow up on health facilities that do not submit reports on time, check on completeness and correctness of health information provided.** Discuss monthly NHIS submissions from health facilities with your program officers at the district office before they are submitted to the Provincial Health Information Officer. Health information must be a standing agenda item at your monthly management meetings.
Always give feedback to Officers in Charge of health facilities on any issues that arise from the data they submit. Feedback is useful to keep staff motivated to continue submitting the data. At least they know that someone is making use of the data they submit.

Discuss any signs of progress, regression or stagnation in the performance of the district. Management meeting discussions on health information must be complemented with regular district (Quarterly) Performance Reviews. These reviews should bring together the District Health Team and all the Officers in Charge of Health Centers in the district – including those from church health facilities, NGOs and private for profit providers of the health services operating in the district. Train your health facility staffs on the use of routinely collected data to determine health priorities, identify performance gaps, monitor health trends, evaluate programs, and identify areas for replication and dissemination. (See ANNEX 3: The District Quarterly Review format/template).

Evaluation is about looking back at the complete picture, the good and the not-so-good, and being able to account for these.
It lays the foundation for the next planning cycle and is about answering some of the following questions:

- How much resources did we use overall?
- What has been the impact of the resource utilization and implementation of activities?
- Could we have achieved better results with a different approach? Could it have been done better?
- Did the services and programs address current basic health needs and future health needs?
- How efficient were we in utilizing available resources?
- Did the community receive equal access for equal need and did we address equity issues?
- What were the pitfalls and constraints?

**Bottleneck Analysis**

You can use the bottleneck analysis approach to assess the function of district health service delivery, in terms of *effective coverage, access and utilization* of services. Ideally health services should be accessible to all individuals who constitute the target population of an intervention, i.e. potential coverage. However, for a variety of reasons, only a proportion of the target population actually uses the available services. There is always a gap between “potential coverage” (100% coverage) and actual coverage (effective coverage). The bottleneck approach evaluates six determinants that affect the achievement of effective service coverage:
• **Availability of essential health inputs** (e.g. drugs, vaccines, equipment)

• **Availability of human resources**

• **Accessibility of health facilities** and outreach points can be affected by physical barriers, distance, travel time, etc.

• **Initial utilization of services** (interventions) - this is first use of health services such as first antenatal visit. This helps in analysis of the gap between supply and demand of services

• **Continuous coverage**— this indicates the extent to which the full course of contact or intervention required to be fully effective is achieved e.g. proportion of children receiving full immunization

• **Effective coverage**— this reflects the quality of intervention which is the minimum amount of inputs and processes sufficient to produce the desired health effects; e.g. complete immunization is necessary but insufficient; the child should receive all vaccines, on time, vaccines of good quality and potency, all administered with a sterile syringe. (see diagram on bottleneck analysis at district level)
Determinants of Effective Service Coverage

Causal factors leading to Supply, Demand and Quality Bottlenecks

**Determinants from Quality**
- Effective Coverage: Quality/Impact
- Continuous Coverage and Completion
- Initial Utilization: Proportion of Service Capacity Used
- Accessibility: Physical Access of Services
- Availability: Human Resources for Health
- Availability: Essential Health Commodities

**Determinants from Demand**
- Causality: Adherence to Protocols
- Causality: Community Involvement

**Determinants from Supply**
- Causality: Managerial Shortcomings
- Determinants from Supply

**CAUSALITY CAUSATION COMMUNITY INVOLVEMENT**
- Service Delivery Platform: Community Based - Outreach Services - Facility Based

- Minimum amount of inputs & processes enough to produce desired health effect
- Extent to which full course of interventions to be fully effective was achieved
- Physical accessibility of service delivery points ( Ease with which clients can access facility, outreach session)
- Sufficient and skilled workforce (trained to provide quality and effective interventions or services)
- Critical Health System Inputs: Drugs, Vaccines, other commodities

