

**Papua New Guinea National Department of Health**

# **Independent Capacity Diagnostic Assessment**

**Final Report**

**December 2013**

## Acknowledgments

The diagnostic assessment team wishes to acknowledge and thank the staff of the National Department of Health (NDoH), representatives of the Department of Personnel Management, Auditors General's Office, Christian Health Services Secretariat, Development Partners (DPs) in the health sector, technical advisers to the NDoH including those sourced through the Health and HIV Implementation Service Providers (HHISP) the Australian Government and including the Church Partners Program.

In addition, we would like to thank the Chief Executive Officers from the Western Highlands and Eastern Highlands Provincial Health Authorities for their insights and openness during our phone conference with them.

The assessment team would like to sincerely acknowledge and thank staff from the Australian Government, who provided guidance and support throughout the consultancy, all those who gave their time and knowledge to inform the assessment as well as providing documents, and Abt JTA for smoothly and efficiently managing the logistical support.

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## Abbreviations and acronyms

AIP	Annual Implementation Plan
AGB	Autonomous Bougainville Government
ADB	Asian Development Bank
AP	Aid Post
ARB	Autonomous Region of Bougainville
ASR	Annual Sector Review
CBSC	Capacity Building Service Centre
CACC	Central Agencies Co-ordination Committee
CEO	Chief Executive Officer
CHBC	Community Home Based Care
CHP	Community Health Post
CHS	Christian Health Services
CHSTAM	Christian Health Services Technical Assistance Mission
CHW	Community Health Worker
COA	Chart of Accounts
CP	Central Province
CSTB	Central Supply and Tenders Board
DFAT	Department of Foreign Affairs and Trade (of the Australian Government)
DHFF	Direct Health Facility Funding
DHO	District Health Office
DNPM	Department of National Planning and Monitoring
DoF	Department of Finance
DoT	Department of Treasury
DPs	Development Partners
DPLGA	Department of Provincial and Local-level Government Affairs
DPM	Department of Personnel Management
EEO	Equal Employment Opportunity
EHP	Eastern Highlands Province
ESP	East Sepik Province
FBB	Facility Based Budgeting
GoPNG	Government of Papua New Guinea
HC	Health Centre
HFG	Health Function Grant
HSIP	Health Services Improvement Program
HHISP	Health and HIV Implementing Service Provider
HRH	Human Resources in Health
HRM	Human Resource Management
HRMIS	Human Resource Management Information System
HSPC	Health Sector Partnership Committee
ISP	Implementing Service Provider
KRA	Key Result Area
MDG	Millennium Development Goals
MOA	Memorandum of Agreement
MP	Morobe Province
MSPDB	Medical Supplies Procurement and Distribution Branch
MTDP	Medium Term Development Plan
NBSC	National Budget Steering Committee
NDoH	National Department of Health
NEC	National Executive Council

NEFC	National Economic and Fiscal Commission
NGO	Non Government Organisation
NHIS	National Health Information System
NHP	National Health Plan 2011-2020
NHSS	National Health Service Standards
OD	Organisational Development
PGAS	Provincial Government Accounting System
PER	Public Expenditure Review
PFM	Public Financial Management
PHA	Provincial Health Authority
PLLSMA	Provincial and Local-Level Services Monitoring Authority
PNG	Papua New Guinea
PSTB	Provincial Supplies and Tenders Board
RPHSDP	Rural Primary Health Service Delivery Project
RIGFA	Review on Inter-Government Financing Arrangements
SEM	Senior Executive Management (of NDoH)
SIA	Supplementary Immunisation Activities
STI	Sexually Transmitted Infection
SWAp	Sector Wide Assistance Program (approach)
TA	Technical Assistance
TAM	Technical Assistance Mission
TB	Tuberculosis
TOR	Terms of Reference
WB	World Bank
WHO	World Health Organisation

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# Executive summary

## Introduction

The National Department of Health (NDoH) is an organisation in transition as it seeks to carry out its legislative and policy mandate to improve access to and outcomes from health services in Papua New Guinea in accordance with the National Health Plan (NHP) 2011 -2020. The main partner in this task is the Christian Health Services, which provides 47 per cent of the country's health services. While progress towards the NHP's objectives is lagging behind, there are a number of positive developments.

## Purpose

The purpose of the Capacity Diagnostic was to- i) review progress since the baseline assessment derived from the last capacity diagnostic done in NDoH in November 2011; ii) review the current capacity of the Christian Health Services Secretariat (CHS) and iii) identify ongoing capacity development needs to implement the NHP 2011-2020.

## Key Findings

Considerable progress was noted since the last capacity diagnostic in November 2011. The government has substantially increased its investment in health and including Christian Health Services, with an overall increase in budget by about 70 per cent from 2011. The majority of staff positions have been filled, and about 100 new graduates from a variety of disciplines have been recruited, bringing a fresh sense of dynamism and new skill skills to the department. In terms of technical assistance to NDoH, the transition from the Capacity Building Service Centre (CBSC) to the current integrated service provider (ISP) arrangements, have been well managed.

NDoH management is taking a more discerning attitude towards the use of international technical (TA) support in the department, and there is increased awareness of the need for the Department to focus its activities to support capacity development at the provincial level.

Policy has been developed in response to key government initiatives such as the Free Primary Health Care and Subsidised Specialised Health Care. In Human Resources (HR), an Arrest Plan and a National Health Sector Human Resources Policy has been developed. In finance the change in the Chart of Accounts (COA) will potentially improve links between plans, budgets and expenditures; in public health there is progress being made in malaria control program; and in infrastructure, a plan and budget is being developed to address the failing infrastructure in the sector.

A National Executive Council (NEC) cabinet submission approving PGK 40M, for the equalization of salaries between Government and CHS health workers was reported to be officially endorsed by NEC in early November 2013. Note that the 2014 Budget has only allocated an additional Papua New Guinea Kina (PGK) 11.8M for CHS in 2014.

## Main challenges and issues

Despite the considerable progress since 2011, many challenges and issues remain. These include internal issues such as poor links between policy and legislative review, budget execution and compliance, inadequate line management, procurement, internal audit staffing and implementation, supply and distribution, high vacancy rates in many areas<sup>1</sup>, inconsistent people management, an infrastructure program is 12 months behind schedule in the first two years and infrastructure units with weak capacity due to under resourcing and gaps in expertise.

External factors affecting infrastructure approvals through the Central Supply and Tender Board (CSTB), weak linkages with Treasury and the Department of Personnel Management are hampering Provincial Health Authorities (PHA) development and resolution of core finance and Human Resource Management (HRM) issues.

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<sup>1</sup>For example, in the Commercial Services Branch 63%; HR Branch 34%; Internal Audit 50%, and Public Health Branch 29%.

The diagnostic team also identified different approaches to capacity development amongst development partners, as well as an increase in capacity development activities being undertaken by the NDoH itself. An overall framework is now required in this area to ensure best uses is made of this assistance, and to focus on the building of longer term sustainable solutions to the needs identified.

## **Key capacity development/TA recommendations**

The review recommends targeted TA in a number of areas. These include:

- On-going high level and consider short term technical advice for the Policy and Legal units based on their operational work plan. Specific content areas proposed in section 2.2.
- Support for the development of a NDoH HR Strategic Plan with a series of underpinning HR action plans and for an induction, coaching and mentoring program for newly recruited graduates in NDoH.
- Support to undertake a sector wide strategic planning review of resources to deliver annual infrastructure programs, matching resources with annual plans.
- In Public Health, support for providing an epidemiology and population health technical service to NDoH and to the provinces until sufficient national staff are trained.
- In the Finance Branch, short term support to assess the whole public financial management (PFM) process for the NDoH, including internal horizontal relationships with NDoH sections such as policy and planning and external relationships with Department of Finance and Treasury.
- For the Internal Audit Office, long term external technical assistance (international) to review internal audit policy and standard operating procedures for internal auditing, with a view to shifting from a 'policing' modality towards a focus on systems audits which will provide feedback and solutions for continuous improvement of financial management practice.
- For the CHS Secretariat, urgent support required to assist them in the management and roll-out of payroll, other human resource management (HRM) functions and IT functions.
- The GoPNG and Development Partners develop a shared understanding and approach to capacity development assistance, in particular its relationship to NDoH annual planning processes, NDoH training and staff development programs, and long term sustainability and aid effectiveness.

Note that the NDoH provided comments to the first draft of this report and in which some new proposals for technical support had been included, which had not been discussed with the assessment team. In general, the needs identified by the NDoH are supported by the assessment team. However we recommend further consideration of the best way in which this capacity can be built. Where these have now been included in this final report, this it is noted and we also recommend that these are discussed internally as well as with DPs, and the different mechanisms by which these capacity needs can be met .are considered, before a final decision is made.



# 1. Context

The National Government of Papua New Guinea has overall responsibility to provide health services to its people. The National Department of Health (NDoH) is the steward of the health system and is to:

Guide and influence policy directions to the health sector, support the National Health Board to develop and recommend the National Health Plan to Government, develop evidence based and sustainable standards, monitor the implementation of the National Health Plan (and standards) and to provide technical assistance to support the provinces.<sup>2</sup>

The NDoH Corporate Plan 2013 -2015 is driven by the NHP 2011 -2020 and the major priorities and focus areas for 2013 -2015 are:

- Implement the Free Primary Health care and Subsidized Specialised Health Care Policy
- Roll out health reforms of Provincial Health Authorities (PHAs) and improve governance and service delivery at provincial levels
- Improve the medical supplies and distribution system
- Strengthen support to the Christian Health Services
- Develop and implement the health workforce plan
- Improve health Infrastructure
- Improved governance.

Four independent consultants undertook an external capacity diagnostic assessment in Port Moresby from 26<sup>th</sup> October to 4<sup>th</sup> of November 2013. The purpose of this assessment is to:

- Review progress since the 2011 capacity diagnostic assessment of the NDoH<sup>3</sup>;
- Review the current capacity of the Christian Health Service (CHS) Secretariat and
- Identify ongoing capacity development needs to implement the Papua New Guinea National NHP 2011 -2020.

The assessment team was also asked to identify TA required to implement key policies; assess the relevance and effectiveness of external development assistance and in particular the provision of technical assistance; and review existing governance and quality assurance arrangements for capacity development support.

The team took the approach to regard technical assistance within a broad framework of capacity development. Capacity development is complex and requires a shared understanding to be able to bring about system change.

Capacity development is best expressed in aid effectiveness terminology whereby the Government of PNG sets its broad development and capacity development goals and needs. To these the development partners harmonise a coherent response, which is aligned to the government's expressed needs.

In a recent paper, which examines the issue of DP harmonisation the authors propose that the "easiest way to achieve harmonisation is to pursue alignment."<sup>4</sup> For example, if DPs acknowledge government ownership by aligning with national priorities and using country systems then aid simultaneously becomes harmonised so DPs can spend less time on coordination efforts.

The definition used in this report for capacity development encompasses the following:<sup>5</sup>

- Capacity is the ability of people, organisations and society as a whole to successfully manage their affairs.

<sup>2</sup> National Department of Health Corporate Plan 2013 -2015 "The Next Steps".

<sup>3</sup> Winter J, Vermeulen T, Matheson D, Opito A (2011) *National Department of Health Capacity Diagnostic Report*, JTA

<sup>4</sup> Smoke P, Winters M, 2011, *Busan and Beyond: Donor Program Harmonisation, Aid Effectiveness and Decentralised Governance for Development Partners*, Working Group on Local Governance and Decentralisation

<sup>5</sup> OECD (2005) *Living Up To The Capacity Development Challenge: Lessons Learnt and Good Practice*, Paris

- Capacity development is the process whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time.
- Capacity development is a complex system involving a process of change from within, which goes far beyond technical assistance and training approaches that have often been associated with this concept.
- Capacity development must address ‘the how’, ‘the what’ as well as ‘the why’.

Support for capacity development refers to the process whereby partners such as DPs or in-country partners act together in support of capacity development. They can reinforce existing capacity including through:

- Using, identifying, stimulating and unleashing capacity that is under-utilised or applied to lower-priority activities;
- Investing in new capacity where needed; and
- Catalyse and preserve capacity in unfavourable circumstances such as poor governance or conflict.<sup>6</sup>

## 2. Findings since the 2011 NDoH capacity diagnostic

### 2.1 Overall assessment of NDoH

In 2013 the health sector budget totals Papua New Guinea Kina (PGK) 1,314M, of which approximately 20 per cent is made up of external resources from Development Partners (DPs)<sup>7</sup>, with the largest portion of these coming from the Australian Government. This is about a 70 per cent increase in the total health budget from 2011.<sup>8</sup>

The review team found that there has been considerable progress in the Department since 2011, although some areas only show limited progress. Some of the highlights are:

- The majority of staff have now been substantially appointed, key management positions have been filled, and about a 100 new graduates from a variety of disciplines have been recruited, bringing a fresh sense of dynamism and new skill skills to the department.
- Internal NDoH governance committees have been reactivated and are meeting.
- In term of technical assistance to NDoH, the transition from the Capacity Building Service Centre (CBSC) to the current ISP arrangements, have been well managed, resulting in shifting attitudes towards technical support in the department.
- Increased awareness of the need to develop capacities at the provincial level.
- A plan and budget to develop the failing infrastructure in the sector.
- The CHS Secretariat has expanded in size and scope of operations, and preparing itself for a greater role in representing the CHS and managing the CHS workforce.

Nonetheless, concerns remain, particularly in terms of the Department’s ongoing capacity to implement the NHP. Internal issues with policy and legislative review, budget implementation, procurement and supply, and people management are still evident. External factors affecting performance are the delays in infrastructure approval at the Central Tender and Supplies Board and weak linkages with Treasury and the Department of Personnel Management (DPM).

<sup>6</sup> It should be noted that, while experts continue to have varying, although converging, views on definitions relating to capacity, bilateral and multilateral donors increasingly agree on these basic elements of this complex process that constitutes capacity development.

<sup>7</sup> The term development partners refers to multilateral and bilateral partners to the GoPNG

<sup>8</sup> In 2011 the total health budget was about PGK 972.9M

## 2.2 The Strategy and Policy Branch

### 2.2.1 Overall assessment

The Strategic and Policy Branch is made up the following units: strategic planning and economics; policy, legal and partnerships; health reforms; monitoring and evaluation and research. Due to time restrictions not all units were assessed or in detail. According the establishment data provided to the assessment team this division has 65 staff positions of which 10 positions<sup>9</sup> (15 per cent) are currently vacant. Currently two long term international advisers work in this division and their inputs are highly regarded by counterparts. This division has made good progress since 2011 and has its management team in place had some other significant achievements.

### 2.2.2 Findings

Major achievements for this division since 2011 are the production of:

- The Medium Term Development Plan for projects and programs (infrastructure, plants and equipment) (MTDP) 2011 -2015 and this plan is discussed in more detail in the infrastructure sections of this report
- The NDoH Corporate Plan 2013 -2015, business rules and internal governance committees
- Community Health Post Policy 2013
- Free Primary Health Care and Subsidised Specialised Health Care policy 2013
- Recruitment of young energetic new graduates into the division generating an opportunity, if supported through orientation, coaching and mentoring for positive culture change to occur.
- Development of a policy to support facility level funding evaluation.

The Free Primary Health Care and Subsidised Specialised Health Care for PNG policy recommends a two phased implementation plan, one dealing with smaller rural facilities (aid posts, health centres) and the other with hospitals. PGK 20M has been budgeted to compensate facilities for the removal of user charges. The policy has been approved, and is now with the Health Economics unit of NDoH for implementation. This will be a very complex policy to implement and has a very high political profile. It would benefit from a project structure to oversee implementation, staffed with a multidiscipline team. At this point it appears that insufficient resources are being applied to its implementation.

There are a number of initiatives from different provinces exploring ways to better resource peripheral facilities, which hold promise for managing the Free Health Care policy. Favoured by the NDoH planning branch is Facility Based Budgeting (FBB) – where facilities are set up with a budget covering all their costs, without necessarily handling the money directly. A Direct Health Facility Funding Project (DHFF) has also been conducted in the Autonomous Region of Bougainville since August 2011 which has recently been evaluated. A continuing action research agenda following progress with all these initiatives as they mature will be important to provide the evidence base the NDoH requires to make effective policy in this area.

In NDoH comments on the draft report a request has been made for some short term assistance in FBB in 2013. The capacity needs in this area are substantial. How to make sure they are best met requires further discussion in-house and with DPs on the best approach, expected outcome from TA support and its duration. Given the centrality of this policy to the government, the capacity gap might best be met by both movement of additional NDoH capacity to this area, as well as external assistance.

A policy development process template has been prepared and it will be important to ensure that all stakeholders (internal and external), are identified and engage in the policy development process

<sup>9</sup>This number includes IT positions

and that the policy process remains flexible, inclusive and participatory. Policy implementation is still remaining difficult. Lessons learnt during the whole policy process need to be feedback into the policy process so that there is continuous learning and improvement. It is important to regard policy not as a static process but a continuous process from development, to implementation to lessons learnt and improvement. The agenda for the NDoH health research team should also include action research during policy implementation.

**Legal support:** The legal unit will need to review major piece of legislation, including the National Health Administration Act and the recent Provincial Health Authorities Act. The government's review of the Organic Law will require the Department to consider the health sector implications and ensure that health service delivery is enhanced and not impeded by proposed changes. Short term technical support to respond to these needs will assist the two staff in this unit to accomplish this work.

**Sector performance monitoring and research:** One of the most effective tools at the NDoH's disposal to lead the sector is the monitoring and research function. The annual sector review is a sophisticated performance monitoring tool whose effectiveness is limited by capacity to disseminate its findings in ways that the information is best understood by the sector. As noted in relation to Free Health care, an active implementation research agenda is urgently required to inform this new policy initiative as it rolls out. The review strongly supports increased technical assistance in these areas and specifically for the National Health Information System (NHIS) and Research units. However, further consideration needs to be given as to how this is best delivered. Options for direct TA need to be considered alongside strengthening the local academic institutions (eg UPNG, IMR) as the preferred method of building research and analytical capacity.

**Partnerships:** As part of its role to advise and guide provinces, local governments and health services providers, NDoH has developed the partnerships policy and engaged staff to oversee the partnerships process. One of the main areas of responsibility for this team is to assist with the drafting of and negotiations around Memoranda of Understanding and Agreements with health sector providers. Technical support in the form of long term technical collaboration providing on the job coaching will help to build capacity in the Department to implement this area of work.

**Economics Unit:** Strategic investment planning, including budget forecasting and the development of the Medium Term Expenditure Framework, is conducted by the Economics Unit. This supports the work of Finance in developing the budget. NDoH has requested short-term technical support in three periods in 2014 to support thinking about how best to adjust this process: in February, in April and again in June just before the 2015 budget submission.<sup>10</sup> In addition the National Health Accounts surveys are now being completed. The process of data analysis and dissemination of these results requires technical support as a means of on-the-job training for staff in the unit. Again, these proposals were not raised with the assessment team and will require further discussion in-house and with DPs to work out the best way forward.

The newly established NDoH corporate committees and in particular the Performance Monitoring Committee, will provide opportunity for this division to engage and promote horizontal dialogue about progress and challenges on the implementation of the NHP, the Corporate Plan and harmonisation across divisions and present and analyse monitoring and evaluation and research findings. It will be important to monitor the progress and outputs of this Committee in the future.

Areas of challenge include:

- The monitoring, evaluation and identification of policy gaps related to implementation of the NHP with a focus on the production and measuring of results.
- A disjunction between policy and legal work when these areas need to be working in synergy.
- Implementing the Free Health Care Policy.

<sup>10</sup> This work will be done in conjunction with the Finance Branch

- An inclusive, flexible and participatory policy development process.

### 2.2.3 Conclusion

The current long term technical support to the division should be assessed in terms of their contribution to the attainment of the division's operational plan and NHP KRAs. High level technical support to the division should be continued and consider targeted short term inputs, for the future and identify the technical support and outputs required in the operational plan of the division.

The cohort of new graduates presents a unique window of opportunity for the NDoH. Orientation and induction programs to the PNG civil service and the NDoH need to be put in place and coaching and mentoring programs, with specific mentoring program for females set up. This group present a unique and exciting opportunity to change the culture of NDoH and this opportunity should not be missed.

## 2.3 The Human Resources (HR) Branch

### 2.3.1 The role of the HR Branch

This section of the report provides a summary of the capacity diagnostic findings in relation to the HR Branch. Reformatations to address the identified issues are set out in Section 4 of this report while a more in-depth analysis of the issues is in Annex 4 of this report.

The role of the HR Branch is critical as effective leadership and people management in NDoH and across the health sector are essential to the implementation of the NHP. In this regard, the NDoH HR Branch has a two-fold responsibility<sup>11</sup>:

1. To co-ordinate and implement HRM functions in NDoH, along with other NDoH managers who have supervisory and leadership people management responsibilities;
2. To lead the development and implementation of broader human resources for health functions and programs across the health sector, in co-ordination with other NDoH Branches, health partners, and central agencies.

However, in practice this distinction is not always that clear cut as some issues have an impact in both areas and broadly speaking, the staff of NDoH are also part of the PNG's human resources for health, playing a vital policy and co-ordination role in the health sector.

The internal NDoH staff management functions include managing the payroll, staff performance appraisal, staff development, recruitment and selection, workplace ethics, and occupational health and safety.

External sector-wide HRH functions include developing health sector HR policy, setting the policy framework for pre-service training<sup>12</sup>, workforce planning, industrial relations (in conjunction with DPM), recruitment, and managing payroll services for hospitals that do not yet have full access to the Alesco payroll system. It also works to a limited extent with other health sector partners to implement common HRM initiatives across the health sector<sup>13</sup>.

### 2.3.2 Overall assessment

Since the last capacity diagnostic in October 2011 there have been substantial improvements in staff management within NDoH and sector-wide HRH matters. For example, within NDoH:

<sup>11</sup> The functions and legislative and policy mandate of the HR Branch are outlined in more detail in **Annex 4**.

<sup>12</sup> With the move of most sector-wide training functions to the education sector, NDOH's training role is in transition and, as such, below in the section of the Training and Curriculum Unit the review team recommends that its role in this area be reviewed. However, the HR Branch still retains a staff development function in relation to its own staff.

<sup>13</sup> To a lesser extent, it also provides HRM support to the NCD Health Service and the Provincial Hospitals but these are mainly payroll functions. It does not provide any direct HRM services to health services run by the provincial governments or district authorities. The HR Branch's role in relation to PHAs is evolving and unclear at this stage.

- The majority of staff have now been substantially appointed, dissipating concerns about job security, although the overall high vacancy rate in critical parts of NDoH remains a concern<sup>14</sup>
- A significant number of new staff, including a significant number of young graduates have been engaged providing a new sense of dynamism to the department, although a large number of them are still to be placed on the payroll.
- A large number for staff have participated in the Public Service Induction Program and the TMS Leadership and Organisational Development Program (PLICIT), improving their competencies and sense of belonging to one organisation.
- Previously dormant HR related committees have also been revived and appear to be taking the lead of some issues (e.g. staff development issues)

In relation to human resources across the sector (HRH) there have also been significant achievements, for example:

- A Workforce Arrest Plan has been developed to address immediate critical staff shortages in the health sector and will be submitted to NEC for approval
- NEC has recently approved the first National Health Sector Human Resources Policy on in the, which recognizes that *how staff are managed* is just as important as the number of staff.
- NEC has recently approved the equalization of remuneration between Government and CHS health workers. This should slow down the migration of CHS staff to the government sector.

These developments, if well managed, present a significant opportunity to tap into the renewed sense of optimism and commitment of some staff, especially the young graduates. However, a number of issues remain outstanding that still impact heavily on NDoH's capacity to take the lead in implementing the NHP. These are discussed in the subsections below.

### 2.3.3 Findings

The findings are divided into the two areas identified above, the management of staff within NDoH set out in **subsection 2.3.3.1**, and broader sector-wide HRH issues set out in **subsection 2.3.3.2**.

#### 2.3.3.1 Internal NDoH people management

While the number of staff is of critical importance, *how staff are managed* is even more important. As noted by Adano in his review of HRM in the health sector, "The way health workers are recruited, managed and supported is central to the quality of services that they are able to deliver"<sup>15</sup>.

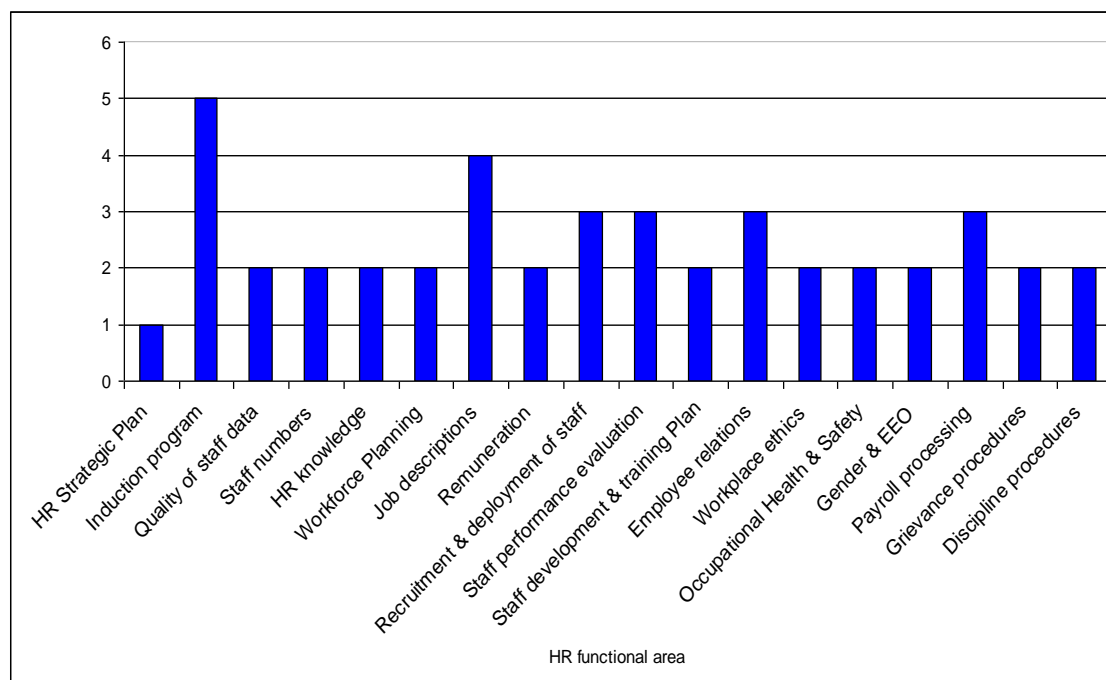
In this regard, while there have been notable improvements in a number of areas, group and individual discussions with the HR Manager and unit managers of the HR Branch raised a number of concerns about the lack of effective leadership and *management* of staff in NDoH and a lack of a strategic focus in HRM<sup>16</sup>.

A structured interview was also conducted with the HR Manager, who was asked to rate the effectiveness of 18 HR functions in NDoH on a scale from one to five. The summary of the results indicates that most HRM functional areas received a score of two with an average score of **point 2.44 out of five**, as set out in **Figure 1** below:

<sup>14</sup> For example, in Commercial Services Branch 63%; HR Branch 34%; Internal Audit 50%, and Public Health Branch 29%.

<sup>15</sup> Adano, U; McCaffery J; Ruwoldt P; Stilwell B: (2008) *Human Resources for Health: Tackling the Human Resource Management Piece of the Puzzle*, Technical Brief # 14, The Capacity Project, Intrahealth International

<sup>16</sup> The discussions with staff were guided by the structured questionnaire set out in **Appendix A to Annex 4**.

**Figure 1: Perceived effectiveness of HRM in NDoH**

From the results it is clear that the overall effectiveness of HRM management in NDoH is quite low. Of particular concern is the lack of effective staff performance management (SPM) in NDoH as SPM provides a mechanism to link individual employee's work activities with the Corporate Plan and, in turn, with the implementation of NHP. The HR Branch has recently started to address this to ensure that SPM is part of the work culture of NDoH<sup>17</sup>.

