Independent State of Papua New Guinea

Ministry of Health

NATIONAL HEALTH PLAN 2001 – 2010

HEALTH VISION 2010

POLICY DIRECTIONS AND PRIORITIES

VOLUME I

TABLE OF CONTENTS

MAP OF PAPUA NEW GUINEA	ii
FOREWORD	iii
ACKNOWLEDGEMENTS	v
INTRODUCTION	1
BASIS OF THE PLAN	2
Lessons from the Past	2
The Current Situation	3
The Political Directives	4
The Legislative Framework	4
The Foundations for Future Progress	6
THE WAY FORWARD	8
The Vision	8
The Mission	9
The Challenge	9
The Goal	9
The Policy and Strategic Framework	9
Policy Direction and Priorities	10
THE IMPLEMENTATION FRAMEWORK	18

FOREWORD

As Papua New Guinea enters the new millennium, it has taken the opportunity to assess its successes in meeting its obligation to promote and protect the health of its people. Health policies and priorities have been reviewed and the National Health Plan 2001–2010 developed with a view to putting Papua New Guinea on the path to progressively realising its obligations within the first decade of the new millennium.

The right to enjoy the highest attainable standard of health and to provide facilities for the treatment of illness and rehabilitation are fundamental human rights belonging to all citizens of Papua New Guinea. Under the National Constitution and international human rights instruments, the State has made a solemn commitment to the people of Papua New Guinea to respect, promote and protect their rights. Although progress has been achieved in some fronts there is much work to be done to fulfil our obligations and promises. In particular, priority must be placed on the health and development of our children, who are the future of our country and our most valuable resource.

The National Health Plan 2001–2010, of which this volume is a significant part, becomes the policy framework within which all health services must be planned and implemented. The Policy Directions and Priorities in this volume initiate the complex process of planning for health services that will be provided for all Papua New Guineans as we enter the new millennium.

The process was initiated following the National Executive Council directives for the National Department of Health to incorporate the recommendations of the mid-term review of the National Health Plan 1996-2000 into this Plan and to have it completed by the end of 1999.

The Plan is a result of collaborative effort between stakeholders within the health sector, other government agencies, churches and other non-government organisations, international partners, the corporate sector and community representatives.

The goal of the Plan is to improve the health of all Papua New Guineans through the development of a health system that is responsive, effective, affordable and accessible to the majority of our people. This goal is in line with the *National Goals and Directive Principles* as enshrined in the Constitution.

The priority during the Plan period will be to ensure that the people of Papua New Guinea, in particular women and children, attain good health. This will be achieved through access to health education, elimination of immunisable diseases, safe motherhood, control of priority diseases, good nutrition, safe water supply, quality patient care and effective collaboration with all partners.

Given the complexity of the issues, the enormity of the challenge and the scarcity of available resources, the policy framework and the priorities outlined in this Volume and detailed in Volume II of the Plan will guide provinces and districts to develop their 5–year strategic implementation plans.

The Plan clarifies the roles and responsibilities at all levels of governments. The challenge now is for all those levels of government to provide the leadership and resources required to implement the Plan. In order to ensure that health services are effective and sustainable, resource allocators and health service providers must be made accountable to the people they serve.

The people of Papua New Guinea must not merely be passive recipients of government services, but active participants. They must be empowered to take greater responsibility for their own health and to play a greater role in the design and implementation of programs that affect them.

I believe the identified priorities and objectives in the Plan can be successfully achieved through collaboration and in partnership with other government agencies, churches and other non-government organisations, the corporate sector, international development agencies and the community.

I look forward to attaining an improved level of health status for our people and a brighter and healthier future for our nation.

As Minister responsible for health, I have great pleasure in introducing the first National Health Plan for the new millennium.

May God bless our people and a united Papua New Guinea.

Hon. Ludger Mond, MP
Minister for Health

ACKNOWLEDGEMENTS

This is the fifth National Health Plan developed since the first plan in 1974. Many lessons have been learnt over the years as well as valuable experiences which all contributed to the formulation of this excellent Plan, the first of the new millennium.

During the two years spent developing this Plan there has been an enormous amount of work by many individuals and organisations in a highly collaborative, consultative and professional manner.

I am extremely satisfied that the National Health Plan 2001–2010 is a home-grown, high quality and clear blueprint for health sector development for the next ten years.

To the many individuals and organizations who made meaningful contributions to the development of this Plan, I express my heartfelt thanks and gratitude. Many have contributed but those who deserve special recognition are:

- Members of the Ministerial Task Force;
- Members of the Secretariat and Working Committees;
- Central Agency Representatives;
- Provincial Administrators, Health Advisers and District Representatives;
- Chief Executive Officers of Public Hospitals;
- Papua New Guinea Institute of Medical Research Staff;
- Staff of School of Medicine and Health Sciences;
- Church Representatives;
- Health Workers' Union Representatives;
- AusAID Staff and Technical Advisers;
- WHO, UNICEF and UNFPA Representatives and Staff;
- Japanese International Cooperation Agency Representative.

I would like to express a special note of appreciation to AusAID for funding the consultative and training workshops, technical assistance, and the printing of the four volumes of the Plan, and for supporting the development of 5-year strategic implementation plans.