- First use of, or contact with service or intervention (Affordability, Acceptability)
- Physical accessibility of delivery points ( Ease with which clients can access facility, outreach session)
- Sufficient and skilled workforce (trained to provide quality and effective interventions or services)
- Critical Health System Inputs: Drugs, Vaccines, other commodities

**DETERMINANTS FROM SUPPLY**

**DETERMINANTS FROM DEMAND**

**DETERMINANTS FROM QUALITY**

National Department of Health

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8. SCOPE OF DISTRICT HEALTH SERVICES AND PROGRAMS

As the District Health Manager you will oversee and coordinate the work of a team of health professionals tasked with implementing a number of public health programs and providing facility based health care services. Ensure that officers responsible for any of the programs and health care services do so in accordance with national health policies, plans, treatment protocols/guidelines and standard operating procedures. It is your responsibility to ensure that annual program and service delivery activity plans are an integral part of the overall district health plan. Make sure that each officer documents evidence of implementing their annual activity plan.

Public Health Programs
These range from the Healthy Islands concept which aims to develop healthy communities and populations in healthy environments to the more complex delivery of public health programs. Public health programs include those for the prevention and control of communicable and non-communicable diseases; the provision of safe water supply and sanitation and waste disposal; provision of safe nutrition, food supply and food security; enforcement of policies or rules for the protection and promotion of health; freedom from tobacco use, alcohol and substance abuse.
In the context of delivering public (community) health programs, Village Health Volunteers are expected to conduct (monthly) home visits to households in their respective village; provide health education, screen for specific diseases, encourage health center visits, and monitor child growth and development. During household visits and through routine community sensitization events, Village Health Volunteers are expected to educate communities on key health messages, including hygiene and sanitation, encourage access to care at health facilities, malaria prevention, nutrition, family planning, maternal health and general health awareness.

**Disease Prevention and Control**

This program area consists of a composite number of disease prevention and control programs implemented as part of the overall district health plan. Program implementation involves a diversity of health professionals who include Medical Officers, Nursing Officers, Health Extension Officers, Community Health Workers, health facility Officers in Charge, Environmental Health Officers, Laboratory staff, Disease Surveillance Officers, support staffs, etc.

You must ensure that these programs are locally relevant, horizontally integrated and have linkages across program activities. It may be necessary to constitute technical working groups to address emerging and specific disease prevention and control activities in your district. To the extent possible, your staff complement must include a District Disease Control...
Officer whose responsibility is to lead and coordinate the various programs that fall under this category of programs.

<table>
<thead>
<tr>
<th>COMMUNICABLE DISEASES</th>
<th>NON-COMMUNICABLE DISEASES</th>
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<tbody>
<tr>
<td>• Expanded Program on Immunization</td>
<td>• Diabètes</td>
</tr>
<tr>
<td>• Malaria and other vector borne diseases</td>
<td>• Hypertension</td>
</tr>
<tr>
<td>• Neglected Tropical Diseases (e.g. Yaws, lymphatic filariasis)</td>
<td>• Cardiovascular Accidents</td>
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<tr>
<td>• Tuberculosis and leprosy</td>
<td>• Alcohol Related Illnesses</td>
</tr>
<tr>
<td>• Acute Respiratory Infections</td>
<td>• Malignant Diseases (Cancer)</td>
</tr>
<tr>
<td>• Sexually Transmitted Infections (STIs)</td>
<td>• Injuries</td>
</tr>
<tr>
<td>• HIV/AIDS</td>
<td>• Mental Health</td>
</tr>
<tr>
<td>• Food and Water borne Diseases (dysentery, Typhoid, Cholera)</td>
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</tr>
<tr>
<td>• Other diseases with a potential for outbreaks and epidemics (dengue, chikungunya)</td>
<td></td>
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<tr>
<td>• Disease Surveillance (acute flaccid paralysis, neonatal tetanus, measles, leprosy)</td>
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**Health Promotion, (Information, Education, Communication)**

Health Promotion is considered to be the backbone of all public health programs. It is a vehicle for empowering individuals and communities to take responsibility for their own health and to make healthy choices about their wellbeing. Health promotion has three main components: (i) Community action, participation and partnerships for sustainable local level health programs (ii) Research to identify individuals’ perceptions of health and health issues and (iii) Development and implementation of locally specific health promotion activities – including
the production of appropriate, accessible and affordable communication materials through traditional and popular media.

