

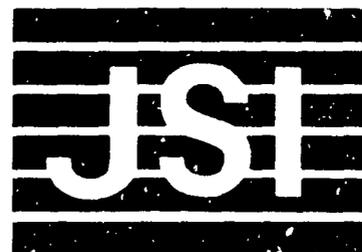
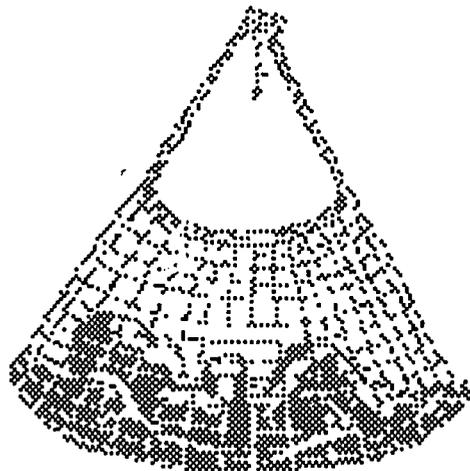
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FINAL REPORT

for the

PAPUA NEW GUINEA CHILD SURVIVAL SUPPORT PROJECT

(USAID Contract No. 492-0017-C-00-0073-00)



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EXECUTIVE SUMMARY

THE PROJECT

The Papua New Guinea Child Survival Support Project, US\$ 5.44 million project funded by the United States Agency for International Development, began in September 1990 and ended on 31 March 1995. The overall goal of the Project was to reduce child and maternal mortality rates in PNG by improving maternal and child health service delivery in the rural areas. In achieving this goal, the Project has been successful in the development and implementation of several interventions in the delivery of maternal and child health services in Papua New Guinea. Highlights include:

❖ **THE TEN STEP CHECK FOR ALL SICK CHILDREN**

This revolutionary, user-friendly tool and training method enables poorly trained rural health workers to accurately and rapidly diagnose and treat the main causes of child death and disease. Its introduction and use is supported by coordinated and linked training materials, community health education, training and supervision, and district financial planning and management systems.

❖ **A LOW COST TRAINING AND SUPERVISION MODEL**

The CSSP has developed and implemented a low cost, economically sustainable health worker training, community education, and supervision model in two provinces. This new system replaces a variety of ineffective, expensive, and unsustainable training approaches. A total of 808 health workers were trained in PNG.

In addition, an effective, easy-to-use health worker training materials format and style was developed, field tested, and implemented on a wide scale by the CSSP Project. An economically viable training materials development and production system was implemented to ensure the materials' wide dissemination. This complete training model will be implemented in 18 additional provinces with AIDAB and UNICEF technical support under the National Child Survival Program.

❖ **A DISTRICT ACTIVITY FINANCIAL PLANNING AND MANAGEMENT MODEL**

In conjunction with the training model and materials development activities, the CSSP Project developed and implemented a simplified financial planning and management system. This system and its tools address the problems of accountability, numeracy, and weak managerial skills at provincial and district levels. This system is being implemented by AIDAB and UNICEF projects in all provinces in 1996.

❖ **FERVENT ADVOCACY FOR CHILD SURVIVAL, MATERNAL HEALTH, AND RURAL HEALTH FUNDING**

The CSSP Project has labored hard to create a multisectoral alliance of politicians, government departments, non-governmental organizations, international and bilateral donors which collaborates to develop a national consensus on child survival and maternal health. The fruit of the CSSP's efforts, the National Child Survival Program, has effectively channelled resources and activities towards the rehabilitation and revitalization of the collapsed rural health delivery system in the face of a major decline in funding.

❖ **IMPROVED HEALTH SECTOR DONOR CO-ORDINATION**

initiated by the CSSP, an informal donor collaboration network was established. This network provides coherent and effective support of the GPNG's efforts to improve the health status of the population and to respond to the public health emergency in child survival and maternal health. As a result of these efforts, PNG will receive major donor funding for child survival and maternal health action.

❖ **THE INSTITUTIONALIZATION OF CHILD SURVIVAL ACTIVITIES WITHIN THE NATIONAL AND PROVINCIAL DEPARTMENTS OF HEALTH**

The CSSP Project assisted the GPNG to establish an active and operational Child Survival Secretariat. With its core staff of eight, the Secretariat manages the delivery of maternal health and child survival outreach services in 20 provinces and the CSSP-developed Health Worker Training in 18 of PNG's 20 provinces. The Child Survival Secretariat, based in the PNG National Department of Health, coordinates annual government inputs of about US\$ 2 million and donor inputs of nearly US\$ 6 million. The Secretariat provides overall management for outreach and training programs in all of PNG's provinces.

A final USAID external evaluation of the PNG Child Survival Support Project was conducted in February 1995. This evaluation recommended the United States Agency for International Development consider the replication of the CSSP training model and training materials by other USAID-funded child survival projects.

I. THE CSSP PROJECT: A BRIEF TIMELINE

The Papua New Guinea Child Survival Support Project was the first in a series of USAID-funded projects to utilize a new approach -- the direct involvement of and collaboration with national governments -- to project conception, design and implementation in the South Pacific Region. This Project was also the first exclusively health project located in entirely one country in the South Pacific.

Data available at the time of project inception indicated serious maternal and child health problems in Papua New Guinea (PNG). In 1981, the infant mortality rate was estimated at 72 per 1,000 live births and the child mortality at 42 per 1,000 live births. Maternal mortality in PNG was estimated to be one of the highest in the world; 700 - 800 per 100,000. The resulting impact on productivity and the drain on human and material resources would have a deleterious effect on the future development of the country.

Notwithstanding these data, there was considerable evidence of the Government of Papua New Guinea's (GPNG) commitment to the health sector. Between 1975 and 1987, GPNG expenditure for health increased from 2.8 to 3.4 percent of GDP, and from 8.4 to 9.1 percent of total government expenditure. Despite this support, the health delivery system continued to falter, and the levels of preventable disease and death remained unacceptable.

The Child Survival Support Project (CSSP) was proposed as early as 1987, with implementation beginning in September 1990. However, many factors and assumptions stated in the original project design document were no longer operative when the JSI CSSP team arrived in PNG (see Annex 1: "Lessons Learned").

The overall goal of the USAID-supported Papua New Guinea Child Survival Project (CSSP) was to reduce child and maternal mortality rates in PNG by improving maternal and child health service delivery in the rural areas. The original project had five specific objectives:

1. To obtain baseline and technical information for policy formulation, planning and evaluation.

2. To strengthen the Regional Support Units (RSU) by training staff which will help create a system of continued technical support and training for provincial health staff in order to improve their effectiveness in providing MCH services.
3. To upgrade technical and management skills of MCH workers and establish a diploma course in MCH Nursing Administration.
4. To establish viable and effective medical logistics systems to ensure effective delivery of MCH services.
5. To strengthen health services through improved coordination between the Department of Health, Church Health Services, and other donors.

USAID envisioned the project having two distinct phases:

Phase I involved extensive research and planning. A series of research studies and pilot projects were designed to generate information which would serve as the basis for designing the implementation phase of the project (Phase II). This two-year first phase would allow adequate time for the collection and analysis of the base line data and the conducting of pilot studies and lay the technical, programmatic and organizational foundation for Phase II. The activities conducted during Phase I (e.g., training, operations research) would ensure that the minimum skills and knowledge essential to strengthening the capacity exist, and that conditions required to establish operative mechanisms for institutionalizing capacity were met. The institutional outputs of Phase I were to be used in Phase II to put in place structures to support the delivery of health services in the provinces and to carry out the promotion, planning and management of maternal and child health services.

During the course of implementing Phase I of the Project, it was realized by the CSSP, USAID and the DOH that the End of Project Status Indicators (EOPSIs) were either unrealistic or impossible to measure. In PNG, clinical records are the only sources of information about people's health. However, recording and reporting of clinical information at both the inpatient and outpatient level are consistently poor. Thus, in August 1992 USAID and the Child Survival Project jointly adopted a new set of project EOPSIs. The new set of EOPSIs shifted the analysis from coverage rates to process indicators, emphasizing:

1. The quality of maternal and child health services provided at aid post and health center levels;

2. Improvement in knowledge and promotion of community participation in health care: and
3. Improvement in the management and training support services.

In April 1993, near the end of the first phase of the Project, an external evaluation of the project was conducted by USAID. The report of the evaluation team raised concerns about both JSI and USAID management and Project performance.

In response to these concerns, a team of USAID, GPNG, JSI and CSSP Project representatives met in Port Moresby in late August 1993. These sessions produced a clear and succinct implementation strategy for Phase II of the Project.

Phase II of the CSSP Project would focus on the selection of four target provinces and implementation of a provincial training plan. These four provincial departments of health, selected in consultation with GPNG, would develop a detailed implementation plan and budget for district level training activities. Training materials would be further developed, tested, and incorporated into the district level provincial training activities. In order to provide additional skill transfer to GPNG staff, a "CSSP Fellows" program was designed to take the place of the overseas short-term training component. Each fellow would "shadow" a CSSP technical advisor, providing individualized counterpart training. New research studies were put on hold and only current operations research and studies previously contracted by the CSSP continued.

Project staffing was modified by mutual agreement between the GPNG, USAID, and JSI. The Health Services Management Advisor/Chief of Party left the project to take another assignment, and the Logistics Management Advisor was appointed Chief of Party.

In November 1993, the Ministerial Task Force to Review the National Department of Health (NDOH) recommended a set of organizational changes to be implemented by the NDOH, National Government, and the National Legislature. This national panel of experts identified major constraints in the *structure and organization* of the NDOH brought about by the decentralization of national authority and funding to provinces and by serious manpower and human resource development failure. The Task Force also identified major constraints in the *budget process* and *lack of financial accountability* causing low productivity and poor service delivery leading to rapid increases in death and disease. Similar constraints in *quality of care* and *health systems* such as the lack of standards, and the lack of clinical and management skills, were cited as the cause of poor service delivery and the spread of disease by health facilities. The provision of *supplies and equipment*, though essential to the delivery of health services, is underfunded and poorly managed, particularly at the periphery. The Task Force condemned the *health information systems* for leading to poor planning, lack of accountability, low productivity,

and inadequate support to all health services resulting in poor service delivery. The quality of the coordination with *intersectoral organizations* contributed further to the inadequate support to all health services. The lack of *community participation* in the delivery of health services was seen by the Task Force as responsible for continuing preventable death and disease as well as poor service delivery.

The Task Force played an important role in bringing the issues surrounding the delivery of health services to the forefront. Building on this development, the CSSP began a series of proactive efforts, including briefings for UNICEF officials on the public health emergency in PNG, an informal health sector donors luncheon to update and coordinate donor activities, and a forum for dialog and discussion between the international donors in PNG and senior officials of the PNG National Department of Health. The result of these efforts was the establishment of the PNG Child Survival Crash Programme. A national, intersectoral, high level Child Survival Crash Programme Steering Committee was established by the Prime Minister's Department.

Almost immediately following these positive political developments in Papua New Guinea, USAID announced its decision to close the South Pacific Regional Office and the PNG Country Office. The CSSP Project was instructed to make no commitments which would obligate it to any activity or expenditure beyond two months time. This announcement brought into question the future of the PNG Child Survival Support Project.

Following the USAID regional closure announcement, discussions were held with the GPNG, National Department of Health, and other donor agencies in an effort to minimize the loss of more than three years investment in maternal and child health development in Papua New Guinea.

On 21 February 1994, The Child Survival Crash Programme was launched in PNG's Parliament House by the Prime Minister and the Speaker of Parliament in the presence of Government Ministers, Members of Parliament, Provincial Premiers and Administrators, Secretaries of Government Departments and other senior civil servants, as well as the media. This was followed the next day by the "Doer's Dialogue", a meeting of concerned leaders, Provincial Administrators, and Provincial Assistant Secretaries for Health.

The CSSP continued to elicit and coordinate donor support for the Child Survival Crash Programme: UNICEF/PNG committed US\$ 595,000, the Australian Government (AIDAB) agreed to provide essential immunization and camping equipment worth US\$1.18 million, the Asian Development Bank (ADB) committed an additional US\$1 million for medical equipment and training, and WHO agreed to support training, equipment and supplies. USAID and the Child Survival Support Project would continue to provide technical assistance and training materials.

Phase II Project activities including the selection of four target provinces, the preparation of provincial implementation plans, and the recruitment of CSSP Fellows and a project administrator were brought to a halt by USAID's instructions of 24 January 1994 interpreting the closure of the USAID/RDO/SP. The preparation of health worker and community training material as part of the district level training package proceeded.

On 27 January 1994, at the request of the USAID Regional Development Office/South Pacific, JSI presented a set of scenarios for two project closure dates -- September 1994 and March 1995. The March 1995 closure scenario called for the CSSP Project to complete development of the training materials, test their application in two provinces, make final revisions, and complete wide national dissemination. This scenario also called for continued technical support of the National Child Survival Crash Programme.

This level of activity was to be maintained and accelerated, while reducing expenditures, until additional obligated USAID funds were committed to the project. However, the delay in the extension of the CSSP and the obligation of additional funds postponed for seven months the implementation of provincial health worker trainings in the two target provinces.

At the end of March 1994, USAID/Washington agreed to continue the CSSP until 31 March 1995. The contract continuing the project through to the end of March 1995 was signed by all parties in June 1994. In July 1994, in anticipation of the closure of the USAID/RDO in Fiji, project oversight was transferred to USAID/Manila Office of Health, Population and Nutrition (HPN).

In August 1994, following a change of Government in PNG, spending cuts were implemented for all non-salary (and some salary) government expenditures. Medical supplies and vaccines were either not ordered or not distributed due to cash flow problems. The 1995 budget legislation reduced National Department of Health expenditures from 140 million Kina (US\$ 119 million) to 67.8 million Kina (US\$ 57.6 million) and re-centralized the operation of 14 provincial hospitals and 37 million Kina (US\$ 31.5 million) from provincial health budgets.

Despite these drastic budget cuts, the National Child Survival Crash Programme remained intact, active, and effective. Press coverage and political commitment to child survival continued to strengthen. The Government and the opposition parties agreed on the need for action on child survival and maternal health.

In February 1995 a national workshop was held to disseminate the CSSP developed materials, methods, and interventions. The workshop was used to prepare for the AIDAB project to assist the National Child Survival Program. Over 130 participants -- Provincial MCH Matrons, Provincial Rural Health Services Matrons, Provincial Inservice Training

Coordinators, Provincial Accounting Officers, Health Secretaries, Senior National Health Officials (including the Minister and Deputy Minister of Health), and members of Parliament attended.

By the end of the Project in March 1995, the PNG Child Survival Support Project had successfully:

1. developed an effective training model;
2. completed the development of coordinated health worker and community health education training materials, established materials production capacity within GPNG, and achieved their wide national dissemination;
3. developed a simple and effective planning and financial management model;
4. Trained a total of 808 health workers in Gulf and New Ireland provinces; and
5. Assisted the GPNG to establish an active and operational Child Survival Secretariat, with its core staff of eight, to manage the delivery of maternal health and child survival outreach services in all 20 provinces and the delivery of CSSP-developed Health Worker Training in 18 provinces.

A final USAID external evaluation of the Child Survival Support Project was conducted in February 1995. This evaluation recommended the United States Agency for International Development consider the replication of the CSSP training model and training materials by other USAID-funded child survival projects (See Annex 2).

II. THE PROJECT'S LEGACY

With support from the PNG Child Survival Support Project, rural health delivery systems are being restored under the PNG National Child Survival Program.

A new and appropriate PNG rural development system, based on low-cost, sustainable district level training and routine outreach services to all rural communities.

The district level MCH training package was well applied in at least two provinces. Mechanisms are in place for the GPNG to extend their application in the future.

A new district-level training model was implemented throughout the country.

New community education and health promotion models, implemented in two provinces in PNG, are being implemented nationally in 1995.

A system is in place for the incorporation of other child survival and maternal health interventions into the district-level training program.

The capacity for materials development and materials production have been established within the PNG National Department of Health.

Linkages have been established with the Department of Education and the Department of Provincial and Local Government to widely disseminate CSSP developed community education and literacy materials with consistent health messages.

Training systems development has advanced sufficiently for the CSSP efforts to be incorporated into the Asian Development Bank's five year, US\$ 24 million Human Resource Development Project. In addition, the Australian International Development Assistance Bureau (AIDAB) has committed US\$ 4 million to fund a one and a half year interim Child Survival Project in 1995 - 1996 as a bridging activity to the larger planned US\$ 29.5 million MCH & Child Survival Project in 1996.

A provincial and district level financial management system developed by the CSSP is in place to support sustainable training and outreach services. This financial management model, developed and implemented by the CSSP Project in two provinces, will be

implemented nation-wide by the AIDAB follow on Child Survival Project and by the PNG Population Project in 1995.

All 524 hospitals, health centres, and sub-centres are being re-equipped with medical equipment for the delivery of maternal and child health services. This was funded by AIDAB.

The vaccine cold chain is being upgraded with the provision of 350 gas/electric refrigerators, vaccine transport boxes, and vaccine carriers.

The current high risk injection practices and inappropriate injection equipment are being replaced with the WHO recommended re-sterilizable plastic syringe and steam sterilizer system.

Tools and policies are in place for the improvement in medical supply management.

Operational outreach delivery of child survival interventions, immunization, and community health education is in place.

A strong National Child Survival Secretariat has been established to provide leadership, coordination, and management of the multisectoral National Child Survival Program.

An effective intersectoral and interdepartmental National Child Survival Task Force is in place to coordinate, initiate, and monitor child survival activities.

Child survival and maternal health is now high on the national agenda.

Health sector donor coordination mechanisms have been solidly established.

III. THE ELEMENTS OF PROJECT SUCCESS

The prerequisites of the Project's success were a clear understanding of the deficiencies of the health system, its health workers, managers, and support systems, as well as the identification of mechanisms for overcoming them. This was provided by a series of studies conducted prior to the Project and later studies and pilot projects conducted for and by the Project.

The CSSP supported activities which led towards the achievement of the Department of Health's objectives.

The CSSP team rebuilt the confidence and trust of GPNG officials through this support and through formal and informal skill transfer activities.

The Project team developed strong linkages throughout the health sector.

The Project produced excellent materials and practical solutions to intractable planning, equipment, and managerial problems.

The Project collaborated widely to develop a national consensus for major improvements in child survival and maternal health.

The Project team developed and implemented a low cost training and supply model supported by a simple financial management and program planning model. These models enhance sustainability and wide spread replication.

The Project developed and effectively implemented 12 sustainable interventions in the delivery of maternal and child health services in Papua New Guinea.

A. Child Survival Interventions

❖ THE TEN STEP CHECK FOR ALL SICK CHILDREN

This revolutionary, user-friendly tool and training method enables poorly trained rural health workers to accurately and rapidly diagnose and treat the main causes of child death and disease. Its introduction and use is supported by coordinated and linked training

materials, community health education, training and supervision, and district financial planning and management systems.

❖ **TRAINING MATERIALS MODEL**

An effective, user-friendly health worker training materials format and style was developed, field tested, and implemented on a wide scale. An economically viable materials development and production system was implemented to ensure the materials wide dissemination.

❖ **COMMUNITY EDUCATION MODEL**

An effective, user-friendly community health education materials format and style was developed, field tested, and implemented on a wide scale. Health workers and community organizations can be trained to deliver health messages to rural communities. An economically viable materials development and production system was implemented to ensure wide dissemination of the materials.

❖ **LOW COST TRAINING AND SUPERVISION MODEL**

A low cost, economically sustainable health worker training, community education, and supervision model was developed and implemented in two provinces. This new system replaces a variety of ineffective, expensive, and unsustainable training approaches. This model will be implemented in 18 additional provinces with AIDAB and UNICEF technical support under the National Child Survival Program.

❖ **DISTRICT ACTIVITY FINANCIAL PLANNING AND MANAGEMENT MODEL**

A simplified financial planning and management system was developed and implemented to enable the implementation of the training and supervision model in two provinces. This model and its tools address the problems of accountability, numeracy, and weak managerial skills at provincial and district levels. This system is being implemented by AIDAB and UNICEF projects in all provinces in 1996.

❖ **PROVINCIAL HEALTH PLANNING SYSTEM**

An effective five-year provincial health planning system was developed in collaboration with the National Department of Health's Division of Policy, Planning, and Evaluation, The World Health Organisation (WHO), and the University of Papua New Guinea. Led by the National Health Planner, provincial health plans were developed in 18 of PNG's provinces and the National Capital District.

B. Health Service Delivery Interventions

❖ REHABILITATION OF THE VACCINE DELIVERY SYSTEM

Based on a 1990 - 1991 CSSP study, plans were made to standardize, replace, and upgrade the inadequate cold chain equipment component of the vaccine delivery system. Replacement equipment procured by government and donors has included 400 LP gas refrigerators, 2000 vaccine carriers, 1000 long range vaccine transport boxes, and 100,000 ice packs. Appropriate training materials are in preparation.

❖ THE RE-EQUIPPING OF RURAL HEALTH CENTRES FOR MCH

Through the PNG National Child Survival Program, donors provided more than US\$ 2 million in MCH equipment for rural health centres, and have committed to the provision of additional needed equipment. The CSSP was instrumental in coordinating the development of equipment lists, obtaining donor funding, and providing technical assistance for the development of equipment procurement specifications. Sustainable MCH and Child Survival service delivery and training was enhanced by equipment standardization.

❖ SAFE INJECTIONS FOR IMMUNIZATION

Based on a 1990 - 1991 CSSP survey, plans were made to standardize, replace, and upgrade the inadequate injection and sterilization component of the vaccine delivery system. Replacement equipment procured by government and donors has included 1,500 WHO/UNICEF steam sterilizers and appropriate re-sterilizable plastic syringes. Replacement of injection and sterilization equipment at health centre level should be completed by 1996. Appropriate training materials are in preparation.

❖ ADVOCACY FOR CHILD SURVIVAL, MATERNAL HEALTH, AND RURAL HEALTH FUNDING

A multisectoral alliance of politicians, government departments, non-governmental organizations, international and bilateral donors has collaborated to develop a national consensus on child survival and maternal health. The National Child Survival Program has effectively channelled resources and activities towards the rehabilitation and revitalization of the collapsed rural health delivery system in the face of a major decline in funding.

❖ HEALTH SECTOR DONOR CO-ORDINATION

Initiated by the CSSP, an informal collaboration network was established to provide coherent and effective support to the GPNG's efforts to improve the health status of the population and to respond to the public health emergency in child survival and maternal health. Day-to-day and long-term collaborative mechanisms are now in operation. Major donor funding for child survival and maternal health action was an outcome of this process.

❖ **MEDICAL SUPPLY MANAGEMENT**

Developed in 1991-1992 by the CSSP Project, JSI's USAID-funded REACH Project, and WHO EPI, a user-friendly graphical minimum-maximum stock management reporting system was eventually implemented. This system was installed in all Department of Health Area Medical Stores computers in 1992 and was not used until early 1995, following the Minister of Health's Advisory Task Force review of the PNG Medical Supply System. With the assistance of GPNG and ADB consultants effective warehouse supply management and rational drug procurement should take place in 1995.

❖ **THE INSTITUTIONALIZATION OF CHILD SURVIVAL ACTIVITY**

The Project assisted the GPNG to establish an active and operational Child Survival Secretariat, with its core staff of eight, to manage the delivery of maternal health and child survival outreach services in 20 provinces and CSSP developed Health Worker Training in 18 of PNG's 20 provinces. The Child Survival Secretariat, based in the PNG National Department of Health, manages donor inputs of nearly US\$ 6 million annually and annual government inputs of about US\$ 2 million. The Secretariat liaises with and provides overall management for outreach and training programs in all of PNG's provinces.

A network of over 200 officials at the national and provincial level work with the Child Survival Secretariat to implement and further develop child survival and maternal health activities. The child survival activities of the Departments of Health, Education, Communications and Information, Home Affairs and Youth - Women's Division, and Provincial Affairs and Local Government are coordinated by the Child Survival Secretariat through the National Child Survival Task Force.

IV. THE PROJECT GOAL AND PURPOSE

The overall goal of the USAID-supported Papua New Guinea Child Survival Project (CSSP) was to reduce child and maternal mortality rates in PNG. The purpose of the CSSP Project was to improve maternal and child health service delivery in rural areas.

In the initial design of the Child Survival Support Project and the subsequent project redesign exercises in 1992 and 1993, a set of targets that served as measurable indicators of progress toward that Project goal were confirmed. These targets were:

1. To strengthen specific technical and management services supportive of maternal and child health in Papua New Guinea;
2. To improve the availability of essential drugs and supplies for maternal and child survival;
3. To prevent cases of measles, diphtheria, pertussis, and tetanus;
4. To increase diagnosis and effective treatment of malnutrition in children and the chronic diseases and medical conditions related to malnutrition;
5. To increase community awareness of good food and nutrition practices;
6. To prevent pneumonia in children;
7. To increase the effective detection and treatment of pneumonia at aid posts and health centres;
8. To increase the effective prevention and treatment of malaria in mothers and children at aid posts and health centres;
9. To increase the effective prevention and treatment of secretory, persistent and dysenteric diarrhoea in children at home, at aid posts, and at health centres;
10. To reduce maternal mortality by increasing the percentage of births which are supervised;

11. To reduce maternal mortality by improving the quality of obstetric care in health centres; and
12. To reduce maternal mortality by improving the safety of childbirth in the community.

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V. THE CSSP IMPLEMENTATION STRATEGY: OCTOBER 1993 - MARCH 1995

A. Management Strengthening

The PNG Child Survival Support Project provided technical assistance to the National Department of Health and Gulf and New Ireland Provincial Divisions of Health to support better management of maternal and child health services. This assistance was provided through formal committees, informal technical working groups, and cooperative and collaborative activities with other donors.

The management areas which have major effects on the provision and delivery of maternal and child health services are: planning, monitoring, and evaluation; budget and finance; training and human resource development; management and health information systems for action; logistics systems; supervisory systems; and information, education, and communications.

Collaboration and participation in the Government's National Child Survival Program was essential to the CSSP achieving its limited objectives in 1994 - 1995. This program to restore maternal and child health services will effectively implement child survival strategies throughout Papua New Guinea. The Child Survival Support Project has been instrumental in developing and shaping the National Child Survival Program.

B. Policy Development

The Child Survival Support Project maintained a strong advocacy role in maternal and child health issues. The Project has responded to the needs of the NDOH by providing technical assistance to workshops, committees, panels, and task forces established by the NDOH to review, manage, or set policy related to MCH issues or essential support services.

The CSSP priority policy issues were: child survival; safe motherhood; the MCH funding crisis; vaccine preventable diseases; the restoration of rural health services through outreach patrols, aid posts, and health centres; and the overhaul of the medical supply system.

The CSSP assisted the GPNG to establish the policies, strategies, and activities necessary to improve the health of mothers and children in Papua New Guinea. These efforts by the CSSP Project have culminated in the creation of the National Child Survival Programme and the development of the PNG Minister of Health's Draft National Health Policy "White Paper" in March of 1995 (see Annex 3).

C. Upgrading Provincial MCH Services

The CSSP Provincial Training Program improved the knowledge, skills, and experience of district level health staff in the prevention, diagnosis, and treatment of patients with CSSP target diseases and conditions. Health worker attitudes and community education in the prevention and early treatment of the target diseases and conditions were a major focus area. The program improved the ability of the provincial and district health staff to plan, budget, manage and supervise district MCH services. The National Child Survival Program enabled major improvements in health infrastructure necessary for the successful implementation of the Child Survival Support Project.

The CSSP assisted the provincial health management teams to prepare an annual provincial training plan, budget, and schedule. A cheque account was established at a local bank, and was operated along with a simple manual accounting system by the Health Division. Training of accountants and other officers by the Project underpinned the management accountability and sustainability of the district level training program. The CSSP team worked with the provincial health management teams to implement the training plans. District level training courses were conducted by the provincial In-Service Coordinator and district level trainers.

The program depended primarily on CSSP funding for the first year of training and supervision support and planning and budgeting for MCH training and outreach activities for the following years. Complete sustainability ultimately depends on community support and the financial support for improved and effective health service delivery given by provincial and national government.

The content of the CSSP support package was adjusted according to provincial needs and capacity.

D. The Basic Training Package

This package of CSSP supported activities included the establishment of provincial Child Survival Task Forces, the conducting of training workshops, the development and

production of training materials, training of trainers, district level in-service training, counterpart training, and community health education. These activities were implemented as part of the National Child Survival Program. The key training activities were short and frequent district level competency based training for all district health workers and health promotion in communities.

1. Provincial MCH Task Force Meetings

Provincial Child Survival Steering Committee meetings were held two times each year to promote community awareness and support for Maternal and Child Health issues. Participants included prominent political, religious, women's groups, and business leaders. The major aim of these meetings was to promote adequate funding for MCH activities in the province by both provincial government and NGOs.

2. Provincial MCH Workshops for Planning & Budgeting

Seeking long-term, sustainable improvements in District MCH services, budget planning and management training is included in each provincial level training of trainers workshop. Participants are Health Centre Officers-in-Charge, district Officers-in-Charge, and the Provincial Health Management Team. District MCH plans and budgets are developed and consolidated into a provincial MCH plan and budget. This process seeks to develop distributed management capacity and to introduce accountability to reduce the operational costs of training and outreach services.

3. District Level Training Packages

Training materials have been developed in the Child Survival Support Project technical intervention target topics:

Supply Management	Child Survival	Malnutrition and Nutrition
Pneumonia	Malaria	Diarrhoea
Birth Supervision	Immunization	Safe Childbirth

Training modules, video tapes, flip charts and posters for health worker training and community health education with consistent content and format have been developed, duplicated, and printed. These materials were designed to be used in health centre based training for health workers and for communities. Audio visual equipment and the training materials were provided through CSSP training workshops. All materials are linked to

the PNG Standard Treatment Book series and to each component of the training material series.

4. Provincial Training of Trainers Workshops

Training of Trainers workshops introduced the district level CSSP training packages to key district level health staff. These district level staff are trained to conduct health centre based in-service training courses using the district level training packages. Each workshop covers four child survival topics (for example the Ten Step Check for All Sick Children, Immunization, Diarrhoea, and Acute Respiratory Infection). In addition, all Training of Trainers workshops cover planning and budgeting for training.

5. District Health Centre Based Training

Training for health workers, including aid post orderlies and community health workers, were held in district health centres, using the district level training packages. Eight quarterly, single topic, one day training courses are planned for each district in the country.

6. District Supervision and Outreach Support

District supervision takes place during the district inservice training courses, while outreach support is carried out by MCH patrols under the National Child Survival Program.

7. National In-Service Training Workshop

A National Inservice Trainer workshop was held to disseminate the CSSP district level training packages to all Provincial In-Service Coordinators to enable them to introduce CSSP training in their own provinces.

E. Research to Support Child Survival Interventions

Research studies, operational research, and the implementation of pilot projects were required to develop and support Child Survival interventions and training.

Several research and pilot studies were proposed, approved, completed and reviewed. The findings of studies have been applied to the Child Survival Support Project's MCH interventions, the training packages, and to the rehabilitation of the rural health delivery

system under the PNG Child Survival Program. (See Annex 4 for a detailed list of all research activities conducted by the CSSP Project)

VI. PROJECT SUSTAINABILITY

Following the October 1994 Health Sector Donor Luncheon, sponsored by the Child Survival Support Project, the Australian International Development Assistance Bureau (AIDAB) indicated a willingness to provide funding to support the training and outreach components of the PNG National Child Survival Project.

A follow-on project was designed by the NDOH Child Survival Secretariat in November and December 1994.

A team from AIDAB Canberra visited PNG in late February 1995 and had a series of meetings with the Departments of Health and Finance (OIDA - Office of International Development Assistance), UNICEF, AIDAB PNG, and the CSSP team. Agreement in principle was reached on the project, its scope of work, and its management (See Annex 5).

The most interesting new component of the project is in the area of financial management. Based on the financial management model implemented by the CSSP Project in Gulf and New Ireland Provinces (and unique in PNG), project funds will flow through a centrally operated bank account to separate checking accounts in each of 20 provinces. The project managers in the National Department of Health will operate and retain title to all of these accounts while authorizing drawing rights for each provincial account under the joint signatures of two provincial health officials. Each account will receive about 5 weeks operational money, based on provincial cash flow need estimates. Each provincial health office will maintain book keeping accounts using a simple manual accounting system. These will be submitted monthly to the central project office. Upon acquittal of all expenditures, the following month's funds will be deposited in the provincial account.

A. The AIDAB Funded Follow on Child Survival Project

1. General

The AIDAB-funded follow-on project, titled "Australian Assistance to the Papua New Guinea Child Survival Program", will begin on 31 March 1995 and end on 31 December 1996. AIDAB's five year AUSS\$ 40,000.000 Maternal Health and Child Survival project

is expected to enter the design phase in April - May 1995 with implementation around mid 1996.

2. Project Management

The Project's management agent will be UNICEF/PNG. Day-to-day management will be under the direction of the UNICEF/PNG Representative Dr. Hamid Hossaini. Dr. Keith Edwards (CSSP MCH Physician) will serve as the program manager. Carol Apami, the CSSP Administrative Assistant, and Grace Kamuna, the CSSP secretary, will be employed to provide office support.

The GPNG project manager will be the National Coordinator of Child Survival under the National Department of Health's Assistant Secretary for Family Health.

The project will be managed on behalf of the GPNG and donors by a management committee operating as a sub-committee of the National Child Survival Task Force. This sub-committee is composed of representatives of the Department of Finance and Planning's Office of International Development Assistance, AIDAB/PNG, The National Department of Health, and UNICEF/PNG. Required to meet quarterly, the committee may meet more frequently as needed.

3. Monitoring and Evaluation

Quarterly external evaluations will be conducted by a UNICEF consultant (Allan Bass, CSSP Chief of Party). Reporting systems will be developed and implemented for outreach patrols. The CSSP training model's reporting system will be continued.

4. Project Components

a. Training

The CSSP health worker training model will be extended to the remaining 18 provinces where all health workers will be trained in child survival and safe motherhood interventions. All CSSP developed interventions will be included, along with additional interventions as appropriate.

While the CSSP training was accelerated in 1994 -1995 due to early project termination, provincial level training of trainers will be conducted every six months with district level inservice training conducted in each health centre every four months. This will ensure that health worker training becomes routine. Training will be coordinated by Dr. Keith Edwards.

b. Outreach Patrols

According to 1985 World Health Organisation estimates, only 25% to 35% of PNG's population are served by fixed health facilities. Immunization coverage data following the collapse of outreach services have confirmed this estimate.

The CSSP advocated the revival and restoration of outreach services as part of project support to the PNG National Child Survival Program. Without the restoration of outreach services, health worker training would have little impact on the health status of children and mothers.

The project provides funding for recurrent costs (travel allowances, fuel, and some transport - negotiated case by case).

The project will support four outreach patrol visits to each community in PNG per year.

c. Financial Management

The failure of government mechanisms for the allocation of funds, the disbursement of funds, and the accountability of expenditures for non-hospital health services was identified by the CSSP as a major constraint on the operation of PNG's rural health services.

The CSSP developed and successfully implemented a simple financial management system to address these problems. The application of this model is integrated with training and is considered to be a training component of the project, and will serve to introduce accountability and the tools necessary for achieving that accountability.

This financial management model will be implemented in all of PNG's provinces for the management of project funds disbursement for training and outreach patrols.

5. Project Budget

a. AIDAB Component

The total value of the AIDAB component of the project will be US\$ 4 million. The components of the AIDAB budget are approximately:

1. Administration (UNICEF): US\$ 0.38 million
2. Training: US\$ 1.62 million
3. Outreach patrols: US\$ 1.62 million
4. Equipment: US\$ 0.38 million

Project staff salaries are included in the training component. National project staff are included in the regular GPNG budget.

b. GPNG Component

Despite of severe financial constraints, and the financial restructuring of the Government, the GPNG has committed and budgeted additional funds to the project.

The GPNG has committed itself to the "timely provision of vaccines" in the "Memorandum of Understanding" signed on behalf of the PNG National Department of Health by the Office of International Development Assistance in the National Department of Finance and Planning.

B. Other GPNG Resources for Child Survival

The broad intersectoral alliance for child survival has attracted funding and in-kind support from national government departments and bilateral and multinational donors. In addition, provincial and local level governments are making budgetary and in kind contributions in support of local child survival activities. Local and community governments are implementing micro projects to restore health centres and aid posts as well as providing local funds for MCH outreach patrols.

The resources listed below are committed for the year 1995.

❖ DEPARTMENT OF HEALTH

The Department of Health will provide US\$ 425,000 for vaccines.

❖ DEPARTMENT OF PROVINCIAL AND LOCAL GOVERNMENT

The Department of Provincial and Local Government will provide US\$ 680,000 for combined outreach patrols.

❖ DEPARTMENT OF EDUCATION

While details are not clear, the Department of Education has committed itself to the printing and distribution, through the primary school system, of CSSP developed literacy and community education materials with child survival messages.

❖ **DEPARTMENT OF COMMUNICATIONS**

While details are not clear, the Department of Communications has committed itself to use its provincial radio broadcast network to broadcast child survival health information on a regular basis. A twice weekly child survival quiz show began in February 1995.

C. Other Donors

❖ **WORLD HEALTH ORGANIZATION**

WHO has agreed to the provision of technical assistance and US\$ 30,000 in 1995 to assist one or two provinces to develop improved outreach immunization services. Systems developed would be replicated in all other provinces.

As part of the International Year of Health Promotion, WHO has committed the provision of US\$ 140,000 for provincial level health promotion activities, 75% of which is for child survival messages. A separate topic is to be widely promoted monthly.

❖ **UNICEF**

UNICEF has an approved non-salary budget of US\$ 1.5 Million for maternal and child health. This will be used to support outreach patrols, water and sanitation interventions, and advocacy.

❖ **UNFPA**

UNFPA has committed itself to the funding of outreach patrols in 2 provinces.

❖ **ASIAN DEVELOPMENT BANK**

ADB has committed itself to the funding of the procurement of US\$ 1,000,000 in MCH equipment for rural health centres.