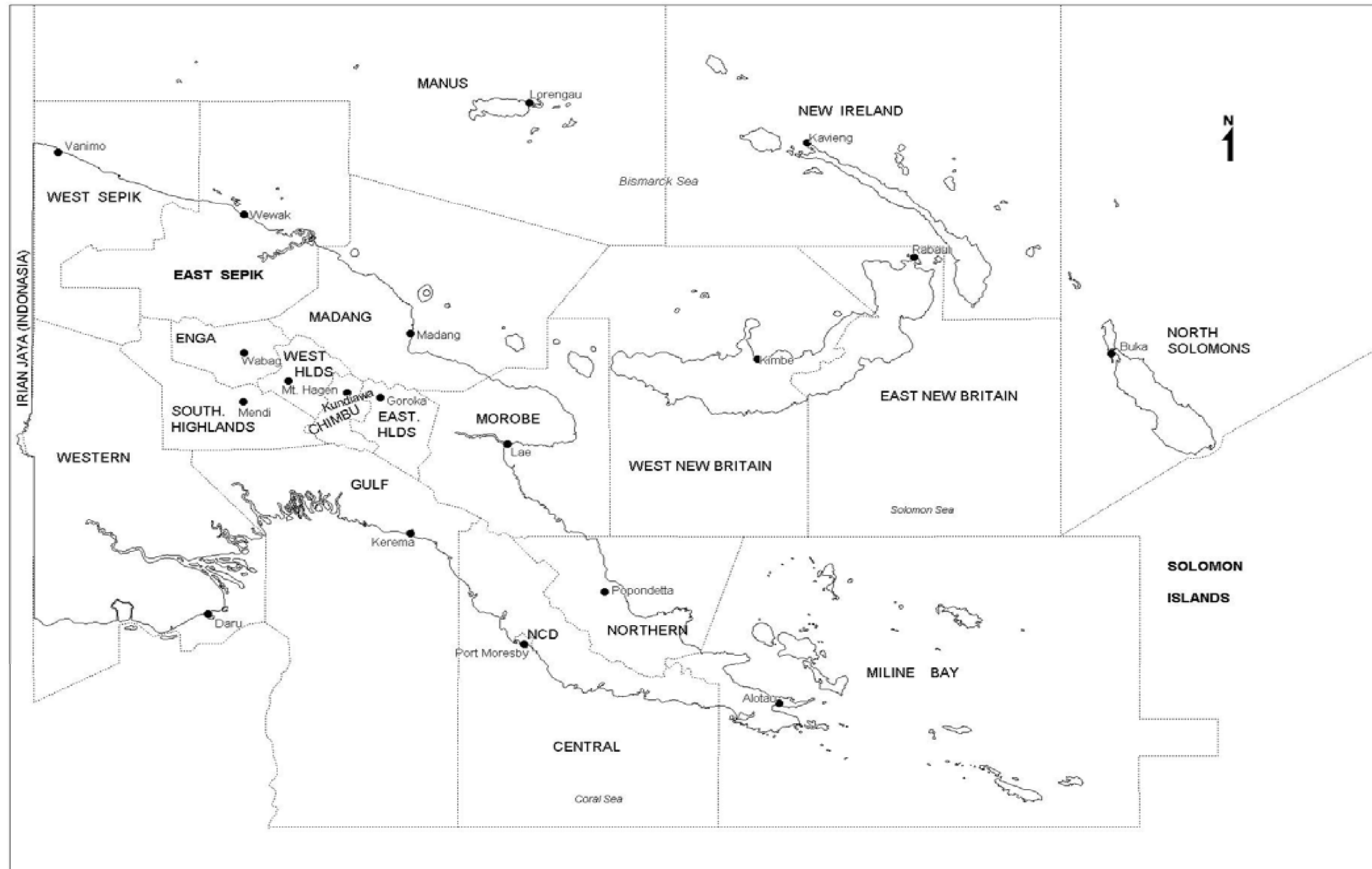
A special note of appreciation also goes to the World Health Organization for providing technical assistance throughout the process.

With God's grace and leading, this monumental and important task was completed.

I join the Minister for Health in commending this Plan to the people of Papua New Guinea.

Puka I. Temu (Dr.)
Secretary for Health

MAP OF PAPUA NEW GUINEA



INTRODUCTION

The National Health Plan 2001–2010 comprises four volumes. This volume of the Plan outlines the overall policy directions and priorities for the health sector over the next ten years. Volume II contains details of the specific program policies and strategies. Volume III is presented in 2 parts. Part 1 provides national health statistics and comparative tables while Part 2 provides disease statistics, levels of program coverage and information on staff and facilities by province and district. Volume IV provides the guideline for strategic implementation planning at all levels.

This volume outlines the basis of the Plan and prescribes the way forward through a shared vision, a single goal and clear policy direction and priorities. It further defines the implementation framework for resourcing, monitoring and evaluating the Plan.

Priorities identified in this volume are based on the overall health situation and were agreed upon at the consultative workshops. Resources for health in Papua New Guinea are limited. To address priority health concerns cost-effective interventions have been identified in the Plan. If implemented fully these will bring about the widest possible health outcomes in a sustainable manner.

Priorities identified below deserve the most attention, given the scarcity of available resources and the priority health concerns of the country. These are:

- health promotion;
- family health, with a focus on women's and children's health;
- elimination, eradication and control of priority diseases;
- health protection;
- human resource management;
- strengthening district health and hospital services;
- improving access to medicines and medical supplies;
- strengthening partnerships.

The Plan also allows for greater flexibility to develop and implement programs based on future trends and local health priorities.

Given the strong political commitment to the health sector, the legislative framework under which the health services will be administered and the clear policies and priorities, Papua New Guinea has all the necessary ingredients for attaining further progress in the health sector over the next 10 years. Many positive health sector achievements have been realised over the last five years. This has built a firm foundation on which further sustainable progress will be made.

The first decade of this new millennium gives us the opportunity to address the many health challenges in a systematic and sustainable manner. The implementation of the policies and priority health programs outlined in the Plan will guarantee further progress towards the goal of improving the health of Papua New Guineans.