**Health Protection (Environmental Health Services)**
This program area aims to achieve sustainable development based on the protection and promotion of community health initiatives. This is achieved through implementation of water supply and sanitation programs (WASH), food safety and quarantine, and the promotion of safe health and work environments. These programs aim to improve access to safe water supplies, and sanitation, safe and clean air, enforce relevant legislation related to health protection, facilitate environmental health impact assessments and implementation of vector control programs, and ensuring adherence to International Health Regulations (IHR).

**Family Health Services**
This group of priority health programs aims to improve access to and to reduce maternal, neonatal, infant, childhood and adolescent conditions and deaths and to improve the quality of life – mainly of women and children. The program menu consists of safe motherhood initiatives (Sexual and Reproductive health, including Family Planning); neonatal and child health programs and services (including immunization and nutrition programs). These programs also aim to prevent, manage and control gender based violence as a cross cutting theme.
Oral Health Services
These services have promotive, preventive and curative components to their approach in schools and in the public arena. The program promotes oral health and the prevention of oral disease, the early detection, treatment and referral for specialized treatment.

Mental Health Services
Mental health problems are increasingly becoming very prevalent as a result of the rapid pace of development, introduction of new norms of behavior, evolving culture and the breakdown of traditional norms. These developments have brought about increasing rates of substance abuse (marijuana and alcohol), increases in domestic violence against women and law and order problems. The main strategy for the program area is to promote more community based care complemented by institutional care where community care is not feasible.

Rehabilitation and Ambulatory Care
This program is part of continuum of care which starts with promotive, preventive, curative and then rehabilitative care. Under rehabilitation are included physiotherapy, occupational therapy, counselling services, orthotics and prosthetic services – delivered as supervised outpatient treatment and home nursing care.
**District Curative Health Services - facility based care**

Curative health services are mainly facility based. In some circumstances these are delivered through mobile and out reach services. According to the National Health Service Standards (NHSS), the health delivery system consists of a vertical hierarchy of 7 levels of increasingly sophisticated health care services.

The district health system consists of 4 levels of health care service delivery. Level 1 which consists of Aid Posts – the first level of contact between the community and the formal health care system. Level 2 consists of Community Health Posts (CHPs) whose role is defined in the Community Health Post policy of 2014. Level 3 is the Rural Health Center or Urban Health Center depending on the geographic location of the facility. Level 4 is the District Hospital which is the highest level of service delivery within the district and is the first referral hospital within a district. The packages of health services and programs, minimal equipment and staff requirements and standard facility designs for each of these levels of care are defined in the National Health Service Standards of 2011.

The continuum of health care and patient referrals are expected to follow this ascending hierarchy of service delivery levels. Standard treatment guidelines and protocols provide the basis and guidance for patient management and referral to higher and comparatively more sophisticated levels of health care. Referrals are not necessarily to the next level...
which is immediately above the referring institution – but to the most accessible level that has the capability (trained staff, equipment, essential supplies, and infrastructure) to provide the required intervention. For example if a patient presents at a Community Health Post (level 2) and requires emergency surgery, the patient will normally be referred to Level 4 (District Hospital) or Level 5 (Provincial Hospital) and not necessarily to level 3.

**Disaster Preparedness and Response**

The district health system has a role in local disaster preparedness and response. The responsibility for coordinating district disaster preparedness and response rests with the District Administrator or Chief Executive Officer of the DDA. As District Health Manager you are responsible for coordinating the health response.