ADB has also signed a Memorandum of Understanding with the GPNG for a five year, US\$ 24 million project titled "Human Resources Development in the Health Sector". The core component of this proposed project is specifically the further implementation and institutionalization of the CSSP district health worker training model. The district health worker training component was budgeted at US\$ 5.5 million. This project was delayed by the PNG financial crisis, with probable implementation in 1996 - 1997. ADB has also made available annual grants of US\$ 300,000 for health worker training.

❖ **AUSTRALIAN INTERNATIONAL DEVELOPMENT ASSISTANCE BUREAU**

AIDAB has provided additional funding for the purchase and distribution of US \$ 1.18 million in MCH equipment, camping equipment for outreach patrols, and 300 gas/electric refrigerators to health centres throughout PNG. This expenditure was committed during AIDAB's 1994 financial year. The equipment has arrived in PNG with private sector distribution to be completed by the end of May 1995.

AIDAB has programmed support for a WHO Epidemiologist position in the PNG National Department of Health to enable the development of surveillance systems and to enable the measurement of Child Survival Program impact.

VII. FINANCIAL REPORT

The Child Survival Support Project started in September 1990 and ended on 31 March 1995. Originally, the Project was funded by a grant of US\$ 7.27 million from the U.S. Government's United States Agency for International Development. Following the USAID decision to end the Project prematurely, the budget was reduced to US\$ 5.44 million. The Government of Papua New Guinea's National Department of Health and Provincial Health Divisions contributed their personnel and some operational costs.

A. Summary of Expenditures

At the time of this report, all final expenditures related to the implementation of the PNG Child Survival Support Project have not been processed by the contractor (JSI). A final summary of expenditures and an analysis of variances will be included as an addendum to this report when all expenses have been processed.

VIII. ADMINISTRATIVE REPORT

A. Project Closure

On 19 November 1993, USAID announced its decision to close the South Pacific Regional Office and the PNG Country Office. The CSSP was instructed to make no commitments which would obligate the project to any activity or expenditure beyond two months at any point in time. This announcement brought into question the future of the PNG Child Survival Support Project.

Following the USAID regional closure announcement, discussions were held with the GPNG, National Department of Health, and other donor agencies in an effort to minimize the loss of more than three years investment in maternal and child health development in Papua New Guinea.

Phase II Project activities such the selection of four target provinces, the preparation of provincial implementation plans by the selected provinces, and the recruitment of CSSP Fellows and a project administrator were brought to a halt by USAID's instructions of 24 January 1994 interpreting the closure of the USAID/RDO/SP. The preparation of health worker and community training material as part of the district level training package proceeded.

On 27 January 1994, at the request of the USAID Regional Development Office/South Pacific, JSI presented a set of scenarios for two project closure dates -- September 1994 and March 1995. The September 1994 closure scenario called for limited development of the child survival training materials and their application in one province, followed by early closure. The March 1995 closure scenario called for the CSSP to complete development of all training materials, test their application in two provinces, make final revisions, and complete wide national dissemination. This second scenario also called for continued technical support of the National Child Survival Programme.

This level of effort was to be maintained and accelerated, while reducing expenditures, until additional obligated USAID funds were committed to the project. However, the delay in the extension of the CSSP and the obligation of additional funds postponed for seven months the implementation of provincial health worker trainings in the two target provinces.

At the end of March 1994, USAID/Washington agreed to continue the CSSP until 31 March 1995. The contract continuing the project through to the end of March 1995 was signed by all parties in June 1994. The total of funds obligated over the life of the project was reduced to US\$ 5,443,688. In July 1994, in anticipation of the closure of the USAID/RDO in Fiji, project oversight was transferred to USAID/Manila Office of Health, Population and Nutrition (HPN).

In October 1994, USAID Manila requested the CSSP to prepare a project close-out plan, which was submitted and approved in November 1994 (See Annex 6).

B. Contract Issues

In the four and a half year life of the PNG Child Survival Support Project, six contract modifications were negotiated and signed.

❖ MODIFICATION ONE (23 OCTOBER 1990)

The purpose of this modification was to increase the Total Estimated Contract Cost (by \$40,100 from \$6,327,825 to \$6,367,925) to provide Separate Maintenance Allowance and Special Storage Costs for the Health Services Management Advisor/Chief of Party

❖ MODIFICATION TWO (9 MAY 1991)

The purpose of this modification was to increase the Total Estimated Contract Cost (by \$40,100 from \$6,327,825 to \$6,367,925) and realign budget to:

1. Cover a personal security system for each of the long-term Project staff; and
2. include the budget and program for research activities.

❖ MODIFICATION THREE (18 JULY 1991)

The purpose of this modification was to increase the obligated funds of the contract by \$1,221,700 (to \$2,898,000).

❖ MODIFICATION FOUR (10 MAY 1992)

The purpose of Modification Four of the CSSP contract was to extend the period of performance by the Medical Logistics Advisor (A. Bass) for approximately 12 months

(until on/about September 1993) at no additional cost and realign budget line items to provide for the necessary funding adjustments.

❖ **MODIFICATION FIVE (19 NOVEMBER 1992)**

Modification Five was issued to increase the obligated funds of the contract by \$1,650,000 (to \$4,548,000).

❖ **MODIFICATION SIX (9 JUNE 1994)**

This modification was issued to reflect the new Project end date of 31 March 1995 following the announcement by USAID of its intention to close down the USAID Regional Office in Suva, Fiji. The revised budget (\$5,443,688) and several other changes to the contract were included in this modification.

C. Staffing

The original CSSP team in Port Moresby consisted of a Health Services Management Advisor/Chief of Party, a Maternal and Child Health (MCH) Physician, a Community Health Nursing Advisor, a Logistics Management Advisor, and two local hire administrative personnel.

At John Snow Inc.'s U.S. headquarters, a team consisting of a part time Senior Project Manager, a part time Project Backstopper, and a part time secretary provided the necessary technical, administrative, financial, and personal support to the expatriate technical advisors in Papua New Guinea.

Based on the USAID project paper and the RFP, the original JSI project design specified a scheduled staff reduction of the technical/administrative staff based in Papua New Guinea over the life of the Project. The MCH Physician was to be a six year position, the Health Services Management Advisor/Chief of Party a five year position, the Community Health Nursing Advisor a three year position, and the Logistics Management Advisor a two year position. The project's local Hire Administrative Assistant would have left the Project at three years, while the Secretary would have served over the full six years of the Project. While this schedule of staffing reduction seemed inappropriate and impractical, subsequent events allowed for a more rational staffing pattern to evolve.

At the request of the GPNG in 1992, the Logistics Management Advisor position was extended by one year. Six months of the extension were funded through the CSSP contract and an additional six months were funded by other external consultancies.

In 1993 the contract of the Community Health Nursing Advisor was extended by three months (October - December 1993) to enable the completion of the first year of the Community Health Nursing Administration Diploma Course.

Following the development of the Phase II strategic plan, the Project staffing was modified yet again. The Logistics Management Advisor became the Chief of Party, the MCH Physician remained as planned, and the local hire administrative personnel remained. A Project Administrator with USAID experience was to be recruited to assist in the administration of the Project.

Following the USAID/RDO/SP closure orders, the recruitment of the Project Administrator was cancelled.

When the decision was made that the Project would end 31 March 1995, it was decided that this core team (two technical advisors, two administrative personnel) would remain for the remaining life of the Project.

IX. PROPERTY DISPOSAL

The PNG CSSP procured, with the formal approval of USAID, more than US\$ 379,000 in non-expendable equipment valued at more than US\$ 100. This included vehicles, computers, and office equipment for the four Regional Support Units as committed by USAID under the original project design. Other equipment was purchased to support project management and the JSI team of advisors.

As agreed by USAID and added to the contract in 1994, the Project funded the construction and installation of prefabricated housing units for the Southern Regional Epidemiologist and for the Senior Tutor of the Community Health Nursing Administration Diploma Course.

In 1994 - 1995, equipment was procured for the development and production of training materials by the Project team, which had by then expanded by nine national staff.

In anticipation of Project closure, the CSSP prepared a document that detailed the transfer of non-expendable property purchased by the CSSP to the GPNG. This document included a complete log of all property valued at more than US\$ 100. This document was reviewed by USAID and approved. The CSSP held meetings with senior officials of the NDOH to ensure a smooth transition to the new Child Survival Project without loss of momentum. The NDOH agreed to the assignment of the all equipment used by the CSSP for office administration, training materials development and production to the follow-on Child Survival Project (See Annex 7).

ANNEXES

PNG Child Survival Project Final Report

1. Lessons Learned
2. 1995 External Evaluation Report of the CSSP Project
3. PNG Minister of Health's Draft National Health Policy "White Paper" (March 1995)
4. List of Research Projects, Studies, and Pilot Projects Conducted by the CSSP Project
5. Australian Assistance to the PNG National Child Survival Program (March 1995)
6. CSSP Project Close-Out Plan
7. CSSP Project Financial Summary
8. CSSP Project Property Transfer Document

ANNEX 1

Lessons Learned

**An Assessment
of the
Papua New Guinea
Child Survival Support Project
1991 - 1995**

(USAID Contract No. 492-0017-C-00-0073-00)

Written by:

Abul Hashem
Consultant
John Snow, Inc.

March 1995

I. SUMMARY

A. Introduction

The Papua New Guinea Child Survival Support Project (CSSP) was a bilateral technical assistance project between the Government of Papua New Guinea and the United States Agency for International Development (USAID). The Project was developed in response to the desire of the Department of Health to explore policy options and to design pragmatic structural reforms which will provide increased capability to reduce maternal and child mortality rates in PNG by improving maternal and child health service delivery.

This report was written to provide an overview of the accomplishments of the CSSP Project and highlight lessons learned for future child survival activities.

B. The Goal and Purpose of the CSSP Project

The goal of the CSSP Project was to reduce infant and child mortality in Papua New Guinea (PNG). The infant mortality rate is 72 and child mortality rate is 42 per 1000. Maternal mortality ratio in PNG is one of the highest in the world; 700 to 800 per 100,000. The leading cause of mortality in the country is pneumonia (21.9%), followed by conditions originating in the perinatal period (11%), malaria (9.2%), meningitis (6.1%), tuberculosis (5.5%) and diarrheal disease (3.2%).

C. Philosophical Approach to Project Review

The first major premise on which this CSSP Project review is based is to provide a succinct summary of the goals, strategies and accomplishments of the Project. Only after understanding the Project and the circumstances which surround its implementation can a meaningful evaluation of the activities and results achieved occur.

A second major premise on which the review is based is that Project Papers are planning documents which specify outputs, benchmarks, indicators of progress, inputs required, as best can be seen prior to the implementation of the project. After a project has commenced, however, changes take place based upon conditions and the implementation experience. In order to produce the desired results, mid-term corrections and adjustments are appropriate. Therefore, in conducting the review, all Project partners (DOH, USAID,

and JSI) were encouraged to revise benchmarks and indicators of progress to bring them into line with what is realistic in view of three years of the implementation experience.

D. Methodology

A JSI/Washington staff member who is thoroughly familiar with Papua New Guinea visited the project in July-August 1994 for two and a half weeks. During this visit he reviewed USAID project papers, the reports produced by the CSSP Project, and relevant documents of the Department of Health and interviewed the Project staff, officials of the government and other international organizations involved in child survival activities in Papua New Guinea. The progress of each Project component was reviewed and compared to the stated objectives and indicators.

II. LESSONS LEARNED

A. Background

1. Introduction

The island of New Guinea lies between the Solomon Islands and Indonesia, approximately 100 miles north of northeast Australia. As the second largest island in the world, it has a land mass of 462,840 square kilometers, which includes more than 600 offshore islands. The island is divided, with the country of Papua New Guinea comprising the eastern half and the Indonesian province of Irian Jaya located on the western half.

Papua New Guinea (PNG) is a parliamentary democracy which gained independence from Australia in 1975. PNG's topography ranges from snow-capped mountains and volcanoes to low lying swamps, with over 75% of the island covered by rain forests. Contact with the outside world has been limited; as late as 1983, new groups of people living stone age lifestyles were contacted for the first time.

PNG is essentially an agricultural nation with 80% of the population engaged in subsistence farming and the raising of livestock. One-third of the gross domestic product (GDP) is agricultural, another 40% is found in mining.

Papua New Guinea has a population of about four million of which one fifth (20.4%) are women of reproductive age (15 - 44 years). More than two fifths (43.1%) of the population are younger than 15 years of age. Over 700 distinct languages are spoken in the country.

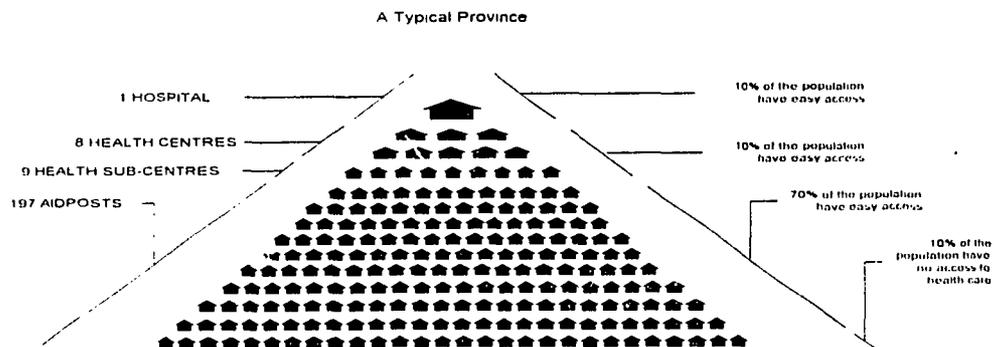
The crude birth rate in PNG is 35.3 and the crude death rate is 13 per 1000, resulting in an annual growth rate of 2.2%. The infant mortality rate is 72 per 1000; child mortality is 42 per 1000. Maternal mortality in PNG is one of the highest in the world: 700 to 800 per 100,000. Leading causes of death in the country include; pneumonia (21.9%), certain conditions originating in the perinatal period (11%), malaria (9.2%), meningitis (6.1%), tuberculosis (5.5%), and diarrheal disease (3.2%).

2. Health Care Services

Health services in Papua New Guinea are provided by both government and non-government sources. Non-governmental providers include churches, private practitioners, industry and traditional healers.

The health services structure for PNG takes on a pyramid form (See Figure 1). Aidposts are at the base, health subcenters and health centers are in the middle, and provincial hospitals are at the top. The national referral hospitals are at the apex. With about 88% of the population living in rural areas, the provision of rural health services is given high priority by the government.

Figure 1 (The Health Services Structure in Papua New Guinea)



The provincial hospitals are staffed by doctors, nurses, nurses aides, and orderlies. Health center staff include health extension officers, nurses, nurse aides, and orderlies. Aid posts are staffed by an aid post orderly who has one to two years training in basic curative treatment and health promotion. Approximately 50% of the rural health services available are a result of churches and missions. The church health workers work primarily in two areas: the provision of health services in the rural areas, and the training of nurses and community health workers. Churches are now responsible for one provincial hospital, 27% of the health centers, 64% of subcenters and 5% of the aidposts in the country.

Table 1 (Distribution of Health Facilities: Government and Churches)

	Health Centers	Health Sub-Centres	Urban Clinics	Aid Posts
Government	140	130	36	2304
Churches	54	173	-	115
Others	-	2	-	-
Total	194	305	36	2419

The government subsidizes church health services in the areas of salaries, operating costs, health extension costs, and supplies.

There are 25 privately owned pharmacies in 11 urban centers covering approximately 80% of the urban population. The private health sector is small. In 1989 there were 61 private medical practitioners, which constitutes about 25% of all medical practitioners in the country. Medical practitioners in the private sector provide general medical services.

With approximately 80% of the population living in rural areas, the provision of rural health services is given high priority by the government. PNG is divided into 19 provinces. The government has decentralized rural health services. Each province administers the delivery of health services within the province. The central DOH provides support to the provinces through four regional support offices.

PNG has an extensive "fixed facility" system offering "reasonably good access" to health services for approximately 96% of the population. "Reasonable access" to health services is defined as the availability of health services within two hours walking distance. Despite the extensive provision of health services in rural areas of PNG, mortality levels among children and mothers remain high. Although rates have declined in recent years, estimates of health care coverage give poor prospects for the health and welfare of women and children in PNG.

Assessment of health services consistently show the need for additional training, equipment (especially for immunization program), and improved logistics management, as well as improvement in the overall quality of services.

The government places a high priority on health services. Nine percent of the annual national budget is allocated to health, which is the fourth highest sectoral allocation. The annual health budget in 1994 is 140 million Kina. Last year, all sectors suffered budget cuts except health and education. This indicates the government's commitment to strengthening the health care system, reducing infant and maternal mortality, and increasing the life expectancy rate.

Decentralization of all of PNG's public health services has been a topic of discussion since 1993-94. Legislation on the issue is currently being prepared for submission to Parliament.

B. The Child Survival Project

1. Project Objectives

In 1989, USAID began support of the Papua New Guinea Child Survival Project (CSSP) to reduce child and maternal mortality rates in PNG by improving the delivery of maternal and child survival services in rural areas. The project had five specific objectives:

1. To obtain baseline and technical information for policy formulation, planning and evaluation;
2. To strengthen the Regional Support Units (RSU) through a training of trainers and create a system of continued technical support for provincial health workers;
3. To upgrade technical and management skills of MCH workers and establish a diploma course in MCH Nursing Administration;
4. To establish viable and effective medical logistics systems to ensure effective delivery of MCH services; and
5. To strengthen health services through improved coordination between the DOH, Church Health Services and other donors.

USAID envisioned the project implementation as having two phases:

Phase I involved research and planning. A series of research studies and pilot projects were designed to generate information which would serve as the basis for the implementation of the project in Phase II. The activities conducted during Phase I (e.g., training, operations research) would ensure that minimum skills and knowledge essential to strengthening capacity exist, and that the conditions required to establish operative mechanisms for institutionalizing capacity were met. The institutional outputs of Phase I would be used in Phase II to put in place structures to support service delivery in the provinces and to carry out the promotion, planning, and management of maternal and child health services.

The project's activities served either technical or institutional objectives related to service delivery for maternal, child health and child survival care. The activities directed at institutional viability included advisory services, special studies, and coordination/consensus building exercises. The activities directed at technical viability included:

1. Training and technical advice to improve the skills of the health workers and their ability to communicate with the community,
2. Health education to increase community awareness and the ability to participate in health care
3. Operations research, special studies and pilot interventions to improve the existing information and knowledge base.

In the course of project implementation, it was realized by the CSSP Project, USAID and the DOH that the Project's performance indicators were either unrealistic or impossible to measure. In PNG, clinical records are the only sources of information about people's health. However, the recording and reporting of clinical information both of the inpatient and outpatient records are consistently poor. Therefore, in August 1992 USAID and the Child Survival Support Project jointly adopted a new set of End of Project Status Indicators (EOPSI's). These new EOPSI's are detailed in Attachment 2.

The major difference between the old and new set of performance indicators was that the emphasis shifted to coverage rate analysis of three major areas:

1. The quality of maternal and child health services provided at aid post and health center levels:

2. Improvement in knowledge and promotion of community participation in health care; and
3. Improvement in the management and training support services.

Due to USAID's global reorganization plan, the PNG Child Survival Support Project will close down one and a half years early, at the end of March 1995. The contract was amended in July 7, 1994. The amended contract requires the Project to focus on three areas: the PNG Government-sponsored Child Survival Crash Program, training, and the further development of training and IEC materials.

2. Program Implementation

In September 1990, the Regional Development Office of the United States Agency for International Development (USAID) in Suva, Fiji, awarded the Papua New Guinea Child Survival Project (CSSP) to John Snow, Incorporated (JSI), through a competitive bid process. Within two months of the contract award, four expatriate project advisors arrived in PNG and two local staff were hired. The Department of Health provided the Project with office space.

Prior to the expatriate team's arrival in PNG, a team building exercise was conducted at JSI/Boston headquarters with the objective of promoting a common understanding of the project's goals and objectives. Participants in the exercise included: a representative from USAID/Suva, key JSI/Boston staff, the Chief of Party/Health Management Advisor (Jerry Russell), the Logistics Management Advisor (Allan Bass), the Maternal and Child Health Advisor (Dr. Keith Edwards), and the Community Nursing Advisor (Margaret Street).

On arrival in PNG, the team developed a six-year workplan which detailed Project activities and established a Project implementation timeline. The team also prepared end of project target specific interventions and submitted those to USAID. These objectives and the related activities are detailed in Attachment 3.

a. Project Management

In its first three years, the Child Survival Support Project had four expatriate advisors -- a Health Management Advisor (also the Chief of Party), a Logistic Management Advisor, a Maternal and Child Health physician, and a Community Health Nursing Advisor. There was also a Papua New Guinean Administrative/Financial Assistant and a Secretary. In the fall of 1993, Due to USAID's decision to scale down Project activities, both the

Health Management Advisor/COP and the Community Health Nursing Advisor positions were eliminated. The Logistics Management Advisor became the CSSP Chief of Party. Also, a decision was made at that time to hire a senior administrator to carry out the Project's administrative functions. The administrator was not hired because in late 1993, during the time of agency reorganization, USAID put all Project activities on hold. During this time, USAID decided upon a new termination date for the Project.

The Project was provided headquarters office support by a Program Associate in JSI/Boston. JSI's International Division Vice President provided overall management guidance.

Until early 1994, technical guidance of the Project was provided by the Office of Health, Population and Nutrition in Suva, Fiji and a USAID representative in Port Moresby, PNG. Technical responsibility was transferred to the USAID/Manila Office of Health, Population and Nutrition in early 1994.

Discussion and Lessons Learned

The CSSP advisors worked very closely with the Department of Health. They shared office space in the Department of Health and implemented the program with the DOH officials. The CSSP had two local administrative staff, but no cooperating country professional/technical staff. Although the CSSP expatriate advisors made every effort to transfer technology through training and technical assistance, having local professional on board would have made the Project more accessible to the local professionals and would have made technology transfer easier.

Recommendations

Design of programs of such nature should always include the provision of local professionals.

b. Research

Although several anthropological studies have been conducted in PNG, few systematic studies have been completed on the population's health care practices. The Department of Health collects epidemiological information through clinical records, but few studies have analyzed the supply and demand of health services. The CSSP Project, therefore, undertook a number of research activities to identify problems and potentially effective interventions.

The research component of the project was contracted separately and this was not signed until nine months after the project started, resulting in a delay. Another delay occurred due to the process of soliciting appropriate researchers. This activity involved obtaining a draft proposal and provisional approval from USAID and the CSSP Research Advisory Committee. Further proposal reviews by three international reviewers resulted in modifications which were time consuming and had to be tailored for each individual project.

b.1. Literature Review

At the beginning of the Project, the CSSP MCH Physician collected and analyzed available data relating to the targets and end of project status indicators. A report was produced which summarized this analysis and necessary research projects which would provide further data and test interventions to address the targets. This analysis and discussion by the CSSP Research Advisory Committee led to the formulation of the research agenda which was a listing of required research by category. Later in the Project, at USAID's request, a panel of independent research experts were requested to review the research agenda and revise it. The result of this analysis was that 90% of the agenda remained unchanged. Some additional social/anthropological research projects, were suggested by the review panel, but these projects were rejected by USAID.

CSSP requested a group of researchers from the Papua New Guinea Institute of Medical Research (IMR) and the Department of Community Medicine (DCM) to review available research findings on maternal and child health, and develop an extended research agenda for the Project. The group, which was named the CSSP Research Advisory Committee, reviewed 20 documents and came up with an exhaustive list of recommended research topics. These topics, which ranged from maternal and childhood diseases, teen-age pregnancy, family planning, transportation, to management information systems, were submitted to CSSP and USAID in April 1992, eighteen months after the beginning of the Project. Due to this delay, recommendations of this study group had limited use in selecting research topics.

b.2. Research and Pilot Projects

From this exhaustive list of recommendations, the CSSP selected thirty-eight research and four pilot studies. Thirteen research projects and four pilot studies were commenced. To date, all of the research projects have been completed. However, the pilot studies are still in progress. Eight of the thirteen research projects and all of the pilot studies were conducted by CSSP advisors. Of the five other research projects, four were conducted by

the Department of Community Medicine at the University of Papua New Guinea and one was completed by the PNG Institute of Medical Research.

Attachment 4 provides a list of the research projects and pilot projects conducted under the CSSP Project and the organizations that conducted them. This list is an indication of the limited institutional research capabilities available in PNG.

The CSSP convened a research committee to review and approve research proposals. Members of the committee included the First Assistant Secretary of Health, Assistant Secretaries of the Family Health, Policy and Planning sections, representatives of USAID Port Moresby and Suva, and representatives of the CSSP.

The approval process caused a significant delay in research activities. Since USAID/Suva was the final approving authority, the approval procedure required the documents to be sent to Suva after the approval of the research committee.

b.3. Application and Dissemination of Research Findings

The studies undertaken by the CSSP Advisors have had direct bearing to Project activities and were directly applied throughout the Project. For example, the findings of the Community Health Nursing Job Analysis were used to design the community nursing administration diploma training program. A study of rural health services, entitled "Study of Health Worker Case Management in Rural Health Services in Papua New Guinea", led to the development of the nationwide Child Survival Crash Program (CSCP). This study found that the quality of services were steadily deteriorating. According to the study, only one in every ten rural health service providers could correctly diagnose and treat the more common life threatening childhood diseases. The community was dissatisfied with the provision of health services. In addition, the facilities were found to lack proper maintenance, appropriate equipment, and supplies. As a result of these findings, the Government has decided to use the CSCP as a means to revitalize the health program in the country.

A CSSP study of the cold chain and the Expanded Program for Immunization (EPI) found that vaccines were not properly handled in area medical stores and health centers, and that the cold chain was not maintained during transportation of the vaccines. The vaccines are stored and transported under inappropriate conditions, and administered without assessing their potency. These findings were presented to the government and donors. As a result, the Australian International Development Assistance Bureau (AIDAB) has committed to supply cold chain equipment equivalent to one million Australian Dollars.

The pilot projects initiated by the CSSP are still generating information. Preliminary findings helped develop training materials, flip charts and training modules. For example, a training course was designed based on the preliminary findings of a pilot project testing the use of an arm circumference measurement tape, which was developed by the CSSP Project, to determine the level of a child's malnutrition. Initially, training was provided in three districts of the West Sepik province, which were funded by the Nutrition Section of the National Department of Health. Encouraged by the success of the first three training programs, the Department of Health requested further training in Gulf Province, which is planned for late 1994.

Studies conducted by outside agencies had limited application due to delayed receipt of the findings and limited relevance of the findings to CSSP work. The students of the Department of Community Medicine conducted three studies for the Child Survival Support Project. Although the studies were low cost (less than K5,000 each) and the findings were presented to the DOH and at the national health conference, the DOH has expressed limited interest in implementing the recommendations. Neither the Department of Community Medicine nor the CSSP have follow-up plans at the time of this writing.

In general, the DOH feels that the researchers came up with too many recommendations which were not always applicable. Lack of adequate financial and human resources in the DOH often limit their ability to implement the recommendations. In addition, the policy division of DOH feels that due to the lack of coordination between the researchers, policy makers and program managers, data gathered by researchers often does not serve the division's needs.

The Department of Community Medicine at the University of PNG (UPNG) advocates an ongoing dialogue between the DOH and the University regarding the application of study findings and recommendations. The University suggests that a committee consisting of the Dean of the Faculty of Community Medicine and the DOH devise a mechanism to apply research findings.

CSSP disseminates research findings in the following ways:

1. Documents are distributed to DOH officials and donor agencies, however, there is no standard distribution list;
2. In two cases, workshops were conducted to present findings. The CSSP has found this extremely useful in generating discussions and interest in the study findings. This also provides an opportunity to discuss the potential application of the findings:

3. Research findings are sometimes presented in workshops organized by other organizations. For example, the findings of the study on reproductive health were presented in the Waigani International Seminar on Population, Family Health and Development, which was organized by the South Pacific Forum. The findings of the studies conducted by the Faculty of Medicine of the University of PNG were presented in their annual workshop with the Department of Health:
4. Relevant findings are included in the training materials developed by the CSSP;
5. Publications in the form of editorials in medical journals and in papers. One such editorial was entitled: "The Rural Health Crisis"; and
6. Three papers were presented at the annual national symposium concerning maternal health, vitamin A, and rice based ORS.

Discussion and Lessons Learned

The CSSP conducted several studies through the University of PNG (UPNG) Faculty of Medicine and the Institute of Medical Research (IMR) and through the CSSP advisors. While the studies conducted by the UPNG and IMR were academic and had limited relevance to CSSP activities, most of the studies by CSSP advisors were problem specific assessments.

Although the DOH was part of the selection process of the research projects, they did not have an active role in selecting the research topics and implementing any of the findings. Recommendations made by the review team were not relevant to the mandate of the CSSP Project, and thus not adopted.

PNG has very limited research capabilities. Other than three students in the Department of Community Medicine who conducted three studies, none of the researchers were PNG nationals. While it is tempting to use outside experts to get the job done quickly, the development process requires that the recipients of the assistance be involved in the process. Clearly, this assists in the development of national expertise. Ongoing communication between program planners, managers, researchers and outside consultants is very important to the creation of well formulated operations research.

Research projects need to be monitored closely to ensure that appropriate information is collected and the findings are presented on time. The key to meeting these needs is a well defined protocol.

Recommendation

Concerted efforts should be made to enhance the research capabilities in PNG. More Papua New Guinean organizations should be encouraged to undertake research projects. The Department of Health should create a research committee that would: identify research areas, approve research protocols, monitor progress of research projects, review findings and monitor application of major findings. The committee should include DOH officials from different units including the policy unit, academic and research institutions, donors and project staff. The committee should be chaired by a senior official such as the First Assistant Secretary.

c. Regional Support Units

In the early 1980s, the DOH established four Regional Malaria Support Units (RMSU), one in each region, to provide malaria surveillance, collect information and provide logistics support to the provinces. In 1985, the DOH established Regional Epidemiological Units (REU), which replaced the RMSUs, to provide on-site technical resources for the provinces. The focus of the REU was narrow: disease surveillance, on-site trouble shooting, control of childhood disease outbreaks and some training.

In 1989, the DOH renamed the units from REUs to Regional Support Units (RSU). The RSUs were expected to function as technical advisory units to the provincial health offices and support them in improving the delivery of rural health services, especially MCH services. However, the role of the RSUs was never clearly defined. As a result, an ambiguity about their role always existed and there were differing opinions within the DOH about their importance, role and responsibilities. In 1993, this ambiguity reached a climax when a decision was made to abolish the RSUs, resulting in the closure of the RSU in the Papuan region.

In 1994, the DOH reversed its 1993 decision to abolish the RSUs. It decided to further expand the role of the RSUs and rename them as Regional Health Extension Units (RHEUs). Although the details are still being worked out, the plan is to completely redefine their function. Their new function would involve: disease surveillance and control; and training of service providers on MCH, environmental health, water and sanitation. Staff positions in the RHEUs are being increased from 53 to 60 and, accordingly, the budget will be increased. The current annual budget of the RSUs is

about K600,000. The RHEUs will be upgraded and headed by an Assistant Secretary. The RHEUs will have an in-service training coordinator who will provide and organize in-service training to the service providers at the health facilities. Under the new design, each regional unit will have the following staff: Epidemiologist, Disease Control Officer, Inservice Training Coordinator, Health Inspector, Matron/MCH, Laboratory Technician, Malaria Technician, Health Education Officer, and Statistician. Most positions are currently filled.

The CSSP was mandated to provide training to the RSU staff, supply equipment and design management and supervisory systems. The CSSP conducted an assessment of the RSUs through site visits to assess staffing and facilities, as well as equipment needs. Based upon these assessments, a protocol was developed for a further comprehensive assessment but it was dismissed because of the DOH decision to abolish the RSUs.

c.1. Equipment

The CSSP provided four vehicles, four photocopiers, four computers and four fax machines to the RSUs.

c.2. Long Term Training

As indicated in the contract mandate, CSSP supported long term training for two DOH staff: Dr. Timothy Paiyakalia, First Assistant Secretary of the DOH and Dr. James Wangi from the Papuan region RSU. The participants found the programs and experiences very useful and recommended similar programs for other RSU officials.

In order to broaden skills development, the CSSP planned to provide short term (three months) regional training for a number of RSU staff. However, this plan was abandoned in late 1993, when USAID underwent a reorganization and the decision was made to end the Project early. These developments also led to the canceling of "CSSP Fellows" program, which was designed to provide on-the-job training to selected RSU staff. Under the fellowship program, the RSUs would have seconded staff to the CSSP for 18 months to work with the CSSP advisors. This was considered an ideal way of transferring skills. The Project considered the fellowship mechanism appropriate in providing practical training to the staff.

c.3. Training of Trainers to RSU/Provincial Staff

The CSSP has designed a training program for service providers on ten maternal and child health interventions. The original CSSP plan was to provide this training in four

provinces. However, this number was scaled back due to the early termination of the Project. The revised plan is to provide such training in two provinces. The two provinces selected for such training are Gulf and New Ireland provinces. They were selected based the following criteria:

1. Status of health as determined on the basis of the available information;
2. Provincial staffing and management capability; and
3. Stability of the law and order environment.

The CSSP has set the following principles for this training: the training will reinforce PNG standard treatment regimes, be cost-effective, cause minimum disruption to routine provision of services, and be easily replicable.

The CSSP adopted a two-step training strategy. The first step was to offer a training of trainers (TOT) to the health center "Officers In Charge" (OIC) and one other service provider from the health center in order that they are able to jointly train the service providers. The second person may include: the matron, disease control officer, in-service coordinator, or sectional heads at the provincial level. These two individuals will travel to the health centers to train the service providers. This was planned to minimize the disruption of services and to put the health center OIC in a position where he achieves status from training his own staff. The rationale behind this was to make the OIC more responsible to the needs of his staff and also to match his knowledge and skills with theirs and create an atmosphere of teamwork. Other benefits include the opportunity to address health center and aid post service delivery constraints at the time of the in-service and to build in a supervisory element to the in-service sessions. It was also decided to train the trainers and trainees concurrently on three or four interventions at a time. The TOT session on each set of interventions will last for three days. Training of the service providers will be for one day (one day of the TOT Training is allocated to the planning and budgeting of the district in-service courses so that their content, location, materials, funding and timing are all locked in place by the last day of the workshop). The RSU staff may also receive TOT. However, the CSSP does not expect the RSUs to provide the training because it is not practical due to logistics, and may cause delay in the training or affect the quality of the training. Affect in quality would be a result of an extra level added in the training cascade (DOH to RSU to Province to District) which may result in distortion of training content). The RSUs are expected to monitor the training programs and provide feedback to the provincial health offices.

The first training of trainers was conducted in August, 1994 in the Gulf Province and the second in September, 1994 in the New Ireland Province. Training of all the trainers and service providers in the two provinces will be completed before 1995. The Department of Health is planning to replicate this training countrywide under the Child Survival Crash Program.

The CSSP also trained the Provincial Assistant Secretary, Inservice Training Coordinator, Chief Accountant and Accounts Clerk in the New Ireland and Gulf provinces on financial management. Eight persons attended this three day training program. The training was conducted by the CSSP program officer from JSI/Boston.

The RSU's are an important mechanism in offering improved health services. They could be used as an effective resource for training the DOH staff and even for supervision and monitoring of the health services in the provinces. Funding remains a major issue. During the life of the Project, the funding available for RSU activities has dwindled to a point where they are office bound. Should funding become available in the future, the RSUs should be helped in increasing their organizational capabilities in the areas of planning, communication, and training. The CSSP has been working with teams from the Asian Development Bank (ADB) to develop a plan to strengthen the RSUs and involve them in the Human Resource Development Project.

CSSP efforts to strengthen RSUs were frustrated by the delay in advertising and appointing the Family Health Advisor positions (regional matron). This was not implemented until mid-1993 due to the continued reorganization of the structure of the DOH. This position was to be the key Child Survival Support Project counterpart for the MCH activities. In addition, efforts to strengthen RSUs were interrupted by the DOH policy and USAID's decision to terminate the project earlier than the planned date. As a result, the CSSP was unable to develop management and supervisory systems for the RSUs.

Discussion and Lessons Learned

Although the RSUs have the potential to be useful in training and monitoring, one of the reasons that the DOH wanted to abolish them may be because the RSUs failed to prove their worth. In a decentralized health system, where the provinces are responsible for planning and implementing their programs and directly report to the central DOH, they may be misfit in the structure. Each province has its own training unit and is, ideally, supposed to be able to meet provincial training needs. Instead of abandoning this unit is logical to strengthen the provincial units since they are closer to the health workers. Any specialized training can be handled through the College of Allied Health Sciences.

even through creating one central training unit rather than four. Since the provinces are responsible directly to the central DOH, the regional support units may not be very effective in supervising them as they do not have any authority.

Recommendation

The importance and usefulness of the RSUs should be carefully assessed to determine if they should be continued and if so, what role they can best play. This assessment should be done by an independent committee consisting of outside experts as well as DOH officials.

d. Training and Skills Development

The health center and aidpost-based service providers have a long history of experience working in the field. Nonetheless, a 1991 evaluation of the PNG Department of Health centers found that 73% of the health center staff and 80% of the aidpost orderlies had not received any updated training since 1985. The last time the aidpost supervisors were trained was more than 24 years ago. Furthermore, the study found that overall staff knowledge, clinical recording skills and attitudes indicate a serious deficit of in-service training which is affecting the quality of the health services.

CSSP activities designed to ensure technical viability included testing and establishing a system for sustainable inservice training at all levels from the provincial to the health center to the APOs. Quality circles were established to encourage skill development of the service providers and improve overall quality and program efficiency.

d.1. Provincial Program Planning

The CSSP Project assisted the Department in developing a planning module and preparing plans for five provinces. The CSSP assisted the DOH in identifying problems in the collection and utilization of health information and developed an outline for MIS. An ADB consultant is now working on this outline to make improvements in the MIS by helping the epidemiology unit manage and analyze epidemiological data and disseminate the findings.