While some functional areas are doing well (e.g. payroll, staff induction, and employee relations) the overall results indicate that improving HRM is critical to NDoH's capacity to implement the NHP.

### Staffing data and HRMIS

To effectively manage NDoH and implement the NHP, it is essential that accurate, comprehensive, and collated data on its staff is readily available to managers in NDoH and other decision-makers in the health sector. However, while data collection and reporting on health indicators and health infrastructure has now improved data collection on staffing continues to be problematic.

For instance, basic data even on NDoH's own staff is not available in an *aggregated form*, besides basic payroll data, to develop a comprehensive staffing profile of NDoH. This is a major capacity gap and prevents the development of effective training and staffing strategies that would support the implementation of the NHP.

This is an issue that cuts across both NDoH's internal management of its staff and its role in relation to HRH across the sector. As such, it requires urgent attention, supported by technical assistance.

### Other information systems issues

While not specifically a HRMIS issue but related to NDoH broader information systems, there has been a persistent problem with email communication and internet access in NDoH. This is severe capacity constraint as it impedes research by staff, ready access to information and rapid communication across NDoH and with its health partners, and has to be addressed as a matter of urgency. Consideration should be given to providing technical support to the IT Branch to resolve this issue.

<sup>17</sup> Organisational research indicates that SPM systems that are an intrinsic part of the approach to work in an organisation are more successful and achieve higher quality outcomes than systems that are purely compliance based. See Harper S & Vilkinas T (2005) "Determining the impact of an organisation's performance management system", *Asia Pacific Journal of Human Resource Management*, volume 43(1), p 93



### 2.3.3.2 Human resources for health (HRH) sector-wide issues

#### Workforce planning in the health sector

Considerable progress has been made by establishing the Workforce Planning Secretariat. It has developed an Arrest Plan to address immediate health staffing needs. However, only limited funding has been provided for the Secretariat and it remains to be seen if they can continue its work of developing and implementing the full Health Sector Workforce Plan.

The HR Branch itself has very low capacity and the Policy and Planning Section Technical Adviser position, which is responsible for workforce planning, is vacant. The other two positions in the Section are occupied by new graduates who have only recently been employed.

Implementation of this Plan and the development of the long term Workforce Plan will require close co-operation with central agencies and, due to capacity constraints in the HR Branch, considerable technical assistance.

RPHSDP has funded a HR Adviser for the HR Branch who has been tasked to also assist with workforce planning. However, this is a generalist position that also has to support other people management and HRH matters NDoH is dealing with and the provinces. Specialized additional support will still be needed for workforce planning due to the scope and importance of the task.

If this position is to take on workforce planning on a more substantive basis it is likely that the term of the consultancy would have to be significantly extended.

#### Industrial and payroll issues in the health sector

For the NHP to be implemented, it is essential to avoid industrial unrest and boost staff morale. Since the last review, the various health sector industrial awards have been implemented. However, the awards also need to be modernised to introduce more flexible and equitable working arrangements across the sector. Other positive development has been the recent decision to equalize salaries between Government health staff and CHS health staff in 2014, although it remains to be seen whether this will be funded on an ongoing basis<sup>18</sup>.

Implementation of the Concept Alesco payroll system is proceeding well and only six hospitals remain to be connected. However, delays continue in putting new staff on the payroll. Resolving this requires closer co-ordination with DPM and ongoing technical assistance.

#### Remuneration and classification of health workers in the health sector

A full review of the remuneration and classification structure for health staff is beyond the mandate of the NDoH capacity diagnostic, but in so far that it impacts on NDoH's capacity to implement the NHP some observations are warranted on this issue. In this regard, skilled and experienced staff are critical to the successful implementation of the NHP and, while certainly not the only factor, the level of remuneration is a key tool to obtain skilled staff in the labour market<sup>19</sup>.

In this regard, numerous reviews have highlighted the low level of remuneration in the health sector in PNG<sup>20</sup>. To some extent this has been addressed in CHS by equalising salary levels between church and government health workers.

However, the overall level of remuneration remains low, particularly for nurses and CHWs, and technical positions that required highly developed skill sets in NDoH.

<sup>18</sup> This was a major recommendation of the (2013) *Christian Health Services Technical Assistance Mission Report*, in their recommended 2014 CHS Budget bid (set out in Attachment 7 of the report)

<sup>19</sup> The link between remuneration and health sector workforce retention and performance is complex but the research indicates that properly targeted incentives can have a significant positive impact on health service delivery. See, for example, Lyn N Henderson and Jim Tulloch (2008) *Incentives for retaining and motivating health workers in Pacific and Asian countries*, *Human Resources for Health* 2008, 6:18, which evaluates range of remuneration strategies.

<sup>20</sup> See, for example, the SWAp Review Report "the Missing Middle", and also Razee H, Whittaker M, Yayasuriya R, Yap L, Brentnall L, "Listening to rural health workers in Papua New Guinea: the social factors that influence their motivation to work", *Medicine & Social Science* Volume 75, (2012) 1-8



### Case Study 1 – The impact of the Public Service Classification System on the health sector labour market

An Administrative Assistant position in NDOH which requires no formal training or qualifications, and for which NDOH has no trouble attracting suitable applications, is paid from grade 8 to 10, while a nurse is paid at a 6 to 8 grade level, but most are at grade 6. Similarly, the critical role of CHW is only classified at grade 5, even after they have been trained to take on additional MCH responsibilities.

In other words, a nursing position which requires a 3 yr qualification and is essential to the system is paid at a much lower grade level than an administrative assistant because that 'fits' the public service classification system, regardless of health sector staffing needs.

While allowances under the awards are accessible by health staff, this does not address the basic classification anomalies or the recruitment difficulties created by the current classification arrangements.

This problem is compounded by having Government health staff placed under the Public Service classification and grading system. While the Christian Health Services do not have their staff under this system, with the equalization of remuneration between the Government and CHS health workers, they in effect follow this model.

By focussing on organisational hierarchy rather than the needs of the health sector, the Public Service classification system sets up perverse incentives for health staff to leave front line clinical roles and move into administrative and managerial roles as illustrated in **Case Study 1**. Effectively, NDoH is competing with the rest of the health sector for its staff and by doing so is indirectly creating serious anomalies in the distribution of health workers<sup>21</sup>. The establishment of a competency-based remuneration system would enable the work value of health sector work to be recognised on a more equitable basis<sup>22</sup>.

At the same time, remuneration level for certain critical positions in NDoH in areas such as contract

management, auditing, policy development and public health are not competitive in the labour market and as a consequence, NDoH is unable to attract suitably qualified staff to these roles. In the short term, the classification and grading of clinical staff should be reviewed to see if changes are appropriate.

In the longer term, a feasibility study into the viability of establishing a health services commission should be conducted, as proposed under **NHP Strategy 3.5.6**.

Such a body, if appropriately funded, could develop attractive terms of employment that would both retain experienced health staff and attract new people to work in the PNG health sector.

### 2.3.3 Conclusion

The HR Branch has made considerable progress since 2011, particularly in stabilizing NDoH through finalising appointments to the new structure. Progress has also been made on sector-wide HRH initiatives such as national HR policy development, workforce planning, and pre-service training.

However, a number of serious challenges remain in the areas of leadership and people management in NDoH, recruitment to key NDoH positions, staffing data (both internal NDoH and broader health sector), workforce planning, and health sector remuneration. To improve NDoH's capacity to implement the National Health Plan these issues have to be addressed as a matter of urgency. Due to capacity constraints, doing so will require considerable technical assistance.

Recommendations to address these issues are in **Section 4** of this report, while a more detailed analysis of people management in NDoH and its role in relation to HRH in PNG is in **Annex 4**.

Other issues not discussed in this summary section (e.g. staff vacancy rates in NDoH, pre-service training) are also discussed in **Annex 4**.

<sup>21</sup> For example, the review team was informed that there are more medical doctors engaged in NDOH in administrative roles than there are in total in the rural health sector in clinical roles.

<sup>22</sup> This was also a recommendation of the UTS work value study on nursing in PNG in relation to nurses but it has not been implemented. See UTS/WHO (2008) *A report on the work value of nurses employed in public health facilities*, p6

## 2.4 The Finance Branch

### 2.4.1 Overall assessment

The finance branch is part of corporate services and is made up of the following units: financial accounting, financial management services, accounts payable and budget and reporting. According to the most recent staff establishment data provided to the assessment team there are twenty three posts of which nineteen are filled (overall four vacancies).<sup>23</sup>

### 2.4.2 Findings

#### Public finance management

PFM focuses on all aspects of the budget cycle which guide all public revenues and expenditures which include: planning, budgeting, budget execution (revenue collection and procurement), internal controls including internal auditing, monitoring, accounting, reporting and external audit. This assessment has been requested to focus on only some steps of the whole PFM process.

However, it is strongly recommended that a review of the whole PFM process is undertaken for the NDoH which would be a cross cutting and inter-sectoral exercise, as some issues have been long standing and require remedy. It would be important that such a process remain iterative and is led by NDoH, with buy in of relevant central agencies, and is not perceived as another ‘assessment.’ Taking a phased or platform approach with achievable milestones to the implementation of improvements as the work is undertaken will be important so that success is built into the process and progress against milestones is tangible. The approach taken by the recent CHS Technical Assistance Mission which worked over a 4 month period could be a useful model to replicate.

PFM in the PNG health sector has had some analysis and recommendations in the past, with the 2011 Health Sector Wide Assistance Program (SWAp) review recommending:

- Revisiting the Chart of Accounts to achieve a good fit between NHP Key Result Areas (KRAs) and programs and then programs and activities.
- A practical ‘bottom- up’ and linked planning and budgeting process
- Improvement in the systems to track expenditures.<sup>24</sup>

#### Chart of accounts

Some small successes have been achieved and implemented to resolve the long standing issue of linking planning, budgeting and expenditure and this has mainly been through the revision of the COA. The COA now includes codes for nine program areas<sup>25</sup> and numerous activities. However the 2011 Diagnostic Assessment noted that the NHP had been costed yet there was no ability to update these. The Medium Term Expenditure Framework uses the costing of the NHP, threatening its credibility. The current changes in the COA will not be able to rectify this.

Any assessment or analysis of appropriated and actual budgets and expenditures against NHP key result areas will need to be undertaken and recoding expenditure data produced by the COA against NHP key result areas. Such an exercise would be a valuable contribution to measuring progress and overall results against the NHP.

#### Planning and budgeting

A more participatory and evidence based budget development process is desirable which is linked to planning, actual budgets available and prior expenditure data and this has been recommended previously. To this end some progress has been made and in 2013 a 80/20 budget process was instituted by the Budget and Finance adviser with a purpose to: “demonstrate and provide the

<sup>23</sup> See Annex 5 for full details of staffing and the finance branch

<sup>24</sup> NDOH Capacity Diagnostic report. November 2011

<sup>25</sup> These areas are general admin and executive; rural health; urban health facilities; public health; disease control; environmental health; health promotion; supplies and distribution and HRM

monetary space to re-programme available funding towards current priorities and away from legacy programmes”.

The process allows for a two stage re-programming and follows the following steps:

- Step 1: Internal budget ceiling of 80 per cent of 2013 appropriation for all programmes
- Step 2: Critical programmes, items subject to contractual agreements and necessary office running costs (referred to as quarantined items) are reviewed individually and either brought back to 2013 level or actual budget submission inserted.
- Step 3: Any balance remaining is offered to Programme Managers through Executive Managers to bid against each other.
- Step 4: Budget and Finance Committee consider the bids and decide which will be incorporated into the budget submission.
- Step 5: Any items that cannot be incorporated into the normal budget submission may be submitted separately to treasury (this was applied to the 100 per cent kits for the 2014 submission).

This process was followed in 2013 and has just concluded the final budget and planning workshop where all bids were discussed and decisions made about competing bids. There is now agreement on a budget which matches the ceiling provided by DOT for Division 240 Goods and Services. Division 241 budgets were also submitted for review including the Church Health Services Budget. Noting that during this process there were some transfers between recurrent budget and development budget, mainly for medical equipment.

### **Expenditure tracking**

Expenditure tracking will now be possible by program areas and this data should be made available during the formation of the next budget cycle.

Larger public expenditure tracking exercises in the sector to facility level should be considered in conjunction with the World Bank in the future. Undertaking a pilot of facility level budgeting would also assist in implementing both more participatory budgeting processes as well as enable facility level expenditure tracking.

### **Overall budget credibility**

For budgets to be credible, the whole budget cycle needs to be addressed, from budget preparation through to spending and expenditures. The NDoH budget process suffers from downward differences between the costed estimates of the NHP, the annual budget submissions, the appropriated budgets as well as actual expenditures, which include both overruns and underperformance. The following data highlights some of these discrepancies.

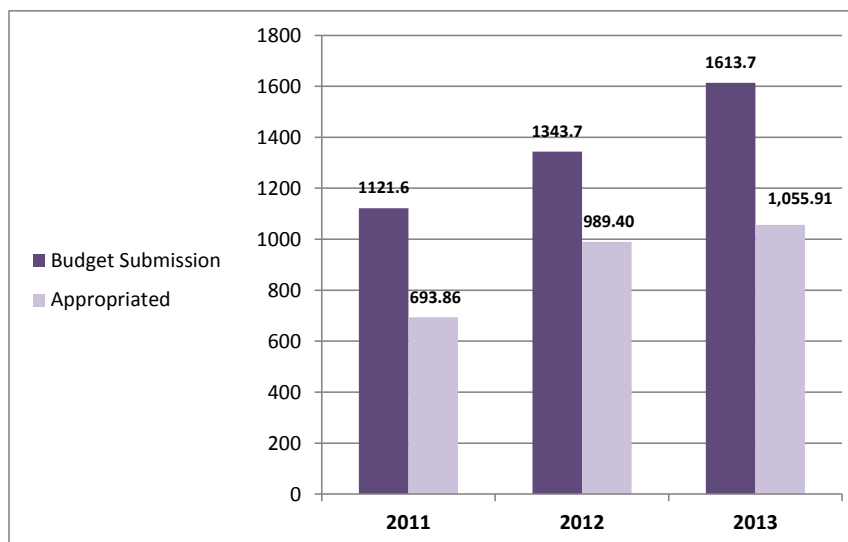
Starting with **Table 1** and **Figure 2** below which show the ‘big- picture’ with sliding downwards differences between the NHP costings, the budget submissions and the final funds appropriated over the past three years (2011-2013) and including funds from DPs. The figures from the Australian Government are provided by DFAT and assumed accurate and for other DPs are approximate figures,<sup>26</sup> so they are shown in separate columns in **Table 1**.

<sup>26</sup> Other DPs include: NZAID, WHO, UNICEF UNFPA, Clinton Fund, ADB, Global Alliance for Immunisation and Vaccination, GFM, GFA, GFT and the EU. Data kindly provided by Navy Mulou NDoH

**Table 1: Difference between NHP costing, budget submissions and appropriated funds**

Year	Accumulated NHP Costing	* Budget Submission	* Appropriated	Australian Govt	Other DPs	Appropriated + Australian govt + other DPs	% Difference App + Aus Gov, DPs to Submission
	1	2	3	4		5	row 5-2
2011	1,339.00	1121.6	693.86	193.19	105.89	992.94	minus 12%
2012	2,678.00	1343.7	989.40	267.50	31.58	1,288.48	minus 5%
2013	4,017.00	1613.7	1,055.91	279.89	19.19	1,354.99	minus 16%
PGK 000s							
* Includes HISP and HFG							

**Figure 2** below shows a graph representation of downward differences between the 2011- 2013 budget submissions and then the appropriated budgets for NDoH. The differences are minus 26 per cent, minus 21 per cent and minus thirty five per cent respectively and without DP contributions.

**Figure 2: Difference between appropriated budgets and submissions 2011- 2013**

By drilling down to budgets in the NDoH itself, budget spending and expenditures are identified in data taken from the 2012 NDoH Annual Report. Unfortunately this could not be compared with 2011 data as there was no financial reporting available in the NDoH 2011 Annual Report. Note that the 2014 NDoH budget submission for 240 and 241 divisions is a total of PGK 1,6541.8M. With the GoPNG stating in the 2014 budget presentation, that the health sector will be a priority for increased funding, it will important to continue to track discrepancies between NDoH budget submissions and appropriated budgets in 2014.

**Table 2** which follows shows the difference between the NDoH 2012 appropriated budget and actual expenditures by budget category for recurrent and development, with an overall underspend of 30 per cent.

The 2012 recurrent budget was underspent by 6 per cent, whereas the development budget was underspent by 62 per cent. This is a similar pattern to the same data as presented in the 2011 Capacity Diagnostic Assessment which showed an overall underspend of 23 per cent in 2010, with recurrent at 6 per cent and development 23 per cent underspent.

**Table 2: Summary by expenditure by economic classification (PGK 000's)**

Expenditure Type	2012 Budget	2012 Actual	% Difference
Personal Emoluments	62,769	60,246	minus 5%
Goods and Services	166,587	166,117	0
Grants and Transfers	13,410	13,400	0
Capital Expenditure	26,002	15,301	minus 41%
Other	0	0	0
<b>Total Recurrent</b>	<b>268,768</b>	<b>255,064</b>	<b>minus 6%</b>
Development Budget (GoPNG / Dev Partners (HSIPTA))	197,216	75,246	minus 62%
<b>Total</b>	<b>465,984</b>	<b>330,310</b>	<b>minus 30%</b>

**Table 3** which follows shows the recurrent budget and expenditures only by NDoH program areas. There is an overall underspend of 24 per cent with human resources, urban health and environmental health being the least able programs to spend their budgets.

**Table 3: Recurrent Budget: Summary by expenditure by program classification (PGK000's)**

Description	2012 Budget	2012 Actual	% Difference
Top Management and Admin	38,893	34,044	minus 12%
Urban Health Facilities	39,391	16,597	minus 58%
Family Health Services	2,897	1,618	minus 44%
Disease Control	7,917	3,896	minus 51%
Environ Health & Water Supply	1038	212	minus 80%
Health Promotion & Education	959	462	minus 52%
Medical Supplies & Equipment	150,659	137,519	minus 9%
Human Resource Development	27,014	11,000	minus 59%
<b>Total</b>	<b>268,768</b>	<b>205,348</b>	<b>minus 24%</b>

The NDoH Finance branch faces many challenges and some of these are:

- Staffing levels not meeting the establishment requirements urgently need to be addressed.
- Underspend in the development budget and compliance issues continue with numerous examples of branches not following procurement procedures as outlined in the finance instructions. Non-compliance with advance management procedures is of concern. The Auditor General Office confirmed that PGK 12M of advances are outstanding from the 2011 audit, monthly reconciliations to Treasury are not routinely done and budget overruns or underspends in divisions are common. Although worth noting is that efforts have been made in 2012 and 2013 to address these outstanding advances.

Broader finance issues in the health sector which require leadership and collaboration across NDoH divisions and other institutions to rectify are:

- Such issues need to be rectified and require management leadership, the implementation of existing internal management tools such as the virement process to get treasury approval to move budgets between divisions, and an active internal audit procedure that picks up inconsistencies in budget execution and follows them through until resolved. Application of such management tools should be linked to quarterly budget reviews so that reallocating funds from underspent areas is documented. This will then strategically assist when addressing issues between budget submissions and appropriations (i.e. especially for high priority areas and specifically in 2014).
- A further long standing issue is the discrepancy between the appropriated budget and the issue of warrants by Treasury. This results in delays in overall budget execution to NDoH branches and health facilities, including CHS. Finance Unit staff report that this has resulted

in a reduction between the appropriated budget and warranted funds to the amount of 10 per cent, resulting in a budget shortfall of about PGK 10M to date in this financial year.

### 2.4.3 Conclusion

The following recommendations are made in light of the issues identified during this and other external assessments. Each task will require some level of short term technical assistance and will focus on improving overall health sector as well as NDoH's budget execution and performance, linking and analysing budgets, plans and expenditures in a more meaningful manner and improve the possibility of achieving NHP key result areas (KRAs) 1, 2 and 3.<sup>27</sup> These are written in order of priority.

- Assess the whole PFM process for the NDoH and not in a piecemeal manner and include internal horizontal relationships with NDoH sections such as policy and planning and external relationships with Department of Finance and Treasury. In this task, also focus on the use of the available internal management tools to enhance budget execution by the finance unit.
- Develop an action plan and performance measures to improve and implement change in the PFM process and increase the use of existing management tools in budget management and execution. This will require external short term technical assistance.
- Develop a methodology to review, assess and analyse NDoH costed plans, planned budgets, appropriated budgets, actual budgets and expenditures by NHP key result areas at least annually. Provide such analytical data to management on a regular basis and is foreseen to be part of the Corporate Governance arrangements.
- The establishment of the Finance and Planning Sub Committee in the Corporate Governance structure offers new opportunities for regular oversight, analysis and linking of planning and finance (budgets and expenditures) progress in the sector. The provision of some short term technical assistance to this Sub Committee could be warranted in order that systems and process are established.
- With the World Bank explore opportunities to undertake public expenditure tracking to the health facility level. Comparisons could be done between facilities run by CHS, PHAs and non PHA provinces. Short terms external technical assistance will be required if this option is perused.

## 2.5 Internal Audit Office

### 2.5.1 Findings

The Internal Audit Office reports directly to the NDoH Secretary. According to the latest establishment figures provided to the assessment team, this office is meant to have ten positions however according to staff records there are five of those positions filled (50 per cent). The staffing levels have improved somewhat since the 2011 assessment (at that time two out of nine posts were filled or 22 per cent). It was reported to the assessment team that it has been very difficult to fill these positions, as well as finding staff with the competency and attitudes required.

There has been a HHISP recruited international adviser providing support to the internal audit office and finance branch full time for the past twelve months and note this position has been in place for 7 years under the previous CBSC and then HHISP.<sup>28</sup> Full staffing establishment and vacancies data for the internal audit office is provided in Annex 6 of this report.

<sup>27</sup> KRAs 1, 2 and 3 are: 1: Improve Service Delivery; 2: Strengthen Partnerships and Coordination with Stakeholders; 3: Strengthen Health Systems.

<sup>28</sup> This adviser left in October 2013

Some progress has been made in the past twelve months, for example, there is now an audit plan for 2013 and there has been a reported decrease in budget irregularities (supported by the Auditor General's Office May 2013).<sup>29</sup>

However, as reported in 2011, the internal audit unit has a 'financial policing function' rather than a focus on systems audits in support of continuously improving financial management practice.

This dichotomy has also been reported on the Adviser's exit report stating: *"it should be noted that the NDoH Internal Audit Division is under extreme pressure to provide urgent investigations which are outside the 2013 audit plan"*.

### 2.5.2 Conclusion

Given the 'policing function' emphasis, the redirection of internal audit staff to undertake investigative work, recent operations of the fraud squad, and the opportunity to get higher salaries in the private sector, it is understandable that filling these vacant posts is difficult and long standing. However, considering the challenges around overall budget execution and the inability to get internal audit performance functions up and running the following three pronged recommendation is proposed:

1. Long term external technical assistance to the internal audit section to: (1) undertake a review of the internal audit policy, premise and standard operating procedures for internal auditing, with a view to shift from a 'policing' modality towards a focus on systems audits which will provide feedback and solutions for continuous improvement of financial management practice; (2) to develop a short and medium term capacity development plan for the internal office staff and provide on the job coaching and mentoring to the internal audit staff; and (3) provide opportunities with cross visits/exchanges to and from locations which have functioning and successful internal audit functions operating.
2. Consider an upward GoPNG reclassification of internal audit posts – which may alleviate the long standing vacancy issue. Competent national advisers could be sourced in the interim, in a capacity substitution role to get this function operating and establish sound internal audit systems and procedures.
3. Supporting the Internal Audit Committee of NDoH and its scope of work. This may require some short term technical assistance to ensure systems and processes are established and functioning. Paying particular attention to addressing the recommendations from the Auditor General's Office and monitoring the balance between internal audit 'policing' work and undertaking internal systems audits in support of continuously improving financial management practice.

## 2.6 Public Health Branch

### 2.6.1 Overall assessment

The Public Health Branch shows marked improvement since the last diagnostic in 2011. At that time, most senior leadership positions in the branch were unfilled, and there were pending shortages of supplies of essential vaccines and tuberculosis (TB) drugs for the sector. The completion of CBSC, coupled with the discontinuation of the role of NDoH as principal recipient of the global fund, was directly impacting on the number of skilled personnel. The impact of the cholera outbreak and the H1N1<sup>30</sup> threat, alongside the need to intensify efforts to improve maternal mortality, were a major challenge.

The immediate commodities crisis was averted with DP assistance, and now two thirds of the 161 positions in the branch have been filled, including the recruitment of a cohort of younger graduates. Amongst the new staff, in some instances, there is evidence of an improved work culture with staff arriving to work early and welcoming opportunities for learning and growth.

<sup>29</sup> Reference cited in Ted Jones the Adviser's exit report, October 2013.

<sup>30</sup> Influenza A virus type



DP supported scholarship programs have been intensified, offering the prospect of PNG professionals occupying many of the technical positions in the Branch within the next five years. The loss of principal recipient status of the Global Fund appears to have had a positive impact, as it assisted the branch to focus more on its core strategic and policy function.

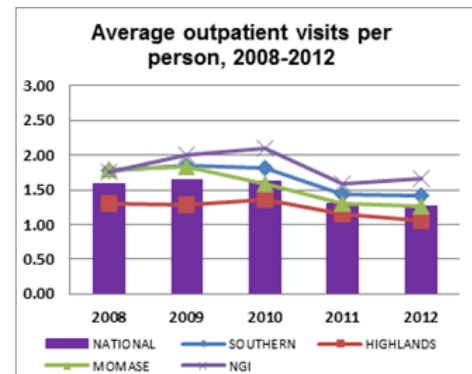
## 2.6.2 Findings

### Current progress of NHP in Public Health

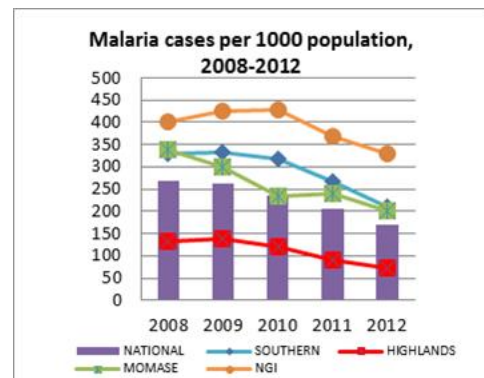
Although progress has been made, performance, capability and capacity of the branch remains well below that required to deliver on the NHP. The Branch leads five of the eight National Health Plan KRAs, including the health related Millennium Development Goals (MDGs) and these are:

- KRA 4 – Improved child survival
- KRA 5 – Improved maternal health
- KRA 6 – Reduce the burden of communicable diseases
- KRA 7 – Promote healthier lifestyles
- KRA 8 – Improve preparedness for disease outbreaks and emerging population health threats.

Findings from this assessment are that implementation of the NHP is falling behind schedule. Progress is barely discernible in national immunization coverage (outside of DP assisted - Supplementary Immunization Activities programs (SIAs), pneumonia case fatality, neonatal deaths, reduced malnutrition, family planning coverage, safe deliveries, emergency obstetric care and child nutrition. The “back to basics” strategy is not yet being reflected in process indicators such as OP visits. If more capacity was being built in the sector, one would at least expect more people to be seen. The graph opposite shows a summary of outpatient visits 2008 -2012 and in decline.



Underneath this bleak national picture, impressive achievements are being seen in some programs and in some locations. There is progress in reducing malaria morbidity and mortality nationally. The national malaria control program has achieved a sustained reduction in cases per 1,000 people in all regions. This success has been building for a number of years, with modest reductions from 2001-2010, and an increased rate of reduction in the last three years. This success offers valuable lessons for other areas. The graph opposite shows the reduction in malaria cases over time.



It is built on effective leadership, sustained funding, effective partnership approaches nationally and at the local level, technology and service innovations (such as Mala-1<sup>31</sup>), accessible diagnostic tests and bed net distribution. Use of these has been informed by locally generated operational research.