All disasters have some impact on community health needs and the functioning of local health services. Acute disasters – such as droughts (*el Niño* phenomena), floods (*la Niña* phenomena), earthquakes, landslides, social disturbances, volcanic eruptions — require emergency health services to come into play. Disease outbreaks and epidemics also fall under this category of disasters.

The District Health Manager must have access to up to date lists of addresses and telephone numbers of persons to contact in the event of a disaster and the latest version of the local District Disaster Mitigation Plan. The major referral institution—the District hospital—should have a hospital disaster/
emergency plan and should conduct emergency drills on disaster response, at least once a year. Acute disasters inevitably have an impact on health infrastructure – for example destruction of health facility buildings. In cases of slowly progressing disasters such as drought and crop failure, the consequences are usually difficult to detect and more long lasting.

**Disaster Mitigation Cycle**

1. Disaster Preparedness
2. Relief during and immediately after the disaster
3. Rehabilitation
4. Reconstruction

Health service inputs are required especially during the Disaster Relief and Rehabilitation period. All health staffs must be familiar with the District Disaster Mitigation Plan and trained on execution of the plan.
9. CONCLUSION

The PNG health delivery system faces a number of performance issues that have resulted in the deterioration of the quality of health care services and poor health outcomes. Whilst there are a number of challenges militating against efforts to improve health services, bolstering frontline health management is one approach that has the potential to offer high returns on investment.

As district health manager you will be required to interact with a number of stakeholders in terms of planning, implementing, monitoring and coordinating health programs and services, as well as to oversee the execution of national policies and strategies at the frontline of health service delivery. In most cases you will be expected to perform these responsibilities without the requisite training in management and leadership skills.

This hand book provides you with some pointers that can assist you to fulfill some of the responsibilities of planning and coordinating the delivery of public health services and to manage health sector resources within your district. Whilst you may not have attained the level of an expert district health manager, it is envisaged that you will be able to at least perform some of the following tasks without the benefit of an academic degree in these subjects:
• Implementation of community based health programs
• Supervision and control of health workers
• Organization and operation of district health programs and services
• Management of all public health facilities
• Coordination and supervision of all public, non governmental and private health systems
• Promoting active links with local government entities
• Preparation of the annual district plan
• Promotion of community participation in local level health service planning
• Raising additional local funds
• In-service training of health staffs
• Collection, compilation and dissemination of routine health information

Good luck!
LIST OF REFERENCES


21. National Department of Health, Papua New Guinea and Department of Foreign Affairs and Trade (DFAT, Australia)
ANNEXES
ANNEX 1.

SUSTAINABLE DEVELOPMENT GOALS
GOAL 3 TARGETS

GOAL 3: To ensure healthy lives and promote wellbeing for all at all ages

3.1. By 2030, reduce global maternal mortality ratio to less than 70 percent per 100,000 live births

3.2. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 percent per 1,000 live births and under five mortality to at least as low as 25 per 1,000 live births.

3.3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

3.4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well being

3.5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

3.6. By 2030, halve the number of global deaths and injuries from road traffic accidents

3.7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family plan-
HEALTH IN THE SDG ERA

1. Good Health and Well-being

ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES

1. Achieve universal health coverage
2. End preventable deaths of newborns and children under 5
3. End preventable deaths of women and adolescents
4. Combat HIV, tuberculosis, malaria and other major diseases
5. Improve maternal health
6. Ensure access to water and sanitation
7. Ensure access to affordable and quality health care for all
8. Promote healthy lifestyle and combat non-communicable diseases
9. Build healthy cities and communities
10. Protect the environment from unsafe chemicals
11. Promote sustainable consumption and production
12. Ensure availability and equitable access to information on health
13. Strengthen health systems
14. Support healthy work environments
15. Strengthen regulatory frameworks and promote quality health care
16. Ensure health and safety in occupations
17. Strengthen health information systems

Annexes 1. Sustainable development goals GOAL 3 TARGETS
3.8. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

3.9. By 2030, substantially reduce the number of deaths and illness from hazardous chemicals and air, water and soil pollution and contamination