BASIS OF THE PLAN

LESSONS FROM THE PAST

The management and administration of the public health system prior to decentralization after Independence was centralised with highly vertical programs and their implementation was focused at the district level. Health programs were highly integrated with the medical officers playing the key leadership role at the district level and strongly supported by the provincial health office and the hospital. The centralised control ensured easier and more effective management of resources and delivery of planned activities. This resulted in marked improvements in the health status indicators of the people.

Following independence the introduction of the *Organic Law on Provincial Government* legitimized the decentralization of the management and administration of all government services including health. Under this Organic Law, health services were divided into transferred, delegated or national functions. There was poor definition of roles and responsibilities between the national and the provincial governments.

This arrangement led to the deterioration of health status indicators from 1981 onwards. Attempts to address this situation through the development of several national health plans were not successful. Plans were developed by national technical program managers with insufficient baseline health data and little or no consultation with provinces and other stakeholders. Provinces were left to develop their own health plans in isolation from the national health plan. This led to the loss of a unified direction and leadership from the national and provincial levels.

The collapse of the national health system was due to decentralization of resources management, lack of control and coordination, withdrawal of doctors from district health centres, the creation of large provincial hospitals, and lack of political will and commitment. Further, support to rural health from provincial health offices and hospitals became less and less and was eventually discontinued in the mid-eighties due to the withdrawal of vehicles and funding. By the early nineties the rural health system had come to a standstill.

This contributed to a complete lack of direction, low staff morale, poor performance and a lack of community confidence in the health system.

The new *Organic Law on Provincial Governments and Local Level Governments* introduced in 1995, which called for effective delivery of government services to the rural population, was an attempt to rectify this situation.

THE CURRENT SITUATION

The poor status of the health of the people has been well publicized and acknowledged. The progress made prior to 1981 has not been sustained and has worsened in some areas. As far as the nation is concerned there are five major issues affecting the national health system and the health of the people. These are:

- The health of the people, in particular rural women and children, is not improving. They are still dying from easily preventable and treatable diseases. Currently in Papua New Guinea:
  - 15,000 babies less than 1 year old die every year.
  - 13,000 children from 1 to 4 years old, die each year before reaching their fifth birthday.
  - 220,000 out of the possible 560,000 children under 5 years are not receiving proper nutrition.
  - 3,700 mothers die each year from complications of childbirth.
- Resources are limited
  - Real per capita spending on health is declining.
  - The Standard 10 Health Program Budget is not fully implemented.
- Management is inefficient.
  - There is a need to improve management capacity at all levels.
- Accessibility to basic health services is inadequate:
  - Services are still unevenly distributed with rural areas being most disadvantaged.
  - Half of all children are not immunized.
  - 60% of pregnant women are not supervised during childbirth.
  - A large number of aid posts are closed.
  - 70% of rural communities do not have access to safe drinking water.
  - 55% of the people are illiterate and the diversity of languages makes health messages inaccessible.
- Community support for health services is poor and individuals and communities are not encouraged to improve and maintain their own health.
  - Health staff are frequently harassed, equipment stolen and facilities vandalized.
  - Communities are not involved in planning and implementing health programs.
  - Many parents do not bring their children to receive basic health services such as immunisation.
  - Health workers do not frequently undertake public awareness and community education.

In the light of these challenges, resources will be focused on priority programs and rural health services. National and provincial strategic implementation plans should demonstrate how these key focused areas will be addressed during the Plan period.

THE POLITICAL DIRECTIVES

The development of the National Health Plan 2001–2010 was initiated by the National Executive Council directives for the National Department of Health to incorporate the recommendations of the Mid-term Review of the National Health Plan 1996-2000 into this Plan.

The directive reflected in National Executive Council Decision No. 251/98 forms the basis of this Plan. In it the National Executive Council directed:

- The National Department of Health to incorporate the Mid Term Review recommendations in the next health plan;
- The National Department of Health to complete the next health plan by the end of 1999 thus allowing provinces and districts adequate time to prepare their strategic implementation plans;
- The Department of Treasury and Planning and Department of Provincial and Local Level Government Affairs to implement program budgeting in Health;
- The increases in funding for medical supplies to offset the sliding of the Kina against the major currencies;
- The National Department of Health to develop minimum standards for rural health services;
- The National Monitoring Authority to support the National Department of Health in monitoring the implementation of the National Health Plan in the provinces.

In response to this National Executive Council directive, the Minister for Health established a Ministerial Task Force in 1998 to oversee the development of the National Health Plan 2001 – 2010.

THE LEGISLATIVE FRAMEWORK

The *Organic Law on Provincial Governments and Local Level Governments* was passed by the National Parliament in 1995 to address the issue of poor delivery of essential government services. Section 42 of the *Organic Law on Provincial Governments and Local Level Governments* provided powers for provincial legislatures to make laws on rural health. However, “rural health” was not defined. This necessitated the development of enabling legislation to define “rural health” and the different powers, functions and responsibilities of the three levels of governments and their respective administrations.

The National Health Administration Act (1997) passed by Parliament in December of that year defines “rural health” and how the public health system is administered between national, provincial, and local level governments. “Rural health” is defined as those facilities and services delivered outside of the public hospital system.

The purpose of the National Health Administration Act is to clarify any confusion that might occur in the implementation of national health policies.

In summary this is the framework under which the public health system should be operating.

Policy Framework

- The National Health Plan is the basis of all health policy. It is carried into effect through national health standards and operative directions.
- Provincial Governments are bound by the National Health Plan and national health standards.
- The Secretary for Health may give technical and policy directions to all staff carrying out health functions, including non-government health service providers.
- Provincial Governments should develop their own planning framework to implement the National Health Plan and formulate provincial implementation plans.