Improvement is also being seen in some localities. The National Capital District had 14,000 children unvaccinated with Penta 3 in 2008, and had reached over 100 per cent coverage two years later. New Guinea Islands region have maintained Penta 3 vaccination levels over 80 per cent for the last three years, and the region has increase supervised deliveries by 10 per cent in the last year. These improvements are impressive, but to achieve system wide improvement, better understanding of the drivers of these successes is required, and attention paid to the mechanism by which good ideas and success are spread across the system.

<sup>31</sup> Artemether and lumefantrine.



Of particular concern is lack of progress in addressing the fundamental equity focus of the NHP, in particular the needs of the rural majority. Equity differences are seen between regions, between provinces, and between districts. **Annex 8** shows the differences in access to supervised deliveries in health facilities between different districts. A women's chance of accessing this basic maternal service differs by a factor of 50 between the best and the worst performing districts<sup>32</sup>. Large urban centers and provincial hospitals are providing excellent access (over 100 per cent in some cases as they attract women from surrounding districts), while remote rural areas, which contain large populations, are extremely poorly served.

As investment begins to increase into the sector, mechanisms to ensure equity is addressed become extremely important. The political economy of the health sector inevitably directs growth to larger urban health facilities, further perpetuating the access inequalities seen in **Annex 8**.

Clearer direction needs to be given to the sector on how to pursue health equity. This is important for the nascent PHAs, where the institutional separation of the hospital and rural services has been eliminated. Equity analysis, and actions being taken to address equity, need to be central to the PHAs operations, and reflected in their resource allocation decisions.

The same applies to the most peripherally focused funding stream, the District Service Improvement Program which is under the control of local MPs, and injects PGK 2M per year into health at the district level, is another opportunity that is currently undirected. The equity issue is also relevant to the increased investment in Christian Health Services, another opportunity to leverage greater resourcing to more rural areas, but which will require stronger central guidance if equity objectives are to be met.

### 2.6.3 Implementing the NHP in Public Health

There is widespread appreciation throughout the sector for the NHP, to quote a PHA Chief Executive Officer (CEO) *"the NHP is the best thing the NDoH has done."* There is also concern that implementation is weak. In order to explore this further, as part of this diagnostic, the plans of a number of the branch's units were reviewed. There were comprehensive strategic plans available; however the Annual Operational Activity Plans were of variable quality.

In a number of plans, there was no budget attached to a number of activities, and where budgets were available, they appeared to primarily reflect DP commitments to specific activities, rather than a logical extension and rational distribution of resources towards all the elements necessary to drive the strategic agenda forward. Operational expenditure appeared to be the driving influence of the plan, and the people resource of the unit, the largest resource component, was not explicit in the plans.

This gap in the planning process reflects the lack of management capacity in some of the units, but also the problems that arise when much of the strategic and financial support is coming from DPs. There is insufficient sense of ownership and control by managers, coupled with an inability to effectively turn strategy into action. Managing a smooth transition from DP led strategy and funding to government led strategy and funding is the core challenge to the provision of technical advice in the branch. Developing a path forward in this respect needs to be tailored to the specific unit, as their needs markedly differ.

### 2.6.4 Technical Assistance

WHO, the Australian Government and the Centre for Disease Control, are currently providing necessary assistance with training for the Public Health Sector in epidemiology and public health. The majority of the newly trained staff will become available to the sector within five years, opening up the opportunity for the phased reduction of existing international technical staff over this period.

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<sup>32</sup> For districts that are adjacent to a provincial hospital, access may be reasonable. Further analysis is required to separate out these from the analysis presented.

External technical assistance is playing a major role in the Branch, predominantly from WHO, with seven international technical personnel active in the branch. Despite this contribution technical gaps remain. Epidemiology skills are urgently required across the Branch, (currently there is one epidemiologist from WHO working in outbreak control), and these skills are also needed at the provincial level. Much of the interface between the branch and the provinces is led by staff with clinical responsibilities; consequently opportunities to progress a stronger equity focused population health approach, as sector investment increases, are being missed. The Centre for Disease Control is supporting in-country Field Epidemiology Training (FET) with the first trainees graduating in 29 November 2013. The program intends to train one field epidemiologist per district in the next five years. Leadership and management are the biggest areas identified as hampering the branch's progress. Current management training that is being undertaken is timely, and this needs to be coupled with the development of a strong performance management culture in the organization. These processes already have the necessary external assistance, and need to be progressively championed by the NDoH senior staff.

There remain substantial gaps in technical areas that development partners can assist with. For example, epidemiology services are required urgently across the Public Health group and the Provinces. Strategic opportunities to progress the NHP are being missed at the national and provincial levels, due to the absence of a population health analysis and advice to the sector.

HIV statistical reports for example, are two years behind, so decisions are being taken in the absence of vital surveillance information. Provincial plans and budgets are being made without the necessary analytical work to take best advantage of new investments. Epidemiological technical assistance is required to fill the time gap between now and when there are sufficient locally trained staff, and those newly trained in epidemiology will require experienced mentoring and support in their early years of practice.

Consideration could be given to DPs providing an Epidemiology and Population health technical "service" to the sector that Branch units and Provinces could access for assistance. This could be provided on a "task note" or ad hoc basis (utilizing the DP who is best placed to provide support), with each unit or province requesting specific pieces of work, allowing program managers to directly control the inputs and hold the service accountable for its work. The discipline of creating a task note and ensuring service provision would be useful skills for units to develop. It would also allow the units to directly employ newly trained staff as they become available and then progressively move this service "in house".

The Technical Assistance in this instance would be clearly seen as capacity substitution, with a limited time frame. Existing technical assistance to the branch needs to more clearly delineate its capacity substitution from its capacity development function. It would assist the branch development if DPs TA deliverables were specified inside the respective Annual Implementation Plans, and accountability strengthened to NDoH unit management. A phased transition from the current arrangement to phasing in the new graduates is required.

These changes would also be assisted by a shift in the way development funding is allocated, consistent with aid effectiveness principles, and placing NDoH more in the driver's seat. Progressive movement to a program approach at the unit level would improve performance by supporting a more effective planning approach, and avoid the current piecemeal planning where funding sources override planning rationale, and managers are not fully in control of the activities in their area.

## 2.6.5 Conclusion

- Capacity substitution required in the medium term to provide epidemiology and population health technical expertise at the national and provincial level.
- Existing DP TA needs a more explicit exit strategy (how to transition from capacity substitution to capacity building to program support).

- The roles and functions of DPs providing TA should be more clearly defined in the operational planning process within the branch, to prevent ‘agenda overload’ gaps and overlaps, more precisely define the contribution the branch expects from the DP inputs.
- A greater level of commitment is required by all parties to use existing and new structures and processes to improve DP coordination, harmonization and achieve better alignment and thus contribute to achieving the NHP KRAs.

## 2.7 The Medical Supplies Procurement and Distribution Branch

### 2.7.1 Overall assessment

A key function of NDoH is the procurement and distribution of medical supplies however significant problems remain in the delivery of medical supplies to health facilities at rural and provincial levels throughout the country. The strengthening of medical supplies procurement and distribution of is a key result area of the National Health Plan (KRA 3.3). This assessment is limited, noting that a multi-year impact evaluation of medical supply reform was recently completed which will be more comprehensive in scope and should be the basis for further discussion of support in this area.

### 2.7.2 Findings

The Medical Supplies Procurement and Distribution Branch (MSPDB) is based in the NDoH head office, which controls a hierarchy of medical stores across PNG. The major medical stores are in Port Moresby, Mt Hagan and Lae, and additional stores in Rabaul, Madang and Wewak. The number of staff in each Area Medical Store varies: Lae 28, POM 28, Hagen 15, Wewak 10, Rabaul 11, Madang 9, MSPD 13. With a total staff of 114 across PNG. The main stores each have 29 staff and MSPDB has 100 staff across PNG. The scope of supplies is for medical and pharmaceutical supplies. Currently MSPDB is facilitating the procurement of 100 per cent of the medical kits for distribution across the health system and this is expected to continue until at least 2015.<sup>33</sup>

Procurement is currently based around yearly stock takes and bulk order procurement is undertaken either by public tender or quotation. Contracts above PGK 0.5M are managed through the CSTB. There was a proposal to reinstate the Pharmaceutical Supply Tender Board during 2013<sup>34</sup>, but this has not occurred to date.

The work culture in the MSPDB is undergoing transition and the recent introduction of the ‘mSupply’ ordering system, will provide a needs based and more efficient online ordering for supplies via mobile phones, SMS or tablets.

A NDoH governance committee for Medical Supplies Reform was recently formed and should provide improved monitoring and governance over the Branch operations and the implementation of Medical Supplies Reforms.

### 2.7.3 Medical Supplies Reform Plan

A Medical Supplies Reform Plan was developed in May 2013 and implementation of the recommendations has commenced. This new reform plan is not the first effort to reform this vital public health service, major reviews were undertaken with little improvement in 2002, 2004, 2005 and 2011.<sup>35</sup> Some key areas of progress in the current reform plan are:

- The introduction of an ICT inventory and ordering system called “mSupply”, to the NDoH head office and Port Moresby stores. This is planned to roll out to key Provincial stores at Mt Hagan and Lae in 2014.

<sup>33</sup> PNG National Health Plan 2011-2020

<sup>34</sup> Medical Supplies Reform Plan, May 2013.

<sup>35</sup> Policy Brief: Medical supplies reform in Papua New Guinea: Some conceptual and historical lessons, Andrew McNee, Visiting Fellow at the Development Policy Centre, Crawford School, ANU, May 2011.

- The infrastructure upgrade program has seen Medical Stores at Port Moresby, Mt Hagan and Lae in the process of upgrading. Further upgrades are planned for the key medical stores at Rabaul and Madang.

#### 2.7.4 Technical advice

The MSPDB has received consistent TA over many years and the Australian Government (through HHISP) currently provides two advisors - one advisor counterparts the Branch Manager in the MSPDB, and a second as counterpart with the Area Medical Stores managers, warehouse management and logistics advice. Note the advisor for warehouse and logistics is a short term role and concludes on December 31st 2013, with the procurement advisor contracted through to 2015. Given the current momentum and success of this work so far, and the contract end dates, we recommend that this technical support (both positions) should continue over the 2014-15 period (which is not 'new' support but continuing existing work).

WHO also provide an advisor for forecasting and quality assurance issues to inform procurements and with positive results.

## 2.8 NDoH infrastructure branches

### 2.8.1 Overall assessment

The infrastructure implementation capacity of NDoH was not part of the 2011 review. A baseline review of NDoH Infrastructure capacity is included in **Annex 9** of this report.

**NHP Infrastructure Program:** The NHP 2011- 2020 establishes a strategy for investing PGK 3.374B in health infrastructure over that period. NDoH has developed a Mid Term Development Plan (MTDP) 2011-15 with a strategy for investing PGK 1.5B, in health infrastructure for the mid-term period, requiring PGK300M expenditure every year. Progress of the MTDP will be the key focus of this review.

**MTDP 2011-15 Health Infrastructure Program:** The MTDP 2011-15 has a priority for improving health services to the rural majority and urban disadvantaged. The plan was developed and costed with broad stakeholder consultation including Provinces, Hospitals and Provincial Health Authorities. It aligned planned projects with respective 5 year Strategic Implementation Plans and the overall National Health Plan 2011-2020.

The scope of infrastructure for the MTDP 2011-15 is for 1,130 infrastructure (building) projects across the entire health sector with project types spanning from local level Aid Posts through District Hospital to Regional Specialist Hospitals. To achieve the MTDP 2011-15, the average annual Infrastructure program is for 226 major infrastructure projects each year. The MTDP infrastructure program also includes static plant and medical equipment.

### 2.8.2 Findings:

**Progress of the NHP Infrastructure Program:** Based on the most recent Capital Works Quarterly Report (July 2013) the progress of the NHP infrastructure program is:

The Capital Works Program has a total of 359 projects and has a total value of PGK 382M as follows:

- 121 projects are for buildings.
- 238 projects are for static plant and biomedical equipment.
- 66 projects are yet to commence, all are buildings.
- 24 projects are in design/documentation, all are buildings.
- 42 projects are in construction/installation, 18 are buildings.
- 41 projects are in post contract defects liability, 13 are buildings.
- 198 projects are awaiting tender approval, 13 are buildings.

The projects are in all phases of delivery from concept through to post contract defects liability.<sup>36</sup> Due to the elongated process of implementation of capital works, the program generally reflects two financial years of activity. This includes projects in implementation (design or construction) through to projects in post contract defects liability (occupation directly after construction).

The Capital Works Quarterly Report does not track progress of all Health Infrastructure projects in PNG with the following notable exclusions RPHSDP, Sexually Transmitted Infections (STI) Clinics (by the Australian Government) and Church and Non Government Organisations (NGO) agency projects.

No qualitative assessment has been made of the design or construction of infrastructure under the National Health Plan to date as this is beyond the scope and time available to this review.

The rate of progress of key building infrastructure for the National Health Plan has generally been poor in the first two years with only 5-13 per cent of key infrastructure under way. The current progress of capital works infrastructure against the Mid Term Development Plan 2011-15 (to July 2013) shows that 40 per cent of the time expended (2/5 years). The corresponding progress in expenditure or value of infrastructure completed or in progress is 24 per cent (0.36/1.5M).

On the figures available, the estimate of progress of infrastructure delivery against the Mid Term Development Plan 2011-15 is a shortfall of 40 per cent. This translates to the current infrastructure program being approximately ten months behind schedule. In addition, the current institutional arrangements for delivery of infrastructure are not delivering infrastructure at the anywhere near the pace required to deliver the NHP and must change.

The current program has a high quantity of Equipment and Static Plant projects, masking the lack of progress in key Building Infrastructure projects. Equally the program does not include STI Clinics and the Rural Primary Health Services Delivery Project.

The NHP has an average annual program of 226 new major infrastructure projects (buildings) on a year to year basis. This is the baseline for measuring future progress of infrastructure for the NHP.

**NDoH Infrastructure Capacity:** NDoH has functioning Infrastructure Divisions delivering infrastructure for the NHP. The capacity to deliver the full scope of infrastructure required by the NHP is weak and needs strengthening. The current level of skills and experience within the Infrastructure Divisions is generally at a low level and there are key gaps in areas of design expertise particularly Health Facility Planning and Cost Control of infrastructure.

Twelve months ago the NDoH's level of performance for infrastructure delivery was poor. However, in the past twelve months there has been positive change in performance with improved output. The recent shift to outsourcing design should continue to grow the capacity for infrastructure delivery. The change in operations to outsourcing will be significant for the Infrastructure Divisions and will change the staff and skills required for the Departments infrastructure activities as it moves from project implementation to project management.<sup>37</sup>

The NDoH Infrastructure Divisions are currently under resourced with key establishment staff positions not filled. Moreover the scale of infrastructure activities required for the NHP needs to be recognized and the numbers of staff infrastructure personnel expanded to meet the challenge. There is a vital need for a sector wide review of resources capacity to deliver infrastructure for the NHP. This should inform future strategies and resources for infrastructure delivery within NDoH. Although assessment of provincial level infrastructure capacity is not part of this report, NDoH identified that capacity building of infrastructure delivery at provincial levels is an overall priority for the health sector. They report that currently infrastructure delivery at provincial level is confined to three provinces, and this limits the flexibility and capacity of the health sector to deliver infrastructure for the NHP.

<sup>36</sup> Defects liability is the post contract stage directly after construction completion where the builder retains liability for defects rectification (usually 1 year).

<sup>37</sup> Both Infrastructure Branches have identified a need for skills upgrade to keep pace with the changing work environment.

The development of a nationwide maintenance strategy is required to match the growth in new facilities across the country. This is a key strategy for building sustainability around infrastructure for the Health Sector. This will require the development of a nationwide strategy with a budget allocation, a maintenance plan for each piece of infrastructure and skilled staff to manage the work. This is a key area of further policy development for NDoH that also acknowledges the accreditation implications of maintaining (or not maintaining) infrastructure as well as a strategy for planning and implementation of maintenance at the facility or infrastructure level. See **Annex 9** for further details.

**NDoH Infrastructure Design Standards:** In the past twelve months Health Facilities Standard Branch has developed design policy standards for Health Infrastructure. A key achievement has been the publication of the National Health Service Standards for PNG 2011-2020, and is based on the Australian Health Facilities Guidelines. This document needs further refinement for the PNG context, sustainability and clinical input.

In addition, design policy standards have advanced with standard template designs for Community Health Posts. The template design approach is a key strategy for predictability in infrastructure across the country and should be expanded for other types of health facilities. The template designs need further refinement with clinical input construction detailing and sustainability. The lessons learned from the RPHSDP should be integrated into the template designs. The recent introduction of NDoH governance committees for Infrastructure Standards and Design provides a mechanism for clinical and stakeholder input into Design Standards and is supported by the assessment team.<sup>38</sup>

### 2.8.3 Conclusion

Progress in the first two years of the NHP infrastructure program has been poor and is currently 10-12 months behind schedule. NDoH has functioning Infrastructure Divisions with weak capacity due to under resourcing and gaps in expertise. The Department recently introduced outsourcing of design, which is significant and positive, and its infrastructure operations will now transition from project implementation to project management.

NDoH should aim to be the National agency coordinating health infrastructure delivery across the sector, and focused on managing quality, standards and results in annual infrastructure plans. To some extent this is already happening and will take time to mature and will be dependent on capacity building across the sector. The quarterly infrastructure program reports should track all projects across the health sector.

Overall the current arrangements for infrastructure implementation are progressing although not at the pace required for the NHP and must change to meet the challenge. A new approach is required with a more ambitious planning of infrastructure projects and more involvement of private sector resources. The annual infrastructure program should match the Mid Term Development Plan on a yearly basis and schedule the required 226 new major projects.

There is an urgent need for a sector wide strategic planning review of resources to deliver annual infrastructure programs, matching resources with the annual plans. There is a key role for DPs to support NDoH in this activity.

Unblocking delays at the CSTB should be a priority for NDoH to improve infrastructure delivery.

The PNG private sector may not be able to fill all the capacity requirements of the NHP as it also has some capacity weaknesses particularly skills and experience in engineering and high end health infrastructure. NDoH may need to extend outsourcing to international resources to a greater extent to fill these gaps. The expansion of the special project strategy may provide a key mechanism for large volume infrastructure delivery and involvement from international resources.

<sup>38</sup> NDoH Governance Charter, October 2013, includes a Standards Monitoring Committee with Health Facilities Design and Standards sub committee. The correct functioning of these committees should provide a forum for clinical and stakeholder input to design and standards.



There is a pressing need for sector wide professional development and in-service training to build local capacity for health infrastructure implementation. This is a key area for DP support.

## 2.9 NDoH and Provincial Health Authorities

The emphasis for this diagnostic assessment was predominately NDoH. However the assessment team was asked to comment on the technical collaboration required by NDoH staff to continue rolling out key GoPNG policies including the PHA process. No visits were made outside Port Moresby but a telephone conference was set up with Western and Eastern Highlands PHA Chief Executive Officers in those locations to facilitate a discussion.

Three provinces have been the pilots for establishing Provincial Health Authorities, under the Provincial Health Authorities Act 2007. The Western Highlands Province, Milne Bay Province, and Eastern Highlands Province have now established PHAs, and a number of other provinces have expressed an interest in making this transition.

NDoH has a group dedicated to assisting the establishment of PHAs, the Provincial Health Authority Reform Team, situated in the Strategic Policy Division of the NDoH.

A recent review<sup>39</sup> and the views of the PHA CEOs, all point to slow progress in establishing the PHAs as well as slow progress in empowering those that have been established. These new organisations face significant obstacles both at the provincial and national level. At the national level, PHAs are requesting greater authority over their finances and workforce, and thus far the NDoH team has been unable to effectively negotiate with the central agencies (DPM, Treasury) over removing these institutional barriers. At the local level, PHAs are formed “by agreement” with the Provincial Governors, in accordance with Organic Law. Such agreements have been hard to reach, difficult to enforce in terms of funding flows, and are time limited so have to be periodically re-negotiated.

This situation has not changed significantly between 2011 and the present. However, there is a review of Organic Law currently underway and this may provide a window of opportunity to address the fundamental tensions that exist between establishing PHAs and the current Organic Law. Short term technical assistance will be required to provide legal input into this review.

There is a proposal to establish a Project Management Unit dedicated to establishing PHAs, independent of the public service. This has been approved by the NDoH Senior Executive Management [SEM] and submitted to DPM in March, 2013. A formal response is still pending.

The GoPNG has expressed its intention to roll out PHAs to a number of provinces, as opposed to focusing on the existing three to resolve the significant establishment problems before taking the concept further.

The success of the PHA in effectively achieving these goals will ultimately depend on each provincial authority’s governance and leadership capacity. It is widely acknowledged that the existing PHAs are amongst the strongest health leadership teams in the country. The majority of provinces do not yet have the capacity to manage the implementation process nor the appropriate governance and leadership ability to achieve the objectives of the PHA Act.

The impasse in PHA establishment, coupled with the potential extension to additional provinces with weaker management capacity, raises issues for the direction of this project and the resources required (in addition to technical assistance) to achieve implementation. A deeper assessment of this situation is required to craft a way forward to meet the governments’ objectives, and this needs to precede decisions about further Technical Assistance.

The two Chief Executive Officers the assessment team spoke with requested that their full time international advisers remain and found this type of technical support extremely positive, helpful and sufficient.

<sup>39</sup> *Provincial Health Authority Implementation Review*, 17 April 2013

### 3. Other findings

#### 3.1 Christian Health Services Secretariat

##### 3.1.1 Overall assessment

The CHS are considered the largest partner in delivering health services to Papua New Guinea and a major contributor to the attainment of the NHP. Churches today cover for 47 per cent of total health services of which 80 per cent is based in the rural remote areas with the remaining 20 per cent in urban areas. Churches also provide and administer twelve Community Health Care Worker (100 per cent) and five General Nurse training schools (70 per cent).

The Christian Health Services formerly known as Churches Medical Council [CMC] is the governing body of the Church run health services throughout the country. The CHS was formed on 12<sup>th</sup> September 1965 by the mainline churches to unite all the faith based churches to be recognised by state as the major partner in National Health and collectively seek funding assistance.<sup>40</sup>

The relationship between the CHS members at the different levels of government varies, yet the general acknowledgment is that no party can survive on its own. Therefore Church partners are involved in Provincial Annual Activity Plans, quarterly provincial performance reviews, in-service trainings, distribution of health functional grants that goes into the provinces, accessing of health grants to the provinces by development partners through HSIP [Health Sector Improvement Program].

Under the Organic Law because CHS operations are rural based, the functions of CHS are the responsibility of the respective provincial governments. As such all activity and finance reports are sent through the provincial health office with copies only to the CHS Secretariat Office for further monitoring and evaluation.

Although the CHS operates autonomously, they recognise the requirements under the Public Finance Management Act and other legislation that require accountability and reporting.

The CHS and its Secretariat are responsible for managing over 700 facilities and approximately 3,300 staff. The CHS Secretariat currently has four staff, with capacity for eight and a plan to expand to fifteen positions. These staff provide functions such as Chief Executive Officer, accounting, IT, human resources and a driver. The Secretariat needs clarity on the TOR for the operations of the Secretariat. The operations are currently guided by vision, mission, goals and objectives. The Secretariat also ensures that its members operate within the legislative frame work of the CHS Act.

##### 3.1.2 Findings

**Legal and policy frameworks:** The CHS operates within a legal framework with the key element being the Christian Health Services Act of 2007. In addition the following NEC decisions are relevant:<sup>41</sup>

- 220/1990- refers to specific re conditions of service of Church Health
- 102/1992 – refers to recentralization of Church Health Services Subsidies
- 132/1996 – refers to a computerization of Church Health Workers salaries
- 375/2013 – refers to recent increase in operational and staffing grants to CHS.

<sup>40</sup> <http://www.chspng.org.pg/facility.html> and briefing note from Joseph Sika CHS

<sup>41</sup> Other relevant agreements for the CHS are: i) State Church Partnership 2008 amongst leaders of the different Christian Churches and GoPNG to be coordinated and monitored by the Department of National Planning and Monitoring; ii) National Health Sector Partnership policy of May 2013 which stands as the over-arching guideline for how CHS will partner with the NDOH, with role delineation at provincial and district levels of health service delivery and iii) Individual Church Agencies have MOU/MOA with respective provincial governments through the health division for health service delivery in the province and districts



The CHS was involved in developing the 2012 -2020 NHP, observes the NHP and supports the NDoH and Provincial health divisions in their strategies to deliver health outcomes.

**Planning, budgeting and fund flow:** All CHS member agencies prepare facility based annual investment program and budget estimates in April of each year. Copies are sent to the Provincial Health Office and the CHS Secretariat. These are guiding tools for the CHS Administration to prepare a consolidated National CHS Budget which is consistent with the Department of Treasury (DOT) budget ceiling. NDoH then prepares the National Health Department Summary Budget and submits it to the DOT. The budget is then appropriated annually by Parliament, CHS Secretariat prepares monthly cash flows for each agency/province, these are submitted the NDoH budget section and NDoH includes the CHS cash flow with NDoH's cash flows and these are then submitted to the DOT for the issuing of warrants.

In 2013 the CHS has an appropriated budget of PGK 94.42M<sup>42</sup> from Government of Papua New Guinea (GoPNG), of which approximately 80 per cent is spent on salaries. Annual budgets, monthly financial requests and reports are produced and these are in line with NDoH and DOT requirements in order to government receive funds.

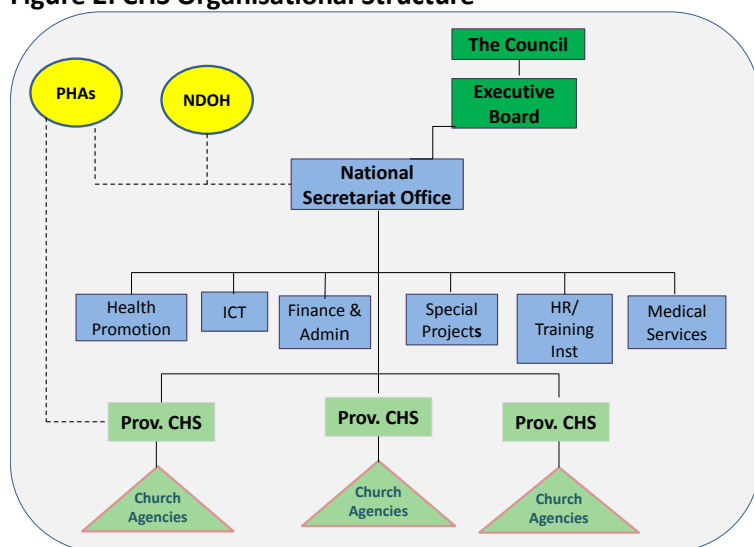
There was no evidence of financial expenditure reporting and analysis, different chart of accounts are used by the CHS from those used by the NDoH as well as different accounting systems. There was also no evidence of reporting by health programs, outcomes or key result areas of the NHP by CHS Secretariat.

There have been recommendations made in other studies about the need to ensure the CHS health workers employed in NDoH-registered CHS health facilities receive the same salary award as other staff and to have an automated, centralised and transparent payroll for the CHS personnel receiving GoPNG funds.

It has been estimated that an additional PGK 40M is required for salaries and goods and services for 2014. Based on the recent CHS Technical Assistance Mission, a National Executive Council (NEC) cabinet submission approving the equalization of salaries between Government and CHS health workers was officially endorsed by NEC in early November 2013. This is a very positive sign however note that the 2014 Budget has only allocated an additional PGK 11.8M for CHS in 2014.

An organisational structure for the Christian Health Services Secretariat was presented to the assessment mission and is shown in **Figure 2**. There are no corresponding terms of reference on which to explore the connection between the proposed structure and the organisation's role and function.

**Figure 2: CHS Organisational Structure**



<sup>42</sup> This amount equals about 3 per cent of the total health sector budget

If this structure above, is implemented or even with the current arrangements, additional capacity support will be required by the national and provincial CHS arrangements.