The CSSP assisted the policy and planning unit develop a monitoring mechanism and provide training of trainers to the supervisors so that they can become effective trainers. This will help redefine the responsibilities of the supervisors, establish them as trainers, and alter the supervisory style.

d.2. Community Based Village Birth Attendants Training

The CSSP, in collaboration with the Department of Health and the Institute of Medical Research, conducted a national workshop to review the experience in training and utilizing Village Birth Attendants (VBA). This included identifying key issues that affect utilization of VBAs and developing guidelines for continuing training and use of the VBAs. It was attended by 30 participants from the Department of Health and a local NGO. The resource persons for this workshop were members of the Department of Health, Prime Minister's Office, NGOs, and the CSSP advisors. The workshop reviewed the experiences of different organizations who have used VBAs, including the methodology, curriculum and materials used in training the VBAs. A national curricula and training manual was developed. Using this curriculum, the CSSP conducted a training of trainers for VBAs, which was attended by 12 provincial nurses.

USAID decided to cut back the Village Birth Attendants' training program and the Community Health Nursing Advisor position was eliminated. However, the CSSP effort has led to the government's initiative to promulgate legislation to promote the use of VBAs in the community. The government is planning to include the VBA program in the CSCP.

d.3. Diploma Course in MCH Nursing Administration

The CSSP Project designed and implemented a diploma course in Nursing Administration at the College of Allied Health Sciences in 1993. This four month course was developed in response to a community level situational analysis which found that child and maternal health needs were not being properly addressed because of the lack of community level service providers' skills. The objective of this diploma course is to improve the management of health facilities by preparing registered nurses for management responsibilities at the district, provincial and regional level. The target audience for this course is management level nurses from the districts and churches who have supervisory responsibilities and wish to become community health nursing administrators. This performance based program was designed to provide the senior nursing officials with sound clinical knowledge, technical competency and an ability to use judgement in community nursing situations and skills in communications to develop their capability to recognize and meet the health needs of the community.

The curricula of the diploma course in nursing administration includes the following: planning, organizing, personnel management, leadership, budgeting and quality assurance. The course includes an eight week practical training in a health district.

The CSSP Community Health Nursing Advisor worked as the course coordinator initially before a suitable person could be identified to direct this program. The CSSP Project sponsored a potential coordinator's completion of a masters degree in nursing education to qualify her to be the tutor for the DCHNA course. After completing the course, the coordinator refused to stay in Port Moresby or take up the required position. The CSSP Community Health Nursing Advisor continued to serve as the Coordinator until a second suitable candidate could be found.

The first course was attended by ten participants, and nine graduated. One of the participants in the course was from Vanuatu. The second course had 14 participants. There are currently two instructors for this course, but the coordinator feels an additional instructor is needed. For practical training, the coordinator would like to visit the institutions before sending the students to check if the institution has adequate facilities for practical training. She would also like to visit the student's organization after they return from the training to observe application.

The coordinator reported that criticism of the program concerns the general nature of the curriculum. She is working to change part of it to make the curriculum more practical and effective.

This program is over a year old and has been facing some problems which need DOH attention. The program does not have any specific budget and does not have the minimum equipment necessary to effectively manage the program. It needs teaching materials, books, computers and a photocopier.

The CSSP Project assisted the College of Allied Health Sciences to construct two housing units for the two instructors of the Diploma in Nursing Administration program that the CSSP has helped establish. The Department of Health has acquired the land for the houses. Sites are currently being prepared for construction, including levelling, connecting water, sewerage and electric power. The CSSP is in the process of selecting the construction contractors as well as obtaining a waiver for source of origin for the procurement of pre-fabricated house.

d.4. Training to Service Providers

In Phase I of the Project, the Child Survival Support Project worked with the National Department of Health, Regional Support Units (RSUs), NGOs, and other international donors (most notably WHO and UNICEF) on a variety of jointly funded training programs. In Phase II of the Project, the CSSP, in collaboration with the NDOH, RSUs and Provincial Inservice Training Units, provided training to service providers in PNG on

the CSSP target diseases and conditions. Training was conducted on the diagnosis, treatment and prevention of pneumonia, diarrhoea, malaria and malnutrition in children. In addition, training was provided on the supervision of village childbirth. Training and clinical practice was coordinated and reinforced by the development of a "Ten-Step Checklist Deskchart" for the diagnosis and treatment of sick children and all training and materials included a special focus on health promotion methodology and community involvement. Other topics included in the training courses were immunization of mothers and children, vaccines and the cold chain, medical supplies and logistics. Health planning, budgeting and accounting of funds were included in all training programs to ensure sustainability.

All health staff in the two target provinces (Gulf and New Ireland) were trained through two provincial "Training of Trainers" Workshops. Each Workshop was followed by two health centre-based in-service courses, which included video training tapes, practical sessions, and community involvement. The trainings in Gulf and New Ireland Provinces were attended by RSU and NDOH staff, as well as health officials from other provinces. The participation of these health officials from other provinces has facilitated the addition of other provinces into the training program. A pool of competent trainers/facilitators has been developed by the CSSP before its closure and will enable the program to continue without disruption. See Table 2 for a complete list of all major training workshops conducted by the CSSP.

In February 1995, the CSSP will hold a rational workshop with participants from all provinces in PNG in attendance. This workshop will serve to acquaint all provinces with the Child Survival Programme and the materials and methodology of the training. It will also serve to introduce the major international donor organizations that will be conducting future health worker trainings in PNG using the CSSP developed training methodologies and materials.

d.5. Training on Nutrition

In order to increase the detection and treatment of malnourished children, the CSSP conducted a pilot project which used an arm measurement tape as a reinforcement tool.

The Middle Upper Arm Circumference (MUAC) Tape Pilot Project focused on the detection of malnourished children by a large number of health workers, including aidpost workers. Under this pilot project, 40 aid post orderlies and 30 health center staff were trained. Following the findings of a qualitative study the training materials were modified and an additional 40 aidpost orderlies were trained in West Sepik province with

Table 2 (CSSP In-Service Training Activities by Category of Staff Trained)

Date	Location	Topic	HEOs	Nurses	APWs	Others	Total
July 3 - 6, 1991	Wewak East Sepik Province	MUAC Nutrition Survey Training	3	3	2	4	12
July 24 - 26, 1991	Mendi, Southern Highlands Province	Malaria Diagnosis, Treatment and Prevention Workshop	10	6	0	1	17
July 6 - 10, 1992	Alotau . Milne Bay Province	5 Year Health Planning Workshop	17	3	0	10	30
Feb. 23 - 26, 1993	Lorengau Manus Province	Combined ARI/CDD Workshop	6	5	0	2	13
Nov. 7 - 12, 1993	Esa'ala Milne Bay Province	APO involvement in Village Delivery Pilot Project	1	0	29	0	30
Nov. 30 - Dec 3, 1993	Amanab West Sepik Province	MUAC District Training Pilot Project	0	0	29	0	29
March 3 - 5, 1994	Madang Madang Province	Momase Regional CSCP Workshop	3	0	0	10	13
March 7 - 9, 1994	Goreka, Eastern Highlands Province	Highlands Regional Child Survival Planning Workshop	4	1	0	10	15
July 27 - 29, 1994	Buka North Solomons Province	Child Survival Advocacy	11	11	0	0	22
Aug. 8 - 12, 1994	Kerema Gulf Province	Child Survival Training of Trainers (1)	12	14	1	2	29
Aug. - Dec., 1994	Gulf Province	District In-Service Training (1 - 4)	0	109	165	0	274
Oct. 17 - 21, 1994	Kavieng New Ireland Province	Child Survival Training of Trainers (1)	15	19	0	8	42
TOTAL			82	171	226	47	526

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Annex 1 : Lessons Learned

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the modified materials. The materials were modified further and used for child survival health worker training in Gulf and New Ireland provinces. This malnutrition detection and treatment intervention has been adopted by the national nutrition section and the National Department of Health as their major strategy to detect and treat malnutrition of children of one to five years of age.

d.6. Other Training Programs

The Department of Community Medicine conducts two programs. One is a diploma course on community health, and another is a masters degree program in community health. The CSSP Logistics Advisor teaches several components of these programs, including one week on EPI and another week on logistics management. Last year the Logistics Advisor led a one week operations research program for the students. This course is very popular among the students because it is a hands-on training. The CSSP MCH physician teaches clinical courses and community medicine courses in the program. There are two courses on district level training programs and community education materials. One of the courses is for fifth year medical students, the other is for diploma and masters students in community health. The CSSP MCH Physician is also an external examiner for both courses.

d.7. Training and Health Education Materials

The CSSP has developed a number of training and health educational materials. These were designed to assist in training as well as in the provision of health education. These materials are developed on global child health issues as well as six specific issues: pneumonia, diarrhea, malaria, malnutrition, immunization, and high risk pregnancy. Training materials, flip charts, posters, videos and radio programs are used. A list of these materials is given in Attachment 5.

The CSSP Project is planning to develop training materials on three other areas: the cold chain, logistics supply and community education.

Discussion and Lessons Learned

Training is an important component of the CSSP Project's activities. The Project has established a diploma course at the College of Allied Health Sciences to develop the management capability of the supervisory nursing staff. This program is in its infancy and will need significant support to develop. The Department of Health should carefully review its needs. The CSSP also designed a training of trainers for the Officers-In-Charge of Health Centers and senior supervisory nurses, and another training program for

the service providers. The project will be able to complete these training in two provinces during its lifetime.

The training methodology and materials used by CSSP is very effective. A USAID official observed that, as a result of the five day training, a Department of Education employee with no prior medical experience was doing a better job in determining actions needed for children. This was accomplished through the introduction and use of the "10-Step Checklist" developed by the CSSP Project. The CSSP developed a large number of training and health education materials. The health education materials are also used in training community volunteers and educating the public. These materials, piloted in the two provinces, should be used nationwide.

Service providers across the country require training. Therefore, the training programs and educational materials piloted in the two provinces should be replicated nationwide and CSSP should help the DOH develop an action plan to implement a national program.

Papua New Guinea has one of the highest maternal mortality rates in the world. One of the reasons for this is unassisted childbirth. Assistance by a trained person during birth can help significantly reduce the maternal mortality rate. The CSSP was mandated to train Village Birth Attendants (VBAs). The project has conducted a workshop to review the experience of other organizations and designed a training curriculum. Several organizations are involved in training the VBAs. Thus, justifiably, the CSSP has decided to take action on other priority issues and leave this to current organizations involved in training VBAs. The government has moved to add training and the use of VBAs to the legislative agenda.

Community volunteers can be effectively trained by using appropriate training methodology and materials to identify symptoms that required medical attention.

Recommendation

The DOH should undertake a priority program to train village birth attendants using the curriculum developed by CSSP and develop a referral system with the health center and subcenters to treat complicated cases.

e. Logistics Management

The DOH has 3,000 items in the inventory. About 600 of those are drugs. The annual procurement budget of the DOH is K20 million. Improvement in the procurement, storage, inventory control and distribution of logistics have been recognized. The

problems are complex and range from an old, inadequate system to personalities vested in the current system and reluctant to make changes. Many attempts were made to address these problems without much success. One important result of the CSSP attempts is that people at the DOH are now more aware of the problems. The DOH has created the position of "Logistics Officer" in the Family Health Section to work towards improving logistics management.

The CSSP Project realized from the beginning that trying to change the system in the national and provincial level could be a frustrating experience. As a result, the CSSP adopted a "bottom up" approach. They have included logistics management in the curriculum of the service providers' training and in the training materials.

The basic elements taught to the service providers are:

1. How to store commodities, including vaccines and medicines;
2. How and when to order vaccines, medicines and other logistics based on consumption patterns; and
3. How to maintain records of logistics receipts, distribution and stocks.

The CSSP Logistics Management Advisor worked with the DOH officials and a programming consultant to introduce minimum-maximum inventory control and supply drawdown forecasting methods to the existing computerized inventory control system in six medical stores. The CSSP has conducted an assessment survey of EPI operations and the vaccine cold chain. The findings revealed a serious inadequacy in the maintenance of the cold chain and the rapid destruction of vaccines before their use in the immunization program.

The CSSP Logistics Management Advisor assisted the Department of Health in developing a standard list of cold chain and EPI equipment for the health centers. The list specifies the equipment and quantity provided to each health facility and has been included in the DOH catalogue of standard supply items. This enables the DOH to procure, store and distribute the equipment to the health facilities on a regular basis. Based upon this list, the Australian International Development Assistance Bureau (AIDAB) has supplied some equipment to the health facilities on an emergency basis for the Child Survival Crash Program.

e.1 Training on Logistics Management

The CSSP has conducted the following training programs on logistics management and related issues:

- **Assessing Primary Health Care Logistics**

Sponsored by the Faculty of Medicine, University of Papua New Guinea (UPNG), August 26-30, 1991 and September 21- 25, 1992 and October, 1994.

- **Training of Trainers in Family Planning**

Sponsored by the Family Planning Services Expansion and Technical Support (SEATS), February 10-28, 1992

- **The Vaccine, Cold Chain and EPI Sustainability**

Sponsored by the UPNG Faculty of Medicine, March 12, 1992

- **EPI Evaluation**

Sponsored by UPNG Faculty of Medicine, March 16 - 31, 1992

- **EPI Technical Course for Health Center Officers-in-Charge of New Ireland and Western Highlands Provinces**

Sponsored by the DOH, October 13-15 and October 26-28, 1992

- **EPI Technical Course for Health Center Officers-in-Charge**

Central Province, August 1993

- **EPI Technical Course for Health Center Officers-in Charge**

National Capital District, September 1993

- **Missed Opportunities for Immunization**

Sponsored by UPNG, Faculty of Medicine, May, 1994

- **Missed Opportunities for Immunization**

College of Allied Health Sciences, October, 1994

e.2. Logistics Management Materials

The CSSP Project has produced the following Logistics Management materials for DOH use in trainings:

1. CSSP produced instruction sheets and a poster on filling, usage and management of ice packs following the delivery of 100,000 ice packs procured with DOH funds;
2. Developed a policy protocol for the destruction and removal of the expired medical supplies, vaccines, and drugs from the distribution system;
3. Developed simplified vaccine requirement estimation/order methodology for health facilities. Also, developed a new method of estimating the daily requirement of vaccines; and
4. Developed an instruction sheet on the method of using pressure cooker sterilizers to sterilize glass syringes and small instruments without using paper wrapping.

Discussions and Lessons Learned

Logistics management is another major component of the CSSP Project. The Project conducted an assessment of the logistical situation. The resulting information found logistics management problems to be complex, ranging from procurement to transportation. The Project alerted the DOH officials about the gravity of the situation. As the first step in a comprehensive solution to the problem, the DOH needs to make a firm commitment to bring about changes in logistics management.

Recommendation

The DOH and donors should consider developing a long term project to improve the logistics management system. The project should include procurement, warehousing, distribution, logistics management information system, transportation and staff training.

The DOH should also consider privatizing part of the logistics system that may initially include warehousing and distribution.

f. Coordination

f.1. Mechanism for Coordinating the Activities of NGOs, Government, and other Donors

A number of non-governmental organizations (NGOs) and private voluntary organizations (PVOs) are playing important roles in the health sector, in addition to the DOH and church-run facilities. They include Save the Children (U.K.), Project Concern International (PCI), and Rotary International. Additionally, a number of donors such as USAID, WHO and UNICEF support the health program in PNG. Most of these organizations have their own projects, use different consultants with varying expertise, interests, priorities and approaches. This confuses the DOH and often duplicates efforts.

The Government has assigned the Ministry of Finance and Planning, Office of International Development Assistance (OIDA) to coordinate the donor activities, but their role mainly concerns financing the projects. As a result, coordinating the activities of the donors becomes the responsibilities of the respective departments. Since this has not been a priority issue to the DOH, the CSSP Project has been mandated to assist them in coordinating the child survival activities of service providers and donors.

The CSSP initiated coordination of child survival activities under the Child Survival Crash Program (CSCP). UNICEF, WHO and AIDAB joined the CSSP along with church health services, various NGOs, the departments of Home Affairs and Youth, Agriculture and Health, to begin implementing the CSCP. As an active member of the multi-sectoral steering committee headed by the Prime Minister, and the Task Force chaired by the Secretary for Health, the CSSP has played an important role in organizing meetings and implementing their decisions.

The CSSP is playing an active advocacy role for promoting child survival issues in PNG. To boost the Child Survival Crash Program in PNG, the CSSP is currently supporting the CSCP Coordination Committee in an effort to get the program endorsed by Pope John Paul II during his upcoming visit to PNG in January of next year.

f.2. Working with Church Health Services

Churches and missions provide about half of rural health services, employ 16% of all health workers, and make considerable contributions toward training rural health workers

in PNG. These operations are fully integrated into national health services and, where the need exists, substitute for government run facilities. The training and other interventions provided by the CSSP directly benefit the church and mission managed facilities.

f.3. Re-establishing Nutrition Board

The following are four chronic health problems in PNG which are often responsible for malnutrition: infestation, chronic diarrhea, chronic malaria, and tuberculosis.

Despite the malnutrition problem, in the last ten years the Nutrition Board has not developed any activities. The DOH has recently developed an alternative coordination mechanism which is called National Interdepartmental Food and Nutrition Committee. The CSSP MCH Physician participated in the committee meetings and contributed to a workshop which developed an outline of the national nutrition policy. Based upon this information, a national nutrition policy was developed which was presented to the National Executive Council. The CSSP worked with the DOH to draft the policy.

Discussion and Lessons Learned

The CSSP Project has coordinated activities with the Child Survival Crash Program (CSCP). The CSSP has been working closely with UNICEF, who is willing to continue the coordination activities in the absence of the CSSP Project.

The CSSP was expected to coordinate the activities of the Church Health Services and assist in the reestablishment of the Nutrition Board. The Church Health Services received CSSP assistance in training their service providers and joined the Crash Program. The church health programs are heavily subsidized by the DOH and follow their mandates.

The DOH was not interested in reestablishing the Nutrition Board and developed an alternative mechanism. Thus, the CSSP did not have any role in the reestablishment of the Nutrition Board. The CSSP Project did, however, assist the DOH in the development of the nutrition policy.

g. Sustainability

For the first three years of the project, the CSSP had four technical advisors, covering the areas of Health Services Management, Logistics Management, Child Health Care and Maternal Health Care. In addition to performing their respective jobs, the advisors were interested in transferring their skills to local professionals. This proved to be more

difficult than anticipated. The main barrier to the transfer was that the DOH was not able to designate counterparts to the advisors in a timely manner.

The First Assistant Secretary of the DOH is the counterpart of the CSSP Chief of Party. However, the current COP is also the Logistics Advisor and in that position, his counterpart is the Assistant Secretary of the Family Health Section, who is not a logistics specialist. The DOH, however, has recently approved a logistics officer position and they plan to hire soon. By the time someone will be hired in that position, the project will be approaching its closure.

The MCH Advisor did not have a counterpart until four months ago (April '94). The designated counterpart is the training coordinator in the DOH. In his position as training coordinator, he is able to work effectively with MCH advisor in the areas of conducting and managing training programs as well as developing training and health education materials. He is considered very efficient and effective. There was no designated counterpart to the Community Health Nursing Advisor.

In the interest of continuing the activities initiated by the project, the CSSP Advisors feel that skills in the following areas should be developed in the DOH:

1. Primary Health Care Logistics;
2. EPI and Cold Chain Management;
3. Logistics Supply Management;
4. Training Materials Development and Use; and
5. Experiential Training Methodology Development.

The CSSP staff are willing to work with the DOH officials towards this goal if the DOH designates appropriate staff.

While agreement has been reached about the importance of transferring skills to the local health officials, some DOH officials felt that the issue did not receive enough attention from the beginning. Besides skill transfer, people also felt that it is important to develop the commitment of the appropriate officials. This is considered a much tougher job than transferring skills.

The Asian Development Bank (ADB) is considering continuing some of the activities initiated by the CSSP. The ADB has recently developed a Human Resource Development Project that includes a provision to continue the training activities initiated by the CSSP Project. The CSSP-developed model will be used in providing training to the DOH staff.

The CSSP has initiated a number of activities to improve health services nationwide that should be continued. These include:

- **The Child Survival Crash Program (CSCP)**

The CSSP has been playing a key role in coordinating the activities. It has been working closely with UNICEF who is in a position to take over this responsibility.

- **Task Force**

The Task Force constituted to oversee the week-to-week management of CSCP. This committee consists of representatives from five government departments, donors and various NGOs. UNICEF should be able to facilitate the coordination activities of this committee.

- **District Level Training**

The CSSP has designed a district level training program, developed all the training materials and implemented the training in two provinces. CSSP worked closely with some district and RSU officials who should be able to continue these activities without outside technical support. However, this training has been included in the HRD proposal of the ADB.

- **Training and Educational Materials**

The CSSP developed education and training materials which should be distributed to the service centers. The DOH can easily do this without external assistance.

- **Pilot Projects**

Preliminary findings of the pilot projects on Mid-Upper Arm Circumference tape and Ergometrine for Village Delivery are encouraging and these should be replicated throughout the country.

- **Overhauling The Cold Chain**

Based on CSSP findings, AIDAB has supplied some cold chain equipment to the DOH to improve the functioning of the cold chain. The CSSP has prepared a list of appropriate equipment.

- **Training in Logistics Management**

The CSSP has undertaken a program to train warehouse staff, medical supply officers and health workers in logistics management. The DOH should continue this activity. The new logistics officer should be able to conduct such training.

Discussion and Lessons Learned

A high priority of CSSP has been to develop the skills of DOH officials in order that activities initiated could continue. However, this effort has not been completely successful due to the significant delay in the GPNG's designation of counterparts. The counterpart to the MCH physician was designated in April 1994 and the DOH is currently in the process of hiring the counterpart for the logistics advisor. The National MCH Physician works in the family services section and it is recommended that the CSSP work closely with him.

The CSSP was located in the DOH building. This resulted in constant communication between the project staff and the DOH officials. While this is helpful to transfer ownership of the project to the DOH, this does not necessarily guarantee sustainability of the project.

Recommendation

The donors and the DOH should consider the issue of skills transfer from expatriate advisors and sustainability of project activities during the design phase.

h. Child Survival Crash Program

In early 1994 the Government of PNG launched a two-year health program, called The Child Survival Crash Program (CSCP). The program was conceived by the CSSP Project and UNICEF, who jointly convinced the Government to launch this program. The program has a dual purpose:

1. Revitalize the health program through training staff, equipping health centers, ensuring regular logistics supply, and improving management; and
2. To create an awareness among the politicians, community leaders, and the public concerning the child health issues.

At the beginning of the program, all the Premiers and Provincial Secretaries were brought to Port Moresby to discuss the state of the national health program and enlist their support in the CSCP.

The program has five components:

1. To train the service providers in the country following the CSSP model and by using CSSP training materials, thereby developing a core group of trainers;
2. To create health and sanitation awareness through a village patrol which educates people by using the CSSP developed "Happy Healthy Family" flipchart. This flipchart has been developed in three languages-English, Pidgin and Motu. UNICEF funded the printing of the chart. To activate agriculture extension workers, community leaders, teachers, health workers, and district managers (approximately ten in total) to participate in the "village patrol";
3. To supply essential equipment to the clinics. The CSSP prepared a standard list of equipment. AIDAB is supplying part of the equipment, costing about \$A1.2 million. Cost of equipment per center is approximately \$A2,000;
4. To revitalize health services through the repair and renovation of health facilities and the restoration and expansion of village patrols; and

5. To institutionalize supervision, monitoring and evaluation of health services. The village patrol will provide an opportunity for the supervisory staff from the health center to visit aidposts.

Under this program district level patrols will visit the villages on a regular basis. Actual frequency visits are yet to be determined. The Patrols will be headed by the district manager, who is the top civil servant in the district. The participants of the patrol will include DOH health center level service providers, representatives of NGOs, women's groups and churches. UNICEF provides promotional and training materials for the program. The CSSP Project will assist the CSCP with training and educational materials, developing the content of the message while the individual organizations decide on the techniques used to disseminate the message.

A vital aspect of the Child Survival Crash Program is the patrol of the villages. This provides an opportunity for the district civil and health officials as well as NGO and other development organizations to communicate in a face-to-face setting with the villagers.

Empowering health workers and creating a sense of dignity and responsibility for serving the community may help improve the services which the crash program aims to achieve.

Some of the important achievements that are expected to be made during the two year crash program are: improving iodized salt supply, making hospitals baby-friendly, making all aid posts functional, and retraining service providers.

Discussion and Lessons Learned

The Child Survival Support Project (CSSP) was designed to improve maternal and child health services in rural areas of Papua New Guinea.

The strategy adopted was to:

1. Train service providers and managers;
2. Improve the logistics supply system;
3. Establish a regional support system to ensure sustainability in the rural health facilities;
4. Establish a mechanism to coordinate the efforts of donors, government departments, NGOs and churches; and

5. Conduct research to identify effective interventions in all of the abovementioned areas.

In last four years, the Project was modified twice to alter the performance indicators in light of the country situation, as well as USAID's global reorganization policy. This also affected the CSSP's management structure. Given all of this, the CSSP has made a positive contribution towards improving the maternal and child health services of Papua New Guinea.

The single most important contribution CSSP has made towards improving the MCH program in PNG is the launching of the Child Survival Crash Program. This program, launched by the Prime Minister of the country, aims at sensitizing the national, provincial and community leadership concerning the health of mothers and children, and revitalizing the health program in the country. Although it has been developed as a "Crash Program", because of the urgency of the situation the government is planning to drop the word "Crash" from the program and make it an integral part of the health services. The two-year "crash" encompasses all the essential elements of a well-run health program: staff training, equipping the clinics, improved logistics management, improved management information system, and coordination-- all that the CSSP was mandated to do. Given the limitations of resources the government may not be able to achieve all these. Termination of the CSSP in March, 1995 aggravates this shortage of resources further.

Recommendation

CSSP was a large program with a very broad mandate. As a result, CSSP should prepare a list of priority activities in the CSCP and concentrate efforts.

ATTACHMENT 1

PERSONS CONTACTED

Department of Health

Timothy Paiyakalia, First Assistant Secretary

Sarah Rubero, National Epidemiologist

Dr. Isaac Ake, Coordinator, Child Survival Crash Program
Former Secretary of Health

Andrew Posong, Assistant Secretary (Policy)

Steve Klein, Chief, Pharmaceutical Unit

Russel Kitao, Health Planner

Enoch Posanai, Assistant Secretary, Family Health

Dr. James Wangi, Epidemiologist, RSU, Papuan Province

Department of Community Medicine

Adrian Sleigh, Professor and Head
Department of Community Medicine
University of Papua New Guinea

College of Allied Health Sciences

Elizabeth Kendrun, Coordinator
Diploma in Community Health Nursing Administration

UNICEF

Hamid R. Hossaini, Country Representative

Tony Naleo, Project Officer

The Child Survival Support Project

Allan Bass, Chief of Party and Logistics Advisor

Dr. Keith Edwards, MCH Physician

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ATTACHMENT 2

END OF PROJECT STATUS INDICATORS

(As in the original document)

USAID stipulated the following End of Project Status Indicators (EOPSI):

1. Reduce the institutional case fatality rate of:

- i. Acute Lower Respiratory Infection (ALRI) by 20%
- ii. Malaria by 20%
- iii. Diarrhea by 20%

2. The following should be increased:

- i. Availability of ORS by 100%
- ii. Use of ORT by 100%
- iii. Surveillance of under five malnourished children by 50%
- iv. Supervised delivery of high risk women by 15%
- v. Immunization coverage for measles by 25% (to 60%)
- vi. Immunization coverage for 3rd dose of T.A. by 20% (to 60%)

Revised end of project status indicators:

- A. To strengthen specific technical and management services supportive of maternal and child survival in Papua New Guinea by:
1. Establishing a diploma course in community health nursing
 2. Strengthening management and services of RSUs
 3. Supplying equipment and vehicles to RSUs
 4. Strengthening supervision
 5. Developing community level IEC
 6. Developing school health program
 7. Strengthening in-service training
 8. Strengthening health center and aid post management
 9. Strengthening donor and NGO coordination
 10. Improving information dissemination
 11. Strengthening church health services
 12. Strengthening health in the private sector
 13. Publishing technical reports
 14. Establishing health care financing
- B. To increase the effective detection and treatment of pneumonia at aid posts and health centers and prevent pneumonia in children.
- C. To increase effective treatment and prevention of malaria in mothers and children at aidposts and health centers.

- D. To increase effective treatment and prevention of secretory, persistent and dysenteric diarrhea in children in the homes, at aidposts and health centers.
- E. To increase diagnosis and effective treatment of malnutrition in children and the chronic diseases and medical conditions related to malnutrition.
- F. To increase community awareness of good food and nutrition practices.
- G. Reduce the maternal mortality by increasing the percentage of supervised births.
- H. Reduce maternal mortality by improving the quality of obstetric care in health centers.
- I. Reducing maternal mortality by improving the safety of child birth in community.
- J. To prevent cases of measles, diphtheria, pertussis, and tetanus.
- K. Improve the availability of essential drug and supplies for maternal and child survival.

ATTACHMENT 3

PROJECT OBJECTIVES

Objective # 1. To obtain baseline and technical information for policy formulation, planning and evaluation.

Activities:

- Review, compile and analyze literature and identify research gaps
- Assess ways of improving overall health services for mothers and children
- Conduct special studies
- Develop pilot projects and studies on use of child survival techniques
- Review or conduct studies of management, organization and quality of health services
- Hold community based child birth assistance workshop and promote the training of TBAs

Objective # 2. To strengthen the Regional Support Units (RSU) by training staff which will help create a system of continued technical support and training for provincial health staff in order to improve their effectiveness in providing MCH services.

Activities:

- Review the facilities, staffing, equipment, functioning and financing of the RSU
- Procure and provide equipment to the RSUs
- Arrange Master level training for two RSU OICs
- Provide training or trainers to RSU/provincial staff

- Develop management and supervisory system for the RSU to operate, manage and supervise the provinces

Objective # 3. To upgrade technical and management skills of MCH health workers and establish a diploma course in MCH Nursing Administration.

Activities:

- Establish a diploma course in MCH Nursing Administration
- Design and conduct inservice training courses in maternal and child health
- Provide inservice training to trainers (of CHWs)
- Provide training to provincial health workers on nutrition
- Develop and test health education materials on MCH for out-reach workers
- Develop management systems

Objective # 4. To establish viable and effective medical logistics systems to ensure effective delivery of MCH services.

Activities:

- Determine equipment needs of the provinces in order to maintain an effective cold chain and assist in procuring those
- Assess cold chain and medical and MCH logistics system
- Assist in developing training materials in cold chain and medical logistics management for Area Medical Stores and chiefs and provincial health staff
- Develop management systems to improve procurement and distribution of vaccines and medical equipment

- Design and develop in-service courses in drug and cold chain logistics management system for Area Medical Supply and provincial health staff
- Develop a system for disposal of contaminated sharps produced by immunization program

Objective # 5. To strengthen health services through improved coordination between the DOH, Church Health Services and other donors.

Activities:

- Develop mechanisms for coordinating the activities of the NGOs, the government and donors
- Work with Church Health Services
- Assist in the re-establishment of the Nutrition Board

ATTACHMENT 4

LIST OF THE COMPLETED RESEARCH AND PILOT PROJECTS AND ORGANIZATIONS THAT CONDUCTED THE PROJECTS

Research Projects

Implementing agencies

- | | |
|---|--------------------------------------|
| 1. Rural Health Services | Dept. of Community Medicine,
UPNG |
| | PNG Institute of Medical
Research |
| 2. Community Health Nursing Job Analysis | CSSP |
| 3. Evaluation of Maternal Health Services | CSSP |
| 4. Study of Provincial In-service Units'
Policies and Activities | CSSP |
| 5. An Assessment of Medical Supply and
Logistics systems | CSSP |
| 6. Rice-ORS Acceptability study | CSSP |
| 7. An Assessment of Cold Chain and EPI | CSSP |
| 8. A Review of Hemophilus B
Vaccination | CSSP |
| 9. Vitamin A Ophthalmological
and Dietary Intake Survey | CSSP |
| 10. Reproductive Knowledge and
Behavior survey | PNG Institute of Medical
Research |
| 11. Childhood Pneumonia in the
Eastern Highlands of PNG:
An Ethnographic Approach | Dept. of Community Medicine,
UPNG |

- | | | |
|-----|---|-----------------------------------|
| 12. | Non-Communicable Diseases in Adult Manus Islanders | Dept. of Community Medicine, UPNG |
| 13. | Factors Affecting Utilization of Health Services on Karkar Island, Madang Province, Papua New Guinea. | Dept. of Community Medicine, UPNG |

Pilot Studies

- | | | |
|----|--|-----------------------------------|
| 1. | Pneumococcal vaccine field trial in children | PNG Institute of Medical Research |
| 2. | Pneumococcal vaccine for pregnant women | PNG Institute of Medical Research |
| 3. | Mid-upper arm Circumference Tape Pilot Project | CSSP |
| 4. | Ergometrine for village delivery pilot project | CSSP |

ATTACHMENT 5

LIST OF TRAINING AND EDUCATIONAL MATERIALS

1. Pneumonia:
 - Service Providers' ARI Diagnosis, Treatment and Prevention Training Module
 - Treatment Flow Chart
 - Video on the Assessment of Children with Respiratory Infections *
 - Tuberculosis Score Chart
 - Respiratory Rate Electronic Timer *
 - ARI Community Education "Face-to-Face" Flipchart
 - ARI Poster (coordinated with flipchart)
 - ARI Pamphlet / Adult Literacy Book (coordinated with flipchart and poster)

2. Diarrhea:
 - Service Providers' Diarrhoea Diagnosis, Treatment, and Prevention Training Module
 - Video on Diagnosis, Treatment & Prevention of Diarrhoea
 - Treatment Flow Chart
 - How to Make a "Tippy-Tap" for Handwashing in the Village
 - Diarrhoea Community Education "Face-to-Face" Flipchart
 - Diarrhoea Poster (coordinated with flipchart)
 - Diarrhoea Pamphlet / Adult Literacy Book (coordinated with flipchart and poster)

3. Malaria
 - Malaria Diagnosis and Treatment Flow Chart *
 - Malaria Community Education "Face-to-Face" Flipchart
 - Malaria Poster (coordinated with flipchart)
 - Malaria Pamphlet / Adult Literacy Book (coordinated with flipchart and poster)

4. Malnutrition
 - Service Providers' Malnutrition Diagnosis, Treatment, and Prevention Training Module

- Mid-Upper Arm Circumference Tape and Six Step User's Guide
 - Video: How To Use The Mid-Upper Arm Circumference Tape
 - Malnutrition Community Education "Face-to-Face" Flipchart
 - "Six Nutrition Messages" Community Education "Face-to-Face" Flipchart
 - Nutrition Poster (coordinated with flipchart)
 - Nutrition Pamphlet / Adult Literacy Book (coordinated with flipchart and poster)
5. Immunization
- Service Providers' Module on the Giving of Tetanus Toxoid Immunizations to Women of Childbearing Age at Aidposts
 - Video on "How to Use the Steam Sterilizer" *
 - Immunization Community Education "Face-to-Face" Flipchart
 - Immunization Poster (coordinated with flipchart)
 - Immunization Pamphlet / Adult Literacy Book (coordinated with flipchart and poster)
6. High Risk Pregnancy
- Service Providers' Training Module on the Role of the Aidpost Worker in Village Delivery
 - Flipchart
 - Safe Childbirth Community Education "Face-to-Face" Flipchart
 - Safe Childbirth Poster (coordinated with flipchart)
 - Safe Childbirth Pamphlet / Adult Literacy Book (coordinated with flipchart and poster)
 - Drama Play for Radio on Safe Childbirth Practices in the Village

7. General

- Service Providers' Training Module on the Ten-Step Checklist for all Sick Children
- Ten-Step Checklist for all Sick Children Deskchart (Clinic / Health Centre Version)
- Ten-Step Checklist for all Sick Children Deskchart (Aidpost Version)
- Video on "How to do the Ten-Step Check"
- "Happy, Healthy Family" Community Education "Face-to-Face" Flipchart
- "Happy, Healthy Family" Poster (coordinated with flipchart)
- "Happy, Healthy Family" Pamphlet / Adult Literacy Book (coordinated with flipchart and poster)
- Advocacy Pamphlet / Adult Literacy Book
- Paediatric Standard Treatment Book (6th Edition)
- Obstetric and Gynecology Standard Treatment Book (3rd Edition)
- Mother's Health Record Book
- Child Health Record Book (updated)
- Patrol Activities Checklist
- Medical Imprest System and Forms for Aidpost Workers
- Community Health Worker Pre-Service Training Modules
- Training of Trainers (TOT) - Workbook 1
- Training of Trainers (TOT) - Workbook 2

* These materials were pretested before finalization and translated into Pidgin English and Motu languages. Materials marked with an asterisk (*) are based on materials produced by WHO. All other materials are original and were produced for the PNG CSSP Project by JSI

ANNEX 2

1995 External Evaluation Report of the CSSP Project

A TRIP REPORT ON THE EVALUATION

OF

THE TEN STEP CHECK SYSTEM FOR ALL SICK CHILDREN:
A CHILD SURVIVAL INTERVENTION DEVELOPED AND IMPLEMENTED BY

THE CHILD SURVIVAL SUPPORT PROJECT
USAID Project 492-0017-C-00-0073-00

IN PAPUA NEW GUINEA

Prepared for:

The U.S. Agency for International Development/Manila

Prepared by:

Mary Aalto Leiter, RN, BSN

February 5 - 15, 1995



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LIST OF ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
AIDAB	Australian International Development Assistance Bureau
ARI	Acute Respiratory Infections
APO	Aid Post Orderly
ASH	Provincial Assistant Secretary for Health
CAHS	College of Allied Health Services
CDD	Control of Diarrhoeal Diseases
CHW	Community Health Worker
COP	Chief of Party
CS	Child Survival
CSP	Child Survival Program of the NDOH
CSSP	Child Survival Support Project
EHP	Eastern Highlands Province, PNG
EPI	Expanded Program for Immunizations
FAS	First Assistant Secretary
GPNG	The Government of Papua New Guinea
HEO	Health Extension Officer
HRD	Human Resources Development
ISP	Interim Support Project proposed for funding by AIDAB
JSI	John Snow, Inc., the U.S. Contractor for the CSSP
LMA	Logistics Management Advisor
LOP	Life of Project
MCH	Maternal and Child Health
NCD	National Capital District
NDOH	National Department of Health
OIC	Officer in Charge of a health center/subcenter
OPHN	Office of Population, Health and Nutrition
ORT	Oral Rehydration Therapy
PACD	Project Activity Completion Date
PHC	Primary Health Care
PHS	Primary Health Services
PHD	Provincial Health Division
PNG	Papua New Guinea
POM	Port Moresby, Papua New Guinea
PROAG	Project Agreement
RDO/SP	U.S. Agency for International Development/Regional Development Office for South Pacific located in Suva, Fiji
RSU	Regional Support Unit
SOW	Scope of Work
TA	Technical Assistance
TOT	Training of Trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VBA	Village Birth Attendant
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

The Papua New Guinea Child Survival Support Project (PNG CSSP) was designed in 1989 by USAID with the government of PNG (GPNG), to improve the quality, efficiency and effectiveness of the delivery of maternal and child survival services in rural areas of PNG. John Snow, Inc. (JSI) was awarded the CSSP in September 1990. The original PACD was August 31, 1997, with a projected USAID LOP contribution of \$9.4 million.