3.a. Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

3.b. Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

3.c. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
3.d. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks
ANNEX 2.
MANAGEMENT OF ESSENTIAL DRUGS AT
FACILITY LEVEL

The District Health Manager is responsible for coordinating the procurement of essential drugs and medical supplies for the district. You will be held accountable for drug shortages that may arise in facilities within your district. The Officer in Charge of a District Hospital or Health Center is responsible for the day-to-day stock management and distribution of drugs and medical supplies to health facilities under his/her management. Some drugs are ordered from the Medical Stores—under the “pull system” and others are distributed and delivered under the “push” or “kit system”.

Under the “kit system”, drugs are delivered directly from the manufacturers through third party distributors to Aid Posts, Community Health Posts and Health Centers in the form of “drug kits”.

Essential drugs and medical supplies for the district hospital/health centers are ordered from Area Medical Stores on a two-monthly basis.

The 100% Kit for level 1 facilities is different from that of a level 2 facilities. You must ensure that all your health facilities have the “100% Kit Information Booklet” which details the contents of the kits for Health Centers and Aid Posts.
**Stock control**

You must be able to calculate minimum stock levels for health facilities so that you can assist staff to calculate the same. The basic formula for calculating minimum stock level is:

\[
\text{Total doses of average course of the drug} \\
\times \text{Usual number of patients treated with the drug within the ordering period/interval}
\]

E.g. **Panadols** needed = 6 tablets x 15 patients daily x 90 days (3 months)  
= 6 x 15 x 90  
= 8,100 Tablets of Panadol are needed every 3 months

Enforce simple stock control procedures at health facilities by encouraging and teaching staff to maintain accurate records at all times. All your facilities should maintain stock cards for each consumable item, including surgical supplies. If an item, e.g. Ampicillin, comes in different strengths, there should be a different card for each strength.

If the actual number available does not equal the amount that was the balance stated on the card, you should record ACTUAL amount and then investigate the reasons why there is a discrepancy.

The card should have columns to record information each time an item comes into or goes out of the store/dispensary.

- Date of receipt or issue
- Received from: indicate the name of where the stock was received from, the issue voucher number
• Issued to: indicate the name of the place where the items are being issued to, e.g. OPD, etc.
• Quantity received/ quantity issued – record in terms of numbers of units
• Balance in Stock: this is a running balance
• Signature: of the person responsible for the transaction

The minimum stock is the most important figure and is the basis of the stock control system and it must be recorded in the stock card and in the stock book carefully

Once a month – about the same time every month - just before making medical store orders – staff must conduct a physical count, i.e. count the actual correct stock balance and record this on the stock card. Draw a (red) line under the last balance entered on the card and make an entry.

Make sure that staff use near expiry date drugs first and place drugs with longer shelve life at the back of the shelves. Discuss with the hospital (provincial or district) pharmacist on arrangements to transfer near expiry or overstocked drugs to the hospital for faster consumption. Consult your provincial pharmacist for proper procedures for disposing expired drugs.
ANNEX 3:
QUARTERLY DISTRICT REVIEW REPORTING

QUARTERLY DISTRICT HEALTH REVIEW REPORT

PERIOD: Quarter 1 - Quarter 2 - Quarter 3 - Quarter 4

…………………… DISTRICT

District Health Profile

District Hospital

No. of health centers

Number of Community Health Posts

Total No. of Aid Posts

• No. of Aid posts open/operational

• No. of aid post closed

Children Under 1yr. of age:

Children 1-4yrs old;

Number of women (15-45yrs)

Number of Pregnant Women:

Number of Eligible Couple (CYP) for FP services

Date of Review:

Quarter under Review:
# Top Ten Causes of Morbidity and Mortality in the District

<table>
<thead>
<tr>
<th>Cause of Morbidity</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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<td>6.</td>
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<tr>
<td>9.</td>
<td></td>
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<tr>
<td>10</td>
<td></td>
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# Public Health Programs: Immunization (1)