Recently the Minister for National Planning and Monitoring released an information note which describes a structure for the Church Partnership Program<sup>43</sup> (CPP) an overarching governing body, called a Churches Development Council which will have a Secretariat. This governance structure is to be established to enable the facilitation and disbursement of PGK 50M to churches through the CPP (some of which is for health), under the auspice of the Department of Planning and Monitoring. There will need to be coordination between the CHS Secretariat and the CPP to ensure overall harmonisation of both efforts in the health sector.

### 3.1.2 Conclusion

The CHS Secretariat confirmed their desire for long term technical assistance with this mission as well as the CHS Technical Assistance Mission (TAM). While excellent progress has been made by the CHS staff over the past two years to improve their processes and procedures, more is required and long term support for the CHS Secretariat is essential.

#### **Recommended technical assistance:**

- Recommendations from the TAM such as the need to revise the Christian Health Service Act of 2007, the urgent need to develop a partnership agreement with the NDoH and PHAs need to be addressed and short term technical assistance will be required for this work as the requisite skills do not currently exist in the Secretariat.
- Short term technical assistance should be provided to assist The Council and Executive Board with writing and approving the terms of reference for the CHS National and Provincial Secretariats and its units and staff. Once staff terms of reference are done then the competency of staff can be assessed against the terms of reference and a capacity development plan for staff developed and implemented.
- As the bulk of the CHS funds from the NDoH is spent on salaries, and thus sorting out an automated payroll is a priority for the CHS. In addition, within the context of the structure chart for the Secretariat, the assessment team was told that a total of 8-11 staff will be required initially. Priorities areas will be finance and administration, IT and human resources management and payroll (mentioned above). Therefore capacity support will be needed to agree on which payroll system will be used, establish the system and include management at the CHS Secretariat level or at the provincial level within the PHA; as well as short term capacity support to provide orientation and training to any new Secretariat staff and especially in NDoH requirements for budget preparation, financial management and reporting.

## 3.2 Rural Primary Health Services Delivery Project

The Rural Primary Health Services Delivery Project (RPHSDP) is a multi-donor project with an eight year time span and a program for developing 32 new Community Health Posts and 120 Community Health Posts upgrades in eight Provincial areas. The project has been operating for 18 months and the initial time period has been used for preparation of projects for construction and capacity building Provincial Health Authorities. It is also providing an enabling environment for the provincial health system to participate in Infrastructure delivery, using RPHSDP resources and importantly uses the Provincial Supply and Tender Boards.

The initial progress of the project has been slow and this review understands that tendering and construction activities for some projects are due to commence before the end of 2013.

Some key characteristics of the RPHSD are:

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<sup>43</sup> This CPP has been funded by the Australian Government through the previous democratic governance program and provides funding to the 7 largest churches to improve their governance

- It is delivering infrastructure to health facilities in strategic areas of PNG
- It has a multi discipline team approach<sup>44</sup>
- It is one avenue for the for delivering infrastructure support in PNG,
- It is supporting institutional strengthening of Provincial Health Authorities and exposing them to the roles and responsibilities of participating in infrastructure delivery,
- The project is already providing lessons learned for the health sector which need to be identified, discussed and institutionalised as deemed fit.

The RPHSD project is providing the eight provinces with experienced PNG health system mentors to improve the capacity of the health leadership in those provinces. It is anticipated that 6 PHAs will be operational by mid 2014, and potentially eight PHAs by 2105.

The project delivery systems are developing frameworks for committee representation through Project Steering Committees, Project Coordinating Committees and Health Partnership Committees. These institutional arrangements provide an enabling context for other health infrastructure projects in those provinces.

The RPHSD project plans to have 16 staff positions over its duration. Of which, nine posts will be for internationals and seven for nationals, with eight posts being full time and over the project duration and the remaining eight, providing short term inputs. This resource needs to be taken into account when considering additional technical support to the NDoH. The following table provides a summary of these sixteen positions.

**Table 4: Staffing Positions in RPHSD**

Position	Contract Term
Project Manager (International)	Full time - 2 years ending April, 2014
Deputy Project Manager/Quality (International)	Full time - 3 years ending September, 2016
Finance & Procurement Specialist (International)	Full time - 4 years ending April, 2016
Institutional Strengthening Specialist (International)	18 months over 4 years from November, 2012
Health Policy Adviser (International)	Weeks commencing 2 <sup>nd</sup> November, 2012
Health Communications Specialist (International)	15 months over 4 years from November, 2012
Health Promotion/Community Dev. Specialist (National)	Full time - 3 years ending August, 2015
Gender, Social & Community Development Spec't (International)	15 months over 4 years from April, 2013
Health Systems/Clinical Specialist (International)	15 months over 4 years from July, 2013
Social Safeguards Officer (National)	Full time - 3 years ending June, 2016
Senior Construction Manager (National)	Full time - 3 years ending August, 2015
Environmental Engineer/Architect (International)	15 months over 3 years from March, 2013
Health Mentor - West New Britain & ARB (National)	Full time - 3 years ending September, 2015
Health Mentor - Milne Bay & East Sepik (National)	Full time - 3 years ending September, 2015
Health Mentor - Morobe & Eastern Highlands (National)	Full time - 3 years ending October, 2015
Health Mentor – Western Highlands & Enga (National)	Full time – 3 years ending September, 2015

<sup>44</sup> The team includes Infrastructure Advisors (Architects and Engineers), Clinical Advisors, Community Engagement Advisors, Health Mentors and Advisors, Legal Advisors, ICT Advisors, Communications/Publicity Advisors as well as Administration and Procurement capacity.

### 3.3 External development assistance in health and quality assurance mechanisms

#### 3.3.1 Aid Effectiveness

A number of people, from both the NDoH and the DPs, noted that TA is not well coordinated. Gaps and overlaps occur, and unnecessary tensions arise between development partners when multiple requests are made to different partners.

There are existing broad policy, principles, local processes and structures to guide, interface and coordinate both between partners (DP meetings) and between DPs and NDoH. In terms of broad policy and principles the GoPNG is represented on the G7+ New Deal<sup>45</sup> which builds on international commitments endorsed also by Australia, including the Paris Declaration of Aid Effectiveness (2005)<sup>46</sup>, the Accra Agenda for Action (2008) and Busan (2010).<sup>47</sup>

These commitments clearly place the host governments in the 'driver's seat' of their development goals and agenda which include the need and response for capacity development. These also challenge the DPs to improve alignment, harmonization, results, partnership and mutual accountability in countries they are present.

PNG NDoH has developed internal processes and structures to affect greater DP alignment and harmonization in terms of capacity development. Note some of these processes or structures are current and operating, some partially operational and others are new proposals:

- Current and operating: The NDoH Secretary has responsibility to Government for implementing the PNG Development Strategic Plan, NHP and MTDP
- Current and operating: In 2012 NDoH developed a Technical Support Plan to track and manage DPs contributions to the health sector
- Current and operating: Operational Policy Directive on DP funded technical assistance with accompanying proposals to seek approval for planned, ad hoc and emergency technical assistance.
- Partially operational: The HSPC major focus is on sector-wide issues which need discussion with central agencies and provinces. In terms of capacity development and TA it is primarily an approval/endorsement mechanism, rather than a deliberative body. The HSPC is meant to meet quarterly but meeting frequency has slipped and only one meeting has been held so far in 2013. Note that the HSPC was intended to have a capacity development sub-committee which has never actually met.
- New proposal: The NDoH Resources Committee of the new Corporate Governance, arrangements, which includes a DP (as co-chair) and is responsible for DP coordination and to review and approve proposals (national and province) for technical assistance.

The Government of PNG has committed itself to an Aid Effectiveness agenda, the NDoH has developed governance structures and processes to better put themselves in the driver's seat of capacity support to their sector.

In terms of Aid Effectiveness, all DPs the assessment team spoke with are aligned to the NHP and committed to contributing to it. The DPs meet monthly, mainly to discuss upcoming missions, TA requests from the GoPNG and discuss overlap and aim to avoid duplication. However, efforts to

<sup>45</sup> The New Deal for Engagement in Fragile State was endorsed by the G+7 group of 19 fragile and conflict affected countries, development partners and international organisations in April 2011. PNG endorsed this agreement.

<sup>46</sup> OECD The Paris Declaration on Aid Effectiveness 2005

<sup>47</sup> OECD The Accra Agenda for Action 2008 and Busan New Deal 2010

harmonise DPs around a more programmatic approach which also embrace the provincial mandates have been limited.

The key shift which needs to take place is that both NDoH and DPs make greater use of existing procedures, and shift to using new structures, for approving multi-year and responsive capacity development support to NDoH. In terms of ensuring the NDoH is in the driver's seat, the provision of capacity development and short or long term TA, needs to be demand driven and identified by the NDoH in the first instance and embedded into the relevant unit's operational/management plans with clear links to NHP KRAs. The NDoH then needs to be instrumental in developing Terms of Reference (TOR) for this support and preparing proposals in the existing format. NDoH also need to be part of the selection process and performance management of TA, in cases where this does not take place. Much of this work can be performed through the NDoH Resources Committee and then developed into a capacity development/TA plan which is finally endorsed by the HSPC. A greater level of commitment is required by all parties to use these existing and new structures and processes to improve DP coordination, harmonization and achieve better alignment and thus contribute to achieving the NHP KRAs.

### 3.3.2 Technical assistance since 2011

Two DPs, the Australian Government and WHO are the main contributors to long term technical assistance for the NDoH. The RPHSDP project also provides TA direct to the NDoH, in areas such as: institutional strengthening, policy, HR, ICT, as well as health mentors (one mentor to two provinces), to the eight target provinces. The work being done through RPHSDP in health information through trialling improvements in data collection quality and timeliness, the introduction of cell phone technology, the use of geographic information system (GIS) mapping to inform decision making, and the provision of appropriate information back to the health system and accountability bodies at the ward/district/provincial and national levels will be extremely useful to the NDoH in terms of improving these functions and monitoring the NHP KRAs. UNICEF, UNFPA, USAID, JICA and the World Bank (WB) also provide some targeted TA or 'in-kind' technical support. Note that the Australian Government also provides funds to the WB, RPHSDP and the WHO for health.

The assessment team met with DPs whereby UNICEF, RPHSDP and WB attended a roundtable and WHO was contacted by phone. Sincere efforts have been made by the DPs to coordinate the provision of TA, plan inputs and to avoid duplication. All DPs reported efforts to engage with NDoH in the processes involved in establishing capacity support – whether it is in needs identification, TOR development and performance management. DPs such as WHO, UNICEF and UNFPA follow their own institutional arrangements for TA selection and recruitment and the RPHSDP and HHISP involves the NDoH in all steps of the recruitment process, for example, TOR development and selection panels.

Quality assurance mechanisms around the provision of TA in the health sector differ amongst the DPs and need to be streamlined, discussed with NDoH and agreements reached. For example, agreement on principles to guide the provision of capacity support and TA would assist to guide the process; templates to assist high quality TOR development; competency based recruitment and selection processes; output based TA plans linked to NHP KRAs and embedded into unit's operational plans and which are reviewed regularly; clarity on management and reporting lines; annual performance assessments of TA and external outcome evaluations on changes in workplace practice following TA inputs. Opportunities exist for training for NDoH in all these quality assurance mechanisms so that they are strengthened in all steps of effectively managing capacity development and TA.

For the Australian Government, the period since 2011 has seen a transition in the way its TA is provided. Prior to 2011, the main TA delivery mechanism was through a large number of professionals embedded inside the NDoH. Known as CBSC, at its peak it had 120 staff operating in the health sector and up to 49 within the NDoH. The majority of these staff were PNG nationals.

A review of the functioning of CBSC in 2009<sup>48</sup>, noted several design weaknesses which limited its effectiveness:

- the pathway from inputs of TA to the outcomes of improved service delivery and health status were not specified and have remained a 'black box', paving the way for confusion about exactly what CBSC was aiming to achieve;
- it was also assumed (wrongly at that time) that sufficient funds would flow through government systems and the SWAp to address service delivery shortfalls; and
- there was an absence of a clear focus on public health.

The review noted "In focusing predominantly on the *how* of capacity building, which is elaborated clearly and convincingly, the *why* and *what* questions were largely unanswered." The review concluded that the design failed to specify what sort of capacity was needed to be built, and for what public health purpose and this paved the way for a strong policy and planning culture rather than a service delivery orientation within the NDoH.

The CBSC mechanism was closed in 2011, and replaced with an independent service provider - the Health and HIV implementing service provider (HHISP).<sup>49</sup> Although the HHISP operates outside of the NDoH and government public financial management and procurement systems, it is directly responsive to national and provincial Government authorities. Some TA continues to be provided through internationals posted to the NDoH, and these are managed by the ISP, but this has reduced considerably, from 45 in the last year of the CBSC to 10 now (including 3 PHA advisers).<sup>50</sup> The overall assistance is governed through the two government's Partnership Agreement<sup>51</sup> and its health schedule.<sup>52</sup> The move from heavy reliance on CBSC and the use of an ISP is a positive development, and has assisted in enabling a change in the way external support is provided.

Ensuring the GoPNG is in the driver's seat of its own capacity development and is empowered to lead the processes concerned with capacity development/TA provision; from needs identification through to performance assessments is essential. In addition, the bigger issue is to reach agreement with the NDoH and DPs on governance forums – noting the limitations of HSPC above - for discussing Capacity Development and TA support, processes for ensuring an appropriate division of labour, and reporting and accountability requirements which meet both NDoH and DP needs.

<sup>48</sup> Emmott S, Lee K, Weelen P, Kawe W, Leslie S. (2009), *CBSC The Capacity Building Service Centre in PNG Independent Evaluation Report*

<sup>49</sup> Also referred to as the ISP

<sup>50</sup> With a mix of long and short term advisers

<sup>51</sup> <http://aid.dfat.gov.au/Publications/Documents/png-partnership08.pdf>

<sup>52</sup> [http://aid.dfat.gov.au/countries/Documents/outcome\\_health\\_schedule.pdf](http://aid.dfat.gov.au/countries/Documents/outcome_health_schedule.pdf)

## 4. Recommendations

The following is a summary of key recommendations related to the provision of technical assistance and more detailed recommendations around overall capacity development can be found in the body of the report.

### Strategic Policy Branch

The current long term technical support to the division should be assessed in terms of their contribution to the attainment of the division's operational plan and NHP KRAs. High level international or national technical support to the division should be continued and consider targeted short term inputs, for the future and identify the technical support and outputs required in the operational plan of the division. Short term assistance has been specifically requested for support with: facility based budgeting; legal support; economics unit and performance monitoring and research.

### Human Resource Branch

#### HR Branch Recommendation One:

**To strengthen leadership and people management in NDoH, establish a training program for the staff of the HR Branch made that includes the following elements:**

##### *Short term (next 12 months)*

- Training in HRM data collection, collation and analysis and the development of an effective HRMIS (Alesco may be able to be used for this) for at least 10 nominated HR Branch staff
- Training in staff performance management, based on General Order 5, for all NDoH managers at grade 15 and above.
- Training and job rotations for the new graduate to develop appropriate workplace competencies (e.g. computer skills, communication skills, problem solving skills etc) (this could be formalised into a Graduate Trainee Development Program in NDoH).
- Specific mentoring for female staff, to address gender equity issues in the workplace.

##### *Medium term (next two years)*

- Training in training needs analysis for nominated staff from the Training and Curriculum Section in the HR Branch, so that that can develop a NDoH Staff Development Plan
- Training in basic people management skills for HR Branch staff (developing job descriptions, recruitment & selection, performance management, occupational health and safety, workforce planning etc based on the General Orders and contemporary HRM practice)
- Expanding support for leadership and organisational development programs (e.g. such as the PLICIT program) to cover all staff in NDoH and the staff of the CHS Secretariat.

#### HR Branch Recommendation Two:

**To assist the HR Branch to address the key HR issues identified in the 2013 NDoH capacity diagnostic provide technical advisory support in the following key people management areas:**

##### *Short term (next 12 months)*

- The development of a NDoH HR Strategic Plan with a series of underpinning HR action plans (e.g. the proposed NDoH Capacity Development Plan 2014 and the HR Branch Annual Activity Plan) to ensure that key people management issues are addressed in a systematic manner and at both a strategic and operational level



- The development of a NDoH Recruitment Action Plan to fill identified vacancies as a matter of urgency. Such a plan should contain strategic and focused recruitment strategies and targets.
- Review of the role of the Training and Curriculum Section in the HR Branch in relation to supporting pre-service training and the recommendations of the CHW and Nursing Schools Capacity Diagnostic reviews.

*Medium term (next two years)*

- Developing the long term Health Sector Workforce Plan.
- Reviewing of the classification and grading structure of NDoH with a view to upgrade positions in the short term and the development of a separate health worker competency-based classification and remuneration.
- Supporting a feasibility study into the viability of establishing a health services commission type arrangement for the employment of government health workers.

### Internal Audit Unit

Long term external technical assistance (international) to the internal audit office only (and not shared with other branches):

- Review of the internal audit policy, premise and standard operating procedures for internal auditing, with a view to shift from a 'policing' modality towards a focus on systems audits which will provide feedback and solutions for continuous improvement of financial management practice;
- Develop a short and medium term capacity development plan for the internal office staff and provide on the job coaching and mentoring to the internal audit staff; provide opportunities with cross visits/exchanges to and from locations which have functioning and successful internal audit functions operating
- Activate and support the Internal Audit Committee for NDoH to ensure systems and processes are established and functioning.
- Government of PNG upward reclassification of internal audit posts and national advisers in the interim, in a capacity substitution role to get this function operating and establish sound internal audit systems and procedures.

### Public Health Branch

- Provide an epidemiology and population health technical service to NDoH and to the provinces until sufficient national staff are trained (WHO/ the Australian Government)
- Develop an exit strategy (how to transition from capacity substitution to capacity building to program support) for existing TA to be implemented over the next 5 years.
- Specify the roles and functions of all DPs in providing TA in the operational planning process within the branch, to prevent 'agenda overload' gaps and overlaps and more precisely define the contribution the branch expects from the DP inputs.

### Commercial Services Branch and Health Facilities Standards Branch

#### **Infrastructure Resourcing and Facilities Management Strategies:**

Short term technical support to develop four implementation policy outputs:

- Health Sector Strategic Planning Review of Resources to Deliver Annual Infrastructure Programs,
- Facilities Management - Health Sector Planned Maintenance Strategy,
- Facilities Management - Health Sector Asset Management Strategy,



- Develop a Provincial Health Authorities Infrastructure Capacity Building Strategy to support PHAs infrastructure development based on their capacity/needs and consistent with national policies and functions.

This assistance would either be a short term advisors or project based advisors to work within NDoH Infrastructure Divisions to develop these Strategies in consultation with key stakeholders including PHAs, Provincial Governments, Churches, and NGOs.

### **Infrastructure Training Programs and Skills Augmentation**

Short term advisors or project based advisors to assist NDoH to upgrade personnel skills, the aim of this support would be to develop expertise in NDoH in the following key areas:

- Provide in-service training and professional practice courses for infrastructure professional personnel and mentoring to build skills in areas of identified skills gap including Program Management, Contract Management, Health Facilities Planning, Infrastructure Cost Planning and Building Services (Engineering).

The type, format, and duration of this support would need to be developed with a more in depth analysis of the priorities for skills upgrade and training required across the sector. The Short Term Advisors may provide Personnel Supplementation until NDoH can back fill personnel as counterparts. The professional development courses could be opened to industry wide participation including PHAs, Provincial Governments, Churches, NGOs and the private sector

### **Christian Health Services Secretariat**

We recommend some overarching LTA with additional (technical) STA as required to address unique areas such as:

- Revise the Christian Health Service Act of 2007 and develop a partnership agreements with the NDoH and PHAs as recommended from the Technical Assistance Mission
- Assist the Council and Executive Board with writing and approving the terms of reference for the CHS National and Provincial Secretariats and its units and staff. Once staff terms of reference are done then the competency of staff can be assessed against the terms of reference and a capacity development plan for staff developed and implemented.
- Establish an automated payroll system and include management of the system at the CHS Secretariat level and at the provincial level within the PHA.

### **External Development Assistance**

The GoPNG and Development Partners develop a shared understanding and approach to development assistance, in particular its relationship to NDoH annual planning processes, NDoH training and staff development programs, and long term sustainability and aid effectiveness.

In implementing these recommendations, it is important that Aid Effectiveness principles are respected and there is improved coordination of technical assistance, by reaching agreement with the NDoH and DPs on governance forums – (noting the limitations of HSPC) - for discussing Capacity Development and TA support, processes for ensuring an appropriate division of labour, and reporting and accountability requirements which meet both NDoH and DP needs.

## Annex 1 - Terms of reference

### Independent Capacity Diagnostic Assessment: PNG National Department of Health and Christian Health Services Secretariat October 2013

#### 1. Purpose

- 1.1 The purpose of this independent assessment is to review progress since the 2011 baseline assessment of the National Department of Health (NDoH), review the current capacity of the Christian Health Services Secretariat (CHS), and identify ongoing capacity development needs to implement the National Health Plan (NHP) 2011-2020.

#### 2. Background

- 2.1 The NHP provides the strategic vision for PNG's health sector from 2011-2020. It identifies eight Key Result Areas (KRAs) which focus on improving the health system, strengthening partnerships, improving service delivery, and improving priority health outcome areas. The major health priorities identified in the Corporate Plan 2013-2015 include:
- Free health care and subsidized specialist health services;
  - Improved health infrastructure;
  - Medical supply procurement and distribution reform;
  - Health workforce planning;
  - Provincial Health Authority (PHA) implementation and roll-out;
  - Support the Christian Health Services; and
  - Improved leadership and governance.
- 2.2 Under PNG's decentralised health system, the NDoH is responsible for regulation, policy and standards; sector-wide monitoring and evaluation; procurement of medical supplies; and management of provincial hospitals. The CHS Secretariat is responsible for overall financial management, oversight and reporting of CHS staffing and operational grants to CHS-managed health facilities (47% of total health facilities and up to 80% of health facilities in some rural areas).
- 2.3 In November 2011, an independent capacity diagnostic assessment of the NDoH was undertaken. This assessment focused on four major areas: strategic policy, public financial management, human resources and public health. It did not review medical supply procurement (subject to a separate review) or infrastructure and facility functions of NDoH. This assessment directly informed the 2012 national technical assistance plan.
- 2.4 In March 2012, an organisational review was done on the NDoH structure to see if it meets its organisational mandate to implement the National Health Plan.
- 2.5 In March-July 2013, a CHS technical assistance mission (TAM) undertook a reconciliation and validation exercise to determine the appropriate number of CHS-managed staff and facilities to be funded through the public health system. One of the key recommendations of this report was the need to undertake a capacity diagnostic assessment of the CHS Secretariat in 2013. This is critical to determining their capacity to manage increased funding and new public financial management and performance reporting functions and accountabilities.
- 2.6 This mission is scheduled to provide recommendations on future capacity development support for consideration at the next HSPC (6 November) and annual Development Partner Summit (20 November)
- 2.7 During 2013, NDoH has begun team building activities with the assistance of TMS.

### 3. Scope

- 3.1 The independent capacity diagnostic team will address the following areas as part of this assessment:
- a) Review of performance of each major NDoH functional area against the 2011 baseline assessment (Annex 1 for detailed breakdown of areas and focus questions), including implementation of past recommendations;
  - b) Review NDoH capacity (strengths, weaknesses and barriers) to implement the *National Health Plan*, including staff skills, systems and processes, and make recommendations where improvements can be made;
  - c) Comment on the technical collaborations required by NDoH staff to continue rolling out key GoPNG policies, including:
    - a. PHA process;
    - b. implementing the Free Primary Health Care and Subsidized Specialist Care policy;
    - c. the facility level financing initiative.
  - d) Assess capacity of the CHS Secretariat to implement its mandate effectively, including:
    - a. Financial and program management of current and recommended funding allocations;
    - b. Implementing proposed facility-based budgeting reforms;
    - c. Human resources and payroll systems administration (IT);
    - d. Reporting on performance (through NHIS) of CHS-managed facilities;
    - e. Management of partnership agreements and accreditation processes;
    - f. Monitoring the implementation of free PHC.
  - e) To assess the relevance and effectiveness of external development assistance, in particular short- and long-term advisory and technical support, to support national health functions;
  - f) To review existing governance and quality-assurance arrangements for capacity development support; and
  - g) To identify ongoing capacity needs, areas requiring external development assistance and recommended options for capacity development support and quality-assurance processes.

### 4. Methodology

- 4.1 The methodology of the independent capacity diagnostic assessment will be a combination of document review (Annex 1), in-country semi-structured interviews with key health sector stakeholders (Annex 2) and questionnaire of existing staff members. A review plan will be developed by the team in collaboration with NDoH in advance of stakeholder questionnaires and discussions to further refine the methodology and key assessment questions.
- 4.2 Triangulation of findings is required to ensure that stakeholder perceptions are supported by documented evidence on performance; and conversely, that the relevance, quality and processes of major activities/outputs are validated by stakeholders.
- 4.3 The limitations of this assessment are lack of detailed consultation with provincial health stakeholders; however it is envisaged that a limited number of Provincial Health Authority provinces will be directly consulted to inform findings on this important reform.
- 4.4 This assessment does not include an assessment of the National AIDS Council (NAC) or NAC Secretariat (NACS) due to other recent assessments including the mid-term review of the National HIV Strategy 2011-2015.
- 4.5 This assessment includes all development partner technical support and is not limited to the HHISP provided inputs.

### 5. Duration and Phasing

- 5.1 The independent capacity diagnostic assessment will be undertaken from 14 – 28 October, with reporting to be completed by 15 November. The proposed duration for each phase in the process is outlined in Table 1.
- 5.2 The Aide Memoire presentation and findings will be subsequently considered by the NDoH Senior Executive Management (SEM) monthly meeting on 30 October. If endorsed, the findings will be tabled at the HSPC meeting on 6 November and included as a late addition to the package of documents. Feedback will then be collectively provided back to the review team by 11 November in order to finalise the report by 15 November.

**Table 1: Duration of Capacity Diagnostic Assessment**

Task	Timeframe
Contracting of Capacity Diagnostic Team	17 – 30 September
Review of Documentation	14 – 20 October
Mobilisation of Team	16 – 18 October
Submission of Review Plan	20 October
Stakeholder Consultations	21 – 25 October
Aide Memoire Presentation	28 October
Draft Capacity Diagnostic Report	1 November
Final Capacity Diagnostic Report	15 November

## 6. Team Composition

6.1 A four person team has been proposed to cover the technical areas required to address the Scope of this assessment. In addition, the team must collectively have expertise in monitoring and evaluation (M&E) and experience in working in Papua New Guinea's health system.

- Team leader/Public Financial Management (Joanne Morrison): expertise in developing country health financing and public financial management systems, including resource costings and allocation, budget management and expenditure, procurement, internal and external audit and reporting;
- Human Resources for Health (Theo Vermeulen): expertise in developing country resource for health issues, including leadership and governance, quality and quantity of health workforce, and public sector remuneration and accreditation processes;
- Health Systems/Public Health (Don Matheson): expertise in developing country health system and public health issues, including management of medical supply systems, information communication technology (ICT), research and M&E, public-private partnerships, maternal and child health, and communicable disease control; and
- Health Infrastructure (Michael McKenna): expertise in developing country health infrastructure systems, including procurement and contract management, health facility planning and design, implementation of quality standards and maintenance systems.

6.2 The team will be accompanied by two PNG nationals nominated and engaged by NDoH.

## 7. Reporting

7.1 The assessment team leader, with technical inputs from all team members, will be responsible for the following outputs as per the duration scheduling:

- Submission of a review plan – summary of review questions and methodology, no more than 5 pages in length;
- Presentation of an aide memoire – summary of key findings and recommendations, no more than 5 pages in length;
- Draft report/annexes – overall report detailing key findings and recommendations, no more than 20 pages in length (excluding annexes on each major functional area), including 1 - a structured presentation of capacity strengths, weaknesses and barriers across the organigram, 2- capacity strengthening needs and 3 - potential sources of capacity building (both domestic and international);
- Final report/annexes – As above, revised to incorporate stakeholder feedback.

7.2 All report outputs be evidence based, analytical and formatted and presented to HHISP-standards with an expectation to be published.