Administration of Health

- The main function of the National Government is to oversee the implementation of national policy. It has a role to coordinate and provide technical advice and the support lower levels of governments.
- Provincial Governments are responsible for service delivery through staff at district level. They must also fund health activities.
- Local Level Governments are responsible for funding health activities and should participate in planning for health.
- Public hospitals also have specific functions to support rural health care delivery.

Provincial Health Laws

- Provincial health laws can cover health administration as well as regulation of rural health.
- Provincial Governments can set up their own district health committees and give extra health powers to Provincial Health Boards under their own legislation.

Roles and Responsibilities

- The National Health Administration Act (1997) gives legal responsibilities to certain office holders within the provincial administration.
- Provincial and District Administrators have legal responsibilities to ensure the National Health Plan is implemented.
- An important position is the representative of the National Department in the provinces — “Section 21 Appointee”— who will be the provincial health adviser in most cases. This person is the main link between the National Department of Health and health staff in the provinces.

National Health Board

- The membership of the National Health Board consists of representatives from government, the health sector, the community and health care professions.
- The main functions of the Board are to provide advice to the Minister and liaise and coordinate with other levels of government and health care providers to monitor the implementation of the National Health Plan.

Provincial Health Boards

- Membership of the Provincial Health Board consists of representatives from government, the health sector, the community and non-government health care agencies.
- The main functions of the Board are to provide advice to the Provincial Governments on the implementation of the National Health Plan, and to liaise and coordinate health services.

District Health Management Committees

- The members of the District Health Management Committees represent government, churches, the community, women and health service providers in the district.
- The main functions of the Committees are to liaise and coordinate health services and provide advice to the Joint District Planning and Budget Priorities Committee.

Finances, Planning and Information

- The National Health Administration Act allows provincial health budgets to be monitored to ensure that there is adequate provision for health.
- Governments that provide funding for health services can enter into agreements. The agreements clarify which services are being purchased with the funding and what will happen if it is not spent correctly.

Withdrawal of Health Functions

- The National Executive Council may withdraw health functions and or withhold finances for health functions if health services continue to deteriorate below minimum standards and there is continued deterioration of the health status of the people.

THE FOUNDATIONS FOR FUTURE PROGRESS

A firm foundation for sustainable development in health exists today due to the efforts of health care providers, both within and outside of government service. The following are the some of the key achievements:

- The National Health Administration Act (1997) has been enacted.
- Program budgeting in health through the Standard 10 Health Program Budget is a national policy requirement for rural health service budgets.
- Minimum standards for district health systems and public hospitals are in place.
- The national drug policy has been approved and legislation enacted.
- Nationwide training in planning and budget development to the district level is continuing.
- National Immunisation Days programs have been successful.
- Donors are involved through project support.
- Donor assistance can now be more effectively managed and channelled to implement the National Health Plan through the Health Sector Improvement Program.

- A multisectoral response program on HIV/AIDS through the National AIDS Council and its secretariat is being implemented.
- Advances have occurred in various training programs, especially in nursing, allied health and specialist clinical and public health.
- A National Centre for Health Promotion has been established and is producing and distributing quality health communication materials.
- The numbers of health patrols and extension services are beginning to increase.
- The National Health Information System is significantly better than it was in the past and has the capacity to collect, interpret and report data. Reporting rates are above 90%.
- The *Demographic and Health Survey* (1996), completed with the support of the National Department of Health, has assisted with the reformulation of strategies for maternal and child health programs.
- Family planning training has led to increased new acceptor rates nationwide.
- The Directly Observed Treatment Short-course tuberculosis program has been successful in the National Capital District and Lae and will be extended nationwide.
- Poliomyelitis has almost been eradicated while leprosy is about to be eliminated in the country.

A mammoth task remains beyond these important and positive achievements. While the challenge is great, there is also a greater opportunity and the potential to make significant gains during the lifetime of this Plan.

THE WAY FORWARD

Entering the new millennium with many prevailing health challenges provides an opportunity for the nation to build on the many important lessons and valuable experiences of the last 25 years and chart out the path and capture a new vision for health sector development in the 21st century. By focusing attention and resources on priority health programs Papua New Guinea will achieve the greatest impact on the health of its people.

To achieve this, the Plan provides a clear vision, a single goal and a set of key priorities to guide the development of effective and quality health services.

THE VISION is for Papua New Guinea to be a nation of healthy individuals, families and communities where self-reliance prepares all for healthy living in a healthy island environment.

To be a nation of healthy individuals, families and communities and in the spirit of the National Goals and Directive Principles as enshrined in the National Constitution, Papua New Guineans prefer a future in which:

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

HEALTH VISION 2010

Classification	Indicator	1996	2005	2010
Health Status	Average life expectancy (age in years)	54.5	57.0	60.0
	Infant mortality rate per 1,000	77	65	53
	Childhood mortality rate per 1,000	23	20.5	18
	Maternal mortality ratio per 100,000	370	315	260
Program Coverage	Supervise delivery (%)	45	57.5	70
	Immunisation (%)	50	70	90
	Malnutrition rate (%)	43	32	21
	Safe drinking water (%)	30	40	50
Disease Prevention	Malaria death rate per 100,000	12.9	9.7	6.5
	Diarrhoeal death rate per 100,000	1,610	1,405	1,200
	Tuberculosis treatment completion rate	38	54	70
	HIV sero-prevalence rate — High risk population (%)	0.26	20.00	20.00
	HIV sero-prevalence rate — Low risk population (%)	0.01	0.30	0.30

THE MISSION is to monitor the physical, social and mental wellbeing of people in their communities, and to promote and encourage the maintenance of community health at an acceptable level by planning and delivering preventive and curative medical and other health services.

THE GOAL is to improve the health of all Papua New Guineans through the development of a health system that is responsive, effective, affordable, acceptable and accessible to the majority of the people.