<table>
<thead>
<tr>
<th>Vaccine/Antigen</th>
<th>1st Q</th>
<th>2nd Q</th>
<th>3rd Q</th>
<th>4th Q (Annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep-B (BD)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Pent-1</td>
<td></td>
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<tr>
<td>Pent-3</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Measles-1</td>
<td></td>
<td></td>
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<tr>
<td>Measles-2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>TT-1</td>
<td></td>
<td></td>
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<tr>
<td>TT-2</td>
<td></td>
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</tr>
</tbody>
</table>
Public Health Programs: Immunization (2)

Chart Title

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Quarter 1  Quarter 2  Quarter 3  Quarter 4

- BCG
- Hep-B
- Pent 1
- Pent 2
- Measles 1
- Measles 2
- TT-1
- TT-2

Public Health Programs: Antenatal Care and Deliveries (1)

<table>
<thead>
<tr>
<th>Number/Quarter</th>
<th>1st Q</th>
<th>2nd Q</th>
<th>3rd Q</th>
<th>4th Q (Annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st ANC Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4th ANC Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Facility Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Death (Health Facility)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Death (Community)</td>
<td></td>
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</table>
Public Health Programs: Antenatal Care and Deliveries (2)

Chart Title

<table>
<thead>
<tr>
<th>Quarter</th>
<th>1st Q</th>
<th>2nd Q</th>
<th>3rd Q</th>
<th>4th Q (Annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Out Reach Clinics - Planned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of Out Reach Clinic-Achieved/Conducted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of Mobile Clinic- Planned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of Mobile Clinic-Achieved/Conducted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of supervision visits Planned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of supervision visits conducted</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Public Health Programs: Outreach, Mobile Clinics and Supervision visits (Planned vs Achieved)

Annexes 3. Quarterly District Review Reporting
Public Health Programs: Out-reach, Mobile Clinics and Supervision visits - Planned vs Achieved

Chart Title

- Planned Outreach
- Achieved Outreach
- Planned Mobile Clinic
- Achieved Mobile clinics
- Planned Supervision visits

Public Health Programs: Tuberculosis (1)

<table>
<thead>
<tr>
<th>Indicator/Quarter</th>
<th>1st Q</th>
<th>2nd Q</th>
<th>3rd Q</th>
<th>4th Q (Annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Notification Rate/100,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Detection Rate (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sputum Conversion Rate (%)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Defaulter Rate (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Success Rate (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(%)= Cure rate + Treatment Completion Rate</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>% of TB Patients under DOTS</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>BMU reports completed and sent to PDCO</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Annexes 3. Quarterly District Review Reporting
**Public Health Programs: Tuberculosis (2)**

- Case notification rate
- Case Detection Rate
- Sputum Conversion Rate
- Default Rate
- Cure Rate + Treatment completion rate
- % of TB patients on DOTS

**Public Health Programs: Malaria**

<table>
<thead>
<tr>
<th>Number/Quarter</th>
<th>1st Q</th>
<th>2nd Q</th>
<th>3rd Q</th>
<th>4th Q (Annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of malaria patients diagnosed clinically</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of malaria patients diagnosed by RDT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stock out of Mala-1</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Stock out of RDT</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
### Public Health Programs: STI/HIV/AIDS

<table>
<thead>
<tr>
<th>Indicator/Quarter</th>
<th>1st Q</th>
<th>2nd Q</th>
<th>3rd Q</th>
<th>4th Q</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of STI Patients Diagnosed clinically (Syndromic approach)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total number of STI patients diagnosed by RDT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of STI patients under treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of confirmed HIV patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PICT/VCT service available</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Stock out of RDT/Drug</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
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### Human Resources for Health: Staffing Levels