7.3 Recommendations should be limited to significant areas (no more than 10 in total), be specific and achievable within the 2014-2015 timeframe, and clearly identify the relevant stakeholder(s) to implement them. They should take into account any other relevant recommendations from other recent reviews or policies to avoid duplication.

7.4 The overall report should address all aspects highlighted in Section 4 (Scope), and follow the proposed format set out in Table 1.

**Table 2: Recommended Format for Report Structure****Report Structure**

Title Page	
Acronyms	
Acknowledgements	
Table of Contents	
Section 1	Executive Summary
Section 2	Context
Section 3	Assessment of NDoH Performance
Section 4	Assessment of CHS Capacity
Section 5	Assessment of external development assistance and quality-assurance mechanisms
Section 6	Overall assessment and conclusions
Section 7	Recommendations
Annex 1	Terms of Reference
Annex 2	Stakeholders consulted
Annex 3	Documents consulted
Annex 4	Assessment of Strategic Policy
Annex 5	Assessment of Corporate Services
Annex 6	Assessment of Medical Standards
Annex 7	Assessment of Public Health

**Annex 1 – Detailed Capacity Diagnostic Questions**

<b>NDoH Functional Area</b>	<b>Performance Questions</b>
<b>Strategic Policy</b>	
<i>Policy &amp; Planning</i>	<ul style="list-style-type: none"> <li>What strategic planning and policies to effectively implement the NHP have been developed? Have they been implemented effectively? <ul style="list-style-type: none"> <li>Free Health Care Policy</li> <li>Public Private Partnership Policy</li> <li>Strategic Priorities</li> <li>MTDP 2011-2015</li> </ul> </li> <li>Have policies been effectively costed and within available resource allocation?</li> <li>Is a multi-year expenditure framework operational and informing budget processes?</li> </ul>
<i>Governance &amp; Partnerships</i>	<ul style="list-style-type: none"> <li>Has high quality legal services been provided across relevant strategy, policy and programming areas? <ul style="list-style-type: none"> <li>To extent is legal advice directly improving program implementation?</li> </ul> </li> <li>What steps have been taken to improve development and implementation of systems and processes to support the roll-out of the PHAs? <ul style="list-style-type: none"> <li>What is the ongoing capacity exists to support roll out of PHAs?</li> <li>Has sufficient emphasis been given to stakeholder engagement to resolve bottleneck issues?</li> </ul> </li> <li>Are health sector governance committees meeting their functional mandates? Why/why not? <ul style="list-style-type: none"> <li>Health Sector Partnership Committee</li> </ul> </li> </ul>
<i>Performance Monitoring and Research</i>	<ul style="list-style-type: none"> <li>What steps have been taken to develop and implement a sector-wide research agenda? <ul style="list-style-type: none"> <li>What is the ongoing capacity to implement these?</li> </ul> </li> <li>What major evaluations have been undertaken and are they informing policy and programming?</li> <li>What steps have been taken to improve the quality of NHIS and ICT systems? <ul style="list-style-type: none"> <li>Have they led to improved uptake and use of data to improve decision-making?</li> </ul> </li> </ul>
<b>Corporate Services</b>	
<i>Financial Management Services</i>	<ul style="list-style-type: none"> <li>What steps have been take to improve financial disbursements and acquittals within PNG PFMA requirements?</li> <li>Are there opportunities to further streamline Finance and Health Service</li> </ul>

	Improvement Program support services? What is the impact of new financial controls?
	<ul style="list-style-type: none"> <li>• Are planning and budget processes integrated and managed within Treasury ceilings?</li> <li>• Are budget processes transparent and do they reflect stated priority areas?</li> <li>• What steps have been taken to improve development and implementation of Internal Audit functions? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> </ul>
<i>Medical Supplies Procurement &amp; Distribution</i>	<ul style="list-style-type: none"> <li>• What capacity exists to implement the Medical Supply Reform Plan?</li> <li>• What steps have been taken to improve the forecasting, transparency and competitiveness of medical supply procurements? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> <li>• What steps have been taken to improve distribution of medical supplies (rural health facilities and hospitals)? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> <li>• What steps have been taken to oversee upgrades Area Medical Stores and implement a logistics management information system? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> </ul>
<i>Commercial Support</i>	<ul style="list-style-type: none"> <li>• What is the current capacity to develop, manage and monitor contracts and contractor performance?</li> <li>• What is the current capacity to effectively manage major commercial procurements?</li> </ul>
<i>Human Resource Management</i>	<ul style="list-style-type: none"> <li>• What steps have been taken to develop and implement a Health Workforce Arrest Plan and increase human resources for health?</li> <li>• What is the capacity to effectively manage personnel &amp; payroll services? Are payrolls up to date?</li> <li>• What steps have been taken to improve development and implementation of pre- and in-service training and curriculum for CHWs, nurses and midwives? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> </ul>
<b>Medical Standards</b>	
<i>Curative Standards &amp; Audits</i>	<ul style="list-style-type: none"> <li>• What steps have been taken to improve development and implementation of Health Care Standards Facilities Accreditation? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> </ul>
<i>Workforce Standards &amp; Accreditation</i>	<ul style="list-style-type: none"> <li>• What steps have been taken to improve development and implementation of nursing and CHW standards and accreditation processes? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these</li> </ul> </li> </ul>
<i>Health Facilities Standards</i>	<ul style="list-style-type: none"> <li>• What steps have been taken to improve development and implementation of Infrastructure and Assets Information Standards? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> <li>• What steps have been taken to improve development and implementation of Quality Control and Assurance systems? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> <li>• What steps have been taken to improve development and implementation of National Orthotic and Prosthetic Services? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> </ul>
<b>Public Health</b>	
<i>Disease Control &amp; Surveillance</i>	<ul style="list-style-type: none"> <li>• To what extent are overall public health synergies and integration realised?</li> <li>• What steps have been taken to improve development and implementation the National Malaria Program? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement the NMP?</li> </ul> </li> <li>• What steps have been taken to improve development and implementation of STI/HIV policies/programs? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> <li>• What steps have been taken to improve development and implementation of the National TB program? <ul style="list-style-type: none"> <li>◦ What is the ongoing capacity to implement these?</li> </ul> </li> <li>• What steps have been taken to improve development and</li> </ul>

- implementation of non-communicable disease policies/programs?
    - What is the ongoing capacity to implement these?
- What steps have been taken to improve development and implementation of Disease Surveillance and Emergency Response policies/programs?
  - What is the ongoing capacity to implement these?
- Family Health Services*
  - What steps have been taken to improve development and implementation of child health policies/programs?
    - What is the ongoing capacity to implement these?
  - What steps have been taken to improve development and implementation of maternal health policies/programs?
    - What is the ongoing capacity to implement these?
  - What steps have been taken to improve development and implementation of nutrition and dietetic policies/programs?
    - What is the ongoing capacity to implement these?
- Environmental Health*
  - What steps have been taken to improve development and implementation of Food Safety & Quarantine policies/programs?
    - What is the ongoing capacity to implement these?
  - What steps have been taken to improve development and implementation of Water Supply and Sanitation policies/programs?
    - What is the ongoing capacity to implement these?
- Health Promotion*
  - What steps have been taken to improve development and implementation of Health Islands policies/programs?
    - What is the ongoing capacity to implement these?

## Annex 2 - People consulted

Name	Title	Organisation
Nicola Rowe	Performance Audit Advisor	AGO
Marta Baroro	Ag/Assistant Auditor-General	AGO
Philip Nauga	Auditor-General	AGO
Joseph Wak	Assistant Auditor-General for Departments	AGO
Puba Agako	Assistant Auditor-General	AGO
Charlie Kamli	Director of Audits NDOH	AGO
John Piel	Team Leader and Finance Adviser	CHSTAM
Nathan Kili	Administration Officer	CMC
Geoff Clarke	Program Director, Health and HIV	DFAT
Aedan Whyatt	First Secretary, Health and HIV	DFAT
Carmel Ryan	First secretary, HHISP	DFAT
Ali Kevin	Program Manager, Health and HIV	DFAT
Joanne Ronalds	First Secretary, Church Partnership Program	DFAT
Florence Rahiria	Program Manager, Church Partnership Program	DFAT
Kye Taylor	Development Program Specialist, Health Infrastructure	DFAT
John Kali	Secretary	DPM
Ravu Verenaki	Deputy Secretary, Operations	DPM
Harry Scunthorphe	HR Adviser	DPM
Cedric Kouga	Executive Officer	DPM
Maretta Kouga	HRM Manager	DPM
David Meehan	Director	HHISP
Ben Kingston	Security Manager	HHISP
Karen Harmon	Health Coordinator	HHISP
Ingrid Glastonbury	HISP and Governance Adviser	HHISP
Maia Ambegaoka	Strategic Policy and Planning Adviser	HHISP
Karen Johnson	Laboratory Adviser	HHISP
Karen Richardson	HIV Coordinator	HHISP
Kevin Debruyne	Finance Manager	HHISP
Anna Maalsen	Public Health Management Adviser	HHISP
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Anton Foureau	Grants Coordinator	HHISP
Peter Laing	Health Procurement & Supply Chain Consultant	HHISP
Pascoe Kase	Secretary of Health	NDOH
Elva Lionel	Deputy Secretary, NHP & Corporate Services	NDOH
Ken Wai	Executive Manager, Strategy Policy	NDOH
Agnes Pawiong	Technical Advisor, Health Services Policy	NDOH
Francis Possy	Manager, Governance and Partnerships	NDOH
Pala Vanuga	A/Manager, Finance and Management Services	NDOH
Philip Koney	Financial Accountant	NDOH
Nirop Kavanamur	Manager, Budget and Reporting	NDOH
Vali Karo	Manager, Medical Supplies Procurement & Distribution	NDOH
Willy Porau	Central Public Laboratory	NDOH



Name	Title	Organisation
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Mr Joseph Lipu	HR Manager, HR Branch	NDOH
Mr Albert Kave	Acting Technical Adviser, Personnel & Payroll Services	NDOH
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John Michael	HR Officer, Recruitment & Selection	NDOH
Andrew Toa	HR Officer, Industrial Relations	NDOH
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Peter Toalbert	Manager, Commercial Support Branch	NDOH
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Fidelis Waipma	Technical Adviser, PHA Reforms	NDOH
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John Mora	Technical Adviser, Infrastructure & Assets Standards	NDOH
Romeo Lesi	Technical Advisor, Contractor Quality Assurance	NDOH
Mr Rajesh Nanada	Technical Advisor, National Orthotic & Prosthetic Services	NDOH
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Pamela Kairi	Technical Officer, Professional standards & Accreditation	NDOH
Dixon Dimiri	Technical Adviser, Allied Health Standards & Accreditation	NDOH
Dr Lucy John	Manager, Disease Control & Surveillance	NDOH
John Mondo	Manager, Information & Communication Technology	NDOH
Dr. Magu Garo	Manager, Curative Standards & Audit	NDOH
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Dr James Kintwa	Chief Executive Officer Western Highlands PHA	WH PHA
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Kerry Main Pagau	Senior Human Development Specialist	WORLD BANK
Pierre Signe	Country Representative	UNICEF
Nenette Salvador	Rural Primary Health Care Service Delivery Project	ADB
William Adukrow	WR, World Health Organisation. (Telephone)	WHO

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## Annex 4 - Human Resources Branch

### 1.1 The role of the HR Branch

The role of the HR Branch is critical as effective staff management in NDoH and effective leadership and co-ordination of HRH reforms across the health sector are essential to the implementation of the NHP. In this regard, the NDOH Hr Branch has a two-fold responsibility:

3. to co-ordinate and implement staff management functions in NDoH, along with other NDOH managers who have supervisory and leadership people management responsibilities;
4. To lead the development and implementation of broader human resources for health functions, programs, and reforms across the health sector, in co-ordination with other NDoH Branches, health partners, and central agencies.

However, in practice this distinction is not always that clear-cut as some issues have an impact in both areas and, broadly speaking, the staff of NDoH are also part of the PNG's human resources for health, playing a vital policy and co-ordination role in the health sector.

The internal NDoH HR functions include managing the NDoH payroll, staff performance appraisal, staff development, recruitment and selection, workplace ethics, and occupational health and safety.

External sector-wide HRH functions include developing health sector HR policy, setting the policy framework for pre-service training<sup>53</sup>, workforce planning, industrial relations (in conjunction with DPM), recruitment, and managing payroll services for hospitals that do not yet have full access to the Alesco payroll system. It also works to a limited extent with other health sector partners to implement common HRM initiatives across the health sector<sup>54</sup>.

The mandate for these functions and the framework for the work of the HR Branch derives from legislation and a number of key policy documents. These include the:

- *National Health Administration Act 1997*;
- National Health Plan 2011-2020<sup>55</sup> and the NDoH Corporate Plan;
- National Policy on Human Resources in the Health Sector;
- *Public Services (Management) Act 1995*
- Department of Personnel Management (DPM) General Orders; and
- related industrial relations legislation<sup>56</sup>.

### 1.2 Overall assessment

Since the last capacity diagnostic in October 2011 there have been substantial improvements in staff management within NDoH and sector-wide HRH matters. For example, within NDoH:

- The majority of staff have now been substantially appointed, dissipating concerns about job security, although the overall vacancy rate in critical parts of the Department remains a concern<sup>57</sup>

<sup>53</sup> With the move of most sector-wide training functions to the education sector, NDOH's training role is in transition and, as such, below in the section of the Training and Curriculum Unit the review team recommends that its role in this area be reviewed. However, the HR Branch still retains a staff development function in relation to its own staff.

<sup>54</sup> To a lesser extent, it also provides HRM support to the NCD Health Service and the Provincial Hospitals but these are mainly payroll functions. It does not provide any direct HRM services to health services run by the provincial governments or district authorities. The HR Branch's role in relation to PHAs is evolving and unclear at this stage.

<sup>55</sup> Government of Papua *National Health Plan 2011-2020*, National Department of Health June 2010

<sup>56</sup> Specifically, the *Salaries and Conditions Act 1978*; *Employment Act 1978* (covers casual staff); *Industrial Relations Act 1962*; *Industrial Safety, Health and Welfare Act 1962*; and related regulations.

<sup>57</sup> For example, in Commercial Services Branch 63%; HR Branch 34%; Internal Audit 50%, and Public Health Branch 29%. This is discussed in more detail in **sub-section 2.3** below.

- A significant number of new staff, including a significant number of young graduates have been engaged providing a new sense of dynamism to the department, although a number of them have not yet been placed on the payroll system.
- A large number for staff have participated in the Public Service Induction Program and the TMS Leadership and Organisational Development Program (PLICIT) aimed at supporting the Department in implementing the National Health Plan
- Previously dormant HR related committees have also been revived and appear to be taking the lead of some issues (e.g. staff development issues)

In relation to HRH across the sector there have also been significant achievements, for example:

- A Workforce Arrest Plan has been developed to address immediate critical staff shortages in the health sector and will be submitted to NEC for approval
- NEC has recently approved the first National Policy on Human Resources in the health sector, which recognizes that *how staff are managed* is just as important as the number of staff
- NEC has recently approved the equalization of remuneration between Government and CHS health workers. This should slow down the migration of CHS staff to the government sector
- DPM has progressively devolved its personnel functions to NDoH, hospitals and provincial administrations, which should enable those bodies to more effectively manage their staff, although at the district level there has been only limited, if any, devolution of personnel powers.

These developments, if well managed, present a significant opportunity to tap into the renewed sense of optimism and commitment of some staff, especially the young graduates.

However, a number of staff management and HRH issues remain outstanding that still impact heavily on NDoH's capacity to take the lead in implementing the NHP. These are discussed in the subsections below. **Subsection 2** discusses internal NDoH staff management issues while **subsection 3** discusses broader health sector HRH issues, although it is important to keep in mind that in some issues cut across both areas.

## 2. Internal NDoH staff management issues

### 2.1 People management in the HR Branch and NDoH

While people management is a responsibility of all managers in NDoH, it is the role of the HR Branch to lead the co-ordination and implementation of HRM activities of NDoH. In this regard, while there has been some fine tuning, the essential functions or structure of the HR Branch has not changed since the 2011 capacity diagnostic.

In this regard, while there have been notable improvements in a number of areas (e.g. recruitment, induction, staff attendance) the effective *management* of staff in NDoH remains a concern with low compliance with DPM General Orders in some areas (e.g. performance management, staff attendance in certain branches)<sup>58</sup> and a lack of a strategic focus in HRM.

Group and individual discussions with the HR Manager and unit managers of the HR Branch raised a number of concerns about the way staff were managed and HRM was implemented in the department. Concerns were also raised over the overall low level of HRM competencies both within the branch and amongst NDoH managers in general<sup>59</sup>.

<sup>58</sup> The General Orders are regulations made by DPM under the authority of the *Public Services (Management) Act* and set out the personnel policy of the PNG Public Service. Most government agencies are obliged to follow the General Orders. Many of the personnel functions previously exercised by DPM under the General Orders have been devolved to the agencies, including NDoH and the Provincial Administrations and hospitals.

<sup>59</sup> The discussions with staff were guided by the structured questions set out in **Appendix A to this Annex**.

To further explore the effectiveness of specific HRM functions in NDoH, a follow up structured interview was conducted with the HR Manager of NDoH to obtain his perception of the effectiveness of different HRM functions in the Department. The HR Manager was asked to rate the effectiveness of HRM in the department on a scale of 1 to 5 where 1 is non-existent and 5 is very good. 18 HRM functions or operational areas were assessed through the structured interview. These functions are the key critical functions that make up effective HRM in an organisation<sup>60</sup>.

The limitation of this approach is that due to time constraints it was not possible to do a comprehensive survey across NDoH or with its external clients so it does not provide conclusive verifiable results. Also, the HR Manager may give a more favourable rating than is warranted. However, it still gives some indication of the effectiveness of HRM in the department and supports the findings are in line with the outcomes from the other staff interviews and literature review.

The HRM functional areas and the scores for each area are recorded in Table 1 below while Chart 1 below the table provides a summary of the results.

**Table 1: Perception of the effectiveness of staff management in NDoH**

HR functional area	Score	Comments
1. HR Strategic Plan	1	No HR Strategic Plan in place and little evidence of a strategic approach to HRM, but the HR Branch has an Annual Activity Plan in place.
2. Induction program	5	Many staff have attended the PNG Public Service Staff Induction Program, which is of high quality but this needs to be complimented with a Graduate Trainee Program specifically aimed at the young graduates.
3. Quality of staff data	2	Very limited aggregated HR data available except basic data required for payroll so it is not possible to create a staffing profile of NDoH
4. Staff numbers	2	Very high vacancy rate across the department <sup>61</sup> and in some areas the number of positions is too low (e.g. Commercial Services Branch)
5. HR knowledge	2	A low level of HR knowledge with only 1 or two staff with a specialist HR qualification and only a few staff in the HR Branch with a degree or higher qualification. NDoH managers in other areas have a low level of HR skills and knowledge, esp. about the General Orders
6. Workforce Planning	2	Workforce Arrest Plan developed and submission prepared for NEC approval. However, function is being performed by a Secretariat and not core NDoH staff
7. Job descriptions	4	Most positions have JDs but these need to be reviewed due to changed functions
8. Remuneration	2	Remuneration overall low and not in line with labour market rates except for unskilled labour
9. Recruitment & deployment of staff	3	Most staff now substantially appointed. Recruitment process follows DPM policy but is slow and subject to favouritism and many skilled positions only have a very low number of suitable applicants
10. Staff performance evaluation	3	Very limited application and managers not trained in applying the policy. Current form is complex and long
11. Staff development & training Plan	2	No current training plan and training provided on an ad hoc basis with only limited funds available
12. Employee relations	3	Employee relations has improved considerably with the progressive implementation of the industrial awards but some issues remain outstanding

<sup>60</sup> A listing and brief description of each assessed HR functional area is provided in **Appendix B to this Annex**.

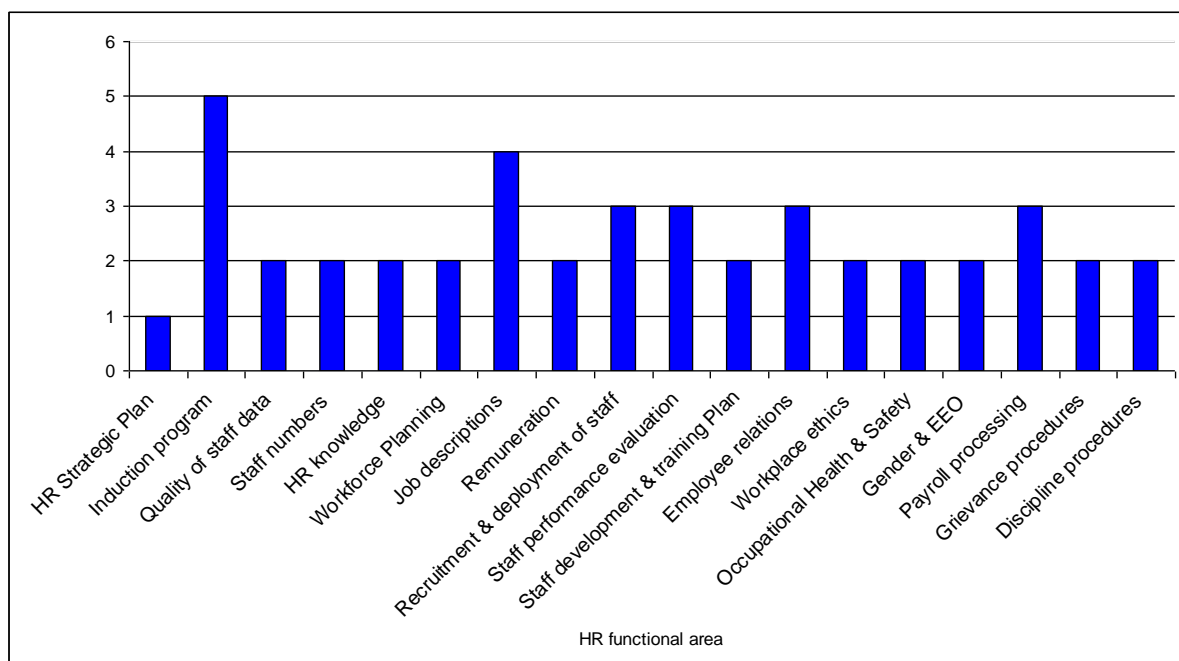
<sup>61</sup> For example, in the Commercial Services Branch 63%; HR Branch 34%; Internal Audit 50%, and Public Health Branch 29%.



HR functional area	Score	Comments
13. Workplace ethics	2	Public Service Code of Conduct applies to all staff but poorly implemented and staff are now aware of it
14. OH&S	2	No NDoH policy in place and poor practices, but GO18 and the <i>Industrial Safety, Health and Welfare Act 1962</i> apply to NDoH
15. Gender & EEO	2	No NDoH policy in place
16. Payroll processing	3	Functions well overall although there are some technical issues to be resolved
17. Grievance procedures	2	No grievance procedures in place
18. Discipline procedures	2	Discipline issues take a low time to resolve and staff discipline in poor in some areas

When these results are summarised and charted, it is clear that the overall perception of the effectiveness of HRM management in NDoH is quite low. Figure 1 below indicates that most functional areas received a score of two with an average score of **point 2.44 out of five**, across all HRM functional areas. This indicates that improving HRM in NDoH is a critical priority to build up NDoH's capacity to implement the NHP.

**Figure 1: Perceived effectiveness of the management of staff in NDoH**



However, there are some notable exceptions in some functional areas such as processing salaries (which has been largely automated through the Concept Alesco payroll system); having job descriptions in place (although they need to be reviewed); staff induction; and employee relations. The results confirm the findings from the general discussions on HRM and organisational development with other NDoH staff and DPM and accord with the review literature on people management within NDoH.

### **Staff Performance Management in NDoH**

Of particular concern is the low rating in the area of staff performance management (SPM). Effective SPM is essential if the department's activities supporting the implementation of the NHP are to be completed in a satisfactory manner. Currently, while the Department has a Corporate Plan and Annual Activity plans in place, linking individual staff activities to these plans is poor, and very few staff have individual work plans as required by DPM General Order 5.

This is a significant capacity gap, as linking individual work plans to the Corporate Plan and Branch Annual Work Plans, provides a mechanism to ensure that required work activities are implemented in a systematic way. It also enables the Department to identify staff development needs and address internal capacity issues that affect the implementation of the Corporate Plan and, more broadly the NHP, on a systematic basis. The HR Branch has recently started a new push to ensure that staff performance management appraisals take place. While this is important, it is critical that SPM is not seen solely in terms of annual reviews but as *a way of working* in the department<sup>62</sup>.

This requires, at a minimum, that all managers are trained in the SPM system that is used and that staff have a common understanding of NDoH work goals. While the current SPM system set out in reflects contemporary management practice, it could be simplified and tailored to more specifically meet NDoH's requirements, rather than generic Public Service requirements<sup>63</sup>.

### ***New graduates in NDoH***

NDoH has since 2011 engaged nearly 300 new employees and as part of this group, about a 100 new graduates. This represents a considerable opportunity for NDoH to be revitalised and needs to be managed carefully. Discussions held with some of the new graduates indicate that they are not being supported as well as they could be and, consequently, NDoH is not deriving the full benefit of employing them. To ensure that they quickly become productive members of NDoH, it is essential that they are provided with coaching and mentoring. There would also be considerable benefit into rotating them through different sections of NDoH, to broaden their skills sets and work experience.

To ensure this occurs, consideration should be given to developing a **Graduate Trainee Program**, that including mentoring, caching, job rotation, team-building, skill development in core required position competencies, on the job structured Action Learning training opportunities, and recognition for their achievements.

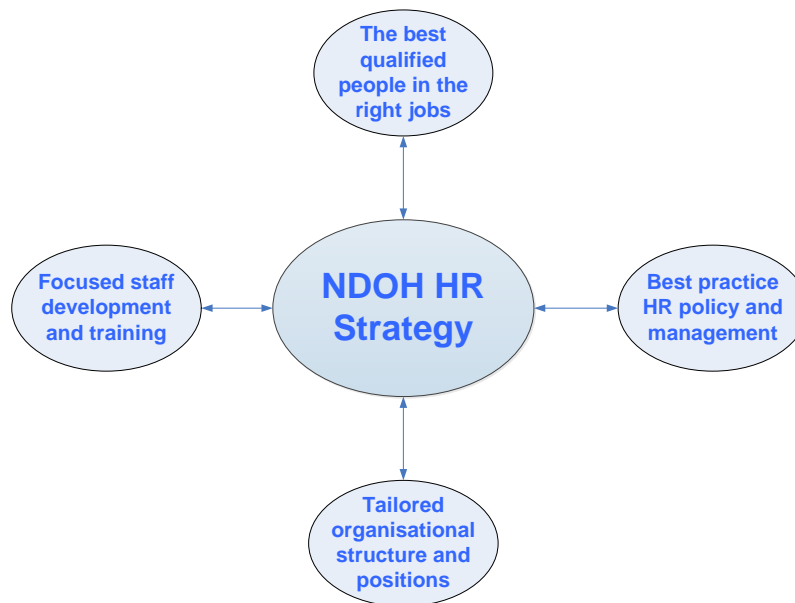
### ***Developing a HRM Strategy***

Many of the leadership and people management issues in NDoH could be more effectively dealt with if NDoH adopts a more active, holistic and strategic approach to the management of its staff. The adoption of a more strategic approach to managing its staff will ensure that HR activities such as staff performance management are conducted to support the main goals of the Department rather than being one-off compliance driven activities.

A more strategic approach will also ensure that each aspect of people management is addressed in a holistic manner and contributes to the implementation of the NHP. A first step in this direction would be to develop a HR strategy based on what HR activities and goals are required to implement the Corporate Plan. A simple model linking the four main areas of successful people management is provided below as a point of reference and as a starting point for discussion in NDoH.

<sup>62</sup> Organisational research indicates that SPM systems that are an intrinsic part of the approach to work in an organisation are more successful and achieve higher quality outcomes than systems that are purely compliance based. See Harper S & Vilkinas T (2005) "Determining the impact of an organisation's performance management system", *Asia Pacific Journal of Human Resource Management*, volume 43(1), p 93

<sup>63</sup> The current system is the standard PNG National Public Service SPM system set out in **General Order 5**.