The project activities were designed to be implemented in two phases. In August-September 1993 plans for Phase II were being developed. In November 1993, the USAID South Pacific program was designated to be closed out in FY94. The PNG CSSP would therefore be terminated early, with a LOP funding reduction to \$6.407 million and a new PACD of March 31, 1995.

The focus of the redefined Phase II would be on a comprehensive child survival (CS) and maternal health training package for district level health personnel, which would be implemented and field tested in two provinces, with needed modifications and improvements made prior to project completion. The training centered around an excellent, well-developed 10-Step Check System for all sick children, which was integrated with community education flipcharts, posters and pamphlets.

In the short time remaining, the USAID-funded CSSP completed the training of trainers and district in-service training of health workers in the two pilot provinces, but did not have adequate time to properly monitor and evaluate the program implementation post-training. The CSSP staff have done a remarkable job in coordinating child survival activities with other donors and PNG agencies since 1990 which I'm sure has helped in securing support from the Australian International Development Assistance Bureau (AIDAB) for a follow-on CSP project.

Recommendations

In general, the proper use of this 10-Step Check system will enable health workers -- especially the lower level health staff in rural areas, but also doctors and nurses in the urban clinics and hospitals -- to correctly identify priority child survival diseases and problems and provide the proper treatment, health education and referral if necessary, thereby improving the health care provided to infants and children in PNG.

I feel that the use of this 10-Step Check, as a teaching and diagnosis/treatment tool or methodology could be of value to health care providers here in the Philippines, as well as in other countries where USAID or other donors supports health programs.

I. BACKGROUND

A. Introduction

The Papua New Guinea Child Survival Support Project (PNG CSSP) was designed in 1989 by USAID with the government of PNG (GPNG), to improve the quality, efficiency and effectiveness of the delivery of maternal and child survival services in rural areas of PNG. The South Pacific Regional Development Office (RDO/SP) of the United States Agency for International Development (USAID), in Suva, Fiji, awarded the PNG CSSP to John Snow, Inc. (JSI), through a competitive contract in September 1990. The original PACD was August 31, 1997, with a projected USAID LOP contribution of \$9.4 million.

The project activities were designed to be implemented in two phases, with Phase I, lasting approximately three years, serving to supply the organizational, programmatic and technical foundation for Phase II. An interim evaluation of the CSSP in PNG was conducted in early 1993, which was used by the GPNG National Department of Health (NDOH), USAID and the TA contractor, in developing the plans for Phase II in August-September 1993.

In November 1993, the RDO/SP was told that the South Pacific program was one of 21 USAID missions worldwide which would be closed over the next three years, with the RDO/SP closing in FY94. The PNG CSSP project Phase II plans were not yet finalized at this time, and, as this project too would be terminated early, implementation plans were necessarily changed to meet the new decisions regarding the program and remaining life of the project. On May 26, 1994, the GPNG signed ProAg Amendment No.7, which was also then signed by the RDO/SP Acting Regional Director on June 3, 1994. The USAID LOP funding had been reduced from \$9.4 million to \$6.407 million. The PACD was changed from August 31, 1997 to March 31, 1995 -- a two years and 5 months reduction in project duration.

Due to early termination, the redefined Phase II activities of the shortened project could not be implemented in depth country-wide, while other activities were discontinued completely or cutback. The focus of Phase II would be on a comprehensive child survival (CS) and maternal health training package for district level health personnel, which would be implemented and field tested in two provinces, with needed modifications and improvements made prior to project completion. It was noted that time would be greatly decreased for necessary activity follow-up and adjustments in monitoring and training tools, due to the early project termination. By the end of project, it was planned that the training package and materials could be utilized by the GPNG wherever it saw fit, using various funding sources.

B. Statement of Work

As part of the consultant's SOW for the end-of-program evaluation of the Child Survival Project in the Philippines, a short visit to Papua New Guinea (PNG) was scheduled to assess the child survival "10-Step Check" system developed and implemented under the USAID-funded Child Survival Support Project (CSSP) in PNG. The evaluation would assess the effectiveness of the 10-Step Check, and also determine if this new methodology could be introduced in the Philippines (or elsewhere), or be used by other donors, in the delivery of child survival interventions.

During the post-PNG trip review with USAID/Manila OPHN staff, the evaluator was also asked to comment on the overall implementation of the PNG CSSP since June 1994 and present closeout status of the project.

C. Methodology

The evaluation was conducted by an external consultant contracted under a purchase order. She arrived in Port Moresby, PNG on 5 FEB 95 and went the same day to Goroka, Eastern Highlands Province (EHP) for six days, to attend the Planning Workshop for the Child Survival Training Programme. She accompanied the CSSP Chief of Party/Logistics Management Advisor (COP/LMA), Mr. Allan Bass and the CSSP MCH Physician, Dr. Keith Edwards. During this workshop, she was able to meet or hear from many national, provincial or district health officers, plus others who had an interest and involvement in child survival/training.

A one day field trip was made to the Gulf Province to assess the implementation status of the 10-Step Check system. A list of people contacted appears as Appendix B. Document review was conducted both in PNG and Manila, and the list of documents reviewed is Appendix C. Upon arrival in Manila, the consultant presented her preliminary findings to the OPHN Project Officer. Based on that debriefing, a format for the written report was outlined, and the report completed on 24 FEB 95.

II. THE PNG CSSP - PHASE II OF THE PROJECT

With the decision for early close-out of the PNG-CSSP, the project focused on achieving the ability to use a comprehensive training "package" covering a variety of child survival services for district level health workers. It would include training of trainers in two provinces, utilizing materials developed and field tested during this time period, with necessary modifications and improvements being made in the training package by the end of project. This set of materials could then be used country-wide by the GPNG.

Coordination activities at the central level would continue with various organizations involved in the national "Child Survival Crash Program," in which the government and NDOH focused attention and also resources on child survival interventions.

No new studies or research would be initiated - those already begun by November 1993 would be completed. Also, the project no longer focused on the institutional development of the Regional Support Units (RSUs) as of September 1993.

In order to establish in-country capabilities among the national staff for utilizing the outputs/products of the CSSP project, a "Child Survival Fellows" training program was instituted where personnel were selected to be a counterpart to a long-term advisor to work together on project activity implementation. This replaced the overseas short-term training activity from Phase I of the CSSP.

A. Project implementation since June 1994

1. Training.

The choice of the comprehensive training package in child survival services as the major focus of Phase II of the PNG CSSP proved to be most beneficial for the health workers in the health system as well as the women and children in PNG.

Two separate Training of Trainers (TOT) workshops were held in two provinces during this last 7 month period -- in Gulf and New Ireland provinces. The first TOT Workshop covered the use of the 10-Step check list and deskchart; introduction of the New Pediatric Standard Treatment Book; use of community education flipcharts and diagnosis, treatment and prevention of diarrhoea. The second TOT workshop was held after two months and covered additional problems of malnutrition, malaria, pneumonia and immunization issues.

Two health workers from every district in the province as well as selected provincial staff were trained at the TOT Workshops. They in turn provided district training on the selected topics to all levels of health workers, including the health center and aid post health workers during four health center-based in-service courses.

The goal of training all levels of health workers in Gulf and New Ireland provinces was met, with 308 and 477 health workers trained respectively. All received the complete package of training and community education materials. The implementation of this programmed approach to diagnosis and treatment with the integration of community health education messages and strategies proved successful.

2. Coordination of Child Survival Program Activities.

From my relatively short 11 day evaluation in PNG observing the CSSP program, I believe one of the major reasons for the success of the USAID-funded CSSP and the NDOH's CSP status is the present TA team - the COP/LMA, Allan Bass and the MCH Physician, Dr. Keith Edwards. As is usually the case, the success or failure of a program is dependent on its leadership, and their ability to interact with program staff and other agencies' personnel.

Both Allan Bass and Dr. Edwards have the enthusiasm, dedication and commitment necessary to promote CSP activities in general and their program specifically. More importantly, they are respected by their national staff, as well as by staff of other organizations with an interest or involvement in child survival.

The successful child survival activity coordination efforts are due to a mixture of personalities which clicked -- Dr. Hamid Houssaini, the UNICEF Country Representative; the honorable Peter Barter, the PNG Minister of Health; high level NDOH National staff; plus Allan and Keith -- and the combined commitment of them all towards a strong national Child Survival Program. The experiences of the USAID-funded PNG CSSP project provided some basis and impetus for the formation and coordination of the GPNG's Child Survival Crash Program which was initiated in October 1993 and launched country-wide in February 1994.

Because of the involvement of both the CSSP COP and MCH Physician with several NDOH and other GPNG groups involved with child survival, and their liaison with other health sector donors (AIDAB/ADB/WHO/UNICEF), positive groundwork was laid for the continuation of the CSSP in some form/activities when USAID funding ceases in March 1995. Being physically located in the same building with the NDOH has been advantageous for CSP coordination and communication.

The Primary Health Services (PHS) Division of the NDOH allocated a national counterpart Training Coordinator, to work with the MCH Physician and he became one of the Child Survival Fellows. Two other PHS employees were also allocated to assist in materials production for the training unit, which allowed for increased production and transfer of skills necessary for program sustainability. In August 1994, the COP/LMA began counterpart training in logistics management for CS and Primary health Care (PHC) for the newly appointed NDOH Family Health Logistics Officer.

B. A Planning Workshop for the Child Survival Training Programme, Goroka, Eastern Highlands Province, February 6-10, 1995

As a final coordination effort, a Planning Workshop for the Child Survival Training Programme was held in February 1995, in Goroka, EHP, which was attended by a cross-section of over 120 participants, from the NDOH, Provincial Health Divisions, UNICEF, CSSP, church/women's groups, NGOs, the National Department of Education and other GPNG personnel.

This workshop set the stage for the country-wide district in-service training of health personnel and the planning for health patrols for the provinces. It introduced the CSP Health Worker training and Health Promotion materials to the Provincial Health Coordinators, who would then have the responsibility to communicate this information to their fellow staff and implement the training in their provinces.

I was extremely impressed with the organization of this well-attended workshop and the focus on participation of the attendees in both the presentations and learning experiences. The quality of the training and health promotion materials was exceptional, as was the simplified algorithmic system of the 10-Step Check, with the integrated community education flip charts, posters and pamphlets.

A much needed addition to the health training program was the inclusion of training with a simplified financial planning and management system, which addressed the problems of weak managerial skills, accountability and numeracy both at provincial and district levels.

With all the key Child Survival players together, coordinated planning was possible for the upcoming year, for both district training in 10 provinces, plus the scheduling of MCH/Immunization patrols during the same period in all 19 provinces.

C. Constraints to project implementation

During this final phase of the CSSP project, finances remained a major constraint. The PNG government changed in September 1994, and a new Minister of Health took office. There was a freeze on

government expenditures along with a 12% devaluation of the PNG currency. Money previously allocated for restoration of rural health outreach patrols (two million kina) was lost. The government decided to operate on a continuing appropriation supply bill rather than submit the 1995 budget to Parliament in 1994. This action stopped new International Bank funding which included the Asian Development Bank Human Resource Development (ADB HRD) Project, which the CSSP had hoped would provide continuation of present training activities in the future.

Limited capability and space for materials production was a constraint, with periodic printing company backlogs. Purchase of additional equipment rectified some of these problems, but a major push will be on now (February 1995) to keep up with the production of materials necessary for the 20 new provincial TOT Workshops which are scheduled to be held one every three weeks from now through December 1995.

A major constraint to program implementation is communication and transport capabilities to training sites, in a country where both are difficult in most provinces. The radio systems are in disrepair, with non-functioning equipment. Proper supervision and monitoring of programs require transportation, by boat, air or land, depending on the district. With the financial crisis, money for transport became non-existent, which effectively stopped travel.

The decision to close out the CSSP program early in itself was a constraint to program implementation, especially waiting during the period while the final plans were being made, as it slowed the rate of on-going activities. Afterwards, there was not enough time remaining in the program to adequately monitor and supervise the training program implementation, in order to make the necessary modifications for final preparation of training materials before the project ended. This activity fortunately will be continued in the follow-on project, which will be funded by AIDAB.

D. Sustainability - Interim Support Project (ISP)

As soon as the final decision was made for early termination of the CSSP project, the TA team began seeking funding from other donors to continue project activities, especially the training of trainers and district in-service training of health personnel.

The USAID-funded CSSP project ends March 31, 1995. During the LOP, its experiences provided some basis and impetus for the GPNG's Child Survival Crash Program, initiated in October 1993 and launched country-wide in February 1994. Task forces at the provincial and national levels manage the program, which covers three main activities - assistance to MCH services, advocacy and multi-sectoral collaboration.

Due to the government's financial crisis, in November 1994, the GPNG requested assistance from the Australian International Development Assistance Bureau (AIDAB) to meet the CSP needs on an interim basis. In response, the Interim Support Project (ISP) was developed which is planned to cover the period between February/March 1995, after which the USAID-funded CSSP will end, and early 1996, when the AIDAB Maternal and Child Health (MCH) Project is planned to begin. This longer-term MCH project hopefully will continue many of the actions implemented in the CSP.

The ISP's objective is to provide interim support to the GPNG's CSP, in order to prevent illness and promote better health in women and children, and reduce childhood mortality. Activities will include delivery of MCH services through fixed facilities and mobile patrols to fully immunize children and give ante-natal care to women, including tetanus immunizations.

The ISP will also support increased competence of health personnel through training, by providing TA, in-service training courses, resource materials productions and distribution costs. Support will also be provided for a team leader and a trainer to provide technical assistance. It is planned that the inputs from Australia, estimated at a cost of AUSS\$ 5 million, will be managed through UNICEF in PNG.

E. Closeout status

At the time of this visit (February 5-15, 1994) close out activities were on schedule as per the monthly close-out plan submitted to USAID. Plans were being finalized between USAID/OPHN and CCSP PNG regarding the disposition plan for non-expendable fixed assets.

III. THE 10-STEP CHECK SYSTEM FOR ALL SICK CHILDREN

A. Overview

The 10-Step Check System for all Sick Children, along with the integrated community education flip charts, posters and pamphlets is an extremely innovative training methodology, made effective because of its simplicity. This package of materials was designed to aid in training as well as provide health education to patients and family.

The program centers on the 10-Step Checklist for All Sick Children deskchart, which enables the health worker to remember to ask about 10 important topics for each child, as well as the corresponding 10 pertinent areas to examine or check on the child, in order not to miss serious illnesses. If a problem area is detected, the third section in the deskchart provides information on the necessary actions to take. With every topic, the important parent education section is included.

This 10-Step Check is not meant, by any means, to replace a normal systematic check of body systems and history taking, which most medical personnel are taught to perform. What it does provide is an excellent screening tool for identifying childhood illnesses, which may go undetected during a clinic visit because the parent doesn't mention the problem, or the health worker may not remember to question the parent about anything besides the chief complaint.

The 10-Step Check desk chart provides continuous reinforcement of the important questions to ask, examinations to perform, and needed actions to take, and health education to give. The flipchart is placed on the desk with the instructions facing the health worker. On the opposite page, facing the parent/child, is a health promotion picture and message.

When a problem area is identified, the chart is flipped to the appropriate step, where the correct treatment and actions are given on the health worker's side, and the appropriate health messages and pictures linked to the disease are shown on the mother's side.

This training package also includes additional flipcharts, posters and pamphlets regarding important childhood diseases, such as Acute Respiratory Infections (ARI), diarrhoea, malaria, etc., which can then be used to further educate the parent about warning signs and preventive measures. A complete listing of the training and health education materials developed by the CSSP and which are available for health workers is shown in Appendix C. (Note: A training module for "The Role of the Aid Post Worker in Village Delivery", plus a "Care of the Mother and Baby After Village Child

Birth" flip chart have been developed by the CSSP. Neither were given out at the TOT Workshops of the Planning Workshop, as the priority focus for the initial district in-service training phase was first on the major global child health issues and target diseases.

B. Practical experience during the Goroka Workshop

In talking with the participants attending this workshop, it was gratifying to hear how so many people have only positive things to say about the 10-Step Check system. Dr. Bob Danaya, the Senior Pediatrician at POM Hospital and Senior Lecturer at the University of PNG stated that all medical students are taught the use of the 10-Step Check in their residency programs in Port Moresby. Matron Kathy Arttu, from Kavieng General Hospital in New Ireland Province, stated that the training program with the 10-Step Check was very successful. She said that "it was an eye-opener for all of us.... The hospital staff use this system, and even the doctors were now finding problems which were not identified for the patients before."

It was extremely interesting to observe the various participants practicing the use of the 10-Step Check system. Our 120+ attendees ranged from doctors, Health Extension Officers, nurses, non-medical health department personnel to non-health related participants.

We spent two mornings, rotating between a large urban clinic and the provincial hospital pediatric ward, working in groups of 5-8 with a preceptor/trainer. Utilizing the 10-Step Checklist desk chart was awkward at first, because we were not familiar with the questions or exam system, and the coordinated treatment located in the Standard Pediatric Treatment Book. By the third patient the first morning, the attendees were more comfortable with the process and system.

The second morning, I remember vividly one participant, a male nurse, who was so unsure of himself the day before, but now exuded confidence in his questions, exams and treatments this day. It was quite evident that he had reviewed the system the night before, and knew how to use the desk flipchart and Standard Pediatric Treatment Book. I found the same thing true of myself.

The best thing about the 10-Step Check system is that it provides all the questions and answers for the health worker, especially the aid post orderlies (APOs) in the PNG who may have been in service for 10-15 years, but who have received no in-service training during that time. These APOs, as well as the PNG Community Health Workers (CHWs), work in the periphery, by themselves, without the close supervision and contact with other health personnel. For them, it takes the guesswork out of diagnosing and treating children with 10 major health problems or

conditions. By asking the questions and doing the exams in a systematic way, the health worker cannot forget to inquire about these 10 problems, and also has the information needed to know how to treat the child and when to refer to another health facility.

C. Implementation status in Gulf Province

The Planning Workshop in Goroka, Eastern Highlands Province, was extremely timely and important, as it gave me an overview of the entire CSSP training program and the training and health education materials available. What I needed now was to evaluate health workers out in the field who had been previously trained in the use of the 10-Step Check System. I had only one day before I left PNG in which I flew round-trip to the Gulf Province, which was one of the two pilot provinces for the district in-service training.

The Gulf is a difficult province in which to travel. Accompanied by the NDOH MCH Coordinator, we went by vehicle to visit an APO and a health center. I wanted to see the APO actually doing an exam while using the 10-Step Check, but unfortunately, the tidal river was too high to cross in the morning, and by the afternoon, there were no more patients. The APO was an older gentleman who's been in service for 15 years. The APO did have the blue Standard Pediatric Treatment Book in his clinic, which was located in the small seaside village of Uami, but I did not see the pink 10-Step Check deskchart, which he said he had brought to his home. Some of the health posters were hung on the walls.

We next went to a district center clinic, with an inpatient capacity of 10, which was in the village of Malalaua. There were 3 nurses aids -- older women -- who worked in the pediatric clinic and community education room; a female midwife who was out in the district; and one male nurse. The Officer in Charge (OIC) was a Health Extension Officer (HEO), a 3 year-trained medical person, with skills below those of a doctor.

There were 2 copies of the pink 10-Step Check deskchart in the clinic area. There were no additional flipcharts or pamphlets on the various diseases which were supposed to be used for health education. There were health education posters on the walls.

The HEO OIC repeatedly stated what a wonderful system this was, and that all his staff knew how to use the 10-Step Check. He chose one of the nurses aides to demonstrate the use of the check. Unfortunately, this older woman had attended the in-service 7 months before, but had not practiced these skills as she did not have responsibility for examining and diagnosing. She only dispensed medicines when ordered. Therefore, out of fairness to her, the HEO should not have had her try to demonstrate this skill, as it was out of the realm of her regular duties.

Next, the male nurse was chosen to demonstrate the 10-step check system, which he was able to appropriately do, but he asked at the beginning if it was necessary to use the desk chart, as he would rather not use it. He was told by the HEO that he must do so, as we wanted to see the use of 10-Step Check deskchart demonstrated.

When we visited the urban clinic in the city of Kerema in the afternoon, we observed two nurses examining children. They used the deskchart, but both placed it on the desk -- facing away from the patient and mother -- and would only glance surreptitiously at the 10 points to check. There seemed to be a feeling among these health workers that patients/families may feel they lack knowledge if they have to look at the flipchart to ask questions. Again, also, there were none of the corresponding flipcharts or pamphlets used for health education of the mothers of the two children.

In all three instances -- but especially at the outlying aid post and Malalaua health center, the deficient factor was close supervision and monitoring of the program after the training of health workers and implementation of the 10-step check system in this province. This was the time of the government's financial crisis, where money for transport and travel was no longer available. One cannot expect compliance to a new system if the positive reinforcement and support is not available from the supervisors or trainers..

With the early termination of the CSSP, the training department did not have the time to go back to monitor project implementation, as their primary focus was preparing the training and health education materials and additional workshops before closeout. In reviewing this visit with the CSSP staff, they already had guessed that these observations would be in evidence. For the follow-on project, time and finances for transportation must be made available to put in place the necessary, proper monitoring, evaluation and supervision system for program implementation.

Another suggestion to be considered is the expansion of the in-service time spent on teaching the 10-Step Check system to spread over two days instead of one. As the use of the 10-Step Check is the center and focus of the system, time should be spent in the very beginning to enable the health worker to become proficient and comfortable with its use, before being sent out on his or her own, with possible limited supervision and support right after training.

D. Conclusions regarding use, potential effectiveness and transferability

1. The 10-Step Check system is a training methodology which can be used to train health workers in the rapid, but accurate, diagnosis and treatment of major child survival diseases and problems, at a very low cost.
2. It is a simplified algorithmic system which coordinates and integrates the aspects of history taking, physical examination, diagnosis, treatment plus health education using one main tool - a desktop flipchart called the 10-Step Check List for All Sick Children.
3. For countries such as Papua New Guinea, where many of the health workers may have received inadequate or limited basic medical training and who are located in extremely rural, isolated areas, the use of the 10-Step Check reinforces confidence and competence of these staff, many of whom haven't received any additional in-service training since their initial schooling.
4. By nature of the desktop flipchart, it automatically ties in and provides health education for the parent, as the pictures and health messages on the flipchart are facing the parent, while the health worker is reviewing the standardized diagnosis and treatment on the opposite side of the flipchart.
5. This modular training system is simple and effective. Again, with everything revolving around the 10 priority topics in the check list, additional materials on these topics -- which include a teaching module, flipchart, poster and community education pamphlet -- have been developed for topics on diarrhoea, ARI/pneumonia, immunization, malaria and malnutrition. The future plans include the completion of these materials for all ten topics.
6. This "training package" is a system. It has been developed for use with child survival topics and childhood diseases. Because it is a tool -- a methodology -- the concept also could (and should) be adapted for use in improving the health worker's skills and knowledge in the diagnosis, treatment and prevention of adult health problems and obstetrical problems.
7. For training of and use by health workers in developing countries, and even in developed countries for that matter, I think this 10-Step Check system is worthwhile and useful. It has several important features: it's simple; it's logical; it's not "high tech"; it's low cost; it doesn't involve the use of expensive medical equipment; it's adaptable to include local conditions and diseases; it's comprehensive - including history taking, physical exam, diagnosis, treatment and health education; and it's standardized with the same childhood disease protocols used anywhere else in the health system.

8. I support and would advocate the use of this 10-Step Check system. Its effectiveness will only be as good as the concomitant monitoring and supervision of the health worker learning and utilizing the system. As was observed in the field in the PNG, due to a variety of circumstances -- early program closure, government financial crisis, etc. -- adequate follow-up monitoring and supervision was not done for the pilot district in-service training in the Gulf Province. I feel that this will not be the case in the follow-on project, because the same CSSP training staff, who are committed to the success of the program, will be involved, and they realize this deficiency and the priority to rectify it.

9. In general, the proper use of this 10-Step Check system will enable health workers -- especially the lower level health staff in rural areas, but also doctors and nurses in the urban clinics and hospitals -- to correctly identify priority child survival diseases and problems and provide the proper treatment, health education and referral if necessary, thereby improving the health care provided to infants and children in PNG.

IV. RECOMMENDATIONS FOR USAID AND OTHER DONORS

1. I feel that the use of this 10-Step Check, as a teaching and diagnosis and treatment tool could be of value to health care providers here in the Philippines, as well as in other countries where USAID supports health programs. I have not had the opportunity to observe the midwives here in a barangay health station (BHS) in a rural area out in the periphery. It is here in the BHSs where I would judge this system would be the most beneficial, as these health workers work alone, without daily contact with other health personnel.

Again, this system does not take the place of regular systematic history-taking and examination routines -- it provides an additional reinforcement to remember to check 10 priority areas for sick infants and children. Therefore, it would not contradict whatever standard diagnosis and treatment systems were in place. It would only enhance them.

2. What would be necessary for USAID or other donors, such as UNICEF, to consider, would be the adaptation and modification of the 10-Step check to reflect a country's local conditions, as well as the treatment regimes/protocols supported by the agency or government. Donors may also have specific guidelines for diagnosis and treatment of various disease entities which they must follow and advocate. These, by necessity, would have to be considered in the modification of the 10-Step Check if it were supported.

V. LESSONS LEARNED

1. People make programs happen. They also make the difference in the success of program implementation. The special mix of the present players coordinating and advocating the Child Survival programs in PNG -- in the NDOH, GPNG, CSSP and UNICEF -- enabled the CSP to succeed.

Because this group had all "bought into the system" of Child Survival activities, and believed in what they were doing, they were able to instill the same feelings in other groups -- other government departments, women's and church groups, NGOs, etc -- thereby redirecting the orientation of health supporters towards primary health care and preventive measures rather than curative care.

2. Community participation and involvement is essential to the success and sustainability of child survival activities. The PNG communities were very active in the form of women's groups, church groups and local government groups - all were resources which agencies tapped to support child survival interventions. Village outreach patrols, a former PNG health intervention, are again a priority in the present CSP activities and are successful because of the cross-sector community support.

3. If a program is to be effective and successful, as much emphasis as is placed on materials production and training must be placed on supervision and monitoring, which are also vital aspects of program implementation .

4. The USAID decision to close out their RDO/SP program, with resultant closure of the CSSP project stimulated a positive change. New funding and donors were found for child survival activities, and continuation of former USAID-funded training program activities was insured.

SCOPE OF WORK FOR EVALUATION IN THE PNG

From the Public Health/Service Delivery Specialist's scope of work:

F. Level of effort: Specific Tasks

7. "On the way to the Philippines, the Public Health/Service Delivery specialist will make a short visit to Papua New Guinea (PNG) to assess the child survival system developed and implemented under the USAID-funded program in (PNG). The new system is called the "Ten Step Check." The Ten Step Check is a new methodology in the diagnosis and treatment of sick infants and children. The system also - importantly -- includes a related health education program for the community. This new system has been implemented in PNG over the last year. No literature has been published on the system; however, the Contractor has written (and the cognizant project officer agreed) that "The Ten Step Check material... opens an important new tool in diagnosis and treatment of sick children with (possible) world-wide application..." The evaluator - an expert in this field - will assess the effectiveness of the Ten Step Check and, as the Philippine CSP is being conducted, s/he will determine if this new methodology can be introduced to the Philippines in the delivery of child survival interventions. Although the evaluator will spend a small amount of time in the PNG, this aspect of the evaluation is for the benefit of the Philippines."

LIST OF PERSONS CONTACTED

Division of Health, Gulf Province

Mr. Luke Furigi, ASH
Mr. Robert Saliou, Rural Health Coordinator
Mr. Simphorian Simun, Health Extension Officer

Division of Health, New Ireland Province

Sister Kathy Arttu, Matron, Kavieng General Hospital

Government of Papua New Guinea

Mr. Peter Barter, Minister of Health

John Snow, Inc., The Child Survival Support Project (JSI/CSSP)

Mr. Allan Bass, COP and Logistics Management Advisor
Dr. Keith Edwards, MCH Physician
Mr. Kanawi Kanandru, Training Coordinator

National Capital District (NCD)

Dr. Robert Danaya, SSMO, Port Moresby General Hospital and
Senior Lecturer, University of Papua New Guinea, POM

National Department of Education, Government of Papua New Guinea

Ms. Pauline Doonar, Senior Curriculum Development Officer

National Department of Health, Government of Papua New Guinea

Dr. Hilda Polume, MCH Coordinator
Dr. Issac Ake, National Coordinator Child Survival Project
Dr. Timothy Piakalyia, FAS (PHS)
Ms. Thalia Wat, Senior Nutritionist, NCSP Secretariat

Papua New Guinea Council of Churches

Ms. Kit Mawason, Secretary, Women's Desk

United Nations Children's Fund (UNICEF)

Dr. Hamid Hossaini, Country Representative

United State Agency for International Development

Mr. Douglas Palmer, Project Officer, OPHN, USAID/Manila

MAJOR DOCUMENTS REVIEWED

Asia Development Bank

Draft Report of a Project Preparatory Technical Assistance on Human Resource Development in the Health Sector in Papua New Guinea. May 1994

Australian International Assistance Bureau (AIDAB)

Papua New Guinea Child Survival Program Interim Support Project (Draft Design Document). February 1995

Department of Health (PNG)

Standard Treatment for Common Illnesses of Children in Papua New Guinea. A Manual for nurses, health extension officers and doctors. 6th edition 1993

Department of Health and the Child Survival Support Project

Training Materials for Health personnel

The 10-Step Checklist for All Sick Children. A desktop flipchart for health personnel.

The 10-Step Checklist for All Sick Children. Module. An In-service Course for District Health Workers.

The Diagnosis, Treatment and Prevention of Diarrhoea in Children. An In-service Course for District Health Workers.

Pneumonia (ARI) Diagnosis, Treatment and Prevention. Module. An In-service Course for District Health Workers.

Malnutrition Diagnosis, Treatment and Prevention. Module. An In-service Course for District Health Workers.

Trainers Workbooks for TOT Workshops 1 and 2.

Program Coordinator's Workbook for the Planning Workshop for the Child Survival Training Programme.

The Role of the Aid Post Worker in Village Delivery. An In-service Training Module for Aid Post Workers.

Mid-Upper-Arm-Circumference (MUAC) Tape with treatment regime.

Training Materials for Community Education:

A Happy Health Family in PNG. Flipchart, poster and pamphlet.

Diarrhoea and Your Family. Prevention and Treatment. Flipchart, poster and pamphlet.

Cough and Fast Breathing Sickness in Children (Pneumonia/ARI). Prevention and treatment. Flipchart, poster and pamphlet.

Good Food for Mothers and Children in PNG - The Six Nutrition Messages. Flipchart; and More Food More Often Every day will make Your Child Strong and Healthy. Flipchart, plus nutrition poster and pamphlet.

Malaria and Your Family. Prevention and Treatment. Flipchart, poster and pamphlet.

Injection Poster.

Immunizations to Protect Your Family. Flipchart, poster and pamphlet.

Care of Mother and Baby after Village Child Birth. Flipchart.

Department of Health and UNICEF

Crisis in Paradise. The State of Papua New Guinea's Children. A call to action. Port Moresby. 1993

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Option Two Proposal to USAID/Manila and USAID/RDO/SP. Papua New Guinea Child Survival Support Project.

The CSSP Quarterly Reports to USAID: October - December 1993

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ADDENDUM TO

A TRIP REPORT ON THE EVALUATION

OF

THE TEN STEP CHECK SYSTEM FOR ALL SICK CHILDREN:

A CHILD SURVIVAL INTERVENTION DEVELOPED AND IMPLEMENTED BY

THE CHILD SURVIVAL SUPPORT PROJECT
USAID Project 492-0017-C-00-0073-00

IN PAPUA NEW GUINEA

Prepared for:

The U.S. Agency for International Development/Manila

Prepared by:

Mary Aalto Leiter, RN, BSN

March 14, 1995

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Upon the request of Dr. E. Voulgaropoulos, OPHN Chief, USAID/Manila, I hereby submit a brief follow-up on two points in my trip report on the evaluation of the 10 Step Check for All Sick Children in Papua New Guinea:

- A. Description of CSSP activities which will be continued in the follow-on AIDAB-funded Child Survival Project; and
 - B. How best to disseminate the "10-Step Check System for All Sick Children" in the USAID system.
- A. Description of CSSP activities which will be continued in the follow-on AIDAB-funded Child Survival Project.

I contacted Allan Bass, the CSSP COP in PNG, requesting an update on the status of the AIDAB CS project, titled: Australian Assistance to the Papua New Guinea Child Survival Program (see Attachment A for the complete e-mail report dated March 7, 1995).

This project begins March 21, 1995 and ends December 31, 1996, enabling continuity of any activities presently funded under the CSSP, which will end March 31, 1995. Following is a list of the USAID-funded CSSP activities which will be continued in the new AIDAB project:

1. Training. The CSSP health worker training model (which has been piloted during CSSP in two provinces) will be utilized in the remaining 18 provinces enabling all health workers to be trained in Child Survival and Safe Motherhood interventions. The "package" (10 Step Check System, modules, flipcharts, posters and pamphlets, etc.) of all JSI/USAID/CSSP-developed interventions will be utilized, as well as other appropriate interventions.
2. The provincial level Training of Trainers, as well as the district level in-service training conducted at health centers, which was initiated in the CSSP, will be continued. These trainings will be held at every six month and every four month intervals respectively, in order to guarantee routine scheduling of health worker training.
3. As one focus of CSSP project support to the PNG national Child Survival Program, the USAID CSSP had advocated the restoration and revival of outreach services. The new AIDAB project will support annually four outreach patrol visits to each PNG community, as well as providing recurrent cost funds (fuel, some transport costs and travel allowances, to be negotiated case by case).
4. Monitoring and evaluation. A UNICEF consultant (Allan Bass, former JSI USAID CSSP COP) will conduct quarterly evaluations. The reporting system utilized in the CSSP training model will continue to be used. Also, reporting systems for outreach

patrols will be developed and implemented.

5. In the new AIDAB project, the financial management model (which includes procedures and methods to address funding problems for non-hospital health services), which was developed in the CSSP, will be utilized to manage all project fund disbursements for outreach patrols and training in all PNG provinces. The financial model application is considered a CSSP project training component, which covers the subject and methods of achieving financial accountability.
6. Dr. Keith Edwards, the CSSP MCH Physician, will be coordinating training in the new AIDAB Project. He will also be UNICEF's program manager for the project. Dr. Edwards is a great human resource, and his continuing involvement in the new project assures quality of and dedication to child survival interventions, especially training.

Two other items of interest noted in the March 7, 1995 e-mail from Allan Bass:

1. The ADB has proposed and signed a Memorandum of Understanding with the GoPNG for a proposed Human Resources Development Project for the Health Sector, for US\$ 24 million over a 5 year period. Due to the PNG financial crisis, the implementation has been delayed till probably 1996 - 1997. Of note: the institutionalization and continued implementation of the USAID CSSP district health worker training model is the core component of this proposed project.
2. The national Department of Finance and Planning have agreed to the use of the CSSP developed financial management model in the new project. Following that agreement, the ADB/World Bank/AIDAB-funded population project (stalled over 8 months due to PHN government financial crisis), for US\$ 35 million over 5 years, has been instructed to implement the same CSSP financial management model in the 5 provinces covered by their project.

I think the utilization of many CSSP components in the new AIDAB CSP program, plus the two additional donor examples, speak highly of the USAID-funded PNG Child Survival Support Project and its staff, and the sustainability of many of its interventions. Its is a rewarding end to a USAID-funded project closeout.

B. How best to disseminate the "10-Step Check System for All Sick Children" in the USAID system.

1. The 10-Step Check System is actually one component of a complete health worker training model. As such, it cannot be "sold" separately. It must be advertised and sold as a total training "package". This package is the 10-Step Check system

-- a training methodology which can be used to train health workers in the rapid, but accurate, diagnosis and treatment of major child survival diseases and problems, at very low cost.

2. This modular training system is simple and effective. With everything revolving around the 10 priority topics in the 10-Step Check List, additional materials on these topics -- which include a teaching module, flipchart, poster and community education pamphlet -- have been developed for topics on diarrhoea, ARI/pneumonia, immunization, malaria and malnutrition. (The future plans include the completion of these materials for all ten topics). Training of Trainers Workshops manuals have also been developed.

At present, the complete health worker training model contains the following materials:

A. CSSP Training Materials for Health personnel

1. The 10-Step Checklist for All Sick Children. A desktop flipchart for health personnel.
2. The 10-Step Checklist for All Sick Children. Module. An In-service Course for District Health Workers.
3. The Diagnosis, Treatment and Prevention of Diarrhoea in Children. An In-service Course for District Health Workers.
4. Pneumonia (ARI) Diagnosis, Treatment and Prevention. Module. An In-service Course for District Health Workers.
5. Malnutrition Diagnosis, Treatment and Prevention. Module. An In-service Course for District Health Workers.
6. Trainers Workbooks for TOT Workshops 1 and 2.
7. Program Coordinator's Workbook for the Planning Workshop for the Child Survival Training Programme.
8. The Role of the Aid Post Worker in Village Delivery. An In-service Training Module for Aid Post Workers.
9. Mid-Upper-Arm-Circumference (MUAC) Tape with treatment regimen.
10. Standard Treatment for Common Illnesses of Children in Papua New Guinea. A Manual for nurses, health extension officers and doctors. 6th edition 1993 (developed by the PNG DOH).