<table>
<thead>
<tr>
<th>Staff Category</th>
<th>National Minimum Standards <em>(NHSS)</em></th>
<th>Current Situation</th>
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</thead>
<tbody>
<tr>
<td>District Health Manager/Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Extension Officer</td>
<td></td>
<td></td>
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<tr>
<td>Nursing Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Health Officer</td>
<td></td>
<td></td>
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<tr>
<td>Disease Control Officer</td>
<td></td>
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<tr>
<td>District Health Information Officer</td>
<td></td>
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<tr>
<td>Family Health Officer</td>
<td></td>
<td></td>
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<tr>
<td>Medical Laboratory Assistant</td>
<td></td>
<td></td>
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<tr>
<td>Pharmacy Technician</td>
<td></td>
<td></td>
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<tr>
<td>Health Promotion Officer</td>
<td></td>
<td></td>
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<tr>
<td>Dental Therapist</td>
<td></td>
<td></td>
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<tr>
<td>X-Ray Technician</td>
<td></td>
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</tr>
</tbody>
</table>

* National Health Services Standards (2011)
### Financial Resources: Funds Allocated for District Health Services for year 201...

<table>
<thead>
<tr>
<th>Category of Funds</th>
<th>Amount (PGK '1000)</th>
</tr>
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<tbody>
<tr>
<td>Planned costs as per AIP/AAP</td>
<td></td>
</tr>
<tr>
<td>Amount Allocated to District</td>
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</tr>
<tr>
<td>Total Amount Disbursed to date</td>
<td></td>
</tr>
<tr>
<td>Amount expected to have been disbursed to date(specify by Quarter)</td>
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</tr>
</tbody>
</table>

### Financial Resources: Total funds allocated by Program Area - For Year 201..

<table>
<thead>
<tr>
<th>Program Area</th>
<th>Amount PGK '1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health Administration and Support Services</td>
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<tr>
<td>Family Health Services</td>
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<tr>
<td>Disease Control</td>
<td></td>
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<tr>
<td>Environmental Health</td>
<td></td>
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<tr>
<td>Health Promotion</td>
<td></td>
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<tr>
<td>HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>Medical Supplies and Equipment</td>
<td></td>
</tr>
<tr>
<td>Human Resources Development (Training)</td>
<td></td>
</tr>
<tr>
<td>Total (should be the same as total allocated to district)</td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 4:  
CONDUCTING A SUPERVISION VISIT

Planning for the Supervision Visit

- Supportive supervision requires staff time, costs for per diem, and travel to remote sites.
- Aim to focus more on problem solving to improve performance than inspection and fault finding.
- Plan to spend sufficient time (from several hours, to a full day or more) to conduct the supervisory visit. The amount of time will vary depending on the needs of the health facility. In some cases a two-day visit would be more effective than just one day. It allows the supervisor enough time to meet health workers to discuss performance goals as well as to meet with the community.
- Make a plan that covers the whole year and is agreed with the rest of the District Health (Management) Team so that every member plans their activities accordingly.

Think through exactly what you will do while on-site. Examples of specific activities you might undertake include:

- Hold an informational and planning meeting with the staff
- Observe specific (clinical) procedures and or practices
- Examine supplies and equipment and facility infrastructure
- Observe patient/client-provider interaction
- Hold discussions with patients/clients
- Examine patient/client records
- Examine inventory records
- Help staff to conduct self-evaluations
- Examine statistical information
- Hold a meeting to address specific problems
It is important that Local government authorities are made aware of proposed supervision arrangements. The Provincial Health Office or Provincial Health Authority should also have a copy of the supervision plan.

- Open supervision files for each of the facilities that the supervisors are responsible for.
- Develop the objectives of each visit to be undertaken. Before visiting a facility review the previous supervision report of the particular facility and take into consideration issues raised in previous visits.