The **HRM Standards 3.1 - 3.4** set out in the **National Health Service Standards** require certain HRM functions to be implemented in the health sector in relation to workforce planning, recruitment & deployment, work analysis & job descriptions, personnel records, staff development and employee relations<sup>64</sup>. In line with its sector wide policy setting role, NDoH developed *the National Health Sector Human Resources Policy* that expands on these standards for effective HRM.

Under the policy NDoH has a quality assurance role in relation to these standards and it is critical that it leads by example and ensure that its own HR practices are in accordance with the HRM Standards<sup>65</sup>. These set a new baseline for the HR Branch to work towards and will contribute greatly to the department's capacity to implement the NHP.

Recently, a HR Adviser has been provided to the HR Branch under the Rural Primary Health Services Program for 15 months over 4 years. The HR Adviser will spend 75% of his time in the NDoH HR Branch and 25% with the eight Provinces in the Project. This will be a valuable source of technical assistance to the HR Branch to address some of the issues identified in this report. However, for the more specialised issues, additional and varying forms of technical assistance will be required.

**To improve people management in the HR Branch and NDoH, it is proposed that NDoH consider:**

- Training all HR Branch staff in basic human resource management competencies
- Training HR Branch staff that have sector wide HR responsibilities in the critical HR functions of HR data collection, policy development, and workforce planning
- Training staff dealing with internal NDoH staff development matters how to conduct a training needs analysis.
- Conducting a training needs analysis in NDoH to develop an internal NDoH Training Plan, addressing the most critical skills staff training needs to implement the NHP.
- Developing a **Graduate Trainee Development Program**
- Training all NDoH managers at Grade 15 and above in the Public Service Staff Performance Management System set out in DPM General Order 5.
- Ensuring that each Branch has an Annual Work Plan and that each staff member has an individual work plan linked to the Branch Work Plan, as required by GO5.

<sup>64</sup> *National Health Service Standards*, NDoH 2010 pp 75-78.

<sup>65</sup> This quality assurance role in relation to the health sector workforce is also identified as a NDoH function under the *Health Administration Act* and the *National Health Plan 2011-2020*.

- Developing a **NDoH HR Strategic Plan** with a series of underpinning HR action plans (e.g. the proposed NDoH Capacity Development Plan 2014 and the HR Branch Annual Activity Plan) to ensure that key people management issues are addressed in a systematic manner and at both a strategic and operational level

## 2.2 Management leadership in NDoH

While broader contextual factors remain important determinants to consider, the 2012 Annual Health Sector Review found that one of the strongest indicators of successful district health services in PNG was the quality of leadership and how health staff were managed<sup>66</sup>. The capacity diagnostic team also found that this is the case in NDoH, with interviews with staff indicated that many managers lack formal qualifications for their area and have poor leadership capacity and the literature review also confirms this finding<sup>67</sup>.

To some extent weak leadership capacity has been addressed through **TMS Leadership and Organisational Development Program (PLICIT)** aimed at supporting the Department in implementing the National Health Plan. This is an ongoing program and a significant number of managers are participating in the program. The review team found that this program has had a positive impact on NDoH in changing the organisational culture to some extent and building a more cohesive department.

At a district level, the Australian Government funded DWU Facility Management course delivered by Divine Word University also had a notable positive impact in improving health services by providing managers with basic skills in HRM, finance, and planning<sup>68</sup>.

These two examples of management training at both the National and district level indicate that carefully *customised management training* in HRM, finance, and planning in the Papua New Guinea health sector context and at the level the target group needs it (rather than generic management training) can have a substantial impact on improving management capacity to implement the NHP, be that at a policy or operational level.

As such, more *closely tailored* management development opportunities warrant further consideration and support by NDoH and development partners. In this regard, NDoH has 24 senior managers, including the Secretary. Ideally the aim should be by the end of 2016 to put this group through a tailored management training program that focussing specifically on: (1) people management skills, knowledge of the General Orders and contemporary HRM practice; (2) financing and budgeting; and (3) planning in the PNG public service and health sector context.

The program could then be progressively tailored and extended down to the Technical Adviser (unit/section head) level as applicable. Such a program would not duplicate the more general TMS program but rather complement it by focusing on the particular PNG public service and health sector aspects that NDoH managers need to know and apply in their work.

To improve capacity in this area, it is proposed that NDoH provide tailored and focussed management training in the core management skills of people management, finance and budgeting, and planning, based on PNG health sector requirements

## 2.3 Vacancies and recruitment strategies in NDoH

While considerable progress has been made in substantively appointed many staff since the 2011 capacity review, the overall high level of vacancies in the HR Branch and in the other nominated

<sup>66</sup>IAHSR (2012) *Independent Annual Health Sector Review, Accelerating Health Improvement in Poor Performing Districts*, NDoH pp 10-11. This seems to hold true in other health settings. See Ian Couper *Management of District Hospitals: Exploring Success*, Health Systems Trust, Durban, South Africa (undated)

<sup>67</sup> Augustine Asante & John Hall, *A Review of Health Leadership and Management Capacity in Papua New Guinea*, The Human Resources for Health Hub, University of NSW, Kensington 2011

<sup>68</sup>IAHSR (2012) *Independent Annual Health Sector Review, Accelerating Health Improvement in Poor Performing Districts*, NDoH p 10

target areas of the 2013 capacity diagnostic remains a pressing concern. This needs to be urgently addressed as it directly impacts on NDoH's capacity to implement the NHP.

For instance, a number of critical leadership positions remain unfilled especially at the Technical Adviser (section head) level, especially in the HR, Public Health and Commercial Services Branches, weakening leadership capacity. As these positions are responsible for leading the main operational work in these areas, this remains a considerable capacity gap in NDoH in implementing the NHP.

Looking across the nominated target areas of the 2013 capacity diagnostic assessment, there are high levels of vacancies in all areas except in the Finance branch. The table below sets out the vacancy rates in these key areas of the department<sup>69</sup>.

**Table 1: Vacancies rates in selected key NDoH branches and units**

Branch or unit	No. of positions	No. of vacancies	Percentage (rounded)	Observations on vacancy rate
<b>Human Resources</b> (only includes HQ based positions)	44	15	<b>34%</b>	<p>High vacancy rate impacts on delivery of both internal and sector wide HR functions and impacts on NDoH's capacity to implement the HR components of the NHP. For instance:</p> <ul style="list-style-type: none"> <li>• Critical sector-wide positions of TA Policy and Planning and TA Industrial Relations are not filled.</li> <li>• Personnel and Payroll TA position is only filled on an acting basis and Contract Officers positions are vacant slowing down the engagement of contracted medical staff.</li> <li>• There are 7 vacancies in the Training and Curriculum Sections out of 14 positions. These roles are critical to the co-ordination of CHW and nursing training across the health sector and NDoH staff development</li> </ul>
<b>Public Health</b>	161	46	<b>29%</b>	High level of vacancies impacts on the Department's capacity to implement the public health components of the NHP
<b>Strategic Policy</b> (includes ITC positions)	65	10	<b>15%</b>	Overall level of staffing is good but poor policy and legal capacity is impacting on the Department's capacity to implement the policy and legal review components of the NHP.
<b>Commercial Services Branch</b>	16	10	<b>63%</b>	Vacancy rate at critical level particularly in the areas of contract administration and procurement. Directly impacts on the Departments capacity to implement the infrastructure components of the NHP
<b>Health Facilities and Biomedical equipment Unit</b>	21	7	<b>33%</b>	Vacancy rate at critical level particularly in the areas of quality control and orthotic & prosthetic services. Directly impacts on the Departments capacity to implement the these components of the NHP

<sup>69</sup> Vacant positions were identified in and extracted from the NDoH Staff Establishment document dated 30 October 2013 in the respective areas. It is indicative of the capacity of the HR Branch that no collated list of current vacancies was available and that no recruitment action plan has been developed to fill these. It is also a reflection of the poor state of collated staffing data in NDoH. Most data is only available in a disaggregated form.

Branch or unit	No. of positions	No. of vacancies	Percentage (rounded)	Observations on vacancy rate
<b>Finance Branch</b>	23	4	<b>17%</b>	Well staffed but capacity problems impact on NDoH's capacity to implement the financing aspects of the NHP
<b>Internal Audit</b>	10	5	<b>50%</b>	Critical function unable to attract sufficient qualified applicants due to low level of remuneration for auditors.

Discussions with staff and observations by the review team indicate that NDoH faces a number of challenges in recruiting staff to these vacancies. These challenges include:

- Low level of remuneration for technical positions compared to the private sector
- Lengthy delays in the recruitment process, causing suitable applicants to withdraw from the process as they receive other offers
- Lengthy delays in putting new staff on to the payroll system
- Only using traditional outmoded forms of advertising with limited information available on the positions and lack of feedback to applicants
- Lack of innovative recruitment strategies and approaches to address critical areas
- The low level of recruiting staff except when a major restructure occurs despite the pressing need
- The need to understand that the department has to actively compete for scarce labour resources
- The need to take steps to make NDoH, and more broadly the health sector, an “employer of choice” to potential applicants, rather than passively waiting for applicants.

To overcome these challenges will require a concerted effort by the HR Branch and, in particular, the Organisational Development Section which does the recruiting, to develop strategies to address these issues.

**Some proposed options to improve recruit and fill critical positions include:**

- The Senior Management Team clearly identifying all vacant positions that are critical to the implementation of the NHP plan and determining which ones are to be filled as a matter of urgency
- The Senior Management Team reviewing the classification and remuneration of positions deemed critical to the implementation of the NHP plan
- The HR Branch maintaining a collated listing of all vacancies with the status of the recruitment process in relation to those vacancies
- The HR Branch developing and implementing more innovative and targeted recruitment strategies to fill critical positions
- The HR Branch providing more feedback to applicants on the positions (including providing a copy of the Job Description for the vacant position)
- The HR Branch developing a NDoH Recruitment Brochure for applicants that tell them about the recruitment process, how long they can expect it to take, who to contact if they have any inquiries and information on NDoH and the health sector
- The HR Branch Reviewing the recruitment process to see how it can be automated and shortened and set specific timeframes for the filling of positions, to avoid lengthy delays

- Staff from the Organisational Development Section actively searching for and identify potential applicants or pools of applicants through various sources rather than passively waiting for job seekers to apply
- The HR Branch training all NDoH managers in the recruitment process and ensure that the process is merit based
- The Internal Audit Unit conducting regular reviews to ensure proper merit based recruitment processes are followed in the selection and appointment of staff.

## 2.4 Structure of the HR Branch

While it is not the Review team's mandate to review the structure of NDoH, where this impacts on its capacity to implement the NHP it warrants comment. In this regard, the previous capacity diagnostic in 2011 indicated that situating NDoH corporate HR functions (e.g. payroll) and sector wide HR functions (e.g. workforce planning) into one division led to a conflation and confusion of roles. This still remains the case.

Sector wide HR functions are strategic level functions, not corporate services, and need to be given a greater emphasis by NDoH given its policy setting mandate. Placing them in Corporate Services has effectively meant that they do not receive the attention they deserve as internal HR matters compete for staff attention.

In any case, with the possible exception of IR, the HR Branch lacks capacity to fully address sector wide HR functions. As a consequence, in practice sector-wide HR matters like workforce planning are transferred to other branches such as Strategic Policy or to not receive the level of attention that they require, as HR Branch staff focus on day to day matters.

One reflection of this has been the establishment of the Workforce Planning Secretariat. While this is a welcome development, it is also a proxy indicator that the HR Branch, as currently structured, does not have the capacity to deal with sector-wide issues that are clearly within its mandate.

This does not require a major restructure but simply a realignment of some functions to avoid conflation of roles and ensure more effective delivery of strategic sector-wide HR functions. The structural review of the Department in 2012 has also identified this as a critical problem and has also recommended separating these functions, with a small unit in Corporate Services to deal with internal HR matters and a larger unit to deal with sector-wide HR matters<sup>70</sup>.

To improve capacity in this area, NDoH could consider transferring internal HR matters to a small unit within the Corporate Services branch and consider transferring some sector-wide HR functions (e.g. workforce planning) to the Strategic Policy Branch or greatly increasing the capacity of the Policy & Planning Section which if decides to keep this function.

## 2.5 Staffing data and HRMIS

To effectively manage NDoH and implement the NHP, it is essential that accurate, comprehensive, and collated data on its staff is readily available to managers in NDoH and other decision-makers in the health sector. However, while data collection on health indicators and health infrastructure is now collected and reported on by NDoH, data collection on staffing continues to be problematic.

For instance, basic data even on NDoH's own staff is not available in *aggregated form*, besides basic payroll data, to develop a comprehensive staffing profile of NDoH or do, for example, a gender or training needs analysis. Externally, the SPAR also only has one indicator related to HRH, even though this is one of the most critical aspects of implementing the NHP. This is a major capacity gap and prevents the development of effective training and staffing strategies that would support the implementation of the NHP. It requires urgent attention, supported by technical assistance.

**To improve capacity in this area, the HR Branch could, with technical support as appropriate:**

<sup>70</sup> HHISP (2013) *Responsibilities of the National Department Of Health in the PNG Health Sector – Review Of The Legislative And Policy Mandate*, Port Moresby May 2013, pp 12-13 (also see recommendations 5.12 & 5.13)



- Assess if the Concept Alesco system could be used to collect a greater range of data on staff to include age, gender, qualifications, training courses undertaken, specialist skills, etc
- Train at least 10 nominated HR Branch staff in HRM data collection, collation and analysis
- Review what options are available to establish an effective HRMIS in NDoH (the Concept Alesco payroll system may be able to be used for this).

### 3. HRH sector-wide issues

In this subsection, broader HRH sector-wide issues that impact on the implementation of the NHP are discussed. In this regard, while the number of staff is of critical importance, *how* health sector staff are managed is even more important. As noted by Adano in his review of HRH in the health sector: “The actual methods used to manage HRH may either hinder or facilitate the accomplishment of some of the core objectives and benefits of health sector reform as well as the goals of larger global health initiatives [...] The way health workers are recruited, managed and supported is central to the quality of services that they are able to deliver”<sup>71</sup>.

The review found that there are a number of critical HRH areas where capacity is lacking and, consequently, impacting on the implementation of the NHP. These issues are: sector-wide workforce planning; industrial award and payroll issues; remuneration of health workers; and the management of sector-wide pre-service training.

#### 3.1 Workforce planning across the health sector

Sector wide workforce planning is a critical function to the implementation of the NHP and a core sector wide function of the HR Branch. Considerable progress has been made in this area. NDoH has recognized the crucial importance of this area and has established the Workforce Planning Secretariat and external and internal committees to address this.

An Arrest Plan to address immediate urgent health staffing needs has been developed for submission to NEC for approval. Once approved, considerable work has to be done to implement the Arrest Plan. As this work is cross-sectoral and involves a number of agencies and institutions, it is highly complex and the person leading this process will require high level project management, advocacy and negotiation skills.

By setting up a secretariat, NDoH has effectively contracted out its workforce planning function. It remains to be seen if this is a sustainable model. In the short term, the funding of 1.3 million for the Workforce Planning Secretariat will soon be expended so another way has to be found to develop the long term Workforce Plan and, more important, conduct the complex inter-sectoral work required to implement it.

However, the HR Branch’s capacity in workforce planning is extremely limited and considerable technical assistance will be required in this area. The function nominally sits in the HR Policy and Planning Section but that section only has three positions and two of them have only been recently filled with new graduates who are effectively trainees in policy and workforce planning. The Technical Adviser position is still vacant and there is not anyone acting in that role.

In addition, the Section is also responsible for HR policy implementation across the health sector (including the recently approved *National Health Sector Human Resources Policy*). Clearly the scope of the work simply cannot be done by two recent graduate staff members, even with technical assistance. This is a severe impediment to the implementation of the HR aspects of the NHP.

RPHSDP has funded a HR Adviser for the HR Branch who has been tasked to also assist with workforce planning. However, this is a generalist position that also has to support other people management and HRH matters NDoH is dealing with and the provinces. Specialized additional support will still be needed for workforce planning due to the scope and importance of the task.

<sup>71</sup> Adano, U; McCaffery J; Ruwoldt P; Stilwell B: (2008) *Human Resources for Health: Tackling the Human Resource Management Piece of the Puzzle*, Technical Brief # 14, The Capacity Project, Intrahealth International

If this position is to take on workforce planning on a more substantive basis it is likely that the term of the consultancy would have to be significantly extended.

**To improve capacity in this area, the following key actions are proposed for consideration:**

- Review and decide where the function of sector-wide workforce planning should be placed
- Based on this, train the relevant staff in workforce planning and data collection and reporting
- Increase the number of staff to at six in sector-wide HR policy and workforce planning
- As a matter of urgency, recruit a Technical Adviser (Section Head) for the Policy and Planning Section or higher position to lead these two critical functions.
- Based on this, train the relevant staff in workforce planning and data collection and reporting
- Increase the number of staff to at six in sector-wide HR policy and workforce planning
- As a matter of urgency, recruit a Technical Adviser (Section Head) for the Policy and Planning Section or higher position to lead these two critical functions.

### 3.2 Industrial and the payroll issues in the health sector

Related to the issue of remuneration are the industrial issues relating to the implementation of the health sector industrial awards and related payroll issues. In this regard, for the NHP to be implemented, it is essential that industrial issues are addressed in a rapid, effective, and equitable manner.

During the last review, concerns were expressed that major industrial action due to the non payment of industrial award benefits. Since then the various health sector industrial awards have been progressively implemented. In the main, NDoH is now in the main complying with its legal obligations and staff are now receiving their entitlement, albeit that there are still some implementation issues.

The practical effect of this has been to substantially reduce the risks of industrial action by the affected health cadres and to ensure that services continue to be delivered. However, it is essential that industrial award entitlements are included in the payroll system as variations so that each health sector worker who is entitled to them actually receives them.

For reasons that are not clear, this has not always occurred with different departments blaming each other for this. To avoid the possibility of industrial action and the lowering of staff morale it is essential that NDoH co-ordinates closely with the Department of Finance and DPM to ensure that all award entitlements are included in the payroll system. Individual staff and system capacity to deal with these issues needs to be strengthened, so that they are addressed on a systematic basis.

Overall, the implementation of the Concept Alesco payroll system is proceeding relatively well in the health sector and only six hospitals remain to be connected by NDoH. However, DPM has expressed concern as to the accuracy of the payroll variations submitted by departments, including NDoH. Delays in putting new employees on the payroll system also continues to be a concern, with many of the new graduates recruited by NDoH still to be placed on the payroll. As this is shared task with DPM, this requires closer co-ordination with DPM.

**To improve capacity in this area, the following key actions are proposed for consideration:**

- As a matter of urgency, fill the positions of Technical Adviser, Industrial Relations and Technical Adviser, Personnel and Payroll, to improve HR Branch's capacity in these areas
- Train the relevant staff in the HR Branch staff in industrial relations and Alesco payroll management
- Review the process of entering award variations into the Alesco payroll system to ensure that there are no delays in doing this
- Ensure that all award entitlements are clearly identified and entered into the payroll system

- Conduct regular meetings with the health sector unions to update them on the status of the implementation of the awards.
- Conduct regular meetings with DPM to address issues related to the industrial awards and the payroll system, to ensure that these issues are addressed in a responsive and timely manner.

### • 3.3 Remuneration of health sector workers in the health sector

A full review of the remuneration and classification structure for health staff is beyond the mandate of the NDoH capacity diagnostic, but in so far that it impacts on NDoH's capacity to implement the NHP some observations are warranted on this issue. In this regard, skilled and experienced staff are critical to the successful implementation of the NHP. While certainly not the only factor, the level of remuneration is a key tool to obtain skilled staff in the labour market<sup>72</sup>.

In this regard, numerous reviews have highlighted the low level of remuneration in the health sector in PNG<sup>73</sup>. To some extent this has been addressed in CHS by equalising salary levels between church and government health workers. However, the overall level of remuneration remains low, particularly for nurses and CHWs, and technical positions that require highly developed skill sets in NDoH.

#### Case Study 1 – The impact of the Public Service Classification System on the health sector labour market

An Administrative Assistant position in NDoH which requires no formal training or qualifications (and for which NDoH has no trouble attracting suitable applications) is paid from grade 8 to 10, while a nurse is paid at a 6 to 8 grade level, but most are at grade 6. Similarly, the critical role of CHW is only classified at grade 5 level, even after they have been trained to take on additional MCH responsibilities.

In other words, a nursing position which requires a 3 yr qualification and is essential to the system is paid at a much lower grade level than an administrative assistant because that 'fits' the public service classification system, regardless of health sector staffing needs.

While allowances under the awards are accessible by health staff, this does not address the basic classification anomalies or the recruitment difficulties created by the current classification arrangements.

This problem is compounded by having Government health staff engaged under the Public Service classification and grading system. While Christian Health Services do not have their staff under this system, with the equalization of remuneration between the Government and CHS health workers, they in effect follow this model.

By focussing on organisational hierarchy rather than the needs of the health sector, the Public Service classification system sets up perverse incentives for health staff to leave front line clinical roles and move into administrative and managerial roles, as even relatively junior administrative roles in NDoH are better remunerated than nurses and CHWs as illustrated in the **Case Study 1**. NDoH is in effect competing with the rest of the health sector for its staff and by doing so is creating serious anomalies in the distribution of health workers<sup>74</sup>.

This issue could be addressed in a number of ways. For instance, a separate parallel classification structure could be set up within the Public Service framework for health sector staff and complex NDoH roles. However, this would still generate flow on effects if the parallel

structure introduced significant remuneration increases. The industrial implications are of significant concern to DPM and such a proposal is unlikely to be supported.

Another option would be to move government health sector staff into a health commission type arrangement with a completely separate remuneration structure based on competencies rather

<sup>72</sup> The link between remuneration and health sector workforce retention and performance is complex but the research indicates that properly targeted incentives can have a significant positive impact on health service delivery. See, for example, Lyn N Henderson and Jim Tulloch (2008) *Incentives for retaining and motivating health workers in Pacific and Asian countries*, *Human Resources for Health* 2008, 6:18, which identifies and evaluates range of remuneration-based retention and motivation strategies.

<sup>73</sup> See, for example, the SWAP Review Report "the Missing Middle", and also Razee H, Whittaker M, Yayasuriya R, Yap L, Brentnall L, "Listening to rural health workers in Papua New Guinea: the social factors that influence their motivation to work", *Medicine & Social Science* Volume XXX (2012) 1-8

<sup>74</sup> For example, the review team was informed that there are more medical doctors engaged in NDoH in administrative roles than there are in total in the rural health sector in clinical roles.

than hierarchy<sup>75</sup>. A competency-based remuneration system would address the issue of clinical staff leaving their roles for administrative roles by rewarding skills and qualifications that are required in the health sector, rather than hierarchical or managerial status. In the discussions with DPM held during the last diagnostic review in 2011, they stated that the establishment of a Health Services Commission was being considered by DPM.

However, there has been little progress on the issue since then. Such a Commission would be a mechanism for setting government health sector terms and conditions separately from the general Public Service conditions and so is less likely to have flow-on effects into the Public Service.

Although consideration of a health services commission is supported by the NHP under **Strategy 3.5.6**<sup>76</sup>, it is a highly complex issue that has now been made more complex by the establishment of PHAs and the broadening role of the CHS Secretariat. The role of the CHS in relation to any proposed health services commission is also unclear and would need to be explored further. Support from central agencies would also be crucial to such a far-reaching proposal.

In the light of the complexity of the issue, the review team recommends that a feasibility study be conducted into the viability of establishing a health services commission or similar arrangement. Such a study could identify and explore all the issues raised by such a proposal and present a range of possible models in a series of concept papers for further discussion at the HSPC and with the CHS and the central agencies.

In the meantime, to address the issue of remuneration as it stands now, classifications of identified positions for which it is difficult to attract suitable candidates could be reviewed jointly by NDoH, Treasury, and DPM to see what changes could be made and are affordable in the short term.

**To improve capacity in this area, NDoH could, with technical assistance, as appropriate:**

- Review the current classification system to see how it impacts on health sector remuneration and staff recruitment
- Review how current classifications could be changed for nurses and CHWs to increase their remuneration
- Conduct a feasibility study into the viability of establishing a Health Services Commission and develop a concept paper for discussion at the HSPC and with the CACC.

**3.4 Pre-service training of nurses and CHWs in the health sector**

A significant expansion and upgrading of the training facilities for nurses and CHWs is essential for the successful implementation of the NHP. Since the last NDoH capacity diagnostic in 2011, a number of significant initiatives have occurred through Australian Government support.

Both pre-service and in-service curriculum and training for health workers has been given a greater priority by NDoH and the Australian Government. For example, the Australian Government has co-financed a program which deploys 8 clinical midwifery facilitators at all four midwifery schools to improving the quality of teaching and student learning; co-financed a public-private partnership with NDoH and Oil Search Health Foundation to establish a reproductive health training unit to deliver in-service training in essential obstetric care and family planning; providing funding for 1400 scholarships for midwives and nurses; co-financing infrastructure rehabilitation and providing technical assistance.

The Australian Government is also working with NDoH and all health worker training institutions to implement a quality improvement program based in the capacity diagnostic assessments of the nursing and CHW training institutions done since 2011<sup>77</sup>. In addition, AusAID funded the roll-out the

<sup>75</sup> <sup>75</sup> This was also a recommendation of the UTS work value study on nursing in PNG in relation to nurses but it has not been implemented. See UTS/WHO (2008) *A report on the work value of nurses employed in public health facilities*, p6

<sup>76</sup> PNG National Health Plan 2011-2020, Volume One, p 24

<sup>77</sup> PNG Capacity Diagnostic Mission for Nursing Schools, JTA December 2012 and the PNG Community Health Works School Diagnostic Audit, UTS Access, November 2012

DWU-managed Rural Health Facility Management Training courses to all provinces in 2010-11 and this now is an integral part of the re-design of the Health Service Improvement Program (HSIP).

As there have now been major capacity diagnostics in nursing and CHWs training, this review will only briefly comment on NDoH's role in this area, rather than focusing on the training itself as was done in the last NDoH capacity diagnostic in 2011.

Firstly, NDoH has a support role to the colleges but the scope of this role is changing and unclear as the colleges move fully into the education sector and accreditation issues are progressively resolved between the stakeholders.

Secondly, the nursing and CHW capacity diagnostic reports envision both a different and expanded role for NDoH in relation to the training institutes. For example, the Capacity Diagnostic on the nursing colleges recommended a broad auditing role for NDoH.

As a consequence, the role of the Training and Curriculum Unit in the HR Branch in this area requires a more detailed review. It is difficult to make an assessment of the capacity of the Unit and what technical assistance it requires when its role is in a state of transition.

However, it is clear that with seven vacant positions out of 15, the Unit is severely understaffed and lacks capacity even to address the internal staff development needs of NDoH. Any wider role for the unit would require considerable more resources and additional technical support.

**To improve capacity in this area**, the role of the Training and Curriculum Section should be reviewed, to identify clearly what its role should be in the light of its changing role and the recommendations made by the Nursing and CHW School capacity diagnostic reports.

The 2012 review of NDoH's structure against its legislative and policy mandate also proposed that the curriculum development function be removed from the Training and Curriculum Section and transferred fully to the training institutions<sup>78</sup>.

This recommendation is also supported, with the caveat that while this may be suitable in the area of nursing (where the universities will take over training), CHW schools may require continuing support in this area, although this does not necessarily have to come from NDoH.

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<sup>78</sup> HHISP (2013) *Responsibilities of the National Department Of Health in the PNG Health Sector - Review Of The Legislative And Policy Mandate*, Port Moresby May 2013, Section 4.6

## Appendix A to Annex 4 - HRM & OD Structured Questionnaire

### **NDoH HR BRANCH:**

1. How do you perceive the leadership quality of NDoH managers?
2. What steps have been taken to improve NDoH leadership capacity in the last two years?
3. What improvements or changes have occurred in the Branch over the last two years?
4. What further changes are required to increase staff capacity?
5. How has the HR Branch changed between October 2011 and now?
6. How has the structure and culture changed?
7. How are staff being managed? (is recruitment, performance management, workplace ethics)
8. What forms of technical assistance have been provided in this area and what is required?