B. CSSP Training Materials for Community Education:

1. A Happy Health Family in PNG. Flipchart, poster and pamphlet.
2. Diarrhoea and Your Family. Prevention and Treatment. Flipchart, poster and pamphlet.
3. Cough and Fast Breathing Sickness in Children (Pneumonia/ARI). Prevention and treatment. Flipchart, poster and pamphlet.

4. Good Food for Mothers and Children in PNG - The Six Nutrition Messages. Flipchart; and More Food More Often Every day will make Your Child Strong and Healthy. Flipchart, plus nutrition poster and pamphlet.
 5. Malaria and Your Family. Prevention and Treatment. Flipchart, poster and pamphlet.
 6. Injection Poster.
 7. Immunizations to Protect Your Family. Flipchart, poster and pamphlet.
 8. Care of Mother and Baby after Village Child Birth. Flipchart.
3. The present materials are undergoing some modifications for changes noted from the results of the two pilot programs and this evaluator's observations. Afterwards, the final materials will be printed/mass produced. When this process and the completion of the remaining support materials for the 10 topics is done, USAID should contact Dr. Keith Edwards, who will be the Program Manager of the new AIDAB CSP, as well as the coordinator for training. USAID's intentions for using this training model in other areas should be discussed, as well as the possibility of Dr. Edwards writing a brief monograph regarding the model, and how it could best be modified and utilized in other countries.
4. USAID should seriously consider sending a representative -- from a country which they feel might be able to utilize this training model -- to the PNG to actually see the training system being implemented. This is by far the best advertisement for the system, as well as allowing the representative to discuss program problems and successes, and best methods for modifying the program to meet country needs, with Dr. Edwards and the rest of the staff. At the same time, details and logistics for materials production can be viewed and discussed.

Again, I feel that the use of this 10-Step Check, as an effective, useful teaching, diagnosis and treatment tool, could be of value to health care providers here in the Philippines, as well as in other countries where USAID supports health program. I would strongly support its modification and implementation in and for other countries.

In general, the proper use of this 10-Step Check system will enable health workers -- especially the lower level health staff in rural areas, but also doctors and nurses in the urban clinics and hospitals -- to correctly identify priority child survival diseases and problems and provide the proper treatment, health education and referral if necessary, thereby improving the health care provided to infants and children. USAID's child survival strategies would be well supported by the utilization of this training model.

ANNEX 3

***PNG Minister of Health's March 1995 Draft
National Health Policy White Paper***



DEPARTMENT OF HEALTH

DRAFT POLICY PAPER

14 February 1995

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I. INTRODUCTION

In December 1994, the Minister for Health, Honorable Peter Barter, appointed a Ministerial Advisory Committee to advise him on ways to improve national health services. In a consultative process drawing on the experience of more than 70 experts from the NDOH, UPNG, the Church Medical Council, WHO, UNICEF, representatives from professional associations including the National Doctors Association, PNG Nurses Association, CHW Association and Laboratory Technicians Association, bi-lateral development agencies, and representatives from the wider community, nine Sub-Committees were established to "review relevant areas of Health and to propose policy, strategies, resources and Management Systems that could assist in improving the Administration and the delivery of health services in the Country."

All nine Sub-Committees and their members were brought together on 24 January 1995 to report their findings and recommendations. The presentations were followed by a half day of discussions which highlighted areas where reforms are urgently needed. The Minister for Health then appointed a Drafting Committee to develop a draft policy paper based on the reports and discussions of the Ministerial Advisory Committee.

The Drafting Committee met frequently to pull together the findings and recommendations of the Ministerial Advisory Committee. Other resource materials were also consulted including:

- o The National Health Plan 1991-1995
- o Recommendations of the National Health Conference - 1994
- o Policy Statement on Health Services Presented to Parliament by Minister for Health, Honorable Francis Koimanrea, September 1993
- o A National Plan for Quality Assessment and Assurance in the Health Services of Papua New Guinea, NDOH, MSH, March 1993

The Drafting Committee also made visits to the Department of Finance and Planning, Budget Division, and to the Director of the Constitutional Commission. The purpose of these visits was to explore the feasibility of proposed legislation being considered for the Draft Policy Paper.

The Minister for Health has indicated this draft policy paper will serve as the foundation for the development of the National Health Plan 1996-2000 underlining the long term importance of the policy recommendations.

While the Drafting Committee has attempted to include and reconcile all recommendations in the draft policy paper, priority has been given to the areas of structure and management which determine the ability of the National Health System to deliver health services and improve the health status of the Nation's people.

FORMAT OVERVIEW

The Draft Policy Paper is structured into five Sections, each prefaced by **Highlights** of the Section, enclosed in a box. Following the introduction, the five Sections are:

II. Statement of Issues

This section presents a critical review of the issues and problems facing the National Health System. While the causes of certain problems may be evoked, no attempt is made to provide an in-depth analysis of the failure of existing systems. Solutions are also not presented in this section but further on, in Section V.

III. Priorities

Intentionally kept simple to be focused, there is no absolute ranking of priorities. A goal statement is made and two critical areas identified for reform. Specific priorities are listed, but not ranked; many are concurrent and/or overlapping.

IV. General Policy

This section comprises general policy statements made in several broad areas of consideration. The priorities listed in Section III are widely reflected in the policy statements. They also set the stage for detailed policy given in the next section.

V. New Policy, Initiatives and Strategies

This section develops new policy in nine areas as follows:

- Organization Structure of Health Services
- Health Finance Alternatives
- Health Promotion and IEC
- Preventive Health Services
- Curative Services
- Medical Supplies and Equipment
- Human Resource Development
- Health Research
- Monitoring and Evaluation

For each of the nine areas, the *Policy Statement* is followed by *Proposed Supporting Legislation* where appropriate. These are followed by *Management Initiatives and Strategies* required to implement the stated policy and/or implementation of the proposed legislation.

II. STATEMENT OF ISSUES

Highlights

- o The health of the Nation's people is not improving. Too many women and children continue to die from *preventable* causes. Our rural people are at highest risk.
- o Our hospitals, health centers and aidposts are in terrible condition. Their water systems don't work, electricity is often cut and they are filthy.
- o Health promotion and preventive health services are critical to the improvement of health status among our rural people. Yet both suffer from lack of coordination, poor management and unstable funding.
- o Most of our resources go to urban-based hospitals. They are increasing in size and complexity, yet they are poorly managed and inefficient.
- o Medical supplies and equipment are either in short supply or not available in our health facilities, particularly in the rural areas.
- o Dual government health structures have impaired the delivery of health services. The NDOH cannot properly manage national programmes in the Provinces and cannot provide effective leadership.
- o Funding by the two levels of government is not coordinated nor is it complementary. Funding levels have been unstable and expenditure poorly managed. Standards vary from Province to Province. The allocation of resources has traditionally favored urban-based curative health services.
- o Personnel management regulations are not enforced; discipline and respect for hierarchy are lacking. Staffing levels are variable and promote inefficiency. Direction and long term planning do not exist.
- o Research in priority areas lacks coordination. Results are poorly disseminated and are not used to improve services.
- o Monitoring and evaluation are essential management tools, yet they are lacking in the National Health System.

1. Health of the Nation's People

The indicators of health status, used to measure the health of communities and populations, are not improving in Papua New Guinea. They are:

- o Infant mortality, or the death of babies under one year of age, is 72 per 1000. This means about *24 babies die every day in Papua New Guinea.*

- o Child mortality remains high and has shown no improvement over the last 5 years. PNG has the highest under five child death rate in the Pacific Region; 14,000 to 15,000 children die each year before the age of 5. This represents 38 to 41 child deaths *each day*.
- o Poor nutritional status, under-nutrition and malnutrition affecting brain and body development, is a persistent problem among children under 5 years of age. At least 40 out of every 100 children are not receiving proper nutrition; PNG ranks lowest in the Pacific Region.
- o Maternal mortality, the deaths of mothers during childbirth, is among the highest in the world: *1000 women die in childbirth every year*. Studies reveal the death of a mother is followed by the death of half her children within five years.
- o We are losing the battle against the diseases we suffer from most often (Pneumonia, Malaria and Diarrheal Disease).
- o More and more of our people are suffering from Tuberculosis, Sexually Transmitted Diseases and AIDS.
- o Preventable diseases such as measles, tetanus of the new-born and whooping cough still remain at unacceptably high rates. Immunization coverage for preventable diseases is decreasing nationwide. Papua New Guinea has the lowest immunization coverage in the Pacific Region. In 1993, coverage dropped to an estimated 30% to 40%, about half the coverage in 1989 or equivalent to 1985 levels.
- o Our people are not *informed* nor are they *aware* of important everyday behavior that can greatly improve their health. The population's attitude in health matters is still overly dependent on Government and curative health services.
- o Urbanization and the pressures of western life styles have given rise to new health problems including hypertension, obesity and heart disease.
- o The growth of unplanned settlements surrounding urban zones presents new and serious challenges in health. Crowded, lacking water and sanitation, the settlements breed diarrheal disease, typhoid and tuberculosis. They also give rise to sexually transmitted diseases and AIDS.
- o Water supply and sanitation coverage in PNG's rural communities is poor. PNG ranks among the bottom 10 nations world-wide in terms of the population's access to clean, safe water. As a result, many of our children suffer from life-threatening diarrheal diseases.

2. Condition of Health Delivery Services

In contrast to assertions by most politicians, both at the national and provincial levels, that "health is the first priority", the funding of health services has been unreliable and poorly managed. Support by the Department of Works, the Department of Personnel Management and local communities is sorely lacking.

Standards for health delivery operations, for maintenance, for management both of personnel and finances are ill-defined, poorly implemented and rarely monitored. They also vary greatly from Province to Province, District to District and even among health facilities in a same District. Widespread land issues persist. At the same time, the decline in law and order are adversely affecting all government services. The consequences are evident in the following observations:

Aidposts Poor support, supervision and virtually no in-service training have led to a general deterioration in physical facilities and operations. APOs work on their own in very isolated conditions. APO skills are limited to treating injuries and disease. They are currently not qualified for promotive or preventive services nor do they assist in births. Many APOs are near retirement yet there are no provisions for their replacement. Aidpost closures are reported to be on the rise.

HC / HSC Widespread infrastructure deterioration is accelerating as building and equipment maintenance is insufficient or non-existent. Non-functional water supply systems, discontinued electricity and near total absence of cleaning materials are frequent. Service delivery is heavily inclined towards curative services. Few health personnel are adequately trained in promotive and preventive health and MCH activities. MCH patrols into remote rural areas are rarely undertaken, a casualty of funding cuts. HC / HSC suffer from staffing problems; they do not provide adequate support and supervision to the aidpost level. Many also operate in isolation as road and communication networks fail to reach them.

Hospitals Poor building and equipment maintenance have become standard. Many hospitals are in arrears on utility payments and other basic inputs. Patient accommodations are unhygienic and deteriorating. There is near total inability to continue the provision of inpatient meals and repatriation. Hospital management has deteriorated over the years and individual personalities and standards characterize each section, each department. Hospitals no longer extend their greater skills and experience to the Health Center / Health Sub-Center level and the rural populations. General OPD services are overburdened and specialist care is limited. Security problems are increasing.

Personnel Staffing levels are often too low or too high. Poor attendance and punctuality by health staff, administrative staff and labourers is pervasive. Supervision is lacking at all levels of the public health system. Both

patients and senior officials have indicated a serious attitude problem exists among public servants and casuals employed in the government public health system. Unproductive and redundant staff are retained by a system that cannot manage itself.

3. Health Promotion and IEC

While health promotion and education are recognized pillars in the overall strategy to improve national health status, they have suffered from a lack of coordination and management, and have made inefficient and ineffective use of funding. To date, there has been little *demonstrated* commitment in health promotion and education.

National health promotion activities are not integrated in their practice at the provincial and district levels which results in diminished impact. Language diversity is a particular problem.

Programme development has been inadequate. Communication materials are poorly designed, untested, inconsistent and insufficient in their production.

Available media (face to face exchange, radio, TV and the press) for production and distribution of health promotion messages have been under utilized, poorly utilized (production values are poor) and not utilized in concert with service delivery and community organizing efforts.

Basic hygiene promotion with great potential for improved rural health does not reach villages.

Health personnel in the National Health System often do not set the proper example as well as they might.

4. Preventive Health Services

Lack of coordination in dealing with preventable diseases is a chronic problem. The NDOH's inability to control national health programmes for the prevention of Malaria, Tuberculosis, Leprosy, STDs, AIDS-HIV and others is rooted in poor structural organization and insufficient and unstable funding.

Ill-defined roles in the dual levels of government and the lack of commitment at the provincial level have led to the breakdown of important, life saving national health programmes.

The three top causes of adult hospital admissions are Pneumonia, Diarrheal Disease and Tuberculosis. These three diseases account for most hospital inpatient days. Much can be done to reverse this situation.

When money is in short supply, budget reductions have traditionally been in the areas of health prevention and health promotion.

Current legislation is inadequate in addressing public health problems. The principal weaknesses are:

- o Authority at the NDOH level to ensure programmes are implemented at the provincial level is lacking.
- o Current legislation is inappropriate and outdated resulting in very broad interpretation, conflict and inaction.

Hygienic conditions, on the personal level and community level (sanitation), continue to be very poor in rural areas and in urban settlements. Clean, safe water is a scarce resource.

Logistic support for MCH services and the patrol system is collapsing for lack of funding. Immunization in remote rural areas is not taking place and the incidence of preventable childhood diseases is on the rise. Women do not have access to modern contraceptive methods.

Community *awareness* of preventive practices is very low resulting in persistent, dangerous behavior patterns. This can be attributed to inadequate health promotion.

5. Curative Services

Curative health services receive a disproportionate share of funding (51% for hospitals alone) and serve mostly the urban minority to the detriment of primary health care services serving the rural majority.

Hospitals are not providing support to rural health services in the form of training, outreach services and through communications.

There is a general shortage of adequately trained staff (nurses and specialists) resulting in an inequitable distribution of these staff. Many specialists either do not enter or leave the public health system for the private sector.

Hospitals have increased in size and complexity while becoming less efficient. Too much effort is expended on general outpatient service delivery and in outpatient paediatric care where these services should best be provided at the Health Center level. Access to hospital services by rural populations who need these services is difficult.

Persistent poor hospital management has resulted in the inefficient delivery of services carrying very high costs. Key hospital management issues are:

- o Inadequate financial management and accounting practices.

- o Lack of procedures and internal controls resulting in the loss and abuse of hospital equipment, supplies and other resources.
- o Severely neglected maintenance of equipment, buildings and facilities resulting in their accelerated deterioration.

The referral system is not working. Patients frequently bypass primary care facilities for direct access to a hospital. Those patients who are referred to a hospital often arrive too late.

The role of Hospital Boards needs further clarification.

6. Medical Supplies and Equipment

All too commonly, medical supplies and equipment in health facilities are either in short supply or they are not available. The further removed the health facility from an Area Medical Store, the less well it is supplied. Health facilities serving the remote rural populations have the greatest problems being adequately supplied.

Funding levels for the procurement and distribution of medical supplies have not been stable. Disbursements are irregular and greatly affect the efficiency of operations.

National government financial rules and regulations are not appropriate for the complex procedures required for the procurement and payment of imported medical supplies. The application of the GPNG financial procedures has led to significantly increased costs (10% to 20%) and delays (3 months to 9 months) in the provision of drugs and equipment.

Personnel employed in the procurement, receipt, inspection, warehousing and distribution of medical supplies often lack the necessary skills and training for their respective tasks. Some key positions are not filled.

There is no accountability for drugs, supplies and equipment received by Hospitals, Health Centers and Aidposts. Inventory records are not maintained by these facilities. This results in waste, theft and loss.

Warehouse management and distribution of medical supplies and equipment by the Pharmaceutical Services Section of the NDOH are consistently inefficient and ineffective.

Provinces have no responsibility in the distribution of medical supplies and equipment.

While, in practice, the NDOH functions with a limited set of drugs, it has not defined and implemented an essential drug policy.

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7. Structure and Management of the National Health System

7.1. Decentralization

Implementation of health services, under our decentralized structures, has been tried over many years and found to be lacking in control. There currently exists a multiplicity of provincial mechanisms and standards which have undermined the leadership and management responsibilities of the National Department of Health.

Under the Organic Law on Provincial Government, section 27, national health policy is legally binding on Provinces. However, it is rarely implemented.

The respective roles and responsibilities of the different levels of government and their administrations are poorly defined and subject to broad interpretation.

MUG has spelled poor performance in many health areas, particularly in terms of inadequate support to rural health services resulting in poor service delivery to rural populations.

While Provinces are given broad responsibility and authority in health matters, they are not held accountable. Reporting by Provinces to the NDOH on health and financial matters related to health is poor or non-existent.

Among the transferred and delegated health functions, Disease Control, Family Health including immunization activities and nutrition, and Environmental Health, all have poor performance records.

Village water supply and sanitation rely on small provincial teams led by health inspectors not directly answerable to the NDOH.

7.2. Church, NGO and Private Health Services

Church Health Services

Many Churches have a long tradition of providing health services in Papua New Guinea. Commonly, they serve the people most in need in remote, rural areas. These geographic areas present a special challenge that often require unique solutions. *Self-reliance* is the common ground, the underlying strategy. *Community* interest and their active participation in supporting church health services make it possible and successful.

Church health services are recognized as both more efficient and more effective than their government counterparts. There is a strong preference by the people for church health services over government health services.

However, there is a lack of financial coordination between the Churches, the NDO and provincial health authorities. This has undermined an otherwise solid relationship.

NGO Health Services

While most NGOs seek government collaboration and are cooperative in integrating their valued health services within the government health infrastructure, some elect an independent posture relative to both national and provincial authority. This situation results in the establishment of new health facilities in areas already served and leads to competing facilities.

There are also examples of health facilities being established without proper consultation with provincial or national authority and which expect their recurrent costs to be provided for by the Government.

Private Health Services

Private health services are expanding in response to growing demand, mostly in urban areas. The growth in the private sector will help to serve the small but growing urban minority who can afford such services. However, there are cases of private health facilities not providing standard preventive services. Private health services also do not systematically report as required by law. The NDOH does not adequately monitor private health services with respect to standards of service and the level of fees charged.

8. Financing of the Health System

Central government funding for health, on a per capita basis and taking inflation into account, is shrinking.

Provincial government funding is uncertain, variable, often unverifiable and almost always insufficient. While the initial health budget may be adequate, a change of scope or priorities sees the funds used elsewhere.

Government health facilities are neglected. They are not receiving resources through existing channels. For an increasing number of facilities, their continued operation at the minimum acceptable level is in question.

The complexity and bureaucratic tangle of government financing mechanisms is contributing to the decline of the health infrastructure. Responsibility is bounced between the different government levels as a continuous debate on power sharing, delegation and the transfer of functions make action less likely and more inefficient.

Fewer than half of the Provinces have passed a *Provincial Health Administration Act*. There are different standards for each Province.

Hospitals' share of the health budget is increasing each year to the detriment of primary health care and the rural populations.

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Fewer than half of the Provinces have passed a *Provincial Health Administration Act*. There are different standards for each Province.

Hospitals' share of the health budget is increasing each year to the detriment of primary health care and the rural populations.

Hospitals currently collect user fees. Revenues are in the 2 to 4 percent range of operating expenditures.

Hospital trust accounts are burdened with excessive controls by non-hospital managers.

More than half of the population are exempt from paying hospital fees.

With or without a legal framework, most Health Centers and Health Sub-Centers already collect user fees. Fees collected in government Health Centers are, in most cases, relinquished to provincial Bureau of Management Services. Accounting and internal controls are weak. There is little or no reporting.

Provincial use of revenues generated through health services is unknown. However, the severe neglect of health facilities would indicate revenues are not returned to them.

9. Human Resource Development

The organizational structure for the management of human resources is fragmented, lacks coordination and has resulted in the pervasive absence of authority and the shunning of responsibility in personnel matters.

Department of Personnel Management regulations are not enforced to the point of becoming meaningless. Department of Personnel Management retains ultimate authority over personnel matters but fails to exercise its responsibilities. Attendance and punctuality in the public health sector are poor and disrupting to the delivery of health services. Self-discipline and commitment are increasingly difficult to find. Respect for hierarchy is severely lacking. A serious attitude problem exists among many health sector personnel and is of great concern to patients and senior officials alike.

Staffing levels vary from Province to Province and among similar health facilities. The proliferation of administrative positions and additional levels of government translates into clinical staff being drawn away from the delivery of health services. As more money goes into administrative staffing and its support, less and less is made available for the actual delivery of health services. Thus, in some Provinces with relatively stable health budgets, their health services are failing from increasingly "top heavy" structures.

Career management and performance-based advancement are not practiced.

The NDOH is not providing direction in personnel matters and is not planning for future human resource needs in the health sector. While many APOs are near retirement age, no provisions have been made for their replacement. The shortage of certain specialists (doctors, dentists and radiographers among others) is not improving.

There is currently no established system to disseminate information among health personnel, from the NDOH to Health Centers and through to the Aidpost level.

Professional, technical and management training has not been linked to health sector needs.

While the quality of care in the health sector is recognized as wanting, there has been little in-service training. APOs and CHWs lack promotive and preventive health skills. Training in management skills, at all levels, is insufficient.

10. Health Research

Health related research is carried out by the PNG Institute of Medical Research, the National Research Institute, the Medical Faculty of UPNG, the Department of Health, the Population and Family Planning Project, and Ok Tedi Mining Ltd. While these institutions produce much new and pertinent information, dissemination is limited and the utilization of research findings is poor.

Direction and the coordination by the NDOH of research efforts in priority areas is lacking. This results in the diminished utilization of an important resource in the improvement of health care and health systems.

11. Monitoring and Evaluation

At present, there is insufficient information to properly manage the public health system. The number, type, condition and location of health facilities in the country is unknown. The number, qualifications, experience and location of staff employed in the health services is unknown.

In the same light, overall spending on health services is unknown due to lack of standards and reporting. The distribution of medical supplies and shortage patterns are unknown for lack of reporting. So are basic service statistics on the condition of facilities and the use of the public health system by our populations.

A surveillance system to rapidly detect outbreaks of contagious disease does not exist.

These gaps in our knowledge limit the efficiency with which services are provided and can be seriously damaging to the health of the population.

III. PRIORITIES

Highlights

The goal is to improve the health of our people, 85 per cent of whom are the rural populations. It is necessary to shift resources to our rural populations and to implement and enforce this policy of a more equitable distribution of health resources.

To accomplish this goal, the focus of our efforts will be on:

Health Promotion and Preventive Health Services

Improve and sustain health promotion and preventive health services to reach the rural populations to *permanently* improve their health status.

Management

Reforms are required in all areas and at all levels to implement policy in health promotion, preventive health services and in other areas.

The goal is to improve the health of our people. The urban populations receive most of our resources and they do enjoy better health. It is the rural populations that are in greatest need. To improve their health status, and that of the Nation, it is necessary to shift resources to our rural populations and to implement and enforce this policy of a more equitable distribution of health resources.

To accomplish this goal, two areas of over-riding importance will be the focus of our efforts in the years to come. They are:

Health Promotion and Preventive Health Services

Our public health strategy will aim for improved and sustained health promotion and preventive health services, by far the most cost effective approach and one that will reach the rural populations to *permanently* improve their health status.

Management

The management of our national health system requires reforms in all areas and at all levels. These management reforms will ensure the expedient and cost effect implementation of policy in health promotion, preventive health services and in other areas.

The priorities targeted under each of these two principal focus areas cover most of the weaknesses in the national health system. Concerted planning in the design and implementation of tasks will be required to achieve the best possible outcome. Specific priorities follow:

1. Health Promotion and Preventive Health Services

- ◆ Actively promote community involvement and participation in health matters. Target women for education and a leading role in community participation with all available means.
- ◆ Break the isolation of Aidpost and Health Center staff by linking all levels of the National Health System through a High Frequency radio network.
- ◆ Revive MCH services and the patrol system.
- ◆ Create a National Health Promotion Unit to produce, coordinate and disseminate IEC materials to the broadest possible audience, in particular the rural populations.
- ◆ Train Aid Post Orderlies and Community Health Workers in health preventive services and in health promotion.
- ◆ Expand the Village Birth Attendant (VBA) programme to all Provinces. Include a health promotion role for all VBAs.

2. Management

- ◆ Address the inherent weaknesses of the dual, parallel levels of government and resolve the issues of duplication of effort, inefficiencies and conflict.
- ◆ Promote leadership and managerial skills. Address weak management structures in the NDOH and in provincial Divisions of Health.
- ◆ Invest in personnel management, financial management and planning. Establish a national in-service training programme, particularly in preventive health services, health promotion and in management (all areas).
- ◆ Establish a fully functional Monitoring and Evaluation Unit within the NDOH to provide accurate and timely health and management information.
- ◆ Build a high frequency radio network to link the remote rural health facilities with the district and provincial health administrations, and hospitals.
- ◆ Establish a regularly published health news letter as a management tool to involve and inform all health personnel of initiatives and progress.

- ◆ Improve communications and concertation among the National Departments and with all levels of government.
- ◆ Promote greater autonomy for Base and Provincial hospitals and increase their individual financial and management responsibilities.
- ◆ Insure hospitals are less of a drain on the National Health Budget through increased user fees, cost reduction measures, and through improved community involvement and better management.
- ◆ Establish strategically located rural hospitals. Down-size the Base and Provincial Hospitals.
- ◆ Increase Hospitals' role in outreach services to Health Centers and in providing training to rural health personnel.
- ◆ Improve the management of the medical supply and equipment system to ensure the complete, timely and equitable distribution of essential drugs and supplies, and using the most cost effective means available.
- ◆ Ensure government investments and long term assets (buildings and equipment) are protected through adequate maintenance. Turn this responsibility over to management and staff of the respective health facilities.
- ◆ Promote greater managerial responsibility of government health facilities by allowing them to collect and retain user fees to be applied to the maintenance and operation of their respective facilities.

IV. GENERAL POLICY

Highlights

Reaching the rural majority, 85 per cent of our people, will be the goal to achieve. The focus will be placed on communities to become involved and to actively participate in all health initiatives. Education, of women in particular, will be the privileged means to improve health status. Preventive health services will be revived and expanded to support the effort in health promotion.

The structure of the National Health System must be streamlined and the issue of dual governments resolved. Leadership and authority will be restored to the NDOH. Standards in the delivery of health services and in management will be established and enforced.

Communication, consultation and cooperation will be sought at all levels and in all initiatives. The isolation of rural health facilities must end. A radio network will be developed over rural areas to link all health facilities with the District and Provincial services.

Protecting our investments in health facility buildings and equipment shall be viewed as a requirement. The responsibility for systematic maintenance will shift to the health staff of respective facilities and to the communities they serve.

Personnel management will be reformed to effectively promote discipline, high professional standards and achievement. The needs in personnel will be addressed in long term planning (25 years) and improved management.

The public health sector, viewed from the private business perspective, is an organization in crisis characterized by divided departments pursuing different interests, beset by poor communications, mediocre management and inadequate resources. Morale among dedicated health personnel is low. More alarming, *indifference* is an increasingly common attitude among public servants and casuals employed in the health sector.

The success of the public health sector is measured in terms of untimely deaths averted, illness prevented and improved health behavior patterns practiced by our people. Important successes were made in the 1980's but there has been stagnation, and even decline, over the last five years. While the costs of operating our public health system are ever increasing, the efficiency and effectiveness of our services are weakening. In short, we are losing ground in the struggle to improve the health of our people.

Sweeping reforms are urgently needed and will be pursued to address and correct the growing crisis in the public health sector. These reforms strike at the underlying ills afflicting our ability to improve the health status of our people.

REACHING THE RURAL MAJORITY

While 85 per cent of our populations live in rural areas, they receive too little of our attention and too few of our efforts in health matters. As a result, they are at very high risk for most health problems.

Public health is based on the sound premise that it is better to prevent illness than to treat it. This strategy is also more cost effective and the positive results are long lasting and in some cases permanent, especially in regards to health education and changes in behavior patterns favoring good health.

The focus must be placed on communities to become more involved and to actively participate in all health initiatives. Communities must first be made aware of health issues, their concern elicited to a level of self-motivated action to then help implement and sustain initiatives that directly benefit their health. Communities will be responsible for their Aidpost and will contribute to its operation.

Concerted and sustained efforts will be pursued to educate the rural populations in health matters through well organized and properly funded health promotion activities. All available media will be utilized and Churches, NGOs, women's groups and village councils involved. Women will be the privileged target for education and to play leading roles in community health action.

Health prevention activities will be revived and expanded. These are concrete measures that not only save lives, but greatly help to convince the rural populations of the validity of health promotion messages. In particular, MCH services and patrols will be adequately funded and the Village Birth Attendant programme extended to all Provinces. The Immunization Programme will target 80 per cent coverage and Family Planning services will be made available.

Access to safe water and proper sanitation are the most basic of public health strategies. The NDOH will assist the Water Board, to the fullest of its ability, to improve the provision of clean, safe water in villages and in settlements.

The introduction of Rural Hospitals in strategic localities will make doctors and better curative services more readily available to the rural populations while relieving pressure on the urban hospitals. The Rural Hospitals will also play an important role in supervising and training Health Center and Aidpost personnel.

The location of the Rural Hospitals will be based on population and geography considerations. They will effectively reach and serve the largest rural population possible.

STRUCTURE AND MANAGEMENT

We cannot afford the endless replication of administrative structures and the divided authority and management of our health services and efforts. Years of these practices have proven inefficient and very costly while the benefits to the people have been mostly inadequate.

Leadership and authority must be restored to the NDOH. The Provinces must be unified and concerted in their planning and implementation of health delivery services. The NDOH will endeavor to develop and implement a standard provincial health structure appropriate to the responsibilities and tasks at that level and taking into account population size, geography and regional health problems.

While the Ministry for Health and the NDOH will establish policy and manage the health sector overall, the implementors and technical staff will be in the Provinces and Districts. The distribution of field health staff will be based on the size of populations served.

Standards in all aspects of the delivery of health services need to be developed and implemented. Essential management tools in finance, health and management information systems will be developed and generalized throughout the country.

The medical supply system will be reviewed and reforms in the overall management, in procurement, stock management and distribution system will be implemented. The adequate and continuous supply of medicines is an obvious priority.

Hospitals will be required to manage themselves on tighter budgets. Cost containment will be essential to survive. In the longer term, hospitals are expected to down-size as their efficiency improves.

COMMUNICATION, CONSULTATION AND COOPERATION

Aidpost and Health Center staff are removed from the National Health System by more than distance and difficult terrain. Too little contact with the health system has resulted in poor supervision, inadequate supply of medicines, and a disaffected attitude on the part of many health staff. This leads to frequent absences, poor performance and even the closure of some facilities.

This Administration will seek to break the isolation of our rural facilities by developing a High Frequency radio network. This network will also interface with existing radio networks maintained by Churches, NGOs and other government agencies. Such a communications network will do much to join remote communities with their respective District and Provincial services and result in improved relations and service delivery.

A regularly published health news letter will be established by the NDOH. It will serve as an important management tool to involve and inform all health personnel of initiatives

and progress. It will also provide vital feedback of information generated through the national health information system and the Monitoring and Evaluation Unit.

Aidpost Orderlies are not alone in working in isolation; communication and consultation between the NDOH and the DOFP, DPM, DVSPA, and the provincial levels of government is poor. National and provincial health budgets are established independently without consultation. DOFP regulations make no allowance for the procurement abroad of medical supplies and equipment. These are but a few examples.

The lack of communication and consultation makes cooperation impossible, results in counter-productive efforts, duplication and wastage. Frustration, among all parties, runs high.

The NDOH will strive to improve communications and take a consultative approach wherever feasible. The NDOH will endeavor to foster a spirit of team work and to resolve communication and consultation issues with a mind toward efficiency and cooperation.

PROTECTING OUR INVESTMENTS

We are not protecting our precious long term assets. From Aidposts to Hospitals, the lack of maintenance is resulting in the deterioration of buildings and equipment that should last many more years than they do. Our negligent attitude in maintaining these assets comes at an enormous financial cost to the government and at an equally high cost to our people in terms of poor health service delivery.

The delegated responsibility to provide maintenance for our health facilities has a failed track record. That responsibility now belongs in the hands of the staff who work in the respective facilities and with the communities they serve.

The NDOH will seek a new financial arrangement with Health Centers authorizing them to collect user fees and to retain these revenues. The revenues will be used directly by the Health Centers to properly maintain facilities and equipment. The communities served by Health Centers will have oversight authority to ensure funds are correctly managed and the facilities are adequately maintained.

PERSONNEL MATTERS

Beginning now and for the long term, we need to invest in people who deliver the life-saving health services. Long term planning and improved management are required to build-up our health staff according to personnel *needs*, in numbers and in qualifications. The NDOH will create a division for Human Resource Development which will work closely with UPNG and other training institutions to ensure the requirements in personnel for the Nation Health System are met in the long term.

We need commitment, dedication and discipline as fundamental qualities for all health personnel. New personnel structures and personnel management will seek to achieve the highest level of quality, both in the individual and for the National Health System as a successful organization.

Evaluations and performance based promotion will become standard. Employment contracts will be developed to ensure only the best qualified and most productive individuals are retained.

A new generation of managers will be developed with high personal standards and committed to implementing new professional standards in our institutions.

V. NEW POLICY, INITIATIVES AND STRATEGIES

Highlights

- o Re-centralize responsibility and authority for health matters so the NDOH reassumes a position of leadership in the health of the Nation. Propose legislation streamlining the National Health System. Improve communication and coordination among all levels of the National Health System.
- o Seek stability in the funding of the health sector. Improve equity by shifting resources from urban services to rural services and from hospitals to health promotion and health prevention services. Support legislation for a standard health budget at all government levels.
- o Reinstate health promotion as a national programme. Create a National Health Promotion Unit responsible for a massive effort in health education targeting rural populations and women in particular. Coordinate Churches, NGOs, women's groups, village councils and others in all health education efforts.
- o Reassume authority and financial control over preventive health service programmes. Revitalized Maternal and Child Health services and the patrol system. Expand the Village Birth Attendant programme to national level. Support all health promotion efforts.
- o Contain government spending on hospital services but allow hospitals to increase their self-generated revenues. Promote financial autonomy and improved management in all hospitals. Develop Rural Hospitals from select Health Centers to put doctors and specialist services in the rural areas.
- o Ensure stable funding for the procurement and distribution of medical supplies and equipment. Review and improve the procurement and payment procedures of medical supplies. Provide for improved management at all levels of the supply system. Adequate distribution systems will be developed for the remote rural areas.
- o Correct the deficiencies in the organization of personnel management to make it effective. Create a Human Resource Development Division within the NDOH. Career management and performance-based advancement will be developed. Introduce employment contracts and bonding. Improve long term planning and establish formal links with the nation's training institutions.
- o The NDOH will provide direction, coordination and guidance in research efforts. Improve and facilitate the dissemination and utilization of research findings.
- o A standard health information system will be implemented nationwide. A radio network to link all rural health facilities to the National Health System will be developed. The NDOH will invest in its monitoring and evaluation unit to provide accurate and timely health and management information.

1. Organization and Structure of Health Services

1.1. Policy Statement

1.1.1. Decentralization

Recentralize responsibility and authority for health matters in the Office of the Minister for Health and in the National Department of Health so that National Government reassumes a position of leadership in the health of the nation.

Recentralize the following health improvement functions of Disease Control, Family Health including immunization activities and nutrition, and Environmental Health including water supply under national control.

Establish and prioritize national votes for recentralized key health functions which require adequate and stable funding. This is a priority in areas of health promotion and prevention and for service delivery to rural populations.

The NDOH will establish standards for health delivery systems at all levels. The NDOH will monitor their implementation and continued operation.

1.1.2. Church, NGO and Private Health Services

Church-run and NGO-run health facilities as well as private health facilities will comply with existing operational and professional standards on both National and Provincial levels.

Church Health Services

National Government is committed to support Church health facilities and health delivery services. The National Government will seek to formalize its relationship with these organizations.

The provision of services by all Church health facilities must be consistent with national standards. Management issues will be addressed and resolved.

NGO Health Services

The establishment of a new health facility, whether NGO or church sponsored, or a private initiative, must be approved by the provincial health authorities as well as by the NDOH.

The provision of services and donations by all NGO health facilities must be consistent with national standards. The NDOH will encourage NGOs to seek funding from the private sector. Management issues will be addressed and resolved.

Private Health Services

The provision of private health services will be encouraged. Services must be consistent with national standards and will, in future, be monitored by the NDOH.

To help alleviate pressure on urban public health care facilities and to help shift resources toward rural health services, health insurance schemes will be promoted. The NDOH will examine the health insurance industry and seek to establish standards and regulations to protect the consumer.

The NDOH will encourage private sector specialists to practice, on a part-time basis, in public health facilities to help fill current needs in the public sector. The NDOH will also examine the possibility of re-employing health staff who have left the public health sector, on a part-time basis.

1.2. Proposed Supporting Legislation

A re-statement, for clarification purposes, of respective functions, responsibilities and authority for National Government and Provincial Government in health matters is much needed. The statement should include the following points:

The Minister for Health retains ultimate responsibility and authority over all health functions including:

- transferred powers which rest with Provincial Government,
- delegated functions which rest with Provincial Government,
- national functions of the NDOH which include setting national standards and the monitoring of their implementation at the provincial level.

The appointment of Provincial Assistant Secretaries for Health, or the equivalent position under a different title, and other key staff, should be by the NDOH.

In the event a Provincial Government is suspended or a provincial health authority is determined to be non-functional as evaluated through performance and/or the condition of health services, the NDOH may intervene and:

- revert provincial health authority back to the NDOH,
- send in a health management team to temporarily replace the provincial health authority,
- appoint a new Provincial Assistant Secretary for Health.

1.3. Management Initiatives and Strategies

The Offices of the Minister for Health and the Secretary for Health will issue a document clarifying respective roles, responsibilities and authority in the National Health System.