THE CHALLENGE is to empower individuals, families and communities to take responsibility for their own health and involve all levels of governments and other partners to work together as a nation towards achieving the goal of the National Health Plan.

THE POLICY AND STRATEGIC FRAMEWORK

To address the major health challenges and to effectively implement the policies and priority health programs, the Plan follows a policy and strategic framework where:

- health promotive and health protective services will be revitalised through the Healthy Islands Settings Approach;
- the majority have access to quality basic health services;
- the limited specialist care services will be equitably distributed;
- health workforce training will be oriented towards service needs with more emphasis on management training and improved clinical and technical skills;
- service delivery is improved through adherence to minimum standards;
- cost-effective, well-tested and technically sound interventions are used;
- positive health outcomes will be achieved through health reforms and in partnership with other government sectors, churches and other non government organisations, the corporate sector and the community.

This framework is based upon the National Constitution of the Independent State of Papua New Guinea, the Eight Point Plan adopted at Independence, the *Medium Term Development Strategy 1997–2002,* the *Mid-term Review of the National Health Plan 1996–2000* and the *National Population Policy 2000–2010.*

The Plan also incorporates international and regional agreements to which the Independent State of Papua New Guinea is a signatory. These include the:

- *Declaration of Alma Ata* (1978);
- *Convention on the Elimination of All Forms of Discrimination* (1979);
- *Convention on the Rights of the Child* (1989);
- *World Summit for Children* (1990);
- *Jomtien Declaration*, on education for all (1990);
- *Rio Declaration of the United Nations Conference on Environment and Development* (1992);
- *Program of Action of the International Conference on Population and Development* (1994);
- *Granville Declaration on Emergency Action for Women's Development* (1995);

- *New Horizons in Health* and the *Yanuca Island Declaration of Healthy Islands Settings Approach* (1997).

POLICY DIRECTIONS AND PRIORITIES

Given the complexity of the issues, the enormity of the challenge and the scarcity of available resources, priorities for the National Health Plan are:

- health promotion;
- family health, with a focus on women's and children's health;
- elimination, eradication and control of priority diseases;
- health protection;
- human resource management;
- strengthening district health and hospital services;
- improving access to medicines and medical supplies; and
- strengthening partnerships.

In planning to achieve the goal of the Plan over the next ten years, the policies and directions will be focused on the eight priorities listed above. The following is a summary of the policies of the priority health programs as outlined in Volume II of the Plan.

Health Promotion

Health Promotion

- All health promotion materials shall be research-based, field-tested and approved.
- There shall be a Health Promotion Officer in each district.
- Individuals and communities shall be empowered, through provision of the right information, to accept responsibility for their health.
- Health promotion materials shall be produced and made accessible to target audiences.
- Production of health promotion materials shall be sustained.
- Health promotion programs and training shall be pursued in partnership with all government agencies, churches and other non-government organisations and community groups.

Home Medicine and Self-Care

- Home medicine and self-care shall be recognised as an extension of the formal health care system.
- Home medicine and self-care shall be a component of the Health Promoting Schools Program.
- All over-the-counter medicines sold shall be issued with clear and easily understood instructions and labelling.

Traditional Medicine

- Safe and effective forms of traditional medicine and practices shall be recognised as complementary to the health care system.
- The use of safe traditional practices and herbal medicines shall be taught and promoted.
- Herbal medicine shall be developed as an integral part of the health care system.

- Traditional herbal products for commercial use shall be produced according to good manufacturing practices and be subject to quality control.
- Witchcraft- and sorcery-related practices shall be excluded from the health care system.

Family Health, with a Focus on Women's and Children's Health

Women's Health and Safe Motherhood

- Pre-and post-natal care and deliveries shall be provided free of charge.
- All women shall have access to a trained birth attendant.
- Every woman with complications of pregnancy shall have priority access to specialist medical care.
- There shall be a qualified midwife in every health centre.

Reproductive Health

- All couples and individuals shall have access to information needed to decide freely and responsibly the number, spacing and timing of their children.
- All adolescents shall have access to information and advice on sexual health and family planning.
- All health facilities shall provide high quality family planning services that emphasize client needs, sensitive counselling, choice of methods and comprehensive information.
- All family planning clinics shall make available sexually transmitted infection treatment and cancer screening services.
- Women and adolescents shall be involved in the design and implementation of family planning and sexual health programs.

Child Health

- Routine immunisations shall remain the priority activity at all levels.
- Child health programs shall be strengthened and sustained using relevant components of Integrated Management of Childhood Illnesses.
- All primary school children shall be immunized with BCG and Tetanus Toxoid.
- *Haemophilus influenzae B* vaccine shall be introduced in a phased manner.
- Aid post-based community health workers shall participate in all routine maternal and child health services.
- Supplementary immunisation shall remain a secondary activity as needed.

Nutrition

- Community-based nutrition services shall be adopted and expanded.
- Maternal and child health services shall support community-based monitoring of children's growth.
- Nutrition centres shall be established at all hospitals and district health centres.

Elimination, Eradication and Control of Priority Diseases

Sexually Transmitted Infections

- All blood and blood products from donors shall be screened for HIV and Hepatitis B.
- Pre- and post-test counselling shall be provided to all individuals tested and screened for HIV/AIDS.

- For purposes of Hepatitis B vaccination all health workers shall be tested for Hepatitis B status.
- Routine antenatal HIV and syphilis testing for all pregnant women shall be conducted free of charge.
- Voluntary testing for HIV/AIDS shall be made available.
- All newly diagnosed cases of HIV/AIDS shall be reported and kept in a confidential database at the National Department of Health.
- Condoms shall be made freely available in all health facilities.
- Treatment services for all sexually transmitted infections shall be available free of charge at all levels.