### **WORKFORCE PLANNING**

1. Has the Steering Committee and the technical working group on Workforce planning been established and has it met regularly?
2. Has a workforce plan been developed? If so, how is it being used in NDoH to increase the size and quality of the health workforce?
3. What forms of technical assistance have been provided in this area and what is required?

### **PRE-SERVICE TRAINING AND ACCREDITATION OF NURSES AND CHWS**

1. How is the matching between the colleges output and staff needed in the health sector?
2. How is accreditation fitting into this? Is there congruence between training being provided and accreditation requirements?
3. Has the structure been amended to include more medical and nursing positions?
4. What steps have been taken to improve development and implementation of nursing, midwives and CHW standards and accreditation process? What is the ongoing capacity to implement these?
4. What forms of technical assistance have been provided in this area and what is required?

### **PAYROLL ISSUES:**

1. Are payrolls up to date?
2. Has the new award been fully implemented?
3. Is CONCEPT fully functional and rolled out to all health facilities at the relevant level?
4. What payroll issues are still outstanding since 2011?
5. What is the capacity to effectively manage personnel & payroll services?
6. What forms of technical assistance have been provided in this area and what is required?

### **CHS:**

1. What HR functions does CHS have?
2. How are these being managed?
3. How many HR staff does CHS have?
4. What level of capacity do they have?
5. What forms of technical assistance have been provided in this area and what is required?



## Appendix B to Annex 4 – Description of assessed HRM functional areas

HRM as a field includes a range of interrelated functions or policy areas directly relevant to the effective management of organizations. These functions include:

1. **HR Strategic Planning:** This function includes all planning activities related to developing and implementing key HRM activities to ensure that they are aligned with the agency's corporate plan and business goals
2. **Staff data and HRMIS:** This function relates to collecting, collating and analysing key employee data to guide managerial decision-making in implementing the organisation's work goals.
3. **Staff Induction:** This function relates to all activities developed and implemented to orientate the new employee to the organisation's work, goals, values and culture. It generally also includes orientation to the specific role they have been appointed to.
4. **Work analysis, job descriptions, and classification:** This function includes all activities related to analysing work requirements on the position level to develop matching Job Descriptions and classify positions to the appropriate salary level. It is also used to foster a common organizational understanding of the work to be undertaken (the responsibilities, tasks, and duties), the scope and authority of the position, reporting relationships, financial delegations (sometimes); and the required skills, qualifications, attributes and experience to successfully perform in the position.
5. **Workforce Planning:** This function includes all activities related to planning for current and future staffing needs through analysing and assessing what type of staff are needed, the potential supply of such staff, and what strategies can be put in place to attract staff.
6. **Remuneration or pay policy:** This function includes all activities related to developing terms and conditions of employment to ensure that staff are adequately and fairly remunerated for their work and that qualified staff are attracted and retained by the organization.
7. **Recruitment, selection, and deployment of staff:** This function includes all activities related to the management of the engagement and deployment process to ensuring that the most qualified and suitable staff are engaged by the health organization and successfully deployed to the appropriate health facility.
8. **Staff performance management:** This function includes all activities related to the management and evaluation of staff performance and planning of work on the individual staff level to ensure that the strategic goals and objectives of the organization are successfully met.
9. **Human Resource Development (HRD):** This function includes all activities related to developing employee capacity to successfully fulfil their workplace responsibilities. While this can be treated as a separate function from HRM in that it also occurs separately from the employee relationship, in an organizational context it should be treated as an integral part of HRM and should be strategically and closely linked to the goals and objectives of the organization.
10. **Employee relations (or industrial relations):** This function is concerned with ensuring harmonious workplace relationships through the implementation of good workplace policies. This function includes negotiating with employees, trade unions, and professional associations on workplace issues. It generally operates within a closely defined legal framework that sets out the parameters of industrial relations policies and practices in the workplace.
11. **Workplace ethics:** This function includes all activities related to fostering and improving ethical standards and behaviour through, for examples, Codes of Conduct, workplace policies and training, role modelling, in the workplace and dealing with unethical behaviour through managing employee discipline. It often operates within a closely defined legal framework that sets out the parameters of acceptable behaviour in the workplace.



12. **Occupational health and safety (OH&S):** This function includes all activities undertaken to maintaining a safe work environment for staff and clients who come into the workplace. It may involve a number of policies in different areas (e.g. manual lifting, office or facility environment; security arrangements; HIV/AIDS policy). This function often operates within a closely defined legal framework that sets out the parameters of OH&S policies and practices in the workplace.
13. **Gender and Equal employment opportunity (EEO) policy:** This function includes all activities aimed at ensuring equity or fairness in the workplace. EEO is achieved through the implementation of policies and practices to eliminate all forms of discrimination that are not *directly* relevant to the workplace or a person's ability to do the job such as, for example, gender, age, medical status (e.g. HIV/AIDS) ethic background, religion, political orientation, marital status and disability. This function may operate within a legal framework that sets out the parameters of EEO policies and practices in the workplace.
14. **Personnel administration:** This function includes all activities related to processing and storing staff payroll and personnel information; processing of leave claims; and the processing of data collection for other HRM purposes. It is a critical baseline support function that needs to function effectively as a starting point for good employee relations.
15. **Grievance procedures:** This function enables employees to raise grievances in a structure and secure way, without the fear of reprisal. In this way, it enables successful resolution of disputes and concerns before they become major issues for the organization that may lead to loss of staff morale or industrial action.
16. **Discipline procedures:** This function enables staff infringements of HRM policy standards and applicable legislation to be dealt with in a structured and transparent way, in accordance with the rules of natural justice. They should also enable managers to resolve workplace discipline issues quickly.

## Annex 5 - Finance Branch staffing

The finance branch is part of corporate services and is made up of the following units: financial accounting, financial management services, accounts payable and budget and reporting. According to the most recent staff establishment data provided to the assessment team there are twenty three posts of which nineteen are filled (overall four vacancies) as shown in the table following.

**Table 1: NDoH finance branch staff positions**

<b>Finance management services roles</b>	<b>Status</b>
Manager – finance management services	Vacant
Administrative assistant	Position filled
<b>Financial accounting roles</b>	<b>Status</b>
Technical advisor – financial accounting	Position filled
Accountant – recurrent	Vacant
Bank reconciliation officer	Position filled
Certifying officer	Position filled
Senior examiner	Position filled
Examiner	Vacant
Commitment officer	Position filled
Accounts officer	Position filled
Machinist	Position filled
Data entry operator	Position filled
<b>Accounts payable roles</b>	<b>Status</b>
Technical advisor – accounts payable	Vacant
Officer in charge – pay office	Position filled
Assistant pay officer	Position filled
Travel officer	Position filled
Acquittal officer	Position filled
Technical officer housing and rental	Position filled
Housing and rental officer	Position filled
<b>Budget and reporting roles</b>	<b>Status</b>
Technical advisor – budget and reporting	Position filled
Accountant management	Position filled
Budget accountant	Position filled
Budget officer	Position filled

## Annex 6 - Internal Audit Unit staffing

The Internal Audit Unit and its staff report directly to the NDoH Secretary. According to the latest establishment figures provided to the assessment team, this office is meant to have ten positions however according to staff records there are only half of those positions filled being a total of five people. The staffing levels have improved slightly since the 2011 assessment (at that time 2 out of 9 posts were filled). The following table is a summary of the current position in the internal audit office and vacancies.

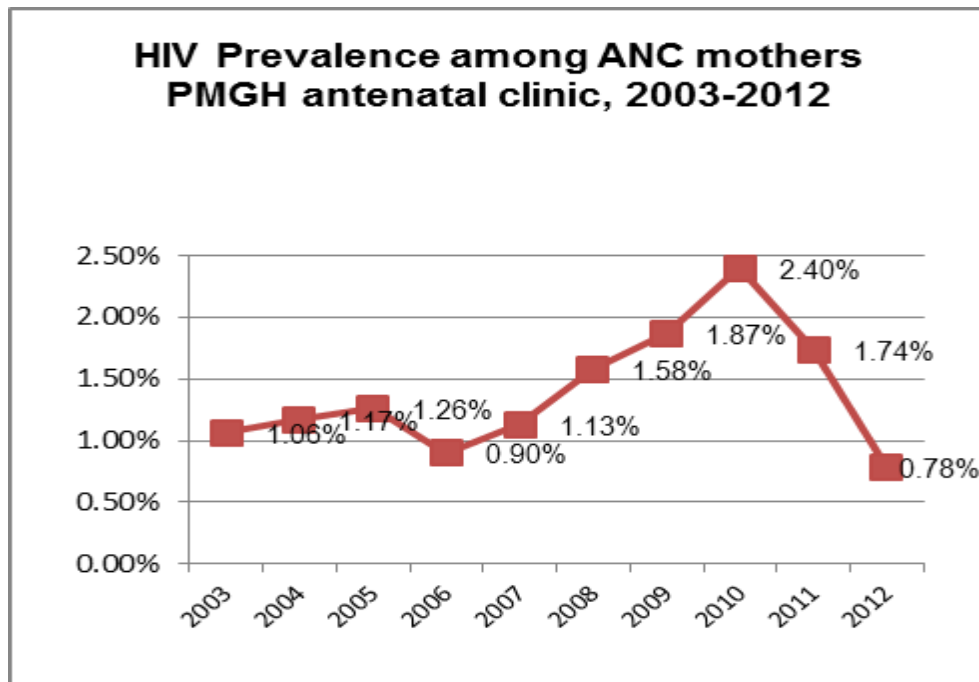
**Table 1: Internal Audit Unit staffing**

PERSONNEL / ROLE	STATUS
Chief audit inspector	Position filled
Administrative assistant	Vacant
Audit manager - Southern	Position filled
Senior internal auditor - Southern	Vacant
Audit manager - Momase	Vacant
Senior internal auditor - Momase	Position filled
Audit manager - Islands	Position filled
Senior internal auditor - Islands	Position filled
Audit manager - Highlands	Vacant/withdrawn
Senior internal auditor – Highlands	Vacant/withdrawn

## Annex 7 - Public Health Branch

### 6.1 HIV/AIDS

Graph 1: HIV prevalence among ANC mothers at PMGH antenatal Clinic



The above graph shows a very positive trend in HIV prevalence amongst ANC mothers at Port Moresby General Hospital, possibly indicating a successful program is in place for controlling the epidemic in PNG's biggest city. However the impact of falling ANC attendance should also be considered as a contributing to this apparent improvement (first ANC attendance fell by 20% 2010 to 2012). The lack of analysis of monitoring and surveillance data from the last 2 years means it is unclear if this success is being replicated in other populations in the country.

Progress is being made, but the NDoH remains a minor actor. Largely the Australian Government funded, with the main providers being from the NGO sector (Catholic Church, Clinton Foundation, Anglicare, Save the Children). Main support is through donor grants (\$170m over three years). Most of the activities are occurring outside of the NDoH, with the strategic coordination coming from the National Aids Council (which reports to and is funded by the PMs office) and this agrees in consultation with stakeholders with advice from a technical group.

The NDoH capacity has reduced with the recent changes, with the removal of 6 technical advisers. Surveillance is two years behind, medical staff engaged in the program are playing a regional role, which is clinically focused rather than population health focused.

### 6.2 TB Control

According to a recent WHO report, there has been a massive increase financial support from the government to the TB program. The TB budget is increasing and in 2013 for the first time GoPNG was the dominant funder. The national TB response is currently inadequate. There ASR shows an increase in case detection but a decline in both the cure rates and success rates in the last 4 years.



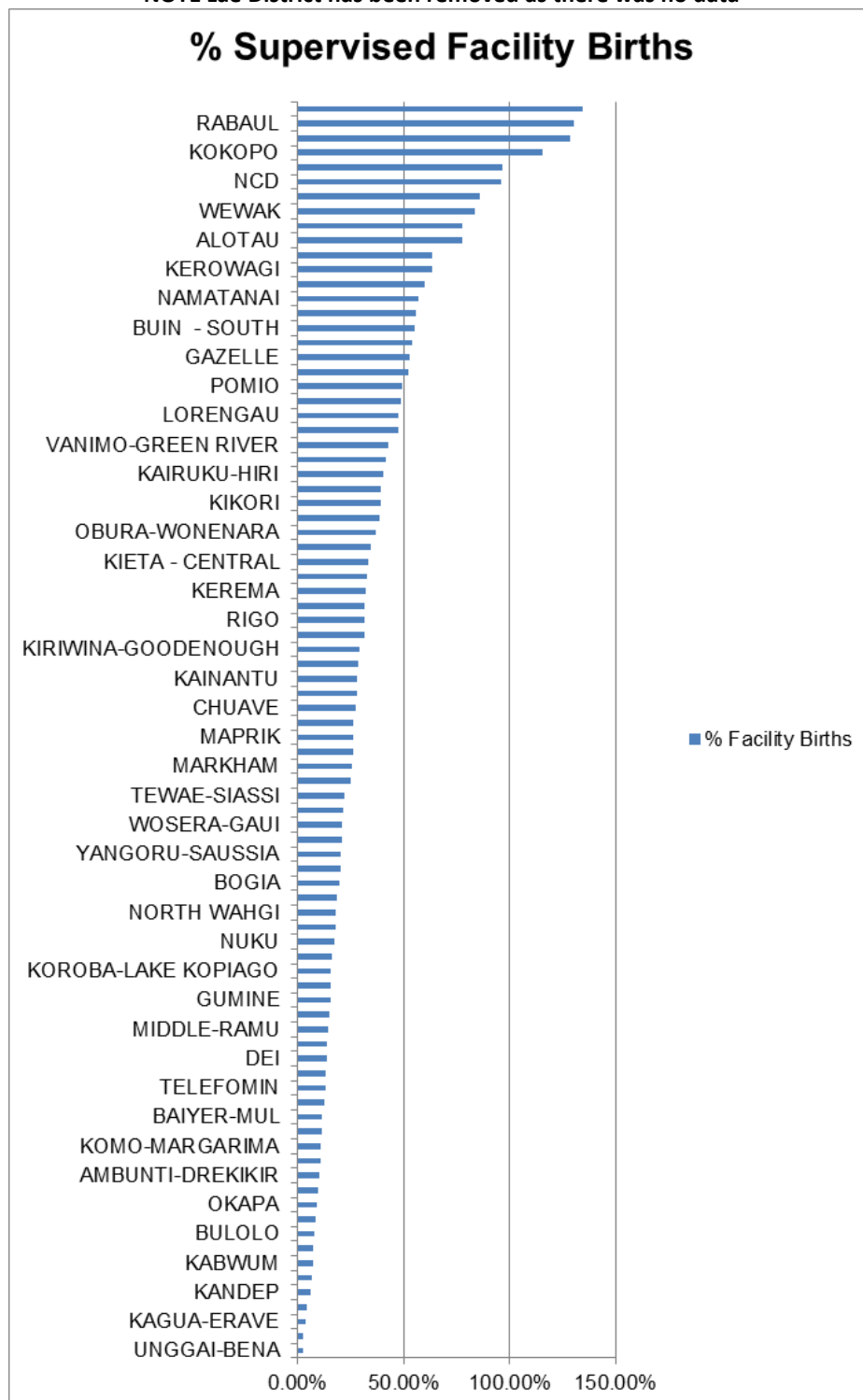
The roles of NDoH and Provincial staff, including monitoring and supportive supervision, should be clearly defined for all levels based on the existing National Health Standards. Supportive linkages (programme and management) between national, provincial and district level need to be developed.

There is also a need to strengthen the routine immunization programme through:

- Continuing of the routine immunization program with enhanced planning for hard-to-reach areas, including urban areas, thereby ensuring equitable access to immunization services for all children
- Re-establishing outreach in areas where it is not happening
- Intensifying integrated EPI/MCH outreach with adequate resources
- Implementing the RED-REC Strategy nationwide through training at health facilities, including planning outreach and tracking defaulters to reduce drop outs
- Supporting the planned re-introduction of the child health register in the country through health facility level training in its use.
- Use SIAs/campaigns to address specific programme needs, such as polio eradication and measles elimination, and requirements for introduction of new vaccines.
- Establish competency-based training at the health facility level, including the basics of EPI, cold chain, vaccine stock management and micro-planning.

## Annex 8 - Access inequity between districts

NOTE Lae District has been removed as there was no data



## Annex 9 - NDoH infrastructure baseline report

### 1. Introduction

This aim of this report is to establish baseline criteria for assessing the capacity of Infrastructure Implementation of the PNG National Department of Health (NDoH). The report is part of an overall capacity diagnostic assessment of the NDoH prepared by an independent assessment team.

### 2. Key NDoH branches for infrastructure delivery

The key Infrastructure Agencies of the National Department of Health responsible for infrastructure delivery are:

1. Health Facilities Standards Branch reporting through the Executive Manager of Medical Standards Division to the Deputy Secretary NHSS.
2. Commercial Support Branch reporting through the Executive Manager of Corporate Services Division to the Deputy Secretary NHP and CS.

Health Facilities Standards Branch and Commercial Support Branch work in partnership to deliver infrastructure for all levels of the health sector. The structure and relationship provides oversight of infrastructure delivery by both the Departments Deputy Secretary's. The organisational structure does allow opportunity for gaps in responsibilities or delivery failures between Divisions.

### 3. Capacity assessment of NHP infrastructure program

#### 3.1 National Health Plan Infrastructure Program

The National Health Plan 2011-2020<sup>82</sup> established a strategy for delivering PGK 3.374B of budget expenditure on new health infrastructure for the period of the plan. A Mid Term Development Plan (MTDP) 2011-15 establishes a plan for PGK 1.501B<sup>83</sup> of budget expenditure for new health infrastructure, requiring PGK300M expenditure every year. The Mid Term Development Plan will be the key focus of this report.

#### 3.2 MTDP 2011-15 Infrastructure Program

The MTDP 2011-15 has a priority for improving health services to the rural majority and urban disadvantaged. The plan was developed and costed with broad stakeholder consultation including Provinces, Hospitals and Provincial Health Authorities aligning the planned projects with respective 5 year Strategic Implementation Plans and the overall National Health Plan 2011-2020.

The scope of infrastructure for the Mid Term Development Plan 2011-15 is for 1,130 infrastructure projects across the entire health sector with project types spanning from local level Aid Posts through District Hospital to Regional Specialist Hospitals, see table below.

**Table 1: Projects on the MTDP 2011-15**

extract from Table 2: Mid Term Development Plan  
2011-15

Types of Projects (Buildings)	Number of Projects
Aid Posts:	668
Community Aid Posts:	44
Health Centres	356
Rural Hospitals:	5
Provincial Hospitals:	14
Hospital:	6
Regional Hospitals	4
Medical Stores	22
PHA Offices	10
Training Institutions	1
<b>Total Number of Major Projects</b>	<b>1130</b>

<sup>82</sup> National Health Plan 2011-2020 Vol1, chapter 7.

<sup>83</sup> Mid Term Development Plan Projects and Programs 2011-15, Vol 2



To achieve the MTDP 2011-15, the average Annual Infrastructure Plan for Infrastructure delivery requires 226 major infrastructure projects each year.

### 3.3 MTDP 2011-15 Static and Medical Equipment Program

The delivery of static plant and medical equipment are also part of the MTDP and is in addition to buildings infrastructure. The scope of investment in equipment and supplies over the 5 year plan is estimated to be PGK101M as outlined in the table opposite.

**Table 2: Level of funding for static plant and medical equipment**

extract from Table 2: Mid Term Development Plan 2011-15

Types of Projects	Estimated Cost	
Medical Equipment:	82.2	PGK (Million)
Static Plant:	18.9	PGK (Million)
<b>Total Value</b>	<b>101.1</b>	<b>PGK (Million)</b>

### 3.4 Annual Infrastructure Plans

The assessment team has requested documents showing Annual Infrastructure Planning and these are still pending.

### 3.5 Infrastructure Program Progress

The assessment team was not provided with any formal data collection on the completion of health infrastructure for the National Health Plan. The following analysis of the infrastructure program is based on the most recent NDoH Capital Works Quarterly Report<sup>84</sup>. This Report provides a snapshot of the NDoH's capital works program in progress as of July 2013.

The Capital Works Quarterly Report does not track progress of all Health Infrastructure projects under way and it has the following notable exclusions:

- Details of projects delivered under the Rural Primary Health Services Delivery Project.
- Details of projects being developed by Church and NGO agencies.
- Details of project for Sexually Transmissible Infection Clinics (STI) funded by Australian Aid and implemented by Charles Kendall and Partners are included in the Report but there are no budget or completion status details.
- A number of the projects in the report are listed with MOUs and responsibility / funds transferred to PHAs, but there are no details of budget and completion status.

The Capital Works Quarterly Report is not a definitive document of all health infrastructure underway in PNG, but it is a fair reflection of the scope of current infrastructure for the NHP.

### 3.6 Current Infrastructure Program Status

The current capital works infrastructure program has a total value of PGK382M and 359 projects. This includes infrastructure (buildings), static plant and biomedical equipment projects in all phases of delivery from concept through to post contract defects liability<sup>85</sup>. Due to the lengthy process of implementation of capital works this program generally reflects the last two financial years of work, as it includes projects either in implementation now (design or construction) or projects in the post contract occupation with current defects liability.

- The program includes a total of 359 projects (121 are buildings).
- 66 projects were yet to commence (all are buildings).
- 24 projects were in design or documentation (all are buildings).

<sup>84</sup> See appendix - July 2013 Works Program Analysis.

<sup>85</sup> Defects liability is the post contract stage directly after construction completion where the builder retains liability for defects rectification (usually 1 year).

- 42 projects were in construction/installation (18 are buildings).
- 41 projects were in post contract defects liability (13 are buildings).
- 198 projects were awaiting tender approval (13 are buildings).

No qualitative assessment has been made of the design or construction of infrastructure under the National Health Plan as this is beyond the scope and time available to this review.

### 3.7 Measuring Progress

The current range of projects in post contract defects liability stage represent work designed and documented in the year 2011-12 and built through 2012-13. The 13 buildings completed represent 5% of the output required for the NHP for year 2011-12.

The current projects in construction generally represent work designed and documented in the year 2012-13. The 18 buildings in construction represent 13% of the output that is required for the NHP for year 2012-13.

The projects in design or documentation now represent the current progress for the 2013-14 year. The 24 buildings represent 9% of the output required under the NHP for the year 2013-14. An additional 66 projects are scheduled as not yet started and still have potential to commence this year.

The rate of progress of key building infrastructure for the National Health Plan has generally been poor in the first two years ranging between 5-13% of planned infrastructure under way. Progress in equipment and plant has been better but less significant in total effect.

On the figures available, the current progress of capital works infrastructure against the Mid Term Development Plan 2011-15 (to July 2013) shows that **40 per cent of the time** is expended (2 of 5 years). The corresponding progress in expenditure on completed infrastructure completed is **24 per cent of the value** is expended (0.36M/1.5M).

Therefore the estimate of progress of infrastructure delivery against the Mid Term Development Plan 2011-15 is a shortfall of 40 per cent.<sup>86</sup> This translates to the current infrastructure program being 10 months behind schedule.

The current program has a high quantity of Equipment and Static Plant projects, masking the lack of progress in key Building Infrastructure projects. Equally the program budget does not include STI clinics and the Rural Primary Health Services Delivery Project.

**The assessment team opinion is that current institutional arrangements for infrastructure delivery are not progressing infrastructure at the anywhere near the pace required for the NHP and must change.**

### 3.8 Baseline for measuring future progress

The baseline for measuring future progress of infrastructure for the NHP requires 226 new major infrastructure projects (buildings) to be implemented on a year to year basis.

As the time line for delivery of major infrastructure can be up to 3 years, this should see the quarterly capital works program reports evolving to have 226 projects at each phase of project delivery, i.e. 226 projects in design/documentation, 226 projects at tender, 226 projects in construction and 226 projects in post contract defects liability.

The quarterly capital works program reports should include all health projects underway in the health sector including NDoH projects, DP Grant projects, and other special projects. This would provide a stronger understanding of the overall progress of infrastructure against the NHP.

<sup>86</sup> This opinion is based on NDoH budget figures provided and requires further clarification.

## **4. Capacity Assessment of NDoH Infrastructure Branches**

### **4.1 Assessment of Health Facilities Standards Branch**

The following is a description of the activities, personnel and operations of this Branch.

#### **4.1.1 Scope of activities**

Health Facilities Standards Branch sets design standards for all parts and levels of the Health sector PNG.

The scope of activities of Health Facilities Standards Branch include:

- National Health Infrastructure Standards and Design (Policy),
- National Health Infrastructure Standards and Design (Design),
- National Medical Equipment Supplies (Specification),
- National Orthotic and Prosthetic Services (Fabrication & Fitting).

In line with the terms of reference for this report the focus of discussion is on the key tasks of infrastructure implementation including design and preparation of infrastructure for construction, biomedical equipment procurement (tender), and for developing design policy standards for the health infrastructure program. The National Orthotic and Prosthetic Services components of this Division will not be covered in this report and should be considered in detail in future reviews.

#### **4.1.2 Infrastructure Program**

The planning of the year on year infrastructure program is largely led by the Department's Strategic Policy Branch. They work across the Health sector to develop the mid term and annual infrastructure plans, which are provided to Health Facilities Standards Branch as the National agency for design and responsible for implementing the annual infrastructure program for capital works and for infrastructure maintenance. As noted elsewhere the Health Facilities Standards Branch activities have recently shifted to focus now on managing design contracts for infrastructure and they retain a key role in setting design standards and co ordinating infrastructure delivery with all parts of the health sector.

#### **4.1.3 Management**

Health Facilities Standards Branch is structured with a manager overseeing four components or sub branches:

- Design Standards.
- Design Implementation.
- Biomedical Equipment.
- National Orthotic and Prosthetic Services.

#### 4.1.4 Personnel

The table below is an extract from the NDoH Establishment Staff Schedule Oct 2013<sup>87</sup> for Health Facilities Standards Branch personnel associated with Infrastructure Design and Biomedical Equipment. The schedule shows the 13 establishment staff positions, with 3 current vacancies. These are staff are all located in the NDoH head office in Port Moresby. A diagram of the Branch organisational structure has been requested.

The Manager of Health Facilities Standards Branch has expressed a view that the Branch is understaffed considering the scope of activities they are expected to undertake and this is agreed. The current level of skills and experience within the Branch is generally at a low level of performance, nevertheless personnel are required to achieve design for health facilities to the high levels of design required by the Design Standards. In addition the Branch operates with no Health Planning Expertise, there may be no personnel with a Degree in Architecture and there are no personnel scheduled for Cost Control responsibilities for infrastructure.

**Table 3: Design Standards/Implementation and Biomedical Equipment Personnel /Roles**

PERSONNEL / ROLE	STATUS
MANAGER - HEALTH FACILITIES	POSITION FILLED
ADMINISTRATIVE ASSISTANT	POSITION FILLED
ASSET INFORMATION SYSTEMS OFFICER	POSITION FILLED
TECHNICAL ADVISOR - INFRASTRUCTURE & ASSET STANDARDS	POSITION FILLED
ADMINISTRATIVE OFFICER	POSITION FILLED
CHIEF TECHNICAL OFFICER - BIOMEDICAL ENGINEERING STANDARDS	POSITION FILLED
CHIEF TECHNICAL OFFICER - HOSPITAL ENGINEERING STANDARDS	VACANT
CHIEF TECHNICAL OFFICER - BUILDING STANDARDS	POSITION FILLED
AUTOCAD DRAFTSMAN	POSITION FILLED
TECHNICAL OFFICER - QUALITY CONTROL & ASSURANCE	VACANT
CHIEF TECHNICAL OFFICER - QUALITY ASSURANCE BUILDING	VACANT
CHIEF TECHNICAL OFFICER - QUALITY ASSURANCE STATIC PLANT	POSITION FILLED
CHIEF TECHNICAL OFFICER - QUALITY ASSURANCE MEDICAL EQUIPMENT	POSITION FILLED

#### 4.1.5 Comments on Resourcing Capacity

Given the scope of the National Health Plan Infrastructure Program the resourcing of the Health Facilities Standards Branch as the national agency for infrastructure delivery is at an acute low level.