Specific issues will be addressed including funding mechanisms, financial accountability performance and reporting. The document will be widely distributed and serve as a reference in matters of contention.

At the provincial level, a Health Committee will be established to ensure coordination and monitoring of all health activities and to provide liaison between district level services and the NDOH. In particular, the Health Committee will embody and enforce NDOH standards and provide accurate and timely reporting.

The NDOH will address issues of communication, coordination and management with its provincial counterparts, Church Health Services and NGOs. Formal mechanisms for coordination and management will be reviewed and strengthened. These management initiatives will give rise to a functioning **Unified Health Structure** which may be formally recognized at an ulterior, agreed upon date.

The Office of the Minister and the NDOH will seek to improve communications with all levels and sectors of the National Health System. To this end, a news letter will be published for distribution to all health personnel nation-wide. The appropriate structures will be established to ensure such a news letter appears on a regular basis.

2. Health Finance Alternatives

2.1. Policy Statement

The National Department of Health will seek stability in the funding of the health sector taking population growth and inflation into account.

Improved equity in the delivery of health services is a central issue and will take into account the lesser ability of rural populations to pay for curative services. To this end, the allocation of government resources will shift from urban services to rural services and from hospitals to health promotion and health prevention services. The NDOH will also endeavor to correct the great differences in funding for health from Province to Province.

The National Department of Health will seek adequate levels of funding by Central Government. Alternant financing mechanisms will be pursued. In particular, greater financial responsibility will be placed on the population through the generalization of user fees in public health facilities.

The National Department of Health will redefine its mission, establish priorities among health services offered and be prepared to eliminate low priority services should it be required by budgetary constraints, present or future. High priority services (health promotion and preventive service, primary health care, medical supply system) will be adequately maintained and not allowed to waste away through budget attrition.

Management skills, and in particular financial management skills, will become a focus for development in the health sector.

Recentralize and redefine the public hospital to Government relationship.

- o The Department of Finance and Planning should establish a separate national vote for each hospital (achieved in January 1995).
- o Government financing of public hospitals should be negotiated and defined on a contractual basis with the individual institutions.
- o A minimum, guaranteed, subsidy level could be established covering, for example, salaries, pharmaceutical supplies and capital replacement.
- o The Government will require hospitals to maximize their revenues and apply them to their operating budgets on a mutually agreed upon line item priority basis. Compliance will be ensured through regular and complete reporting by hospitals, and through audits.

2.2. Proposed Supporting Legislation

National budgeting and accounting standards must be developed and applied in all Provinces. All *Provincial Health Administration Acts* should be repealed and replaced by national legislation applicable to all Provinces. Standards should include:

- o a standard health budget allowing for national monitoring and evaluation,
- o standard accounting practices and standard financial reports on the execution of the health budget. These reports will be sent to the NDOH as well as the DOFP.

The NDOH should have the authority to withhold provincial allocations for health for any Province that does not comply with standards and reporting requirements. To this end, the NDOH will recentralize key health activities by creating national votes.

The operation of hospital trust accounts needs to be simplified and clearly defined. Full financial responsibility and authority should be given to Hospital Management.

Amend the *Public Hospital Act 1994* to clarify the respective roles of Hospital Management, the Hospital Board and the NDOH to include relationships and authority; include a Board member selection process promoting greater representation of the community; allow the Board to review and recommend hospital tariffs for their institution on an annual basis.

National legislation is needed to authorize all Health Centers and Health Sub-Centers to collect user fees. The legislation should also:

- o Authorize each facility to retain its own revenues.
- o Specify the use of revenues to include operating expenditures and facility maintenance and restrict the use of revenues to exclude salaries, compensation of any type for personnel and social events,
- o Require adequate accounting of fees collected and expenditures made including simple and verifiable reporting; require internal controls whereby accounting and fund management are separate functions held by different staff,
- o Provide measures for oversight (not spending authority) by the community, as well as measures for the misuse of funds.

National legislation is needed to establish fee levels in Health Centers and Health Sub-Centers. Fee levels should be expressed as a range (minimum and maximum brackets) and take into account current hospital tariffs. Individual health facilities, in consultation with community leaders, should be authorized to set their own tariffs within the ranges established by the national legislation. Review should be annual.

The NDOH will examine the health insurance industry and seek to establish standards and regulations to promote health insurance schemes and to protect the consumer.

2.3. Management Initiatives and Strategies

Within the NDOH a *permanent* Budget Committee will be established. With members drawn from all NDOH Divisions, DOFP Planning Division and Budget Division, and headed by the Minister's and Secretary's Offices. The committee will establish priorities, a one year action plan, and budget and monitor expenditure accordingly. The Budget Committee will also define areas for donor assistance and funding. It will provide improved communication with the DOFP.

A NDOH Health Finance and Management Steering Committee will be established to plan, monitor and evaluate initiatives in finance and management which require long term commitment and new legislation. This committee will be responsible for developing the management tools needed in hospitals and health centers and ensuring they are implemented. The committee will also provide input to the five year health plan in the areas of health finance and management.

3. Health Promotion and IEC

3.1. Policy Statement

Policy outlined in the 1991-1995 National Health Plan is well articulated and remains valid.

Health promotion will be reinstated as a National Programme. While much has been achieved in establishing an operational framework, there is still a need to create a facility for the coordination, integration and management of the programme.

The creation of an upgraded **National Health Promotion Unit (NHPU)** will be a priority in terms of funding and support. The NHPU should be capable of carrying out the following functions: 1) management of IEC research, design and production process; 2) ongoing integration of IEC process into all disease control programmes; 3) media liaison office; 4) archival, storage, duplication and distribution of IEC materials; 5) Community/NGO health promotion liaison officer; 6) materials research and evaluation.

To overcome language diversity, a pervasive and difficult constraint, communicators versed in the appropriate languages and able to translate health promotion messages will be sought for district level health promotion initiatives.

The year 1995 has been designated the "Year for Health Education". This represents a unique opportunity for the NDOH to jump-start a National Health Promotion Programme into action.

In support of health promotion and to lead by example, government facilities and employees will endeavor to observe accepted health practices. Furthermore, public health regulations must be enforced by proper authorities.

3.2. Proposed Supporting Legislation

Parliament to declare health promotion and preventive health services a national priority. In support of this declaration:

- o The NDOH will establish a National Health Promotion vote.
- o The NDOH will establish a National MCH vote to guarantee funding for MCH patrols and cold chain maintenance.

3.3. Management Initiatives and Strategies

Professional standards in the design and production of communication materials will be enforced. To this end, the NHPU will contract professional production expertise. All materials will be tried, tested and found to be consistent before dissemination.

National resources in the form of theater groups, UPNG Faculty of Arts and others will be drawn upon in production efforts.

The NDOH will take the initiative to negotiate for broadcast time with national government radio and television. Sustained efforts will be made to take national radio programming in health promotion to the provincial radio level, translated into the principal local languages.

Churches, NGOs, women's groups and others will be enlisted in all health promotion efforts to produce a concerted message to achieve a maximum persuasion effect. All forms of media will be utilized but face to face dialogue with mothers, fathers and children will remain a priority.

Health promotion activities will be integrated with formal and non-formal (literacy education programmes. Adult female literacy will be a particular priority.

4. Preventive Health Services

4.1. Policy Statement

Concerted efforts will be made for the NDOH to reassume authority and financial control over preventive health service programmes so that they may be carried-out efficiently and effectively to improve the health status of our populations.

See Section V.2.1, Policy Statement, Organization and Structure of Health Services

In times of budget constraints and tight money, Preventive Health Services will have their funding levels safeguarded.

See Section V.1.1, Policy Statement, Health Finance Alternatives

Revitalize MCH services and the patrol system to provide critical services to the remote rural populations.

Expand the Village Birth Attendant (VBA) programme to national level with district coordination by qualified mid-wives. The VBA programme will also carry an important health promotion component.

4.2. Proposed Supporting Legislation

See Section V.2.2, Proposed Supporting Legislation, Organization and Structure of Health Services

See Section V.3.2, *Proposed Supporting Legislation, Health Promotion and IEC*

Water supply and sanitation responsibilities, delegated by the Water Board to the NDOH, must be clarified and formalized.

4.3. Management Initiatives and Strategies

The NDOH will reinforce its administrative capacity to better coordinate the various Preventive Health Services programmes. In particular, improved communication with the provincial health authorities in order to budget, coordinate and manage the activities of each programme will be addressed.

The NDOH will review and evaluate existing disease control programmes and the need for new programmes in response to growing health threats. Under consideration are control programmes for typhoid, tuberculosis, sexually transmitted diseases and AIDS.

Strategies for the improvement of rural water supply and sanitation will be reviewed with the Water Board. A clear mandate will be defined for each party. Cooperation will be a priority in order to unite in a country-wide effort to provide clean, safe water to the rural populations.

5. Curative Services

1.1. Policy Statement

Contain government spending on hospital services by progressively reducing their share of the national health budget while allowing hospitals to make-up the difference in government budget reductions through increased fees charged to patients.

A health service agreement (contract) between hospitals and the NDOH will permit the hospitals to have some degree of financial autonomy and allow for long term planning using a 2 or 3 year rolling budget mechanism.

The function of hospitals will be extended to include responsibilities for training and outreach services in surrounding rural facilities. Among such important responsibilities:

- o Rural health staff need to be rotated periodically through hospitals to update and reinforce their diagnostic and treatment skills.
- o Some clinical specialist services need to be extended to rural health facilities. Among these specialists are paediatric nurses, MCH nurses and clinical HEOs.
- o Hospital laboratory services, once improved and/or upgraded, should be extended to support rural health facilities.

Specialists trained at the expense of the Government will be required to serve in the public health system for a period commensurate with the cost of their training. The public service will be performed where the need is greatest, generally in rural health facilities.

The development of Rural Hospitals out of strategically situated Health Centers to provide doctors and key specialist services (paediatrics and general medicine) within reach of rural populations is a fundamental shift in policy away from funding the inordinate growth of a few Base and Provincial Hospitals. Rural Hospitals should be phased-in over 5 years. As Rural Hospitals assume an increasing share of service delivery, the large hospitals are expected to "down-size" and become more efficient at providing specialized services not available in Rural Hospitals.

A referral system including guidelines for overseas referrals will be developed by the NDOH.

1.2. Proposed Supporting Legislation

Review and amend the *Public Hospital Act 1994* to clarify roles and responsibilities.

1.3. Management Initiatives and Strategies

Hospital Boards are in place and are assuming an increasingly active role in improving hospital management. The *Public Hospital Act 1994* is being reviewed and will be amended to clarify roles and responsibilities allowing Boards to be more effective.

Hospitals will re-define their respective roles and their functional capacity (eg. number of beds) over time to take into account improved service delivery in the surrounding rural areas and improved management as secondary care institutions.

Assistance is being provided to Base Hospitals through the *Hospital Management and Operations Improvement Project*, a long term effort financed by AIDAB. Key management issues will be addressed including financial management, the management of hospital resources, improved health and management information systems, and biomedical equipment maintenance and standardization.

Every effort will be made to extend management reforms achieved in the Base Hospitals to the Provincial Hospitals.

Revised job descriptions for key medical staff will include responsibilities in outreach efforts to support surrounding rural health facilities.

In-house training programmes for hospital staff and surrounding rural health facility personnel will be organized.

Hospital Boards will work with the Office of the Minister for Health and the NDOH to establish fees and charges which reflect the higher cost of hospital services and which will help to enforce the referral system.

6. Medical Supplies and Equipment

1.1. Policy Statement

This Government is committed to ensuring all health facilities receive the proper medical supplies in sufficient quantities and on a timely basis. In particular, the remote rural health facilities will be adequately supplied.

Funding of the procurement and distribution of medical supplies will be stable and maintained at a level to ensure all people in PNG have access to drugs.

The Office of the Minister for Health and the NDOH will endeavor to work with the Department of Finance and Planning to define and implement regulations and procedures that will facilitate the procurement and timely payment of medical supplies and equipment abroad.

The NDOH will seek to re-appropriate responsibility and funding for the maintenance of bio-medical equipment from the Department of Works.

To facilitate maintenance and ensure an adequate supply of spare parts, the NDOH will establish standards in equipment for each type of health facility.

Investigate the feasibility of privatizing the distribution system of medical supplies and equipment as a cost saving measure and to ensure an adequate and sustained level of performance.

1.2. Proposed Supporting Legislation

A national essential drug policy will be developed by the NDOH and submitted for endorsement by the NEC.

1.3. Management Initiatives and Strategies

Procurement and payment procedures of medical supplies and equipment purchased abroad that are the responsibility of the NDOH will be reviewed and corrected. Issues of appropriate staffing levels and personnel qualifications will be addressed.

Management of the medical supply system will progressively incorporate professional supply managers working in concertation with pharmacists. Standard operating

order procedures will be developed. An appropriate management information system will be developed and implemented and used to determine budgets, orders and distribution.

The information system will include budget and draw-down information by health facilities which will be used to monitor consumption in monetary terms. This will allow a measure of control with respect to individual health facilities.

The development of inventory systems appropriate to the different types of health facilities will be undertaken. Implementation, involving the training of all staff in the supply system in the new standard operating procedures, will be programmed for the earliest possible date.

Quality assurance and control will be pursued through either existing laboratories (UPNOC) or new facilities. All imported pharmaceutical products are to be monitored for quality, shelf-life and labelling practices.

7. Human Resource Development

7.1. Policy Statement

The delegation of effective personnel management authority by the Department of Personnel Management to the NDOH for government health personnel should be examined. Existing personnel management regulations that are ineffective and poorly applied need to be reviewed.

Create a Human Resource Development Division within the NDOH. This division should have a strong mandate in personnel management.

Career management and performance-based advancement must be developed and effective tools to improve the overall quality of health sector personnel and the delivery of services.

Equal opportunity for women will be enforced as a fundamental policy in human resource development and the up-grading of health sector personnel standards.

The introduction of employment contracts will be examined. Employment contracts would confer purpose to performance evaluations and help to rationally manage careers and to ensure the best people are retained.

The NDOH will seek to integrate involvement of local business and multi-national corporations as responsible partners in the delivery of health care and, in particular, in health education.

Improved long term planning by the NDOH in personnel matters will also require

and mix of health professionals to be graduated and their employment in the National Health System. A 25 year time frame is essential to adequately plan and manage the health sector work force.

The NDOH will consult with training institutions, including UPNG, to ensure course design and content are appropriate to the country's needs. Short course development addressing specific needs for in-service training will also be explored.

Institutional housing should be made available to key medical staff.

7.2. Proposed Supporting Legislation

All health staff trained at government expense should be required to serve in the public health sector for a period commensurate with the cost of their education.

All personnel in the National Health System, in the Church health sector, NGO health sector and in the private health sector should be required to register with the NDOH.

7.3. Management Initiatives and Strategies

Create a single Registration Board, attached to the HRD Division, for *all* personnel in the health sector. Use the information capabilities of the Monitoring and Evaluation Unit to maintain a current database and to provide management information for planning and staffing objectives.

In support of professional and technical training, candidates for pre-service and higher level education will be rigorously screened according to objective criteria.

Twinning, a reciprocal arrangement between our national training health institutions and equivalent institutions overseas, will be pursued to help raise the competence level of specialists.

Develop career pathways and opportunities for HEOs and nurses in both clinical specialty areas and in management and administration.

In-house training, in the NDOH and in all levels of health administration, as well as in our health facilities, is an immediate, cost-effective solution to improving capabilities and performance and will be pursued.

The NDOH will explore the provision of incentives to personnel posted in rural health facilities.

8. Health Research

8.1. Policy Statement

Improve the coordination of health related research within the NDOH to facilitate the utilization of research findings for both curative and preventive health services.

Restore the funding of health systems research in the NDOH.

Promote operations research and evaluation in the areas of health promotion and preventive health services. In particular, target KAP studies related to initiatives in the MCH Programme, the Family Planning Project and specific health promotion activities.

Strengthen the research monitoring and screening capacity of the Medical Research Advisory Committee (MRAC) with administrative help. Restore the MRAC's capacity to extend small grants to young investigators.

Continue the support of the PNG Institute of Medical Research in its role of executor of research on the nation's major health problems, and encourage as appropriate other institutions including the Medical Faculty and the Nation Research Institute. Provide funding support for relevant clinical research.

Within tertiary education, advocate and encourage the training of health-related researchers, in particular those in the social sciences, including economics.

8.2. Proposed Supporting Legislation

None

8.3. Management Initiatives and Strategies

Establish a National Research Council in the NDOH to provide direction, coordination and guidance in research efforts, and to facilitate and improve the dissemination and utilization of research findings.

Continued funding for research should be provided at the programme level.

9. Monitoring and Evaluation

9.1. Policy Statement

Timely and reliable information is a fundamental requirement to manage the public health system. The NDOH will spare no effort in making such information available.

A standard health information system should be implemented nationwide. All Provinces and health facilities will conform to the NDOH standard.

A High Frequency radio network to link all rural health facilities in the national health system will be progressively implemented. This will permit the creation of a national epidemiologic surveillance system to monitor disease outbreaks. It will also allow for improved supervision and supply of all Aidposts and Health Centers.

The NDOH will assume full responsibility for maintaining information systems. To this end, the NDOH will also cover all costs for the systems including stationary, training materials, computers, telephone links, etc.

Funds should be withheld from Provinces if they fail to comply with national reporting standards.

Regular review of information will take place and results published. To this end, the production of an NDOH news letter will be undertaken. The news letter will be designed to communicate information from the NDOH to all health workers including APOs. The national press will also be used to communicate important health information.

9.2. Proposed Supporting Legislation

See Section V.2.2, Proposed Supporting Legislation, Organization and Structure of Health Services

9.3. Management Initiatives and Strategies

The NDOH Information Support Unit will be reviewed and re-organized. The Unit's responsibilities should be expanded and well defined, warranting a new name: *Monitoring and Evaluation Unit (MEU)*. The MEU should be placed under the guidance of technical assistance, an epidemiologist with excellent computer skills. In-house training for MEU staff in data management, analysis and information production will be undertaken. Standard reports and reporting schedules will be defined and adhered to.

The NDOH will enforce existing legislation on reporting requirements of infectious diseases by all health facilities.

A census of all health facilities will be undertaken. Simultaneously, a health infrastructure database will be established in the MEU and procedures developed to maintain the database up-to-date on an annual basis.

A central health workforce database will be established. The system will be based on the registration of all health workers and will be continuously updated. The responsibility for maintaining the database should rest with the MEU.

ANNEX 4

*List of Research Projects, Studies, and Pilot
Projects Conducted under the CSSP Project*

LIST OF THE COMPLETED RESEARCH AND PILOT PROJECTS AND ORGANIZATIONS THAT CONDUCTED THE PROJECTS

<u>Research Projects</u>	<u>Implementing agencies</u>
1. Rural Health Services	Dept. of Community Medicine, UPNG PNG Institute of Medical Research
2. Community Health Nursing Job Analysis	CSSP
3. Evaluation of Maternal Health Services	CSSP
4. Study of Provincial In-service Units' Policies and Activities	CSSP
5. An Assessment of Medical Supply and Logistics systems	CSSP
6. Rice-ORS Acceptability study	CSSP
7. An Assessment of Cold Chain and EPI	CSSP
8. A Review of Hemophilus B Vaccination	CSSP
9. Vitamin A Ophthalmological and Dietary Intake Survey	CSSP
10. Reproductive Knowledge and Behavior survey	PNG Institute of Medical Research

- | | | |
|-----|---|-----------------------------------|
| 11. | Childhood Pneumonia in the Eastern Highlands of PNG: An Ethnographic Approach | Dept. of Community Medicine, UPNG |
| 12. | Non-Communicable Diseases in Adult Manus Islanders | Dept. of Community Medicine, UPNG |
| 13. | Factors Affecting Utilization of Health Services on Karkar Island, Madang Province. Papua New Guinea. | Dept. of Community Medicine, UPNG |

Pilot Studies

- | | | |
|----|--|-----------------------------------|
| 1. | Pneumococcal vaccine field trial in children | PNG Institute of Medical Research |
| 2. | Pneumococcal vaccine for pregnant women | PNG Institute of Medical Research |
| 3. | Mid-upper arm Circumference Tape Pilot Project | CSSP |
| 4. | Ergometrine for village delivery pilot project | CSSP |

ANNEX 5

*Australian Assistance to the PNG National
Child Survival Program, March 1995*

AUSTRALIAN INTERNATIONAL DEVELOPMENT ASSISTANCE BUREAU

**Project of Australian Government
Support
to the
Papua New Guinea
Child Survival Program**

Draft Design Document

February 1995
Version 2

Project of Australian Government
Support
for the
Papua New Guinea Child Survival Program
Design Study

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- 1 Government submission to AIDAB to support the Child Survival Program for 1995-1996
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Glossary

ADB	Asian Development Bank
ARI	Acute respiratory infections
AS	Assistant Secretary
CASP	Commodities Assistance Program
CHNS	Community health nursing services
CSP	Child Survival Program
CSSP	Child Survival Support Project
DF&P	Department of Finance and Planning
EPI	Expanded program on immunisation
FAS	First Assistant Secretary
FHS	Family Health Services
HEO	Health extension officer
HRD	Human resources development
IEC	Information, communication and education
IS	Implementation Schedule
MCH	Maternal and child health
NCD	National Capital District
NDOH	National Department of Health
NEC	National Executive Council
NGO	Non-government organisation
NSP	North Solomons Province
OIDA	Office of International Development Assistance
PCMC	Policy Coordination and Monitoring Committee
PHC	Primary health care
PHS	Primary Health Services
PMG	Project Management Group
PPHS	Preventive and Promotive Health Services
PTB	Public Transport Board
RSU	Regional Support Unit
UNICEF	United Nations Children's Fund
UPNG	University of Papua New Guinea
VSPA	Department of Village Services and Provincial Affairs
WHO	World Health Organisation

EXECUTIVE SUMMARY

1 Introduction

Available data indicates that the health status of women and children in Papua New Guinea (PNG) has been declining in recent years and during 1993 a range of indicators was observed to deteriorate further. In particular, the limited data on immunisation coverage suggested a fall to a national average of about 30%. This is low by international standards and by the historical standards of PNG.

The Government of Papua New Guinea (GOPNG) recognising the need for action and signed the Declaration on Survival, Development and Protection of Children arising out of the World Summit for Children held in 1990. It was represented at the Manila Ministerial Consultation on Mid-Decade Goals for Children held in September 1993 and signed the resulting Manila Consensus expressing commitment to these Goals. At the subsequent 33rd South Pacific Conference held in New Caledonia in October, GOPNG moved the resolution which urged member states to achieve the Mid-Decade Goals by 1995. In that same month it initiated the Child Survival Program (CSP). The CSP was officially launched nationally with high level bi-partisan support in February 1994.

The launch of the Program has proved to be an extremely valuable stimulus to the maternal and child health (MCH) services of the national Department of Health (NDOH). It has complemented the work carried out by the USAID Child Survival Support Project (CSSP). The advocacy functions of the CSP have been outstandingly successful, and the expressions of community concern and political support have catalysed renewed enthusiasm in health personnel. Despite this initial success, and high level public acceptance of the CSP, until recently there has been only a limited amount of field activity, such as vaccinations, and the current financial crisis and the "freeze" on funds for non-salary expenditure has meant that the overall Program has almost ground to a halt.

If some urgent assistance is not given there is a real risk that vaccination levels will fall even further and the burden of disease in children will reach crisis levels. As a result the GOPNG formally approached the Government of Australia (GOA) in December 1994, seeking short term financial support as part of the Australian International Development Assistance Bureau's (AIDAB's) program of assistance to the Health Sector, in a form and time frame that would enable the CSP to continue to operate during 1995 and the first half of 1996 when it is anticipated that other measures will be in place to enable the activities encompassed within the Program to continue in the longer term. This draft project design document (PDD) sets out details for Australian Government support to the CSP which, if accepted by both Governments, will provide the support needed to enable the CSP to continue in all provinces throughout 1995-96.

2 The Proposed Plan of Action

The objective of this project is to provide support to the GOPNG 's CSP, which aims to reduce child mortality, prevent illness and promote better health in women and children. As such it will contain two main operational components and a component for the management of the Australian Government support to the CSP.

Component : The Delivery of Maternal and Child Health Services.

These will be provided through:

- (a) the current 'fixed' facilities within the health system, including health centres, sub-centres and aid-posts: and
- (b) mobile clinics and patrols which are intended to visit every village in the country to provide a full course of immunisation to children and carry out ante-natal care of women including tetanus immunisation.

A range of other essential health services will also be provided.

In addition, this component will contain a range of health promotion/education activities, which seek to bring about improved health behaviour change within the community.

Services from the 'fixed' and mobile clinics and patrols will be provided in every province, working primarily at the district health office level. It is planned that every village will be reached at least three times, and where feasible four times during the 15-month life of the project. Health personnel, many of whom will themselves receive training under Component 2, will conduct health education during every activity in the health centres, sub-centres and in the field.

Australian inputs will include provision of funds to enable mobile patrols to take place, travel funds for the CSP Coordinator and Secretariat staff, preparation and distribution of community information materials, and the distribution of health centre equipment and supplies. Funds to purchase equipment for the patrols and for health centres have already been supplied under a separate AIDAB contribution of \$1.6 million towards the CSP, through the Commodities Assistance Program (CASP). The funds allocated for equipment in that separate contribution include the cost of freight to the ultimate destination of the equipment.

Component 2: Increased Competence of Health Personnel through Training.

This component will provide training for health personnel- community health workers, nurses, health extension officers and doctors- who are working at national, regional, provincial and district levels of the health system.

Inputs will include technical assistance, in-service training courses, travel of facilitators and participants and the costs of preparing, printing and distributing training and resource materials.

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In addition to these two operational components, the project will also contain a component for the management of the Australian Government support to the CSP.

Component 3: Project Management

This component will consist of a set of activities to enable effective delivery of the planned services, management of the Australian inputs, and monitoring of their progress and results.

Specific inputs within this component include funds for technical assistance for the project manager, and the support which he/she will need to promote the effective delivery and to work effectively, including travel and office and financial and office administration and assistance in monitoring and evaluation.

3 Implementation, Management and Financial Controls.

It is planned that Australian inputs of technical assistance, training, materials and operational funds will be managed through UNICEF, as the implementing agent, utilising a project manager who will be designated responsibility for day to day management of the project activities. The project manager will be supported by: a finance and administration officer who will develop effective administrative procedures for the Australian funds; appropriate administrative support staff; and a short term monitoring and evaluation consultant as required. The estimated cost of AIDAB's contribution to the proposed project is \$5 million. The GOPNG will continue to meet the cost of the CSP Secretariat and of staff needed to provide the services in the provinces, together with the necessary timely supply of vaccines for immunisation. The GOPNG will make available the space in the PNG National Department of Health (NDOH), now used by the CSSP team for the project manager and support staff.

A Project Management Group (PMG), operating as a sub-group of the Child Survival Task Force, will be established consisting of representatives from the CSP, the NDOH, AIDAB, OIDA and UNICEF. This group will oversight all project activities, will meet quarterly and more frequently when required, and will have the power to recommend up to 15 per cent movement of funds between project components subject to staying within the overall budgeted ceiling of the project. Final authorisation of any recommended movement of funds will rest co-jointly with the GOPNG and the GOA. It is anticipated that informal meetings with appropriate representatives of the implementing parties will take place more frequently as required.

To achieve the full impact and avoid further deterioration in the immunisation status of PNG children, it is intended that the project of Australian support to the CSI begin in mid-March 1995 and continue until June 1996, with all funds expended in accordance with the project design by December 1996. By that time it is intended that the larger AIDAB funded Maternal and Child Health project will be able to provide longer term support to the Family Health Services (FHS) Branch of the NDOH.

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During the first two months of the project, UNICEF staff together with the CSP Secretariat and the project management team will be responsible for preparing an Implementation Schedule (IS) for formal approval by GOA and the GOPNG.

The IS will provide:

- (i) a detailed operating plan for 1995/96, including a program for the training courses and the patrols to be carried out in each province;
- (ii) a finance and management plan; and
- (iii) a description of the contents and frequency of the reports needed to manage the project successfully and to satisfy AIDAB requirements.

A detailed description of the financial procedures to be used in the project will be particularly important and those procedures are discussed in Chapter 4.

A feature of this project is that a considerable proportion of the funds will be spent at the district and provincial level to meet the operating expenditures of in-service training and mobile patrols. These funds will cover the costs of travel, vehicle and motor boat hire where necessary, and fuel, camping and patrol allowances and other items which would usually be the responsibility of GOPNG using its normal patrol procedures. Specific financing mechanisms for this project will be necessary in order to ensure:

- (i) that these activities continue as planned, and are not delayed due to the cash flow problems currently associated with the usual GOPNG channels; and
- (ii) to ensure strict and timely accountability for funds at all levels.

This will require the development of, and agreement on, feasible administrative procedure by UNICEF, AIDAB and GOPNG. Negotiations to seek suitable procedures are already occurring. Formalisation and implementation of these financial arrangements will be an early major task for the project manager, the project's finance and administration officer and the project's monitoring and evaluation short term consultant, and will be a feature of the IS.

4 Impact of the Project

The following benefits will be achieved if this project is successfully implemented as proposed here.

The immunisation coverage will increase to varying degrees in different locations, and the frequency of vaccine-preventable diseases will decline. A target of 80% immunisation coverage has been set within a 2-3 year period. The proportion of pregnant women immunised against tetanus will increase towards 100%. The greatest and most rapid increases in immunisation coverage will occur in populations accessible to routine MCH mobile clinics which will be re-established, but significant increases can also be expected in remote areas to be visited by patrols.

·The morale of health personnel will rise, as measured by their attendance, presentation and attitude to work. The capacity of health personnel to care for people who attend aid posts, health sub-centres and health centres will increase. The quality of care in health centres and sub-centres will improve through availability of equipment and increased competence and availability of health personnel following training.

·The capacity of provincial Divisions of Health to train health personnel to provide these services will have increased.

·Confidence of the people in the health service will increase and they may be more willing to attend to health messages. Community members will become better informed about the causes and prevention of common illnesses including respiratory infections, diarrhoea and malnutrition. The capacity of people to prevent illness, to recognise need for care and to seek care appropriately, will increase.

·Health service managers will have access to more accurate financial data on costs of MCH activities.

5 Issues Requiring Immediate Attention

Before this project can be formally initiated, and subject to its *early* approval by the GOPNG and GOA it is essential that:

- (i) UNICEF, AIDAB and the GOPNG reach early agreement on the formal arrangements to apply during its implementation and agree on an IS which will provide-
 - (a) a detailed operating plan for the project duration, including a program for the training courses and the patrols to be carried out in each province
 - (b) a finance and management plan, and
 - (c) a description of the contents and frequency of the reports needed to manage the project successfully and to satisfy AIDAB requirements;
- (ii) the GOPNG agree that it will continue to provide at the required times, support staff for the CSP and the timely provision of vaccines and medical supplies to be used in the project.
- (iii) a project manager acceptable to GOA, GOPNG and UNICEF should be appointed. In regard to the latter, steps should be taken immediately to retain the services of Dr Keith Edwards, who is currently engaged by the CSSP, but whose contract expires in March 1995.

The consequences of delay or inaction by any party to the project will be:

- (i) marked decrease in immunisation rates;

- (ii) increase in infant and maternal morbidity and mortality; and
- (iii) increasing differentiation between rural and urban communities in access to health services.

1 INTRODUCTION

1.1 Background

Recurrent funding for health services in Papua New Guinea (PNG) has been declining since 1985. The health status of women and children had been reported as unsatisfactory, and during 1993 a range of indicators was observed to deteriorate further. In particular, the limited data on immunisation coverage suggested a fall to a national average of about 30%.

The Child Survival Program (CSP) was initiated in October 1993 during discussions between the Prime Minister of Papua New Guinea and the UNICEF Country Representative, following: the signature by Papua New Guinea of the World Summit for Children Declaration on Survival, Development and Protection of Children; its subsequent participation in the Manila Ministerial Consultation on the Mid-Decade Goals for Children held in September 1993 and signature of the Manila Consensus signifying commitment to the Mid-Decade Goals; and the resolution The Government of Papua New Guinea (GOPNG) moved at the 33rd South Pacific Conference in New Caledonia in October 1993, urging member states to achieve the Mid-Decade Goals by 1995. It also built on the experience of the Child Survival Support Project (CSSP) 1990-1995 which was funded by the United States Agency for International Development (USAID).

Originally called the 'Crash' program, the CSP was officially launched nationally in February 1994 under the policy direction of a high-level steering committee, the program being managed by Task Forces at national and provincial levels. Regional launch workshops followed. The PNG national Department of Health (NDOH) was given primary responsibility for implementation; the Department of Village Services and Provincial Affairs was to be responsible for ensuring that activities were carried out according to schedule; and all other government departments and agencies together with community organisations were urged to cooperate.

The CSP comprised three main sets of activities, namely advocacy, multi-sectoral collaboration, and assistance in the delivery of maternal and child health (MCH) services. It supplemented the on-going MCH services which are directed at national level by the Assistant Secretary (AS) Family Health Services (FHS), and implemented by the Division of Health in each province and the National Capital District (NCD). In due course the functions now undertaken by the CSP Secretariat will be reabsorbed into the health system, with the expectation that the routine functions of the respective national and provincial Departments of Health will have been reinstated.

In addition it is planned that the longer term support provided by the Australian Government through the Australian International Development Assistance Bureau's (AIDAB's) MCH Project, the design for which is to be developed in April-June 1995, will enable many of the initiatives commenced through the CSP, to continue into the future.

Activities conducted under the CSP during 1994 are shown in Table 1.

Table 1
Child Survival program
Progress report February 1995

Province	Training of Trainers		In-service Training		Outreach
	Date	Funds	Date	Funds	
Southern Region					
Western					Dec (continuing); UNICEF funds.
Gulf	Aug & Oct 94	CSSP	Sept 94	CSSP	Planned; UNICEF funds.
Central					Planned; UNFPA funds.
NCD					
Milne Bay					Dec 94; UNICEF funds.
Oro					Nov 94 CHW training; own funds. Nov 94 Popondetta and Oro Bay districts; UNICEF funds.
Southern Highlands					Jan 95; UNICEF funds.
Highlands Region					
Enga					Oct 94; own funds. Dec 94; UNICEF funds.
Western Highlands					Jan 95; UNICEF funds.
Chimbu					Planned Feb/Mar 95; UNFPA funds.
Eastern Highlands					Planned; WHO funds requested.
Momase Region					
Morobe					Planned; WHO funds requested
Madang					Sept 94; UNICEF funds. Feb 95; UNICEF funds.
East Sepik					Planned; UNFPA funds.
West Sepik					Planned; UNFPA funds.
Islands Region					
Manus					Aug 94; own funds. Oct 94; UNICEF funds.
New Ireland	Sep & Nov 94	CSSP	Oct 94	CSSP	Planned Feb 95; UNICEF funds
East New Britain					
West New Britain					Combined patrols; own funds. Sept 94 (VSPA funds n/a). Dec 94; UNICEF funds.

North Solomons					Dec 94; UNICEF/UNDP funds.
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The Program has proved to be an extremely valuable stimulus to the MCH services of the NDOH. The advocacy function has been particularly successful, and the expressions of community concern and political support have catalysed renewed enthusiasm in health personnel. It has been particularly disappointing that the current financial crisis, and the associated government freeze on spending has threatened to undermine the efforts of the CSP and has almost brought them to a standstill. Notwithstanding this, with UNICEF and CSSP support and funds of the provinces themselves, some activities have been continuing, and the CSP National Task Force continues to meet frequently. Provincial Task Forces have met rarely since the financial crisis removed funding for Program activities.

Outside funding is needed urgently if the momentum created by the launching of the CSP is to be continued.

1.1.1 Papua New Guinea Government Request for Assistance

The GOPNG has now formally asked AIDAB for support to meet the needs of the CSP on an interim basis. This request for short term assistance is expressed in the letter from the Minister for Health to the Minister for Finance and Planning on 9 November 1994, in Working Paper 1. The letter was accompanied by a 13-page document titled 'A Submission on Behalf of Mothers and Children'. Table 2 is taken from that document as a summary of the GOPNG's requests.

The National Health Conference held in May 1994 made several recommendations which are relevant to the GOPNG's request, including: reiteration of the frequent request for a separate MCH vote in the budget for health in the provinces; and urging inter-sectoral action to support the CSP.

1.2 The Proposed Project

This project of Australian support to the CSP, developed in response to the above GOPNG request and presented in this document, is intended to build on the work begun under the CSP by the NDOH, UNICEF and the USAID/CSSP project of 1990-95. It is intended that it should continue until mid 1996 at which stage it is expected that the broader program of Australian support through the AIDAB MCH Project will begin; however, the scope of this Australian support to the CSP is broader than that of the CSSP, in that it will occur over the whole country and will fund outreach programs. This project will be implemented at a time when the health service is virtually completely deprived of non-salary funds.

The draft project design given here was developed by an external consultant, together with key staff from the CSP, using the government's submission as the equivalent of a pre-feasibility study. The consultant visited Oro and Simbu provinces in addition to Port Moresby.

To assist in the preparation of this design the GOPNG presented a detailed submission including inputs expected from other donors. The main task of the design study was to assess the need for assistance and the feasibility of the inputs and activities presented

in the GOPNG's request. The study found that this Australian support was both needed and feasible, but given the government's financial situation and the capacity of the health system, assistance should be limited in its scope. The severe deterioration in services and current financial stringency indicated that assistance through this project should focus on immunisation, and training for the improved capacity of health personnel.

Further discussion on this document by AIDAB in consultation with the Office of International Development Assistance (OIDA) of the PNG Department of Finance and Planning (DF&P), UNICEF PNG, Child Survival Secretariat and the project team of the CSSP occurred in February 1995. This draft design was again modified in the light of those discussions.

2 RATIONALE

2.1 The Current Problems

2.1.1 Health Status of Women and Children

The major causes of death in children under 5 in Papua New Guinea are pneumonia, diarrhoea and malaria, for which standard, economical treatments are available, and for which most patients can be treated at aid post and health centre levels *when* drugs are available. Malnutrition is a frequent primary cause of death and also contributes to the death of children from other causes.