The supervision checklist is based on assessing several key areas in clinical and/or program delivery. Check the elements under review during a particular supervisory visit (see checklist for list of key areas)

- Ensure joint problem solving and follow-up on previously identified problems
- The checklist only serves as an aid to supervision and is aimed at systematically evaluating the various elements of health service/program delivery and provides an opportunity for the supervisor to identify areas where health workers need additional assistance in technical and problem solving skills.
- It is a tool to assess adherence to national policy and its impact at the district, facility and community levels.
- Above all, supervision requires a budget which can be developed using district-level micro planning to estimate what resources are needed for regular and effective supervision.
**The Supervision visit**

As a supervisor you must demonstrate technical, communications and management skills. You must be able to transfer skills and knowledge and facilitate problem solving by the health facility team. Use an inclusive style of communication and make use of the supervision instrument (checklist) to document what is observed during the visit. Hold a meeting with the in-charge and his/her staff at the facility.

- Greet the staff on arrival, show patience and respect when dealing with the in-charge and others throughout the visit.
- Allow the staff to complete any consultations underway and for any handover and meet with staff.
- Practice active listening during the discussions and throughout the interactions.
- Give compliments for jobs well done, new initiatives and innovations.
- Correct errors and wrong practices gently and constructively rather than criticizing or scolding.
- Assist, involve and encourage staff to identify problems.
- Observe service provision and patient/client provider interaction.
- Discuss and analyze with the staff the routine statistics that are collected and submitted and services provided.
- Examine patient/client records.
- Observe work conditions.
- Discuss services with patients/clients and others.
- Help staff conduct self-assessment.
During this meeting, review with staffs the problems and strengths identified during the last visit and ask about progress made toward resolving problems previously identified and any new problems that may have surfaced. Find out what has gone well for the facility/site.

At the end of this initial meeting, all staff should be aware of the objectives of the supervision visit, and should understand how the visit will take place. It should be clear to the supervisor and all staff which areas of the facility will be the focus of the visit.

Give staff practical and workable suggestions on how they can obtain the supplies, equipment and other materials they need to do their work well.
**Immediate Feedback**

- Meet again with staff, summarize and conclude the visit:

  - Acknowledge progress made since the last visit
  - Identify priorities and discuss any issues that need immediate attention
  - Discuss available resources for problem solving
  - Establish a plan for addressing priority issues
  - Discuss follow-up activities that the in-charge will need to undertake

- Summarize specific aspects of care going on well and commend them.
- Summarize specific aspects that need change and discuss what needs to be done and how.
- Share with staff as a group the supervisor’s general impressions on what is going on well and what needs further improvement based on the supervisor’s findings.
- Score the checklist and discuss the result of the percentage scores

**Establish a follow-up plan.**

- Thank staff for their dedication to work.
- Schedule the date for the next supervisory visit, if possible.
- Complete the supervision register and **Supervision Report Form**, noting principal observations, strong points, areas that need improvement and recommended actions.
Complete the supervision report within a week after the visit. The Report should complement the notes left at the site.

*The report should include at least:*

- The action plan established with the staff on-site.
- The recommendations made by the supervisor.
- Follow-up on problem solving, as an active partner or through delegation.

The supervision report should be submitted to the facility/site where supervision took place, the district and provincial offices.
## ANNEX 5: SUPERVISION REPORT TEMPLATE

| PROVINCE |  |
| DISTRICT |  |
| NAME OF AID POST/COMMUNITY HEALTH POST/HEALTH CENTER |  |
| GOVERNMENT/CHURCH/NGO/PRIVATE SECTOR |  |
| DATE OF SUPERVISION |  |
| NAMES OF SUPERVISION TEAM |  |
| NAMES OF STAFF SUPERVISED |  |

**POSITIVE FINDINGS**  
Including acknowledgement of actions taken following the last supervision recommendations

**WEAKNESSES AND GAPS IDENTIFIED**

**RECOMMENDATIONS AND/OR ACTION TO BE TAKEN**

**NAMES AND SIGNATURES OF SUPERVISORS AND SUPERVISEES**

| Supervisor |  |
| 1. |  |
| 2. |  |

| Supervisee |  |
| 1. |  |
| 2. |  |