In a traditional design office the level of personnel to undertake the required 226 public building projects (annually) would be about 40 – 50 professional design staff including health planners, architects, engineers and quantity surveyors (cost advisors) and this would be personnel for design and documentation of building infrastructure only. Additional personnel would be required for development of Design Standards policy.

Under a consultant services outsourcing model the Health Facilities Standards Branch would still require project management personnel to oversee and direct the design consultants. The level of resourcing required for 226 public building projects (annually) would be 20-25 project managers. Each would require technical design knowledge and abilities to liaise and negotiate with consultants and project stakeholders. This would see each project manager overseeing implementation of 10-12 projects annually. This would be a very large work load for each project manager, but it is feasible with efficient management and skilled staff.

<sup>87</sup> Public Service of Papua New Guinea NDoH Establishment Register - Positional Occupancy, Oct 2013.

#### 4.1.6 Staff Recruitment

The Manager of Health Facilities Standards Branch has endeavoured to fill the establishment staff vacancies. He advises that strategies to filling vacancies have been unsuccessful and the following are the key restraints for engaging new staff:

- There is a general shortage of skilled design professional personnel in PNG,
- There is a specific shortage of health design professional personnel in PNG,
- The low levels of remuneration offered by NDoH have been rejected by applicants,
- The Resources and Private Sector are preferred destinations for potential personnel,
- The start up of infrastructure functions in the Provinces has provided competition for personnel,
- Other factors include the lack of suitable housing in Port Moresby, which we understand is a general problem for other NDoH and government staff in general.

**Some additional notes on Health Facilities Standards Branch Resources are:**

- There is an immediate need for Health Facilities Standards Branch to increase staffing levels as the current resource levels are limiting the capacity to implement the NHP.
- The level of resources within the Branch should be also further expanded for a designated period to meet the program/budget challenges of the NHP.
- The Public Service HR structures are an impediment to this Division growing to meet its mandate due to overall man power ceilings and the low remuneration level provided to professional staff.
- The formation of Infrastructure capacity at Provincial Health Authority level is also providing additional competition for infrastructure personnel.
- See late comments on changing skill requirements.

The Branch Manager has identified some general weakness in the skills and experience of personnel and identified a need for skills upgrade and training in project management, programming, design and sustainability.

#### 4.1.7 Operations

##### **Design Standards**

Health Facilities Standards Branch is the national agency for developing design policy for infrastructure health standards across PNG. A policy framework for the design of health infrastructure is emerging although the capacity in the Branch for further policy development is weak. A key achievement to date has been the publication of National Health Service Standards for PNG 2011-2020. This document is based on the Australian Health Facilities Guidelines and needs further refinement for the PNG context and sustainability.

The Branch has identified the key areas of further design standards development include:

- Engineering Services Standards (electrical, mechanical, hydraulic, etc.),
- Asset Management Standards,
- Biomedical Equipment QA Manual (in draft)

##### **Health Planning and Clinical Design**

The review team's assessment is that there has been limited Health Planning and Clinical Input into the Infrastructure Standards and Design. The recent introduction of NDoH governance committees

for Infrastructure Standards and Design should provide for clinical and stakeholder input into Standards and Design and is supported.<sup>88</sup>

### **Template Design Standards**

The development of Template Design Standards for typical health facilities has commenced with the production of at least one policy document for PNG Community Health Posts<sup>89</sup>. This document provides practical guidelines for managing the delivery of a new Community Health Post Buildings with procedural steps for stakeholders engaging with Government including step by step activities and design drawings for a range of standard design template options.

The template designs strategy is a key approach for delivering appropriate and predictable design solutions across the health sector. There will be a vital need for ongoing development of the template designs to ensure that lessons learned are included in the design templates. The scope of the template designs should include full architectural and engineering documentation so that the built solutions are repetitive and predictable.

The PNG Community Health Post Policy document has been used to develop infrastructure solutions for the Rural Primary Health Services Delivery Project. The RPHSDP has refined the template designs Community Health Posts and prepared detail engineering and architectural documents suitable for tendering in a number of construction system alternatives. The update of template designs for the Community Health Post should be considered by the HFSB as part of lessons learned in implementation. The manager of HFSB has a working role on that project committee.

Kit style technical solutions should be considered in the future for smaller and remote location health facilities using template design solutions. This can provide benefits of repetitive and predictable construction solutions (with advantages of reduced cost and labour). The key advantage of kit style construction in the PNG is the predictability of construction, kits ensures a full quantity of materials arrive on site, kits assembly often has reduce construction time on site and delivery of the pre packed kits can be a strategic solution for remote locations.

### **Responsibility for Infrastructure Roll Out**

The division of responsibility for infrastructure roll out between NDoH and other players in the Health sector is currently not clear and needs further policy development by NDoH in consultation with its stakeholders. The direct feedback to this review is that NDoH do not consider they are the lead agency to coordinate health infrastructure for the health sector. If this is the case, there will be a vacuum in leadership for infrastructure roll out. This is a key structural and policy weaknesses that may be contributing to the slow roll out of infrastructure across the sector. It is vital for NDoH to develop a policy framework that sets out agreed roles and responsibilities for infrastructure roll out between itself and key stakeholders and partners.

### **Asset Management**

Asset management Systems across the Health sector are generally ad hoc and in transition from traditional paper records to electronic records. Health Facilities Standards Branch has management systems on a project by project basis but there is no central register of Health facilities with base drawings and conditions reports. Given the rapid expansion of Health Facilities across the country, the development of an Asset Management Systems will be vital for anticipating and monitoring future maintenance needs for the new health assets. This will require professional development and up-skilling of staff at all levels of the health sector and is an area for DP support.

### **Infrastructure Maintenance**

The development of a nationwide maintenance strategy has been identified as absent in the current approach to health infrastructure and will lead to sustainability failures in the future. The need for a

<sup>88</sup> NDoH Governance Charter, October 2013, includes a Standards Monitoring Committee with Health Facilities Design and Standards sub committee. The correct functioning of these committees should provide a forum for clinical and stakeholder input to design and standards.

<sup>89</sup> PNG Community Health Post Policy, Feb 2013.

cogent maintenance strategy will grow in significance as the scope of health facilities increase around the country. Currently maintenance budgets for infrastructure are ad hoc and are often cut back when political imperatives require cost savings in the health system. The establishment of a policy framework for consistent and predictable budgets for health infrastructure maintenance is vital to embed sustainability in the health sector.

The key attributes of a nationwide strategy for maintenance will require a yearly budget allocation (3-5% of infrastructure investment), a maintenance plan for each piece of infrastructure and skilled staff to manage the work. It is a large and complex undertaking and will require DP support.

NDoH policy and implementation strategies for Asset management and Infrastructure Maintenance of health facilities in PNG are currently weak. Further policy development in these areas should acknowledge the accreditation implications of maintaining (or not maintaining) infrastructure as well as a strategy for planning and implementation of maintenance at the facility or infrastructure level. This is an area for DP support.

### **Biomedical Equipment Standards**

The Biomedical Equipment Branch has Policy, Implementation functions including:

- Working with clinicians in the application of Biomedical Equipment (Policy),
- Specification of Biomedical Equipment for all NDoH facilities (Implementation),

There is a legacy of poor sustainability of Biomedical Equipment in health facilities across PNG. There is local capacity to supply of most Biomedical Equipment with Port Moresby based agents representing off shore providers. There is a history of very poor after sales service from the PNG agents. In reality there is no local maintenance capacity and it relies on off shore providers, which is prohibitively expensive. There is also evidence that equipment is being installed in environments unsuitable for the technology with equipment failing in short time spans through corrosion. These are areas of policy weakness or gaps between policy and implementation, not observing lessons learned. The Biomedical Equipment Group is working hard as evidenced by the current Capital Works Program, which has 166 Biomedical Equipment projects for facilities across the entire health sector.

### **Equipment Sustainability**

The reliability of Biomedical Equipment is a key issue for the health sector. Biomedical Equipment is a strategic area that needs ongoing clinical input to assist with the selection of sustainable equipment to move the program to a sustainable basis. The Branch has identified that more consistent purchasing policies will assist in creating a critical mass of equipment that could encourage increased maintenance capacity in the local industry.

### **Equipment Maintenance**

Equipment maintenance is a further area of improvement to support Biomedical Equipment reliability. At this point we have not been able to identify any documents articulating a strategy for maintenance of Biomedical Equipment. Such a document would consider low level maintenance of simple, conventional equipment maintenance and fault correction, such as replacing gaskets, tap washers, replacing fuses, etc., through to complex equipment maintenance and fault correction for autoclaves, sterilizers, radiology equipment, etc.

## **4.2 Assessment of Commercial Support Branch**

The following is a description of the activities, personnel and operations of this Branch.

### **4.2.1 Scope of Activities**

Commercial Support Branch provides services to all levels of the Health sector and to all parts of PNG, it supports the Health Facilities Standards Branch with procurement and contract management for infrastructure and biomedical equipment supply and delivery.

### 4.2.2 Management

Commercial Support Branch is structured with a Manager overseeing two components or sub branches:

- Procurement Group,
- Contract Management Group.

### 4.2.3 Personnel

Below is an extract from the NDoH Establishment Staff Schedule Oct 2013 for Commercial Support Branch personnel associated with Infrastructure and Biomedical Equipment<sup>90</sup>. The schedule shows the 16 establishment staff positions, with 10 current vacancies. These are staff are all located in the NDoH head office in Port Moresby. A diagram of the Branch organisational structure was provided.

**Table 4: Procurement and Contract Management Personnel/Roles**

PERSONNEL / ROLE	STATUS
MANAGER - COMMERCIAL SUPPORT	POSITION FILLED
ADMINISTRATIVE ASSISTANT	VACANT
COORDINATOR - CONTRACT MANAGEMENT	VACANT
TENDER CLERK	POSITION FILLED
CONTRACT ADMINISTRATOR	POSITION FILLED
PROCUREMENT OFFICER - MEDICAL EQUIPMENT	POSITION FILLED
SENIOR PROCUREMENT OFFICER - BUILDING	VACANT
CONTRACT ADMINISTRATOR	VACANT
CONTRACT ADMINISTRATOR	VACANT
CONTRACT ADMINISTRATOR	VACANT
COORDINATOR - MAJOR PROCUREMENT	POSITION FILLED
ADMINISTRATIVE ASSISTANT	VACANT
PROCUREMENT OFFICER - STATIC PLANT	VACANT
SENIOR PROCUREMENT OFFICER - MINOR	POSITION FILLED
PROCUREMENT OFFICER - OTHER EQUIPMENT	VACANT
PROCUREMENT OFFICER - MINOR	VACANT

The above is an extract of from the NDoH Establishment Staff Schedule Oct 2013 for Commercial Support Branch personnel associated with Infrastructure and Biomedical Equipment<sup>91</sup>.

The schedule shows the 16 establishment staff positions, with 10 current vacancies. These are staff are all located in the NDoH head office in Port Moresby. A diagram of the Branch organisational structure was provided.

### 4.2.4 Resource Capacity

Given the scale of the National Health Plan Infrastructure Program this Branch has acute low level of resourcing.

In a traditional procurement and contract administration offices the level of personnel to undertake the required 226 public building projects (annually) would be in the order of 20 – 25 contract administrators and about 5 procurement officers. This would see each procurement officer managing tendering of five projects/month and each contract administrator managing 10-11 contracts in construction.

<sup>90</sup> Public Service of Papua New Guinea NDoH Establishment Register - Positional Occupancy, Oct 2013.

<sup>91</sup> Public Service of Papua New Guinea NDoH Establishment Register - Positional Occupancy, Oct 2013.



Under the design consultant services outsourcing model the procurement and contract administration tasks for this infrastructure branch would double as they procure and administer contracts for both design and construction for each project. This will require further staffing over and above those cited above.

### **Staff Recruitment**

The Manager of Commercial Support Branch has indicated that they have experienced difficulties over a long period in filling establishment staff vacancies. The reasons are the same as identified by the Manager for Health Facilities Standards Branch. Currently there are 6 new staff appointments awaiting HR approval. There is an urgent need to fill the current staff vacancies in this Branch. There current lack of resources in the Commercial Support Branch may be contributing to the high number of stalled tenders at the Central Supply Tender Board. This needs further investigation.

### **4.2.5 Operations**

#### **Policy**

The operations of Commercial Support Branch are based on the Public Finance Management Act and the Departments Procurement Manual. We have requested a copy of the procurement manual.

#### **Procurement & Tendering**

Commercial Support Branch tender infrastructure projects either through public tender or by direct appointment. In line with the PFMA, NDoH has authority to approve and appoint contracts up to the value of PGK0.5M. Projects with budgets above this limit must be submitted to the Central Supply Tender Board for approval and appointment of contractors. This may also include a check and clearance from the State Solicitors office of the tender process.

#### **Contract Administration and Outsourcing**

The outsourcing of design to the private sector is already increasing the work load of this Branch as each new project develops two separate contracting arrangements. This is already stretching resources and the Branch, which has a high number of staff vacancies. The Branch generally has the skill set required for procurement and contract administration of both design and construction contracts. The Branch Manager has identified some general weakness in the skills and experience of personnel and identified a need for skills upgrade and training in project management, programming, procurement and contract administration activities.

## **5. Infrastructure Project Management**

### **5.1 Project Management**

Typically NDoH infrastructure projects are managed in concert with a range of health and government stakeholders. Each major project has a Project Steering Committee that includes local, regional and central agency representation. A typical committee may include delegates from Planning & Finance, NDoH, PHA, the local facility and other participants as necessary or required. The Health Facilities Standards Branch is a key Department delegate on committees providing design advice and design services. When projects move to tendering and construction Commercial Services Branch participate in Project Steering Committees.

Project Steering Committee meetings are generally conducted on a monthly basis when a project is under construction, in design and tendering the meetings are as required to approve stages of completion – brief, concept design, tender documents, etc. The committees are responsible for project delivery and have capacity for project decisions and approvals up to the budget limit. We have requested a TOR for a typical Project Steering Committee.

### **5.2 Activity Planning & Reporting**

As mentioned earlier the annual activity plan for infrastructure is developed by the Policy Division and both Health Facilities Standards Branch and Commercial Support Branch use that as a work plan.

Commercial Support Branch has two key reporting mechanisms within NDoH:

- Monthly Project Control Group Reports,
- Capital Work Quarterly Reports.

The Capital Work Quarterly Reports are distributed across the Health Partnership.

### 5.3 NDoH capacity

The following observations are provided regarding the overall NDoH capacity to deliver infrastructure and the progress of capital work.

The removal of Development Partner Technical Assistance (TA) from the Infrastructure Divisions in 2011 had a short term negative effect on the Departments capacity to deliver infrastructure. The Department's Infrastructure Branches have since reorganized and responded positively without TA support, although they have weak capacity to implement the NHP due to inadequate resources and skills gaps.

The level of performance for infrastructure delivery twelve months ago was very poor. In the past 12 months there has been positive change in performance and improvement in output of infrastructure delivery. The recent shift in strategy by the Department to outsource design services is a positive strategy should assist the growth of the Departments capacity for infrastructure delivery.

Now is the right time to restart capacity building of the Department's Infrastructure Branches with targeted training and mentoring to improve the capacity of existing personnel and to assist the necessary change management required for the new outsourcing approach.

### 5.4 Infrastructure Design Outsourcing

In July 2013 the Department commenced outsourcing of design and contract administration services to private sector consultants and this is a major initiative for Health Infrastructure delivery in PNG. This strategy will significantly improve the Departments capacity (and flexibility) to respond to future infrastructure challenges of the National Health Plan.

In this arrangement the Health Facilities Standards Branch oversee design and carry out quality review of documents prepared by private sector consultants. Commercial Services Branch has a role in tendering and managing those contracts with private sector consultants.

This is an important evolution of the Departments infrastructure activities and mirrors the widespread practice of Government throughout Australia and New Zealand. It provides a substantial boost to the Departments capacity to implement infrastructure for the NHP. It also provides access to a wider body of experienced staff and provides greater flexibility in responding to the NHP requirements. It also limits ongoing employment liabilities for the Department.

The change in operations to outsourcing will be significant for the Departments respective infrastructure branches and will change the staff and skills required for infrastructure activities as it moves from project implementation to project management.<sup>92</sup>

### 5.5 Skills Upgrade

There is a need for comprehensive skills upgrade of the two infrastructure delivery Branches of NDoH. It is important to build sustainable skills and systems for implementing infrastructure. This is a key area for DP assistance to NDoH to support the development of a skills upgrade strategy.

In-house mentoring and on-the-job training are preferred strategies as they retain staff at the workplace. The development of a graduate program could also be considered and may assist in generating enthusiasm and vitality that has occurred in other NDoH Divisions.

<sup>92</sup> Both Infrastructure Branches have identified a need for skills upgrade to keep pace with the changing work environment.

Specialist infrastructure such as health facilities require project managers and project management that integrates design understanding with general competent project management. These skills need to be reinforced within NDoH.

## 5.6 Private Sector Capacity

There is mixed opinion about the local consultant capacity to respond to Departments outsourcing of design. Health Facilities Standards Branch have identified that engineering services is a key weakness in the local consultant capacity. There is also a limited pool of architects with health experience and an even more limited group with comprehensive health experience able to take on the design of major hospital or complex health projects.

The building of local capacity in the PNG private sector will also be a key part of building a sustainable infrastructure delivery capacity in the health sector. The private sector capacity will improve as they gain broader experience in implementing design for health projects. The weakness in local engineering capacity in the private sector is a key area of concern as it potentially will delay all projects in design stage and could lead to widespread variation in construction contracts. There may be a role for development partners supporting the private sector with mentoring, training and education courses to improve understanding of health project design and skills required to deliver sustainable design.

As the outsourcing of consultants is a recent activity there are no formal processes established for consultant appointment with Central Supply Tender Board compliance around the use of consultant resources. The assessment team has requested documents showing typical TOR for appointing consultants and these are still pending. This is an area for further policy development for the Department.

The PNG private sector will not be able to fill all the capacity requirements of the NHP as it has some capacity weaknesses. This may require strategies to include international resources in the delivery of NHP infrastructure. The expansion of the special projects strategy may provide a key strategy for boosting infrastructure delivery to involve international resources.

A further area for future reviews is the construction sector capacity to service the NHP. NDoH Infrastructure Divisions advise that they are often using second and third tier builders for construction of health infrastructure. The preferred first tier builders are often engaged in construction for the resources sector as the projects are more profitable. This is a key issue for health infrastructure quality and sustainability. The second and third tier builders are often less skilled and have reduced capacity to provide appropriate supervision of construction.

## 5.7 Provincial Health Authorities

At this point in time NDoH are almost the only health agency capable of implementing health infrastructure. This is an inherent weakness in the health sector as it provides a single point for infrastructure delivery and the provinces are often unequal partners in the delivery of infrastructure.

Assessment of the Infrastructure capacity of Provincial Health Authorities (PHA) is not part of the terms of reference for this review. There are only three active PHAs at this point (Western Highlands, Eastern Highlands and Milne Bay), all of which have some capacity to implement infrastructure. NDoH have identified that building capacity of infrastructure implementation at provincial level is a priority for sustainable growth in the health sector. The capacity needs to build side by side with capacity building within the NDoH.

Capacity building of Provincial Health Authorities and Provincial Governments will also be essential for the future maintenance of health assets once they are built. This is a key area where development partners can provide support to the health sector.

Form advice received from the RPHSD project it is anticipated that a total of six PHAs will be operational by mid 2014, and potentially eight PHAs by 2105. There is an opportunity to build infrastructure capacity from the ground up with the start-up PHAs. There are important start up

tasks for PHAs infrastructure personnel, which starts with the collation of existing assets across provinces, as well as participating in delivering new assets.

## 5.8 ICT technology

The ICT Branch has not been included in the review of Infrastructure delivery. Currently ICT systems are widely used across NDoH but the equipment and infrastructure is aging and not keeping pace with changes in software. The assessment team found instances of key Divisions with extended disruption to simple systems such as email services and there are Divisions with no access to computer systems at all.

The introduction of new ICT systems will be a key to improving the communication throughout the health sector and it can/will change the way NDoH does business in the future. By example the Medical Supplies and Delivery Division is currently rolling out new software technology to stores improve the ability for the supply chain to understand the status of Medical Supplies and to improve delivery systems. The delivery of infrastructure will also require improved ICT systems to manage the increasing (and more complex) of the infrastructure program. The introduction of an asset management system will be vital in the future for infrastructure management and will require new software and training.

The Department needs to prepare a comprehensive ICT policy as well as budgets and strategy for implementation to match the growing complexity of the health system as it implements the NHP.

## 5.9 Delays in infrastructure delivery systems

The delivery of Health Infrastructure is at a slow rate of progress with most projects being delayed as they move through the design, tendering and construction processes. The lack of resourcing within the Infrastructure Divisions is slowing the productive capacity of the Department to deliver infrastructure. The assessment team identified the major single point of delay is the Central Supply and Tenders Board where projects commonly have lengthy time periods awaiting tender acceptance.

198 Health projects are currently being delayed at the Central Supply and Tenders Board. This is a key area for the NDoH Executive Management to focus energies to improve cross departmental relationships with the Central Supply and Tender Board and to resolve blockage points for health projects within government procurement systems. Some of the problem may be within NDoH and the failure to understand requirements of government procurement systems.

The current value of projects awaiting tender approval is approximately PGK 128M with delays ranging up to 18 months in duration. The delays in tender approval are restraining the ability for NDoH to deliver on infrastructure. Releasing these projects into construction or delivery in the case of equipment would also provide a significant positive stimulus to the PNG economy.

## 6. Options for increasing capacity

Currently the capacity of the Department Infrastructure Divisions to implement new infrastructure is about 25 buildings per year. The shift to outsourcing of design may be able to increase output by another 5-10 buildings per year. This is a realistic output given the resource levels, design standards, requirements for stakeholder consultation and participation in Steering committees as well as design, tender and contracting processes. This is a long way short of the required 226 buildings per year required by the NHP.

To achieve the NHP will require the Health Sector to grow infrastructure implementation capacity across both the health sector and the private sector. The following options are available to the Department to respond to infrastructure requirements of the National Health Plan.

### **Option 1: Substantially increase the resources within NDoH, Provincial Health Authorities and Provincial Governments to deliver infrastructure.**

This will require an influx of up to 60 new infrastructure personnel in the sector, which may not be feasible given the difficulties experienced to date in attracting new skilled

staff in Port Moresby. It may also take considerable time to build new infrastructure teams into functioning and productive units and a surge in new personnel will require capacity building of management, quality and governance measures in the Infrastructure Divisions.

**Option 2: Reduce the number of projects undertaken annually with NDoH resources and look to make up the difference to deliver infrastructure with new external special infrastructure projects, (like the RPHSD Project) and build capacity in Provincial Health Authorities and Provincial Governments.**

The external special infrastructure projects provide the capacity to draw on international resources. The structure of the RPHSD Project has an important attribute of retaining executive control within the Department. It also has the capacity to involve development partners. The multi discipline team approach has advantages in delivering a range of health initiatives and capacity building side by side with new infrastructure.

**Option 3 Expansion of outsourcing of project delivery to the private sector:**

The outsourcing of design is an important strategy that has developed in NDoH infrastructure activities and will be a key ingredient for delivering future infrastructure for the National Health Plan as discussed earlier in this report. The outsourcing could also extend to engaging international consultants to deliver more complex health projects or programs.

**Option 4: A mix of options 1 and 2 and 3.**

**Option 5. Reduce the number of annually planned projects undertaken to match the Departments resources.**

This will substantially lengthen the implementation time of the National Health Plan.

## **7. Resourcing the NHP Infrastructure Plan**

A long term plan for resourcing infrastructure delivery across the PNG Health Sector is urgently required. This should encompass resourcing of NDoH Infrastructure Divisions, Provincial Health Authorities, Provincial Governments as well as NGOs, Churches and the private sector. Such a plan would also need to address the scope and levels of expertise required to implement infrastructure for the NHP and the time span required to build sustainable capacity in the PNG Health Sector to meet the NHP demands.

Building the resources capacity in PNG for the NHP may take a number of years to achieve and will require patient development partner assistance with both short term and long term inputs. The emphasis of development partner assistance should be on building sustainable local capacity, and not just getting the job done. The capacity building will require a range of development tools including training, assistance to formulate special projects and where there are critical gaps in expertise capacity supplementation.

## **8. The Cost of the NHP Infrastructure Plan**

The following is an analysis of the estimated NHP/MTDP infrastructure costs, relative to emerging actual infrastructure costs. The NHP/MTDP estimated the cost of infrastructure to be approximately PGK 1.5B, which includes major infrastructure, medical equipment and static plant. The major infrastructure (buildings) cost is PGK1.399B, see table 5. The NDoH Capital Works Quarterly Report, July 2013 (CWQR) provides timely information for updating costs for some building types as well as emerging costs for Project Management and Medical Equipment and Static Plant costs.

**Table 5: MTDP 2011-15 Projects and Estimated Costs**

extract from Table 2: Mid Term Development Plan 2011-15

Types of Projects (Buildings)	Number of Projects	Estimated Cost (PGK)	units
Aid Posts:	668	66.8	Million
Community Health Post:	44	52.0	Million
Health Centres:	356	361.0	Million
Rural Hospitals:	5	61.4	Million
Provincial Hospitals:	14	80.0	Million
Hospital:	6	632.0	Million
Regional Hospitals	4	20.4	Million
Medical Stores	22	21.0	Million
PHA Offices	10	56.0	Million
Training Institutions	1	35.8	Million
Project management:		12.8	Million
<b>Total Number of Major Projects</b>	<b>1,130</b>	<b>1,399.2</b>	<b>Million</b>

### Divergences in Estimated and Actual Costs

The following examples contrast divergences in the estimated cost of infrastructure for the NHP/MTDP with actual emerging costs of infrastructure, in the first two years of the NHP/MTDP.

#### e.g. 1. Divergence in Community Health Post Project Costs

- The NHP/MTDP assumed the cost for construction of a typical Community Health Post was PGK1.181M.
- The emerging cost for construction of a typical Community Health Post is approximately PGK2.3M<sup>93</sup>.

Extrapolating the emerging cost would lead to an overall cost for the 44 Community Health Posts of approximately PGK110M, an increase in cost of PGK58M (105%).

#### e.g. 2. Divergence in Project Management Fees

The CWQR shows a range of projects with two contracts, one for design / project management and another for construction. This reflects the shift in procurement from in house design to outsourcing.

- The NHP/MTDP includes project management fees of PGK12.8M (or 1% of infrastructure costs).
- The emerging cost for Project Management fees (including design) for major infrastructure is approximately 10% of infrastructure costs<sup>94</sup>.

Extrapolating the emerging cost for Project Management fees would see of the budget as more like 10% of infrastructure costs, and increase to an overall program cost of PGK135M, or more on a pro rata with the total program cost.

General Comment:

The cost for project management fees can vary and is typically <15% of infrastructure cost, including design and contract administration. So the emerging 10% fee is to be expected.

#### e.g. 3. Divergence in Equipment and Static Plant Costs

- The NHP/MTDP estimated cost for Medical Equipment and Static Plant is PGK101M.
- The CWQR shows current projects with an approximate value of PGK88M in the first two years of the program.

<sup>93</sup> For example Sakakadi CHP actual budget is PGK2.288M for construction.

<sup>94</sup> For example Sakakadi CHP actual budget is PGK 0.212M for Design/Documentation Fees.

Extrapolating emerging costs for the full five year term would see the total cost of Medical Equipment and Static Plant to increase to be approximately PGK220M.

**Conclusion**

The above examples show a divergence in the assumptions versus actual costs, which are increasing the cost of infrastructure for the NHP/MTDP. It is timely for a broad review of the NHP/MTDP program to align emerging project costs with the scope of the infrastructure program to be undertaken.

We recommend DP support to assist NDoH with a general review of NHP/MDTP Infrastructure Program costs and for ongoing support to assist NDoH to prepare quarterly updates of Infrastructure Program costs for inclusion in the NDoH Capital Works Quarterly Reports.