The major causes of pregnancy-related deaths in women are bleeding and infection. Early identification of at risk pregnant women is needed at the primary care level for their referral to hospitals for treatment. Supervised delivery is the major strategy for preventing maternal deaths.

Access of women and children to health care has declined over the past several years and is now be regarded as the worst in the Pacific. This is clearly illustrated by the reduction in immunisation coverage and the increasing occurrence of immunisable diseases. Extracts providing details of a number of key MCH indicators are shown in Working Paper 3 of this document.

2.1.2 Health Services

About 20% of the population have access to hospitals, health centres and sub-centres. Another 70% are intended to be served by aid posts, but between one third and one half of aid posts are estimated to be unstaffed and of the remainder, few are able to give immunisations or provide other MCH services other than simple treatments. It is estimated that immunisation coverage for up to 60% of the population of PNG can only be maintained by means of mobile patrols.

The deterioration in services has occurred while relatively large amounts of assistance were being provided by Asian Development Bank (ADB) over the past 15 years, with

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significant inputs also from UNICEF, World Health Organisation (WHO) and bilateral donors such as Australia. The reduction in services is most often attributed to the drastic fall in the percentage of funds from GOPNG available for purposes other than salaries. Related factors are limited availability of vaccines and other medical equipment and supplies, including refrigerators and cold chain boxes; and unreliable access to vehicles and boats. Wet weather, crime and tribal fighting compound the problems. Underlying management deficiencies are also often cited as key factors contributing to the decline in service quality and availability.

Poor health status is often attributed to poor community compliance with medical advice. The causes of poor compliance includes: the distance from place of residence to a health facility; lack of medicines and equipment at health facilities; absences of health staff from their posts; indifferent attitudes expressed by health staff; and incorrect diagnosis and treatment. Studies suggest that community education is rare and that little time is spent on maternal health during routine MCH clinics. All these factors are service-related.

While conflicting cultural beliefs and practices, and lack of education, contribute to poor compliance, they are much less important than poor quality services which discourages attendance at health clinics and aid posts. Hence community awareness activities should follow on from upgrading of services, once people are aware that good quality services are available.

This development of quality services is brought about in part by the training and supervision of staff. With the assistance of ADB funds provided through the first, second and third Rural Health Projects (ADB I, II and III), provincial in-service training coordinators have obtained post-graduate Diplomas in Education (Health) at the Goroka campus of the University of Papua New Guinea (UPNG), and almost every province has had a coordinator appointed. In previous years however, the in-service training programs for rural health staff have become irregular, and extra support is needed.

2.1.3 Access to Maternal and Child Health Services

Maternal and child health services have the following functions:

- (i) to provide immunisations for children aged 0-13 years;
- (ii) to monitor the nutritional status of children;
- (iii) to provide diagnostic and treatment services for sick children;
- (iv) to provide ante-natal care for pregnant women;
- (v) to provide supervision of delivery for pregnant women;
- (vi) to provide advice and services for family planning;
- (vii) to educate the community in matters relating to maternal and child health;
- and
- (viii) to provide supervision for aid post workers, village health aides and village birth attendants where they exist.

These are provided from fixed and from mobile clinics in urban and rural areas:

Increased access to MCH services especially immunisation, requires continuation or re-establishment of regular visits to villages by provincial health staff in the course of conducting mobile MCH clinics, and for the remainder of the population, repeated health patrols. The data regarding the potential for MCH mobile clinics and the need for patrols is known by health centre staff at district level and the situations vary widely from district to district. This information is not available at national level. Planning and implementation is done at district level with participation by provincial health officials.

The current method of funding health services uses a set of 'votes' to allocate funds for specific health activities. One vote is available for Rural Health Services, which covers many activities in the provincial health office and in health centres including MCH services. There is no specific vote designated for MCH. When funds are limited, the amount made available to MCH activities is often reduced, clinics are cancelled, people are disillusioned and fail to attend subsequently, and the system of outreach MCH work collapses. Over the past 15 years the per capita kina allocation of funds for transport, patrol allowances and parts for refrigerators for MCH has fallen or remained the same so that the amount available in real terms has become grossly inadequate.

The grouping of expenditure items within votes does not allow estimation of past expenditure on MCH outreach or on health patrols. Differences in road systems, population density and terrain result in widely varying costs per person contacted, and patrol routes are also defined by the short life of vaccines above refrigerator temperatures and the need for vaccine re-supply.

This project is designed as a short term one justified by special circumstances. Its special features include urgency and a high contribution to operational costs. In projects in future years GOPNG will be expected to provide recurrent costs. One part of the GOPNG funding system in future may be continued expansion of the designation of specific budget votes for MCH services consistent with the recommendation made during the National Health Conference in May 1994

2.2 The Government's Response to These Problems - the Child Survival Program

As discussed in section 1.1, the GOPNG responded to the evidence of the rapidly declining level of maternal and child health by establishing the CSP in order to achieve nine objectives:

- (i) increase vaccination coverage to 80% for all antigens;
- (ii) eradicate poliomyelitis;
- (iii) reduce measles deaths by 95% and cases by 90%;
- (iv) eliminate neonatal tetanus;
- (v) improve maternal health and reduce maternal deaths;

- (vi) achieve 80% usage of oral rehydration therapy (ORT) as part of the control of diarrhoeal diseases;
- (vii) eliminate vitamin A deficiency;
- (viii) iodise all salt for the elimination of iodine deficiency disorders; and
- (ix) make all hospitals baby-friendly.

(Source: Child Survival Crash Programme 1994-1995 for achievement of the Global Mid Decade Goals for Children in Papua New Guinea. Port Moresby, February 1994.)

In the light of the current funding difficulties and other constraints, these objectives will not be attainable in the short term, and the immediate focus will be on increasing the level of immunisation coverage. Nevertheless, the CSP has had strongly positive influences on the health system and the MCH services in particular: staff feel valued for the services they provide; they are showing considerable excitement in the training courses held so far; their enthusiasm is being rewarded with increased community interest and satisfaction and improved patient outcomes; their increased ability to communicate with people is resulting in greater community responsiveness and involvement. The teaching/learning materials prepared under the CSSP project and available to the CSP both for health personnel and for the community, are proving interesting and effective.

This is a considerable step towards the improved health status of women and children in PNG as it will improve service delivery and will be sustainable if supported by funding commensurate with MCH service needs and community awareness activities

2.3 The Priority for this Project

2.3.1 PNG Government Perspective

The Secretary for Health Mr Paul Songo CMG confirmed on 8 December 1994 that the PNG Government will provide the inputs essential to the effectiveness of the proposed Australian support. These are:

- (i) vaccines and medical supplies;
- (ii) the services of the Coordinator of the Child Survival Program, the staff of the CSP Secretariat, and health personnel in the Family Health Services of NDOH together with their office facilities; and
- (iii) office space and facilities including utilities for the project team managing the Australian support in the NDOH.

Staff employed by the departments of each of the Provinces in sufficient numbers to provide maternal and child health services can reasonably be expected to be retained as the result of the priority expressed by the Prime Minister and other Ministers at the outset of the CSP in February 1994. Confirmation of the availability of health staff in the provinces will be sought from the GOPNG as a condition of approval of this project, as will be the timely supply of vaccines and medical supplies.

2.3.2 Australia's Country Program Perspective

The proportion of Australian assistance to PNG provided as project aid will steadily increase over the coming years, with priority given to funding the health sector which, as a guide, is expected to receive approximately 20% of total project funds. The findings of the Joint PNG/Australia Health Sector Study in 1993 have been endorsed by the PNG National Executive Council (NEC).

This Study presented proposals for: assistance to health service management; women's and children's health programs; disease control; environmental health; health promotion; secondary and tertiary services; and additional assistance for disadvantaged provinces. Support for the CSP falls within several of these priority areas.

Australian aid policy favours investment in training and institutional strengthening, although this does not exclude support in other areas where appropriate. The largest part of the GOPNG's request for Australian support to the CSP is for recurrent operational costs especially travel and personnel allowances for health outreach activities.

Although such costs are not usually supported within AIDAB projects, acceptance of that request by Australia is based on recognition of the unique financial circumstance of COPNG at the present time which are having a serious impact on the health of women and children, the most vulnerable members of the community. Support by GOA for this project is to be seen by AIDAB as an short term priority arrangement pending implementation of major assistance through the MCH Project and the Selected Provinces Project, both of which are planned to begin in 1996. This project of support to the CSP will keep assistance flowing in the interim in order to ameliorate the major problem of absence of delivery of MCH services and will augment the work being undertaken by UNICEF.

It must not be expected that assistance with a level of recurrent cost funding such as that proposed for this project will be maintained in the longer term, because it is not consistent with the principle that sustainability of activities ultimately rests with the nation of Papua New Guinea. Sustainability for MCH programs is dependent on:

- (i) a separate vote for MCH programs in the provinces; and
- (ii) an increase in funds required to expand much needed health interventions such as identification of at risk pregnant women, an increase in family planning coverage, increased supervised deliveries, an increase and maintenance of higher immunisation coverage, and expansion of time devoted to information, education and communication (IEC) activities.

2.4 Related Programs

There are a number of relevant programs, supported through ongoing government department activities and through external donors. The major related programs are described below.

2.4.1 Papua New Guinea Government Programs

Health Programs

The ongoing provision of primary health care and MCH programs through the NDOH and provincial health divisions, serving both rural and urban people, are crucial for the health of the population.

Although such services have deteriorated significantly in recent years, and health centre services and disease control programs are being adversely affected by a lack of recurrent funding, they are still substantially in place, and serve as the foundation on which the CSP is built.

In-service training is being conducted in provinces on the initiative of the In-service Training Coordinator and/or of the District Health Officer in Charge. Teaching and learning materials produced under this project of assistance to the CSP will be linked with these departmental training functions.

Other Government Department Activities

Activities operated by the Department of Education (eg the Curriculum Development Division) and the Department of Village Services and Provincial Affairs also indirectly supports the Australian assistance to the CSP. The defence and police forces also provide a limited range of MCH services to their members and dependents.

2.4.2 Donor Supported Programs

AIDAB has already provided AUD 1.6 million through the Commodities Assistance Program (CASP) for the supply and distribution of health centre equipment for the CSP and is also contributing funds for an immunisation program to assist in the restoration of North Solomons Province (NSP). In addition, AIDAB supports the Population and Family Planning Project, the North Simbu Rural Development Project and the Primary Health Care (PHC) Linkages component of the Hospital Operations and Management Project, all of which will have relevance and provide indirect support, to this project of Australian assistance to the CSP

USAID has been a key donor in this area. Its current CSSP has been providing technical assistance through two highly competent and experienced advisers, together with training, research and coordination assistance since 1990.

Unfortunately USAID aid to PNG will cease in March 1995, and with it the funds for the two CSSP advisers. The office space, copy printer, binning machines and guillotines being used by CSSP will remain the property of NDOH and will be available to this Project.

UNICEF will continue its work in social mobilisation and advocacy. UNICEF has also provided funds for outreach activities within the CSP as shown in Table 1.

UNICEF's communication strategy for 1994 and 1995 includes a series of monthly themes, slogans and special events relevant to child survival. Examples of themes are: women's literacy for health; immunisation; handwashing and hygiene; child spacing; polio; control of diarrhoea; coughs and colds; child growth and nutrition; breastfeeding; malaria; measles; safe motherhood; and family food production.

The ADB has also provided extensive assistance for rural health services including PHC and MCH. Its continuing activities are directly relevant to this Project. These include the Third Rural Health Project (ADB III) and the Human Resources Development Project (HRD). The ADB is also a supporter of the Population and Family Planning Project.

Other donors with programs of direct or indirect relevance include WHO, the European Community and Korea.

2.4.3 Linkages to these Programs and Sectors

It is considered important that this project of Australian support to the CSP be coordinated with other health activities in the country, including other AIDAB projects, and those funded by the GOPNG or other donors.

Some basic principles underlie this project:

- (i) a common understanding of the aims and objectives of MCH services should be ensured between all those active in the area;
- (ii) services between programs and projects should be coordinated as far as practicable;
- (iii) there should be minimal duplication of administrative requirements across programs and projects;
- (iv) services assisted through donor funding should aim to become sustainable, and staff should be assisted to develop the required skills and knowledge base to maintain the program on a long term basis;
- (v) training activities should be coordinated so that priority is given to service delivery and the same staff are not required to frequently travel to training programs of separate programs and projects.

Any difficulties which arise due to coordination difficulties should be resolved as soon as possible in the context of the overall agreement on the overall purpose of improving maternal and child health through the delivery service to the rural communities across PNG.

At the national level, this project of Australian support to the CSP will be coordinated by the AS Family Health Services who also oversees all projects and programs relevant to maternal and child health. At the provincial level, the respective AS for Health/Provincial Advisers for Health who are the coordinators for all health programs and training in their provinces will have the oversight for activities in the provinces. Responsibility for management of MCH services rests with the Matron in Charge of Community Health Nursing Services in collaboration with the Coordinator.

Rural Health Services or equivalent officer. All donor-assisted projects work with these officers and with the district personnel who carry out the services. Further discussion of the coordination of this project of Australian support to the CSP is contained in Section 5.1 of this document.

This project will contribute information and direction for the 1996-2000 National Health Plan for which preparation is beginning. As the NDOH re-organisation is implemented, this project will have enabled active field programs which the strengthened Family Health Services Branch in NDOH will be able to develop further. It will assist also strengthen the financial management capacity at the provincial and district level through the monitoring of project expenditure required by AIDAB.

The training and institutional strengthening activities of this project will contribute both to the AIDAB MCH Project planned to commence in 1996, and to the ADB Human Resources Development Project when it commences in 1995/1996.

3. PROJECT DESCRIPTION AND IMPLEMENTATION

3.1 Objectives

The objective of this project is:

To provide short term support to the Government of Papua New Guinea's Child Survival Program which aims to reduce child mortality, prevent illness and promote better health among women and children.

3.2 Target groups

Women and children in all provinces, other family members, the community at large, and health personnel will benefit from the inputs of this project. In addition people who may be ill at the time the patrolling health personnel visit their village may receive assistance by treatment and/or referral.

Increased competence of personnel and additional health centre equipment will enable better care of all patients.

3.3 Location, Duration and Phasing

This project will operate nation-wide from March 1995 to June 1996 with all funds to be expended by December 1996 in accordance with this project design. By this time it is anticipated that the wider AIDAB MCH Project will have begun.

This project will provide funds for outreach activities for all provinces. Ten provinces will receive assistance for training of trainers and in-service training at district level during 1995 and the remaining provinces during 1996.

This project is seen as ambitious by some in seeking to provide assistance to every province, in particular in the North Solomons Province (NSP), where the timing and extent of activities to be carried out will be governed by the security situation in Bougainville. However, the CSP already conducted the first round of immunisation campaigns in this Province with UNICEF funds in protected camp areas and villages in December 1994. Notwithstanding these activities, more work remains to be done. In any event there are additional, complementary activities planned for NSP as part of the reconstruction program for that Province.

This introduction of the project into *all* provinces is considered justified because:

- (i) the need is great in all areas of the country, and perhaps greatest in those province with the highest percentage of remote rural populations and with more difficult terrain;
- (ii) the provinces have *all* indicated their support for this project, and have agreed to give it high priority;
- (iii) the need across all provinces is urgent and time does not allow a slow, phased-in approach; and
- (iv) although there will be problems with establishing funding and supervisory mechanisms in some provinces, the CSP Secretariat are confident that, through the use of both fixed and outreach activities, together with the introduction of a comprehensive training component, and the provision of funds to allow for supervisory visits from both national and provincial health officers, the activities can be carried out with a significant chance of success.

3.4 Detailed Component Description

This project of Australian support comprises three components:

- (i) Component 1: The Delivery of Maternal and Child Health Services;
- (ii) Component 2: Increased Competence of Health Personnel through Training;
and
- (iii) Component 3 : Project Management .

These are described in more detail below, in the logical framework matrix, (Annex 1.3), and the implementation and cost schedules (Annex.1.4 and 1.5).

3.4.1. Component 1: The Delivery of Maternal and Child Health Services

Health services are provided through fixed facilities including health centres, sub-centres and aid-posts, with some involvement of provincial and district hospitals, and through a range of 'outreach' activities.

Within the health service framework there are a wide variety of means for contacting the people who do not present themselves at fixed facilities. The general term 'outreach' is used here to mean all activities conducted outside fixed facilities and implies travel by health personnel to the client, as opposed to travel by the client to the fixed health facilities. When nurses and community health workers (CHWs) travel

by vehicle, boat, air or on foot to villages and urban settlements, for regular scheduled clinics, the activities may be called MCH mobile clinics. When roads and/or vehicles are not available, health staff sometimes walk in order to keep their schedules, and those excursions may be called 'foot patrols'. Less frequent, and irregular visits to villages by health extension officers (HEOs), nurses usually assisted by CHWs, and sometimes health inspectors and health educators are called 'patrols'. The terms are not necessarily used consistently so it is often necessary to enquire about the details of the work programs being discussed in order to know precisely what is meant.

In recent years the provision of services through both fixed facilities and outreach activities has deteriorated. In the case of fixed facilities, the infrastructure and equipment is often in need of repair, drugs are often in short supply, staff are increasingly in need of additional training, and morale is often low. Despite these problems, services have continued in many areas at acceptable levels, due to the dedication and commitment of the staff. In the case of outreach activities the lack of funds for activities other than salaries, and the inability to repair and maintain motor vehicles and boats has meant that mobile clinics and patrols have ceased in most areas of the country.

As described in Section 2.2, the CSP was established by the GOPNG to help address this deterioration in services. This project will support the CSP in its longer term mission.

Component 1. Objective

The objective of this component is to deliver MCH services to the people of PNG through the strengthening of services provided through fixed facilities and outreach activities.

Component 1. Outputs

In achieving the above objective the following outputs are to be achieved:

- (i) health care will become increasingly accessible to all women and children;
- (ii) there will be a move towards change among the people of PNG in their knowledge, attitude and behaviour towards their own health.

Component 1. Activities and Inputs

As stated earlier, this project will provide support to the CSP, for a period of only 15 months. During that limited period it will help ensure that activities relating to the provision of enhanced MCH service delivery from both fixed and mobile facilities proceed according to an agreed timetable. A substantial change in MCH coverage may be achieved within this time if the following constraint can be overcome:

the GOPNG can provide the timely supply of vaccines and other necessary support for cold chain operations to ensure that vaccines remain efficacious in the field.

It is essential that the start made by this project contributes to a renewed commitment to MCH care through the CSP and other NDOH programs when the current financial restrictions ease, and into a broader, longer term program of support by AIDAB and possibly other donors in the area of women's and children's health.

In 1994 AIDAB provided approximately \$1.6 million to the CSP through CASP to help equip the mobile patrols with additional medical equipment and camping gear and for the purchase of essential equipment for health centres and sub-centres including vaccine refrigerators, examination sets and other instruments. Combined with training that will be given through this project, this supply of urgently needed equipment will provide an important stimulus to the staff in these fixed facilities, and enable them to provide an improved level of service.

Only 30% of the population have direct access to services provided through the health centres and sub-centres. The main vehicle for reaching the majority of the population will be through patrols and their provision of face-to-face service, together with IEC in rural communities. Support of these outreach services-mobile clinics and patrols-will be the largest single element of this project and will involve approximately 46% of this project's budget.

Patrols will be organised and operated at the provincial and district level. Provinces will have an annual plan for each of their districts and it is the aim of this project that each village be visited four times each year, although in some more remote locations this will be difficult. Patrols will be on foot, or where conditions allow, they will make use of road, sea and river transport. Funds provided through the project will cover patrol supplies, camping allowances and supervision and fuel. Where necessary funds will be provided for vehicle and/or motor boat hire will

Patrols will be carried out by nurses, HEOs, CHWs and other health staff who are normally employed by the provincial health divisions. The GOPNG has agreed to continue to fund these staff. It is expected that when in a village, patrols will provide a range of services, including the full set of vaccinations for children, tetanus immunisation for women, supply of oral rehydration fluids, and prevention and treatment of vitamin A deficiency. Where relevant they will initiate tuberculosis, leprosy and filariasis control activities, provide ante-natal care and other MCH services, including family planning and treat those in need of immediate care from a variety of illnesses.

An important feature of the patrols will be their activities in health promotion and education. Communities and families will be given basic knowledge on preventive health care and on simple home management of common diseases, through individual and group talks, supplemented by flip charts, posters and pamphlets. Non-government organisations (NGOs), particularly women's groups, will be invited to participate in these health education activities, and learning materials will be made available to them through this project.

The church health services are an indispensable part of the health system especially in maternal and child health and especially in rural areas. They will receive an appropriate share of the available funds to enable them to provide outreach services as well as 'fixed' clinics, and church health staff will be included in the training programs.

3.4.2. Component 2: Increased Competence of Health Personnel through Training

In many areas there has been a decline in the competence of staff providing health services, with many, particularly the older staff members and those in the more remote locations, not having received updated training for many years.

This component of the project plans to address this problem.

Component 2. Objective

The objectives of this component are:

- (i) to train and empower trainers in the provinces to carry out training activities required to increase the competence of health personnel to deliver MCH services; and
- (ii) to enhance the competence of health personnel to deliver MCH services through programs of in-service training.

Component 2. Outputs

In carrying out this component the following outputs will be achieved:

- (i) provincial trainers will be able to train health personnel at district level; and
- (ii) health care workers will be trained to deliver MCH services more effectively.

Component 2. Activities and Inputs

This component will support the costs of engaging a physician/educator, the holding of training of trainers courses and of district level in-service training programs, and the costs of preparing and distributing training materials.

The physician/educator together with the counterpart trainer in the CSP will assist the provincial health officials to prepare an annual training plan, budget and schedule. The training plan will as far as possible be coordinated so that outreach patrols occur as soon as possible after district in-service training programs. The project team will work with province staff to manage implementation of the training program. The current physician/educator, Dr Keith Edwards is essential for the continuation of this project and it is intended that means will be devised to ensure that he continues in his current role.

Training of trainers is to be conducted at provincial level, led by the physician/educator together with his counterpart from the national level and with the

assistance of resource persons from the region and province. Participants will be selected by the AS Health of the province, following the pattern set in the CSSP training courses in Gulf and New Ireland Provinces subject to agreement of the Coordinator of the CSP. The schedule of provincial training of trainers in 1995 is shown in Table 3.

The district-level training courses will be conducted by the provincial In-service Training Coordinator, district level staff who have already been trained as trainers, and where requested, trainers from the Regional Support Units. Each district is expected to conduct two in-service training events after each training of trainers, the costs being met by the project.

3.4.3. Component 3: Project Management

In addition to the two operational components referred to above, this project will also support a third component which will be responsible for ensuring the efficient and timely management of the project inputs. This will be done using a project management, monitoring and evaluation and reporting process outlined in more detail in sections 4 and 5 of this report.

In the case of this project it is particularly important to define clearly the management activities to be followed as the activities are scattered over all provinces and districts of the country and involve several departments of the GOPNG, as well as AIDAB and UNICEF.

Component 3 Objective

The objective of this component is to ensure effective management of this project's inputs and activities.

Component 3. Outputs

In achieving this objective the following outputs will occur:

- (i) effective and efficient use of Australian funds; and
- (ii) an effective monitoring, evaluation and reporting system for this project; and
- (ii) improved financial management and accounting in the provinces.

Component 3. Inputs and Activities

The implementing agency for the project will be UNICEF. A procedure for the management of Australian funds, acceptable to GOA, the GOPNG and UNICEF is being negotiated at the present time and must be agreed before the project can commence. This procedure will minimise the delay to the implementation of the Australian support and will be formulated cognisant of UNICEF's *modus operandi*.

It is anticipated that this project will have two phases, a two month inception phase during which activities will commence and in which the Implementation Schedu (IS)

will be produced, and an implementation phase which will run for the remainder of the project. Due to the need for expediency, it is not practicable to develop the standard Project Implementation Document prior to the proposed project start-up date.

Financial management and accountin training is a function within this component. The objective of this training is to enable provincial health divisions and district health officers to competently manage and account for CSP funds. By introducing tools, procedures, and training in financial management and accountability operational costs for the program would be controlled and wastage of funds reduced. In the long term this would lead to the sustainable operation of routine training and outreach patrol services. The project management team will perform this training on a needs basis.

In addition to this specific training, frequent visits to provinces by UNICEF, the project management and administration team, the CSP Coordinator and staff members of the Secretariat, and officers of the Family Health Service of NDOH will occur to guide, encourage and assist provincial and district health officials and to ensure adequate monitoring of the project. Financial and activity reports will be obtained to ensure prompt availability of funds where needed, and to record the services provided.

Inputs for this component will include the salary and support services for: the project managment and administration team comprising of the project manager, the finance and administration officer and the monitoring and evaluation short term consultant and administrative support staff; and for travel for the CSP Secretariat staff involved in project monitoring and evaluation.

4. FINANCIAL ISSUES

The expected external costs of this project are \$4.97 million, of which \$2.9 million will be committed to Component 1 for the delivery of services and \$ 1.5 million for the training activities within component 2. In addition \$0.55 million will be required to support project management activities of Component 3 to ensure the timely and effective execution of this project.

A summary of costs is shown in Table 4, and the detailed costings are given in the Cost Schedule (Annex 1.5).

Australia will provide the \$4.97 million referred to above as part of its program of assistance to the PNG Health Sector. These funds will be channelled through UNICEF, which will be the implementing agency of the Australian support to the CSP.

The Government of Papua New Guinea will be expected to provide the ongoing inputs essential to the effectiveness of the proposed Australian assistance, comprising

- (i) vaccines and medical supplies;

- (ii) the services and salaries of the Coordinator of the Child Survival Program; the staff of the CSP Secretariat; and health personnel in NDOH and in all provinces in sufficient numbers to provide maternal and child health services; and
- (iii) office space and facilities for this project in the National Department of Health.

These inputs are currently being provided by GOPNG, and no additional commitment by them is proposed.

4.1. Management of the Australian Contribution

It is assumed that there will be very little money available through the GOPNG in 1995 for operational costs of health programs, and that continuation of field services will therefore be dependent on donor funds, and particularly those provided by this project. As long as the 'freeze' of most government expenditure continues, donor funds must be managed outside the regular government financial system to ensure effective use of the funds by government and church health personnel for the specified purposes.

Australian funds for technical assistance, training, materials and operational funds are to be managed through UNICEF.

The system to be applied by UNICEF in this project, acting as the implementing agent for AIDAB funds, will also need to be one in which control over use of funds is precise and detailed and allows full checking. It is for this reason that this project design includes funding of a full time project manager and a financial and administration officer who will have responsibility for ensuring:

- (i) timely flow of funds to the provinces and districts to ensure project activities take place; and
- (ii) tight control and monitoring of the expenditure of funds.

Australian funds flowing through UNICEF will be used for:

- (i) support for technical assistance; and
- (ii) for support of the ongoing government administered training and service delivery activities at national, provincial and district level.

Australian funds will be placed in a special project account established by UNICEF at the national level. This account will be controlled by UNICEF and operated by appropriate signatories to be nominated by UNICEF and the CSP Coordinator, in consultation with the project manager.

As a large proportion of the funds are to be spent in numerous districts continuously for in-service training, mobile clinics and patrols, they can only feasibly be managed at province level.

For the duration of the financial freeze, expenditure of provincial department funds for activities under the project followed by reimbursement from an imprest account is not practicable and direct funding from the national project account will be necessary.

The procedures listed below for funding provincial activities must be seen as a guide only at this stage and may change during the development and formal agreement of the actual procedures that will be put into place.

Checking accounts for this Australian support to the Child Survival Program would be established at a commercial bank in each province. Controlled by the National Child Survival Program Coordinator, these provincial accounts would allow controlled drawing facilities by senior provincial health and welfare officials for the operation of health patrols and district level health worker training. Joint signatories would be required: it is anticipated that two key members of the provincial task force and the Matron of Community Health Nursing Services would be the signatories.

Provincial health divisions would operate an accounting system to be defined and documented in the IS. This accounting system must not conflict with the normal provincial accounting system. One option for consideration is the one-write system utilised by the CSSP. Reconciled monthly, with a one week grace period, the bank account would be replenished as long as full accountability for local expenditure is maintained.

Obtaining letters of agreement from provinces to the procedures adopted will be an early task of the project management and administration team.

4.1.1 Management of Funds for Ongoing Government Activities

National level Activities

Funds may be expended through the bank account at national level for:

- (i) travel and incidental expenses of NDOH staff, the CSP Coordinator and staff of the Secretariat;
- (ii) procurement of a vehicle, office furniture and equipment, office renovations, and computers, where not already available;
- (iii) printing of clinical guidelines and manuals, community education materials, and teaching and learning materials;
- (iv) freight for health centre equipment and supplies;
- (v) distribution costs of educational materials;
- (vi) administration costs of training courses;
- (vii) office operating costs;
- (viii) communications costs;
- (ix) vehicle operating costs;
- (x) technical assistance; and
- (xi) remittances to the provinces.

Two people must sign for all withdrawals and transfers, following UNICEF/AIDAB agreed guidelines.

Quarterly advances of money will be deposited initially in accounts for use in each province, according to programs of work submitted with estimates of costs. Replenishments will be sent promptly to provinces after activity and financial reports have been received. Activity and financial reports are to be submitted within one week of the end of the month. An advance will not be sent in the absence of a satisfactory report. Feedback comments are to be provided on provincial reports as part of the management development program.

Provincial level Activities.

Funds may be expended through a bank account in each province for:

- (i) patrols;
- (ii) training of trainers courses
- (iii) in-service training courses
- (iv) travel by provincial supervisors to districts
- (v) MCH outreach services; and
- (vi) costs of communicating to villages the timetable/program for patrols to their village.

In general the funds are to be used for operating costs only and not for purchase of equipment. Air fares and hire of boats will be eligible expenditure where they represent the most effective and efficient means of providing MCH services. Use of air travel is justified when it allows access to populations which because of time and risk could not be served by walking, or when the costs of fares are less than the costs of a prolonged foot patrol. Air travel for districts and health sub-centres not accessible by road enables effective use of staff time, prompt delivery of vaccine within its period of potency outside the refrigerator, and supportive supervision of field staff. Air freight enables delivery of g.c. cylinders for refrigerators and other essential supplies.

District Level Activities.

Because of the nature of the activities being supported, a high proportion of the funds within this project will necessarily be spent at the district level - principally by district health officials. There will be a large volume of in-service training and field work by large numbers of personnel occurring continuously over the whole country. Planning and implementation must be done at local level by the staff most familiar with the area and the people.

In order to minimise the amount of money to be handled as cash, the expenditure can be segregated. Responsibility for security of cash must lie with the officer who draws the money. The following measures are proposed for possible implementation when the advisers commence work.

Funds for hire of vehicles from the Public Transport Board (PTB) should be transferred through the respective bank accounts or by cheque.

Camping allowances for health personnel can be paid into their bank accounts after each patrol or paid in the same way as has been found acceptable and safe for salaries.

Patrol advances must be carried in cash to be used for payment of carriers and for minor local purchases such as kerosene, and should be kept to the minimum. A number of options exist for the transfer of funds for patrols. The most desirable is that funds are transferred to the AS Health of the province according to routine to the Officer in Charge of Health for the District on satisfactory reporting and acquittal of previous funds.

Other alternatives are that:

- i) funds are transferred according to routine procedure to the District Manager, who will be responsible for security until the cash is paid to a health official; or
- ii) the Health Officer in Charge travels to the provincial health office and draws funds in cash and returns to the district.

Decision between these options can be made by the CSP Coordinator in consultation with the project manager and the AS Health in each province. While a uniform procedure for all provinces is desirable, local conditions or opinions may require a different solution in different places.

Cash is drawn by the most senior health official who will be going out on the patrol and will be personally responsible for security, use and acquittal of the funds.

5. PROJECT MANAGEMENT

This section of the report discusses the organisation and management of the activities of the project and methods for monitoring its progress.

The Child Survival Program is an initiative of the Government of Papua New Guinea and as such it will be administered and organised by relevant PNG officials. Additional management arrangements will be needed to manage the funding provided by AIDAB, through UNICEF, for this project. To do this a Project Management Group (PMG) will be established as a sub-group of the Child Survival Task Force to administer the project. Suggested membership of the PMG is:

- (i) Child Survival Coordinator (Chair);
- (ii) representative MCH Branch of the NDOH;
- (iii) OIDA;
- (iv) the project manager;
- (v) AIDAB; and
- (vi) UNICEF.

The PMG will meet quarterly to monitor ongoing progress of the project and to authorise any movement of funds between project components (to a maximum of 15% not exceeding the overall project budget, and subject to confirmation by AIDAB Canberra). More frequent meetings of the PMG will be held as required. In addition, as part of its external monitoring procedures, AIDAB will initiate a short technical assessment of the project approximately every six months.

5.1 Management and Coordination of Project Activities

5.1.1 At the National Level

The Child Survival Program forms one part of the responsibilities of the government's inter-agency Social Sector Committee, of which the Secretary for Health Mr Paul Songo CMG is the Chair.

The implementing agencies of the CSP are the NDOH, including its Regional Support Units (RSUs) and the Divisions of Health of the Departments of the Provinces. RSUs are branches of the NDOH and have had varying levels of policy support during the past five years. They are now expected by the NDOH to play a role in provincial health care development including the Child Survival Program. The project management team will make use of the services of the expert personnel in the RSUs whenever they are available, to contribute to training and support to the provincial programs.

The NDOH has adopted a revised structure which is awaiting formal approval. Issues relating to this project of Australian support will fall primarily within the responsibilities of the new Family Health Services Branch of the Promotive and Preventive Health Services Division and to a lesser extent within the Division of Curative Services. The organisation chart of the Division of Preventive and Promotive Health Services is shown in Figure 1 and of Family Health Services in Figure 2.

The day to day responsibility for the coordination of activities will rest with the CSP Secretariat. This consists of five officials seconded from the NDOH and is headed by a senior health official who is also designated as the Coordinator of the CSP.

The Coordinator is responsible to the First Assistant Secretary of Preventive and Promotive Health Services, and works in close collaboration with the Assistant Secretary for Family Health of the NDOH. His/her major responsibilities consist of:

- (i) maintaining the interest of political leaders through information and personal contact;
- (ii) maintaining close communication with government departments, church health services and NGOs;
- (iii) ensuring complete integration of the CSP into the policies and programs of the NDOH;
- (iv) managing the delivery of the health centre equipment being supplied by AIDAB through CASP to its correct destinations;

- (v) linking the CSP with donor projects including ADB 3, including the Health Information Systems Development component of this project, and the AIDAB design study for the MCH Project.

This draft project design document proposes the appointment of technical and administrative staff working in an advisory role. They will work in close collaboration with the CSP Coordinator and Secretariat to implement the project under the supervision of the UNICEF Country Representative. The combined staff of the FHS, CSP and the Australian funded project management and administration team will make up the project management team, in which the chief executive is the Assistant Secretary Family Health.

The proposed project organisation chart is shown in Figure 3.

The Secretary for Health has indicated that the office space now occupied by the CSSP and the equipment in it, can be made available to this project. Mr Songo believes that it is most important that the project team should be in the same building as the Family Health Services to enable frequent formal and informal communication.

In addition to the day to day management role of the CSP Secretariat and the FHS Branch, the Government has established a CSP Task Force which has institutionalised multi-sectoral agency and community involvement in maternal and child health services.

The current membership of the National Task Force is:

- (i) Assistant Secretary Family Health, NDOH (Chair);
- (ii) Senior Specialist MCH, NDOH;
- (iii) Assistant Secretary Health Promotion, NDOH;
- (iv) Coordinator, CSP;
- (v) two staff of the CSP Secretariat;
- (vi) two advisers from CSSP;
- (vii) WHO Country Representative;
- (viii) UNICEF Country Representative and two adviser;
- (ix) ADB Health Promotion Adviser to the NDOH;
- (x) Professor of Paediatrics, UPNG;
- (xi) two representatives from the Department of Education;
- (xii) a representative of the Department of Religion Home Affairs and Youth;
- (xiii) a representative of the National Broadcasting Commission;
- (xiv) a representative of the Department of Village Services and Provincial Affairs.

Additional representatives on the Task Force are from:

- (i) the Department of Information and Communications;
- (ii) the Prime Minister's Department ;
- (iii) the National Council of Women ;
- (iv) the Susu Mama (Nursing Mothers Association); and

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(v) the Churches Medical Council.

AIDAB will also join this Task Force and it is essential that the project management and administration team are requested to join the Task Force as the CSSP advisers vacate their seats on withdrawal of funding for the CSSP in March 1995. It would also be beneficial if a high level representative from the DF&P participated in the Task Force meetings.

The support of the community and of political representatives will be maintained by advocacy activities by the CSP Coordinator supported by UNICEF. Continued support for the CSP by members of the community will depend on the quality of service they receive. Collaboration between government agencies and other institutions will be achieved through the CSP Task Force, and the work of the Coordinator and the Secretariat.

5.1.2 At the Provincial Level

The key coordinating bodies at provincial level are the provincial Task Forces. The usual members of provincial Task Forces are as follows, although this may vary slightly from Province to Province:

- (i) the AS Health, or equivalent (Chair);
- (ii) AS Education; and
- (iii) AS (Community Development and) District Services, or equivalent.

NGO representatives, especially from the churches and from women's organisations, are generally not members. At least some of the provincial task forces have ceased meeting since Government funds were withdrawn because there was nothing for them to do. However, it is seen as particularly important that there be wide representation of women's groups on these provincial Task Forces and that they be encouraged to contribute to local decision making, given the extent to which women will be using the services and will be beneficiaries of them. While variation will be required to reflect local approaches, as a general rule there should be one woman representative from each of the districts in the province on the Task Force. This representation would encourage greater participation in the project, should facilitate more responsive service provision, and in the longer term could enhance women's participation in other public arenas.

The AS Health will have major responsibility for activities at the provincial level. Programs for outreach activities will be prepared by district health staff and transmitted by provincial health authorities to the national project team. First priority will be given to maintaining and re-establishing MCH mobile clinics, where the greatest impact will be seen in the shortest time and second priority to patrols to more remote populations. It will be important to have strong involvement by women in all levels of the project from an early stage.