Airborne Diseases

- The Directly Observed Treatment Short-course program for tuberculosis shall be implemented nationwide.
- Treatment for tuberculosis shall be free of charge.
- Sputum microscopy for diagnosis of tuberculosis shall be provided at the district level.
- *Haemophilus influenzae B* vaccine shall be introduced in a phased manner.

Food-borne and Water-borne Diseases

- Oral rehydration salts shall be made freely available from all public health facilities.
- Monitoring of food and water quality shall be the responsibility of the health sector.
- Typhoid vaccination shall be provided only to emergency care providers and recommended institutions such as boarding schools and prisons.
- Provision of rural water supply shall be the responsibility of all levels of governments.

Mosquito-Borne Diseases

- The Roll Back Malaria (Rausim Birua Malaria) initiative shall be implemented nationwide.
- The new treatment regime for malaria shall be implemented nationwide.
- The search for new and effective treatment and control strategies including vaccine development shall be maintained.
- Spraying shall be conducted in the Highland Region and certain areas of high economic activity such as plantations and mines.
- Mass drug administration for filariasis control shall be adopted and focused on endemic areas.

Diseases under Surveillance

- Active surveillance for poliomyelitis, leprosy, measles, cholera and dengue fever shall be established and sustained.
- Disease surveillance shall remain a core function of quarantine.
- Drug supply for leprosy shall be made freely available at all health facilities.
- Special attention shall be given to leprosy endemic districts including inaccessible areas.
- Provinces shall actively participate in disease surveillance and reporting.
- All diseases under surveillance are reportable and shall be immediately reported to the National Department of Health.

Lifestyle Diseases

- Screening and rehabilitation centres shall be established in all public hospitals.
- Limited diagnostic, treatment and rehabilitative services shall be provided at all regional hospitals.
- Individuals and families shall be responsible for their overseas medical expenses.
- Medicines for treatment of diabetes shall be free of charge.

Malignant Diseases

- All screening services and cancer medicines shall be provided free of charge.
- All government institutions, facilities and public motor vehicles shall be free of smoking and betel nut chewing.
- Screening shall be an integral component of all clinical programs at all levels.

Public Health Laboratory Services

- The Chief Pathologist shall provide technical leadership for all laboratory services including the Central Public Health Laboratory.
- The Central Public Health Laboratory shall provide support to public hospitals, rural health and public health programs.
- The Central Public Health Laboratory shall monitor quality assurance for all public health laboratory activities.
- Confidentiality of all patient-related results shall be maintained.
- Collaboration with other national and international laboratories shall be established and maintained.

Health Protection

Water Supply and Sanitation

- There shall be a multisectoral coordinating body for rural water supply and sanitation at all levels.
- The health sector shall be responsible for monitoring water quality.
- Establishment and maintenance of water supply and sanitation shall be community driven.
- All high schools, hospitals and health centres shall have drought-proof water supply.
- Safe disposal of human and animal wastes shall be an integral part of water supply.
- All towns shall have safe water supply and sewerage systems.

Food and Quarantine

- Quarantine services shall remain a national function.
- Local health authorities shall be responsible for controlling the sale of food and beverages.

Sustainable Development and Healthy Environment

- All new economic and infrastructure development projects and all extensions of such projects shall have in place a comprehensive environmental health impact assessment plan.
- All industries shall establish and maintain safe workplace standards and practices.

- All occupational diseases and workplace accidents shall be reportable.
- All urban local government authorities shall have gazetted dumpsites.
- All hospitals shall have a working system to manage biological wastes.

Human Resource Management

- Health workforce training shall be a national function.
- The National Department of Health shall give priority to in-service training.
- Rural health staff shall be given priority for all training.
- Pre-service training shall be conducted in close consultation with the Office of Higher Education and the relevant tertiary training institutions.
- The participation of women in technical, professional and management positions shall be proactively pursued.
- A dental degree and a technician training program shall be re-established.
- Multiskilling of clinical staff shall be undertaken.
- Provision of specialist medical and dental officers shall remain a national function, while appraisal and discipline shall be delegated to the public hospitals.

Strengthening District Health and Hospital Services

Management Support

- There shall be one public general hospital per province.
- Rural hospital development shall be given priority over public hospitals.
- The minimum level of staff and other resources shall not fall below the minimum standards for curative care.
- Accessibility to aid posts and health centres shall remain a high priority.
- Reliable communication systems to link curative facilities shall be developed.
- The provision of clinical specialists shall remain a national function.
- There shall be at least one comprehensive supervisory visit annually to aid posts and health centres.
- All public hospitals shall maintain a budgetary provision to support emergency evacuations and rural health services.
- User fee charges shall be standardised and applied according to the requirements of national and provincial legislation.
- The provincial government shall meet costs of repatriation from hospitals to the referring district health centres.
- All referrals from district health facilities and between hospitals shall be exempted from all charges except admission fees.
- Referring hospitals shall be responsible for all referral and repatriation expenses of the patient and one guardian.
- All overseas referrals shall be the responsibility of the patient.

Health Facilities

- All designated health lands shall remain the property of the National Department of Health.
- All major and specialised repairs and replacement of medical equipment and static plants, redevelopment and establishment of public hospitals, and health facility master plans and standard designs shall remain a national function.

- Approval to introduce new health technologies shall remain a national function.
- Public hospitals shall be the referral centre for maintenance of medical equipment for rural health facilities.
- Preventive maintenance, and repair and replacement of minor medical equipment and assets, shall be the function of the health facility.
- Institutional staff housing shall be a shared function between the institutions, and the national and provincial governments.

Information Management and Research

- The health information system and adoption of new information technology shall remain national functions.
- Health systems research shall remain an integral function of service delivery.
- Health information shall be widely distributed for planning and decision-making at all levels.
- The Medical Research Advisory Committee shall be the sole body responsible for ethical clearance and the monitoring of medical research.
- All patient-related data shall remain strictly confidential.

Health Care Financing

- Minimum standards shall be used as the basis for minimum levels of funding.
- The Standard 10 Health Program Budget shall be used at all levels.
- The Public Hospitals (Charges) (Amendments) Regulation (1994) shall be reviewed every two years.
- All fee collectors shall be registered and gazetted as collectors of public monies.
- Alternative health care financing options shall be explored.

Outreach Services

- Public hospitals and health centres shall maintain outreach services.
- Clinical specialists shall take the lead and monitor standards in all clinical and public health programs.
- Public hospitals shall be designated in-service training centres for rural clinical staff.
- Information for public awareness and education shall be released without prior clearance.

Rural-Based Patient Care

- The district health centre and the rural hospital shall be the first referral centres.
- Standard treatment regimes shall continue to be the mainstay of patient treatment.
- All clinical staff shall also perform public health duties.
- There shall be at least one supervisory visit annually to aid posts and health centres.

Hospital-Based Patient Care

- Minimum patient care standards shall determine the level of services.
- All general specialist services including general dentistry shall be available at all public hospitals, while rural hospitals and health centres shall provide paediatric and midwifery nursing services.

- Specialists in ophthalmology, pathology, psychiatry, radiology and imaging and ear, nose and throat shall be provided at all level 1 to 3 hospitals.
- A specialist dermatologist, dental surgeon and oncologist shall be provided from Port Moresby General Hospital and ANGAU Memorial General Hospital.
- Multiskilling of clinical staff shall be undertaken.
- Clinical specialists shall take the lead and monitor standards in all clinical and public health programs.
- Private medical practitioners shall be engaged when and where needed.
- Port Moresby General Hospital shall remain the national referral hospital and continue to have specialised staff and high technology equipment in urology, orthopaedics, cardiology, limited cardiac surgery, Computerized Axial Tomography scan and haemoperfusion.
- There shall be two cancer units, one in Lae and the other in Port Moresby.
- All public hospitals down to level 3 shall have fully functional accident and emergency units and provide intensive care services.
- All public hospitals shall have infection control programs.
- All public hospitals below level 3 shall provide full nursing care.

Oral Health Services

- Oral health services shall be an integral part of public hospitals, rural hospitals and health centres.
- Specialist dental officers shall be based at levels 1 and 2 hospitals.
- A general dentist shall be based at all public hospitals.
- Dental officer and dental technician training shall be reinstated.
- Dental officers of public hospitals shall coordinate training and outreach services, including school oral health programs.
- Private dental practitioners shall be engaged when and where needed.
- Procurement and distribution of dental supplies shall be integrated with medical supplies.

Social Change and Mental Health

- Psychiatric patient care and treatment shall be free of charge.
- All physicians caring for adult patients in public hospitals shall be responsible for hospital-based psychiatric units in the absence of psychiatrists.
- Laloki Psychiatric Hospital shall remain the national referral centre.
- Four regional referral and supervisory centres shall be established.
- The cost of referral to the national referral hospital and to the regional centres shall be the responsibility of the referring hospital.
- Community-based patient treatment and rehabilitation shall be established and supported.

Rehabilitation and Ambulatory Services

- The National Orthotics and Prosthetic Services shall remain a national function.
- Specialists at public hospitals shall provide relevant consultative services for community-based rehabilitative services.
- Orthotics and Prosthetic Centres shall be established in regional referral hospitals.
- Prosthetic Units shall be established in all public hospitals.

Disaster Preparedness

- All health institutions shall have in place a disaster preparedness and response plan.
- All health facilities shall have fire fighting and escape systems, and evacuation exercises conducted at least once a year.
- All public hospitals shall coordinate annually a mock rescue and evacuation exercise simulating a major aviation accident.
- An inventory of qualified health personnel and equipment shall be established and maintained for emergency recruitment and deployment.

Private Health Services

- Private health care services shall be recognised as an integral part of the national health system.
- Public health facilities such as public hospitals and clinics shall engage private practitioners and facilities as and when required at an agreed fee for service.
- Drugs for tuberculosis and leprosy shall be made freely available when patients choose to be supervised by private practitioners.
- In the absence of public health facilities and personnel, special arrangements shall be undertaken to engage private health services.

Improving Access to Medicines and Medical Supplies

- Procurement of medical supplies shall remain a national function.
- Distribution of medical supplies within a province shall be a provincial function.
- Provincial transit stores for medical supplies shall be established.
- Local expenditure on drugs for diseases exempted under the *Public Hospitals (Charges) (Amendment) Regulation* (1994) shall be reimbursable.
- A supply system of aid post and health centre kits shall be established.
- No pharmaceutical products supplied through the government system shall be sold.

Strengthening Partnerships

- All stakeholders shall be involved in all stages of health program development and implementation.
- All donor input shall be channeled through the Health Sector Improvement Program in a phased manner.
- Government shall purchase services from churches and other non-government organisations to provide public health and related services.
- The Village Health Volunteer Program shall be developed and promoted.

THE IMPLEMENTATION FRAMEWORK

The National Health Administration Act (1997) provides the overall framework for developing, implementing, monitoring and evaluating the National Health Plan.

As per Section 6 of the Act, Provincial Governments are expected to develop their provincial implementation plans. As resolved at the 1999 Rabaul National Health Conference, five-year strategic implementation plans were to be developed in implementing the National Health Plan 2001–2010. The National Department of Health, public hospitals and provinces are to develop strategic implementation plans. Annual activity plans are to be based on the 5-year strategic implementation plans.

Financing the Plan

To achieve sustainable improvements in the health of the people, it is important that priority health programs receive adequate budget support during the Plan period.

The National Department of Health has taken the lead role in establishing the Standard 10 Health Program Budget format which is now the only accepted budget tool for planning at all levels. Church health services are also required to follow this budget format.

The Standard 10 Health Program Budget includes general administration, urban health facilities, rural health facilities, family health services, disease control, environmental health and water supply, health promotion and education, medical supplies and equipment, human resources development and support services.

Resources to implement the Plan must meet the minimum standards set for districts and hospitals and be based on local health priorities.

In developing the cost estimates of the Plan, a range of assumptions have been made. If circumstances change over the Plan period, some of these assumptions may be revisited and may increase or decrease the cost of the Plan. These initial cost estimates are therefore indicative. Detailed cost estimates need to be based upon the 5-year strategic implementation plans. The present estimates take into account the cost of implementing national policies and the recurrent and investment cost estimates of 6 provinces. In doing so they provide a broad picture of the expenditure requirements to implement the Plan.

The major assumptions used in estimating the cost of the National Health Plan include:

- For rural health services, the initial recurrent costs have been based on the level of services intended in the National Health Plan.

- For public hospitals and other nationally funded activities the 2000 budget appropriation adjusted for inflation will be adequate.
- Medical supplies requirements have been projected based on expected requirements for the population growth and disease pattern of the nation.
- Inflation is applied to year 2001 and beyond at 5% per year.
- The average national population growth rate of 2.3% per year is applied to the summary national cost estimates, when one of the multipliers is based on population.
- It is assumed that each public hospital and urban clinic will require maintenance and renovations at the cost of 2.5% of replacement value, each year, for the life of the Plan.
- Staff levels in the rural health facilities were computed using the national average as per the *National Health Facilities Inventory* (1998).

Considering the major assumptions above and using the costing model for the 10 programs, which includes both recurrent and investment, the indicative cost for the 10 years is estimated at K8.9 billion. In developing the cost estimates current and potential sources of financing for the Plan have been identified. These include the national, provincial and local level governments, multilateral and bilateral agencies, the corporate sector and local, national and international non-government organisations.

While it is acknowledged that the health sector is expected to attract a high level of multilateral and bilateral assistance, the commitment of the national, provincial and local level governments must continue to sustain the level of funding required.

The Government will ensure that the resources provided to implement the Plan will be equitably distributed, effectively and efficiently managed to achieve expected outcomes and sustain the gains made.

Given the unpredictability of the economy in the long term, a contingency plan has also been developed to respond effectively to budget shortfalls or windfalls.

Responsibilities

Health must remain high on the agenda for priority national development and a core business of Government for the people of this nation to enjoy a higher standard of health. For this to happen all levels of government must make a commitment towards achieving the objectives of the Plan. The *Organic Law on Provincial Governments and Local Level Governments* and the National Health Administration Act are both binding in this regard. The Plan defines these responsibilities by program for all levels of government.

Health, however, is the responsibility not only of governments but also of every individual, family and community. There is much that individuals, families and communities can do to maintain their own health. This obviously requires community awareness and education to empower them to make informed choices.

Further sustainable outcomes cannot be achieved by the health sector alone. This requires partnerships with other government agencies, churches and other non-government organisations, the corporate sector and international development partners.

Monitoring and Evaluation

Monitoring and evaluation are an essential component of the implementation phase of the National Health Plan. Monitoring is a routine management tool, which has to be used by program managers to identify problems early and to undertake corrective actions. Evaluation, on the other hand, is the systematic way of learning from experience and using the lessons learnt to improve current activities and promote better plans through a careful selection of alternatives for future action. This involves the analysis of the different phases of program implementation with regards to the program access, efficiency, equity, quality and sustainability.

The reasons for monitoring and evaluation of the Plan are:

- for Government to monitor the health status of the people and the performance of the health system;
- for management to regularly assess the situation and take corrective action when and where necessary;
- to provide program managers with the information required to improve on past performance;
- for management to measure progress against established standards and objectives;
- to measure the cost-effectiveness of delivering health programs;
- to measure the impact of the Plan on the health status of the people;
- to provide information for future plans.

Consistent with the National Health Administration Act (1997), the monitoring of implementing the National Health Plan is the responsibility of the National Health Board, Provincial Health Boards and the District Health Management Committees. Pursuant to Section 30 of the Act, the District Health Management Committees shall report to the Provincial Health Board, which in turn shall report to National Health Board, which shall then report to the Minister for Health on an annual basis. The Minister shall also report to Parliament annually.

To this end, administrations at all levels will collect, analyse and report on a monthly basis based on the objectives of the 10 programs. Nineteen National Core Indicators have been identified in this Plan to monitor access, efficiency, equity, quality and sustainability. The performance of the total health sector will be measured against the achievements of the 19 National Core Indicators over the next 10 years.

These Core Indicators will form the basis of the Performance Monitoring Framework. This Framework is a subsystem of the overall monitoring system and is integrated into the planning and management process at all levels. It will be further developed to monitor the overall development assistance program to the health sector during the Plan period.

This is important in view of the fact that the health sector has commenced moving towards the Health Sector Improvement Program.

Given the 10-year timeframe of the Plan, it is necessary to evaluate the overall national policy direction. The approach taken by the Government to develop the five-year strategic implementation plans allows for a Mid-term review to make the necessary adjustments by carefully selecting alternatives for future action. This Mid-term review exercise will be completed in 2005 with a full-term review undertaken in the year 2011.

This exercise will facilitate the development of the next National Health Plan 2011–2020, which will begin in 2009.