5.2 Project Monitoring and Evaluation

5.2.1 Monitoring Framework

The monitoring of outreach, training and management activities will be continuous. Details of the scheduling of inputs and activities are given in the implementation and resources schedule in Annex 1.4.

5.2.1.1 Responsibility for Monitoring

National Level

At the national level the monitoring of activities, outputs and expenditure on behalf of AIDAB/UNICEF will be done by the project management and administration team. The CSP Coordinator and staff of the CSP Secretariat with staff of the Family Health Services will be responsible for ongoing monitoring of day to day activities.

Provincial level

At the provincial level the monitoring by the Matron of Community Health Nursing Service and the Coordinator of Rural (Community) Health Services, under the direction of the AS Health/Provincial Adviser Health will be responsible for ongoing monitoring of day to day activities.

Monitoring and financial reporting activities will require regular and frequent visits to the provinces by the project management team and NDOH and Secretariat staff. These visits will also provide opportunities for advice on service management issues.

5.2.1.2 Sources of Data

The use of Australian funds is to be monitored closely for achievement of objectives and for accountability. According to NDOH policy, data should only be collected routinely through two methods- the national integrated health information system, and patrol reports- hence these will need to be used as the main data sources for project monitoring.

Any additional reporting and data collection forms that are prepared for use in this project should be approved by the NDOH to ensure that they do not impose unnecessary additional work for those staff recording and reporting data. This should not cause problems as, in general, MCH reports and patrol reports are part of the routine requirements for field officers, and were to have been part of the information system for the intended combined patrols under the Village Services/CSP plan, so that no policy or administrative changes are implied.

5.2.2 Performance Indicators

These will be developed by the project management and administration team, in particular the monitoring and evaluation consultant, in conjunction with the CSP Secretariat during the two month inception phase of the project and will be documented in the IS. The principles to be applied in planning outreach services and

in reviewing reports are accountability, economy and outputs. It has been observed that there are marked differences in productivity and efficiency between different institutions, and observations by advisers may lead to the development of useful guidelines for service provision that can be used well beyond the relatively short life of this project.

5.2.3 Monitoring and Evaluation Plan

Monitoring plans will be developed during the two month inception phase of the project and detailed in the IS. This will involve a detailed time frame for formal reviews and development of process indicators. Activities that will be carried out to ensure that effective monitoring of activities takes place on a planned and logical basis are outlined below.

Monitoring of Outreach Programs and Reports

Schedules and budgets are to be prepared by each province, including the numbers of people and their professional categories who will be participating in each excursion, the places to be visited and the expected time in the field and modes of travel. Most provinces are already well-advanced in planning.

Reports will be consistent with government policy on patrol reports, and will include at least:

- (i) the names of villages visited;
- (ii) numbers by sex and age of people examined and treated and the diagnoses and those with whom community education activities are conducted;
- (iii) numbers of immunisations given by type and sequence (first, second, third etc);
- (iv) ante-natal clients examined and given tetanus toxoid;
- (v) contraception prescribed; and
- (vi) referrals for investigation, observation or treatment.

The monthly field and expenditure reports to be obtained from each of the provinces will be summarised to document:

- i) the show the costs of field work by province;
- ii) total attendances and immunisations and other services provided over all provinces; and
- iii) analysis of special achievements, difficulties and recurring administrative problems as a basis for management action by the health service and/or other government agencies.

From those reports and from the routine health information system reports, estimates of immunisation coverage will be calculated by province and district. Other indicators which may be calculated include ante-natal coverage, contraceptive prevalence rate, sputum smears positive for tuberculosis, cases of other immunisable diseases, and cases of leprosy suspected or diagnosed. The project will enable a data base to be

developed on the walking distance of individual villages from fixed facilities and may help in improved planning regarding the location of facilities to best serve the population.

Monitoring of Financial Reports

Funds expended are to be reported according to purpose, and compared with budget. Expenses are to be itemised, by camping allowances, carriers, vehicle hire, vehicle or outboard motor fuel, air fares/charter costs, and other consumable items.

Outreach funds will not be replenished in the absence of adequate reports which show how each previous advance has been spent. The concern for timeliness will represent part of the financial management development in the provinces to be supported by the project management.

Monitoring of Training Programs

Each training of trainers' workshop will be the subject of a descriptive and evaluative report, contributing to continuous improvement in the effectiveness of the learning process. The reports will be prepared by Papua New Guinean resource persons with the assistance of the physician/educator.

Reports of the district-level in-service training will show:

- (i) the numbers of participants by category and sex; and
- (ii) the topics presented; and any assessments which it is feasible to make.

The reports will provide complete accounting for the funds expended. The district health officer in charge will be responsible for the reports. The reports will include any special achievements as well as administrative issues requiring corrective action by a government agency or by the project management team.

Replenishment of the advance of funds for further training will depend on satisfactory reporting and acquittal of the previous advance.

5.3 Project Reporting

5.3.1 Ongoing Reports

During the inception phase a detailed reporting format will be developed for documentation in the IS. This will include scheduling of monthly reports with their reporting contents to be tabled at the PMG and copied to AIDAB Canberra for their consideration, and six monthly consolidated reports to the PMG also to be made available to AIDAB's Technical Assessment Group (TAG). The TAG will complete an evaluation of the project after 6 months.

Reports will include details of activities carried out during the period, achievements of the project during the period, highlight problems encountered and their proposed

solutions, deviations from the approved plan, and give an outline of the plan for the coming period. Each report will include a summary financial statement.

The first report to the PMG will include a synopsis of the state of maternal and child health and health service delivery by province prior to commencement of Australian funding for the CSP and an overall summary of this for the whole of PNG.

5.3.2. Project Completion Report

A project completion report will be prepared in draft in March-June 1996 for consideration by GOA and GOPNG. The final report will be presented in June 1996. In the event that commencement of the Maternal and Child Health Project is to occur later than June 1996, and this project were therefore to be continued, the date for the Project Completion Report will be adjusted correspondingly.

The completion report will highlight problems, achievements, suggestions for change, and consideration of what contributes to an effective program.

6. BENEFITS, RISKS AND CROSS SECTOR ISSUES.

6.1. Sustainability and Constraints

It would be naive to assume that there are no obstacles to the successful completion of this project. The fact that the current CSP has almost ground to a standstill is testimony to this fact. Nevertheless the proposed activities can be done. The outcomes will be highly significant for improving health service delivery, staff morale and the health of women and children.

The major constraints relate to the current low morale among staff in the rural areas, the lack of operating equipment and facilities in many areas, and most importantly the lack of funding for ongoing operational activities. The funding and proposed activities within this project have been designed to overcome these constraints.

The present state of the community health services derives from inter-related deficiencies in morale and management as well as money. This has often resulted in sloppy demeanour and dress among some health centre staff especially men, and even simple buildings are dirty and untidy. It should be noted that poor morale is widespread in the public sector and it would be naive to consider that the health sector would be immune from this. However, there are undoubtedly many people continuing to provide excellent care despite frustrations, showing that great potential exists for further development in the health services.

The project of Australian support to the CSP focuses on the technical functions. The inputs proposed relate to core functions of the health service, and are intended to permit field work during the government's extraordinary financial situation. The assistance will in itself be developmental through its emphasis on training, community involvement, health promotion and management strengthening. The project will also prepare for AIDAB's Maternal and Child Health Project by enabling field programs to

resume; and by collecting information first hand about health services, health status, and management and financial systems including operating costs for maternal and child health services.

As stated above the most important constraint is financial. The immediate need is for operational funds. The funds requested by the provinces to restore field programs exceed the amount proposed to be available through the Interim Support Project, and the work which can be done will be learned from observations during the project. Where funds are adequate, it is probable that staff numbers will be the limiting factor, ensuring that services are maintained in fixed facilities while staff are on patrol.

Another important issue which will help the project overcome the above constraints relates to the widespread support for the CSP. The Child Survival Program has strong bi-partisan political support, and has attracted keen interest in the community at large with some private sector donations at the provincial level. The Program has aroused enthusiasm among health personnel.

It is essential that the GOPNG maintain funds for the procurement of vaccines, and for the salaries of workers, particularly those in the rural health centres. Without this commitment this project cannot proceed.

In conclusion, there are adequate personnel to provide maternal and child health services but inadequate supplies, equipment, operating funds, institutional systems and management capability. The present situation aptly described as 'collapse' has shown the fragility of the services and the potential for disastrous reversion to conditions before health services commenced in the country. The Child Survival Program is a useful addition to the fundamental MCH services, but neither the CSP nor routine MCH services are sustainable in the medium term if dependent solely on Papua New Guinea national and provincial government funding. Implementation and continuation of the Child Survival Program and of maternal and child health services depends on donor funding, the major sources at present being AIDAB, UNICEF and ADB. The funds provided by AIDAB through this project will help ensure continuation of the CSP and in addition the Country Representative of UNICEF is optimistic about continued support from his organisation. These funds will not immediately solve the current problems, but will go a long way towards resolving them in the medium term

6.2 Benefits flowing from the Project

The following benefits will be achieved if the project is successfully implemented as described in this document.

The immunisation coverage will increase to varying degrees in different locations, and the frequency of vaccine-preventable diseases will decline. A target of 80% immunisation coverage has been set within a 2-3 year period. The proportion of pregnant women immunised against tetanus will increase toward 100%. The greatest and most rapid increases in immunisation coverage will occur in populations accessible to routine MCH mobile clinics which will be

re-established, but significant increases can also be expected in remote areas to be visited by patrols.

·The morale of health personnel will rise. The capacity of health personnel to care for people who attend aid posts, health sub-centres and health centres will increase. The quality of care in health centres and sub-centres will improve through availability of equipment and increased competence of health personnel following training.

·Confidence of the people in the health service will increase and they may be more willing to attend to health messages. Community members will become better informed about the causes and prevention of common illnesses including respiratory infections, diarrhoea and malnutrition. The capacity of people to prevent illness, to recognise need for care and to seek care appropriately, will increase.

·Health service managers will have access to more accurate financial data on costs of MCH activities.

6.3 Cross Sector Issues

6.3.1. Social and cultural

Printed media text and illustrations will take account of literacy levels and cultural factors in perception by means of pre-testing, translation into tok pisin, and training of health personnel in the use of community education materials. The materials prepared so far under the CSSP have been received with enthusiasm by the community and by health personnel, and this project will reproduce and distribute them. Continued development of materials on a range of subjects is desirable, and the project team will collaborate with the Population and Family Planning Project and the Health Promotion Unit of NDOH in their development.

Community participation is being expressed in many different ways. Some examples are: the health-initiated Basic Minimum Needs approach; Village Development Committees under the primary health care system; women's organisations notably in East Sepik and Simbu and in many other places also; and community contributions to small water supply systems construction. The potential for community participation depends on the quality of care which health personnel are providing for the people, which in turn depends on the health management system and funding.

6.3.2. Gender

The majority of nurses providing maternal and child health services are women, assisted by CHWs/aid post orderlies who are predominantly male.

Benefits will flow primarily to women and to their children.

The membership of the national and provincial Task Forces is predominantly male and it is recommended that consideration be given to increasing the number of women members. It is proposed that the provincial Task Forces include the Matron in Charge of Community Health Nursing Services in each province and a representative of the church health services. As a general rule efforts will be made to obtain increased female representation on planning and coordination committees at provincial and district level. The contribution which women can make will be enhanced when their opinions receive attention and full consideration by male leaders.

6.3.3. Environmental

There are no environmental implications.

6.4. Key Planning Assumptions

The potential success of this project is dependent on a number of key assumptions that have been taken into account when designing the project activities and developing the budget. These assumptions are described below.

- Upgraded health services are an essential pre-condition for community trust and participation. It follows that community awareness activities should only be undertaken when training has been done and supervision reports show that an adequate quality of care can be guaranteed.
- Health personnel are generally well-motivated and capable when given equipment, supplies, operating funds, transport, and recognition. Many have become de-motivated by lack of in-service training, lack of supervision, lack of equipment, unreliable medical supplies, and unreliable access to transport to do their work.
- Church health services must be included in the Australian project and given funds for MCH work.
- The enthusiasm aroused by recent advocacy is in danger of dissipating if no resources are available for action. Already there is frustration in provinces when considerable effort was put into planning for CSP combined patrols led by Village Services, and no funds were available. Failure to proceed will result in:
 - marked decrease in immunisation rates.
 - corresponding increase in infant and maternal morbidity and mortality
 - increasing differentiation between rural and urban communities
- Provinces and districts are capable of organising and conducting MCH programs.

· A set of procedures can be devised to enable Australian funds to be used to pay directly for costs of outreach programs and training.

ANNEX 1.6

Job Descriptions for Project Staff

JOB DESCRIPTIONS

PROJECT MANAGER

Qualifications:

Medical graduate, preferable with specialist qualifications in paediatrics or obstetrics.

Experience:

Extensive experience in maternal and child health programs in developing countries, preferably with experience in Papua New Guinea. Demonstrated capability in education and training of health personnel. ability to manage and oversight decentralised project and interact effectively with a wide range of professional and other staff.

Duration:

For the term of the project.

Responsible to:

Country Representative, UNICEF

Counterpart:

Coordinator, Child Survival Program

Tasks:

The Physician/Educator is the Project Manager on behalf of UNICEF responsible for all Australian funded components of project activities, including administration and finance, oversight and carriage of training of trainers in provinces and related district level training, oversight of monitoring and ensuring provincial staff are trained in the skills to satisfactorily account for local expenditure of funds.

The Project Manager will:

- be responsible for ensuring that the project activities of patrols and related training to conduct vaccinations and provide maternal and child health care are carried out in accordance with the Implementation Schedule of this project;
- maximise the provision of child survival services to rural communities across Papua New Guinea;
- manage the Australian contribution to the CSP to the satisfaction of the Project Management Group;
- manage and support staff associated with the project by encouraging their development and by ensuring that they are assisted to acquire the skills necessary for decentralised management;
- oversee and ensure proper financial management of all project funds to the satisfaction of UNICEF and AIDAB and GOPNG, including the establishment of practical arrangements for the distribution of funds from the national to the provincial and district levels and the monitoring and accounting for their use;

- provide training to provincial and district health personnel to decentralise the national capacity to train trainers to the provinces, within the overall objective of that health personnel can satisfactorily conduct health patrols to provide maternal and child health services;
- ensure that the range of print and audio visual materials needed for the CSP is developed and distributed to all provinces;
- cooperate with other health related programs/projects and facilitate coordination of service and training activities between these programs/projects;
- provide information to the community and key people, organise the collection of required statistics, and provide timely and accurate activity and financial reports to the satisfy AIDAB requirements on the use of the Australian funds to the Project Management Group;
- monitor progress on the use of Australian funds, advise the Project Management Group of any major difficulties which arise and potential solutions to these problems and be responsible for the preparation of reports required under the Project Design Document;
- encourage the participation of women in project decision making fora and ensure that service delivery is responsive to the particular needs of women and children:

Finance and Administration Officer

Qualifications:

Professional qualification in finance, accounting or related discipline.

Experience:

Senior administrative experience. Extensive experience of health services an advantage.

Duration:

For the term of the project

Responsible to:

Project Manager

Counterpart:

Officer in Charge, Child Survival Program Secretariat

Tasks:

The Finance and Administration Officer is to be responsible for working with the Project Manager to develop effective administrative procedures for the Australian support to the CSP including the establishment of good financial and other monitoring and accounting procedures, and to work with the monitoring/evaluation consultant in preparing appropriate monitoring procedures.

The Finance and Administration Officer will:

- under the authority of the Project Manager/Physician Educator, set up financial arrangements between the provinces and the national level for this Australian support to the CSP for use and accountability of Australian funds, including the establishment of bank accounts at national and provincial levels, selection of signatories, establishment of recording procedures, funds transfer procedures, replenishment and reporting
- assist the Project Manager to determine appropriate allocations of funds to the provinces for activities to be undertaken through the Australian support to the CSP
- assist in the development of an appropriate monitoring and reporting system for financial and activity reporting
- observe and report on the distribution of Australian inputs and assist the CSP Secretariat logistics officer in the distribution of these inputs;
- liaise with provincial and district staff in the preparation of their reports and assist in the completion of these tasks;
- advise health centre staff on equipment inventories, assets control maintenance, repair and replacement of equipment;
- work with the Project Manager to encourage the involvement of church health services and personnel in activities including participation in health patrols and the receiving of funds for outreach activities and reporting on their use

Monitoring and Evaluation Short Term Consultant

Qualifications:

Professional qualifications in a health discipline, preferably with postgraduate qualifications. Specialisation in immunisation programs and logistics desirable.

Experience:

Extensive experience of health service delivery in developing countries, preferably with experience in Papua New Guinea

Duration:

Quarterly for up to two weeks and during the preparation of the Implementation schedule

Responsible to:

Project Manager

Counterpart:

Assistant Secretary Family Health Services

Tasks:

Assist in the development of the Implementation Schedule to facilitate the following tasks:

- review the implementation and effectiveness of outreach programs;
- review distribution of Australian inputs to the intended destinations;
- monitor and evaluate vaccine supply system to ensure adequate and timely supplies of potent vaccine to all delivery points;
- advise and assist provincial health officials on how to monitor and evaluate their EPI programs;
- advise and assist with recording, reporting, analysis, interpretation and application of data within the health information system of the NDOH, and obtain information from the system for monitoring and evaluation of the Australian contribution to the CSP and prepare reports on the same;
- provide advice to the Project Management Group on effectiveness of activities to date, on the appropriate balance between activities and advise of any changes in approach;
- other tasks as necessary for achievement of the CSP objectives as agreed between UNICEF, AIDAB and the Government of Papua New Guinea.

- work with the CSP Secretariat to ensure the timely preparation and distribution of teaching and public education materials for use in patrols and application in all service areas
- assist the Project Manager to analyse financial and activity data to derive accurate estimates of the costs of field work and assist field staff to understand how this is done and to be able to apply similar principles in the future
- cooperate with the CSP staff, staff from the NDOH and personnel from other related programs/projects to ensure coordinated and complementary activities and to develop the capacity at the provincial and district levels to manage field activities accountably and efficiently
- advise health centre staff on equipment inventories, assets control, maintenance, repair and replacement of equipment
- work with the staff of the project and the CSP to achieve its aims of reducing maternal and child mortality, prevent illness and promote better health among women and children



AUSTRALIAN HIGH COMMISSION, PORT MORESBY
PUBLIC AFFAIRS SECTION
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Number of pages 1
(including this page)

DATE: 22 March 1995

FROM FILE

TO

Editors and correspondents

MEDIA ADVICE: AIDAB Director General's visit: Child health equipment handover today

SENDER: Grant Thompson, Counsellor Public Affairs,
Australian High Commission, Port Moresby

If there are problems with this fax, please phone Papua New Guinea 259333.

The Director General of the Australian International Development Assistance Bureau (AIDAB), Mr Philip Flood, will present immunisation and maternal health equipment valued at \$1.6 million (K1.4m) to the PNG Minister for Health, Mr Peter Barter, today.

The equipment includes 200 refrigerators, 40 freezers, 500 sets of patrol kits containing medical and camping equipment, and 1,000 vaccine carriers.

Media representatives are invited to attend the handover of some of this equipment at 5.20pm in the B3 Conference Room of the National Parliament. The equipment will be distributed to health centres, sub-centres and aid posts, which are the primary source of immunisation and basic maternal and child health services in Papua New Guinea's rural areas. It will help 500 PNG health centres re-equip their mobile maternal and child health patrols and assist in restoring immunisation programs.

The equipment is funded by the Australian Government under AIDAB's Child Survival Program, in consultation with the PNG Department of Health. Mr Flood said: "This is part of a long term project which aims to help Papua New Guinea save the lives of thousands of women and children who die needlessly each year.

"Every day about 50 children in PNG die from diseases which could be prevented by effective immunisation programs.

"One in 22 women in rural PNG die from the complications of pregnancy and childbirth."

Australian assistance to PNG's health sector will total about K60 million over the next three years. Other Australian support in this sector includes projects in population and family planning, hospital management, medical officer training and proposed longer term programs in health assistance for selected provinces and maternal and child health.

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ANNEX 6

CSSP Project Close-out Plan

PNG CHILD SURVIVAL SUPPORT PROJECT CLOSE-OUT PLAN

This close out plan has been prepared by the PNG Child Survival Support Project in consultation with JSI Boston's project backstop and the USAID Office of Health Population and Nutrition at USAID/Manila. The plan summarizes the major project and administrative tasks which will be completed to close this successful United States Agency for International Development Child Survival project.

MONTH	PROJECT ACTIVITIES	ADMINISTRATIVE ACTIVITIES	COMMENTS
NOVEMBER	<p>Phase II training activities in Gulf Province</p> <p>Phase II training activities in New Ireland Province</p> <p>Continue production of materials</p> <p>MCH Physician Technical Development travel to JSI Boston and WHO Geneva</p> <p>Brief new Minister for Health</p> <p>Complete Pneumococcal Vaccine Research Study</p> <p>Provide technical support to the national Child Survival Program</p> <p>Provide donor coordination in Child Survival</p>	<p>EQUIPMENT: Complete approved equipment procurement.</p> <p>FINANCIAL: Routine management</p> <p>PERSONNEL: None.</p> <p>MISCELLANEOUS: Request USAID advice/approval on post-EDP activities, including:</p> <p style="padding-left: 40px;">1) preparation of final technical report; 2) final financial audit; 3) personnel, travel, and shipping costs associated with transfer of documents, financial reconciliation of accounts, and preparation of final financial report.</p> <p>Review office equipment insurance policies to determine if refund of unused policy is applicable/payable.</p>	

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PNG CHILD SURVIVAL SUPPORT PROJECT CLOSE-OUT PLAN

MONTH	PROJECT ACTIVITIES	ADMINISTRATIVE ACTIVITIES	COMMENTS
DECEMBER	Complete Phase II training activities in Gulf Province	EQUIPMENT: Begin field inventory assessment of all non-expendable equipment.	
	Complete Phase II training activities in New Ireland Province	FINANCIAL: Identify and begin reconciliation of all outstanding field advances.	
	Continue production of materials	PERSONNEL: Investigate local labor laws and requirements regarding termination of local hires, severance pay, benefits, and pensions	
	Christmas and Summer vacations for project staff		
	Provide technical support to the national Child Survival Program	MISCELLANEOUS: Identify all outstanding accounts/contracts with vendors in PNG. Notify vendors of project termination. Close-out all outstanding accounts with vendors.	
	Provide donor coordination in Child Survival		

PNG CHILD SURVIVAL SUPPORT PROJECT CLOSE-OUT PLAN

MONTH	PROJECT ACTIVITIES	ADMINISTRATIVE ACTIVITIES	COMMENTS
JANUARY	<p>Revise training materials</p> <p>Continue materials production Fund Central Province training</p> <p>Preparations for National CS In-Service Training Workshop in February</p> <p>Provide technical support to the national Child Survival Program</p> <p>Provide donor coordination in Child Survival</p> <p>Review and finalize Ergometrine Pilot Project report</p> <p>Liaise with ADB and AIDAB on CSSP follow on projects</p> <p>Complete "Lessons Learned" internal evaluation of CSSP</p>	<p>EQUIPMENT: Complete field inventory assessment of all non-expendable equipment.</p> <p>Prepare a list of all non-expendable and expendable equipment to be procured in the final three months of the Project.</p> <p>FINANCIAL: Prepare and submit to JSI/Boston and USAID/Manila a cash flow projection for the final three months of the Project.</p> <p>Limit future field advances to that necessary for Project- related travel to be resolved within 30 days.</p> <p>Terminate field advances to provincial bank accounts and notify provinces of bank account close-out and reconciliation procedures.</p> <p>PERSONNEL: None.</p> <p>MISCELLANEOUS: Provide list to JSI/Boston of all significant documents and materials generated by CSSP Project, including quarterly progress reports, training materials, IEC materials etc.</p>	

PNG CHILD SURVIVAL SUPPORT PROJECT CLOSE-OUT PLAN

MONTH	PROJECT ACTIVITIES	ADMINISTRATIVE ACTIVITIES	COMMENTS
FEBRUARY	Complete National In-Service Trainers for CS workshop Rapid Project Evaluation (USAID) Continue materials production Complete MUAC Research Study and finalize report Complete all field training activities. Facilitate hand over of CSSP activities to GPNG AIDAB follow on Child Survival Project.	EQUIPMENT: Submit non-expendable equipment disposition plan to USAID/Manila for approval. FINANCIAL: Solicit bids for local audit firm and select firm. PERSONNEL: Prepare and present termination letters for hire staff. MISCELLANEOUS: Contact utility companies (i.e. phone) to inquire about closing out accounts and final billing procedures. Arrange for return of rented utility equipment.	Early February By late February

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PNG CHILD SURVIVAL SUPPORT PROJECT CLOSE-OUT PLAN

MONTH	PROJECT ACTIVITIES	ADMINISTRATIVE ACTIVITIES	COMMENTS
MARCH	<p>Complete materials production</p> <p>Facilitate hand over of CSSP activities, materials, and equipment to GPNG follow on project</p> <p>Prepare end of project report</p> <p>Vacate project premises and housing</p> <p>Project expatriate personnel depart PNG</p>	<p>EQUIPMENT: Dispose of all expendable and non-expendable property as per USAID/Manila Instructions. Return leased phone system.</p> <p>FINANCIAL: Final Reconciliation of all provincial field accounts. Remaining money transferred back into CSSP bank account.</p> <p>Begin field financial audit of CSSP Project.</p> <p>PERSONNEL: Payment of final wages, severance, and other benefits to local staff as per requirements.</p> <p>MISCELLANEOUS: All original CSSP field files sent to JSI/Boston.</p> <p>Prepare all CSSP files for on-site storage (3 years).</p>	<p>JSI Boston home office Project Backstop spends last project month in PNG to assist in project close out</p> <p>To be completed by the end of March</p>

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PNG CHILD SURVIVAL SUPPORT PROJECT CLOSE-OUT PLAN

MONTH	PROJECT ACTIVITIES	ADMINISTRATIVE ACTIVITIES	COMMENTS
APRIL - JUNE	None	FINANCIAL: Completion of audit. Final reconciliation of all CSSP Project accounts. Final voucher submitted to USAID/Manila. Submit release form AID 1420-40 for CSSP as required. MISCELLANEOUS: None.	JSI Boston Home Office

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ANNEX 7

CSSP Project Financial Summary

At the time of this report, all final expenditures related to the implementation of the PNG Child Survival Support Project have not been processed by the contractor (JSI). A final summary of expenditures and an analysis of variances will be included as an addendum to this report when all expenses have been processed.

ANNEX 8

Project Property Transfer Document

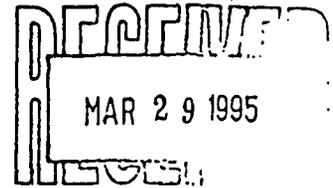


Child Survival Support Project

P.O. Box 9069, Hohola, N.C.D., Papua New Guinea TEL: 25 1299 /24 8733 FAX: (675) 25 8968

Mr. Paul Songo, CMG, OBE
Secretary for Health
Department of Health
Independent State of Papua New Guinea

14 March, 1995



Subject: Transfer of Title to Project Properties

Dear Secretary Songo,

It is with sadness that the United States Agency for International Development funded PNG Child Survival Support Project is coming to a close on 31 March 1995. The John Snow Incorporated Child Survival Support Project team wishes to thank you, your department, and the Department of Health staff for its excellent collaboration and co-operation which contributed to the project's success.

It is with great pleasure that we are able to transfer the title to ownership of the project properties to the Papua New Guinea National Department of Health.

The property to be transferred to the PNG Department of Health includes houses for the Southern Regional Epidemiologist and the Senior Tutor for the Diploma in Community Health Nursing Administration course, vehicles and office equipment for the four Regional Support Units, computers, video equipment, printing, and binding equipment for health worker training and community health education materials production and development, computers and other equipment for the Child Survival Secretariat, and Child Survival Support Project office equipment and computers. A complete log of all property valued at more than US\$ 100 is attached.

We understand that the equipment currently used for training materials production and development, by the Child Survival Secretariat, and by the CSSP office will be assigned to the new Child Survival Project. This will enable a smooth transition to the new project with no loss of momentum.

To complete the transfer of ownership title for these properties please sign the lower section of the attached copy of this letter and return it to us to acknowledge the transfer of title from John Snow Incorporated to the Papua New Guinea National Department of Health.

It has been a great pleasure working with you and your staff.

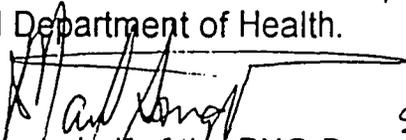
Yours Sincerely,



Allan G. Bass
Chief of Party

ENCLOSURE: Property Log (3 Pages)

Acknowledgement of Transfer of Title to Child Survival Support Project Property from John Snow Incorporated to The Papua New Guinea National Department of Health.


Signed on behalf of the PNG Department of Health:

Secretary for Health

24/3/1995

Date:


Signed on behalf of John Snow Incorporated:

Chief of Party, CSSP

29 March 1995

Date:

OVERSEAS PROPERTY LOG

PROJECT NAME:
COUNTRY:

Child Survival Support Project
Papua New Guinea

DATE: 28-Feb-95
ACTIVITY CODE: 1744

Check one

- PROPERTY INVENTORY & SUPPLIES
 PROJECT NON-EXPENDABLE EQUIPMENT
 PERSONAL INVENTORY AND SUPPLIES
 PERSONAL NON-EXPENDABLE EQUIPMENT

CONDITION
EX EXCELLENT
G GOOD
P POOR

DATE	DESCRIPTION (make, model, etc.)	SERIAL NUMBER	USAID ID NUMBER	LOCAL COST	US\$	LOCATION	CONDITION
Sep-90	1 Book Case Wooden			K230	\$244	CSSP Office	G
Oct-90	PABX - ASB 30 (V033 + 034) Ericsson Telephone System			K576	\$611	CSSP Office	G
Oct-90	Curtains, Rods & Accessories			K240	\$254	CSSP Office	G
Oct-90	White Board x 2			K297	\$315	CSSP Office	G
Nov-90	Typewriter - Brother - EM-750 FX	C03971806		K700	\$742	CSSP Office	Ex
Nov-90	Photocopier - Model Cannon NP3225 (been replaced by a new one)	FJS04137		K3,510	\$3,721	CSSP Office	Replaced
Nov-90	Tea trolley - wooden			K132	\$140	CSSP Office	G
Nov-90	Foldable Table (conference table)			K338	\$358	CSSP Office	G
Jan-91	Fax machine - cannon 270s H11171 - Cannon Inc.	Z9802805		K1,756	\$1,861	CSSP Office	G
Jan-91	Bookshelves metal x 3 (Brownbuilt)			K315	\$333	CSSP Office	G
Mar-91	Diconlx printer				\$375	CSSP Office	P
Mar-91	Diconix Printer				\$375	CSSP Office	P
Mar-91	Compaq 286 laptop computer				\$2,880	Sold	P
Mar-91	Compaq 286 laptop computer				\$2,880	CSSP Office	P
Mar-91	Computer - Model ARC386-20 Turbo, ARC video graphics, monitor,	1751441		K4,095	\$4,341	Child Survival Secretariat	P
Apr-91	4 UHF PR710 Security Radios and 4 chargers	C110181		K3,188	\$3,379	CSSP Office	G
May-91	2 Desk Lamps - Hanimex statement			K106	\$112	CSSP Office	G
May-91		C110184				CSSP Office	
Jun-91	2 Computer Mouse Brand Quick - A			K100	\$106	CSSP Office	P
Jun-91	1 Philips Radio Charger Type: B440/240	9500186		K119	\$126		G
Jun-91	2 Filing Cabinet (Brownbuilt)			K153	\$162	CSSP Office	G
Jun-91		C110190				CSSP Office	
Jul-91	1 only Casio FR-1015S Printing calculator	6419235		K94	\$99	CSSP Office	G
Jul-91		C110186				CSSP Office	
Aug-91	Hewlett Packard Laser Jet III Printer, Model 33449 AS	3038J8499		K2,870	\$3,042	CSSP Office	G

OVERSEAS PROPERTY LOG

DATE	DESCRIPTION (make, model, & etc.)	SERIAL NUMBER	USAID ID NUMBER	LOCAL COST	US\$	LOCATION	CONDITION
Aug-91	Uninterruptable power supply UPS PMW -600	16375		K450	\$477	CSSP Office	
Oct-91	1 Binding Machine (Manual) BDS Product - Dualmatic B4	7909984		K1,125	\$1,193	CSSP Office	G
Oct-91	1 only Computer Table			K226	\$239	CSSP Office	G
Oct-91	1 Battery Pack for LTE Part No. 117229-001			K150	\$159	CSSP Office	P
Feb-92	Health-O-Meter Model 750KL Physician Electronic Scale				\$155	CSSP Office	
Feb-92	Remington PB6600 - Fax Machine	AU6600600		K1,400	\$1,484	RSU - Lae	?
Feb-92	REM 1800D - Typewriter	57310788		K700	\$742	RSU - Lae	?
Feb-92	4 Desktop Computers	128003187		K22,600	\$23,956	REGIONAL SUPPORT UNITS	?
May-92	GEC-Marconi Printerlink Pack # 1				\$150	CSSP Office	G
May-92	GEC-Marconi Printerlink Pack # 2				\$150	CSSP Office	G
May-92	GEC-Marconi Printerlink Pack # 2				\$150	CSSP Office	P
May-92	GEC-Marconi Printerlink Pack # 2				\$150	CSSP Office	P
May-92	GEC-Marconi Printerlink Pack # 2				\$150	CSSP Office	P
May-92	GEC-Marconi Printerlink Pack # 2				\$150	CSSP Office	P
May-92	GEC-Marconi Printerlink BufferPack				\$299	CSSP Office	G
Oct-92	Vehicle - Patrol H/Roof LWB AC diesel			K22,069	\$23,393	RSU - Southern	?
Dec-92	H35 6215 Copier - HCM 6215	EJA26841676		K3,150	\$3,339	RSU - Lae	?
Dec-92	Photocopier & Accessories (replaced old one) Selex GR-4100			K11,041	\$9,716	CSSP Office	G
Mar-93	1 x Radio and Charger (replaced the stolen one)			K795	\$843	CSSP Office	G
Jun-93	1 only 4 Drawer Filing Cabinet			K194	\$205	CSSP Office	G
Jun-93	Filing Cabinet (4 drawer)			K212	\$224	CSSP Office	G
Aug-93	Vehicle - Patrol LWB - H/Roof Diesel			K25,150	\$26,659	RSU - Momase	?
Jun-94	Orion VCR TV Player and Recorder	701-1600387			\$617	CSSP Office	G
Jun-94	Sony M18 Camcorder (Camera)	182750		K1,831	\$1,611	CSSP Office	G
Jul-94	Ultra 16 Bit Coax - Network Board (2)			K500	\$440	CSSP Office	G
Jul-94	1 Desk 1830 x 900mm S/Ped			K590	\$519	CSSP Office	G
Aug-94	Sharp 14" TV/VCR Multi System VT-3480X	311512291		K747	\$792	Gulf Province	G
Aug-94	Dictaphone	SJ46832438		K151	\$160	CSSP Office	G
Aug-94	Sharp 14" TV/VCR Multi System VT-3480X	311512147		K747	\$792	New Ireland Province	G
Aug-94	Sharp 14" TV/VCR Multi System VT-3480X	311512135		K747	\$792	New Ireland Province	G
Aug-94	4 - 2 Drawer Filing Cabinet			K706	\$621	CSSP Office	G
Sep-94	Compaq Contura Aero	742OHJF55036			\$2,425	CS Secretariat	Ex
Sep-94	Compaq Contura Aero	742OHJF55036			\$2,425	CSSP Office	Ex

OVERSEAS PROPERTY LOG

DATE	DESCRIPTION (make, model, & etc.)	SERIAL NUMBER	USAID ID NUMBER	LOCAL COST	US\$	LOCATION	CONDITION
Oct-94	Gestetner Copyprinter Model 5325	5081		K12,466	\$10,970	CSSP Office	Ex
Oct-94	Data General Computer, Viper card, monitor, Uninterruptable power supply	M203767		K9,355	\$8,232	CSSP Office	EX
Oct-94	Hewlett Packard Scanjet IIcx	3414A23753		K1,380	\$1,214	CSSP Office	ex
Oct-94	Binding Machine GBC 5000 (Electric)	GG00321		K3,600	\$3,168	CSSP Office	G
Nov-94	Contura 400C M 250 Compaq	7440HJK33828		K3,444	\$3,031	CSSP Office	G
Nov-94	Sharp 14" TV/VCR Multi System VT-3480X	311512344		K747	\$792	Gulf Province	G
Nov-94	1 Seagate 420mb, Hard disk drive			K331	\$291	CSSP Office	G
Nov-94	2 - 4 Megabyte Simm, 1 - Microsoft Mouse			K480	\$423	CSSP Office	G
Nov-94	1 only TP DX166 desktop computer	covered with label		K1,009	\$888	CSSP Office	Ex
Nov-94	1 TP 15" Multi Syn Monitor	AD0-43800145		K494	\$434	CSSP Office	Ex
Nov-94	HP DeskJet 560	SG42J140CN		K1,035	\$911	CSSP Office	Ex
Nov-94	1 Paper Trimmer No. 2S			K227	\$200	CSSP Office	G
Nov-94	Computer Accessories	748HFN10344		K210	\$185	CSSP Office	
Nov-94	1 Paper Trimmer No. 2S			K169	\$149	CSSP Office	G
Dec-94	3 Paper Trimmers 455mm x 365mm - Japan			K508	\$447	CSSP Office	G
Feb-95	TV-Unit CMT2055-781-192	S4H021777		K429	\$455	CSSP Office	EX
Feb-95	TV-Unit CMT2055-781-192	S4J022591		K429	\$455	CSSP Office	EX
Feb-95	TV-Unit CMT2055-781-192	S4J022587		K429	\$455	CSSP Office	EX
Feb-95	TV-Unit CMT2055-781-192	S4J022524		K429	\$455	CSSP Office	EX
Feb-95	VCR-Unit VT-M348E(SW)S	40909870		K389	\$412	CSSP Office	EX
Feb-95	VCR-Unit VT-M348E(SW)S	40910182		K389	\$412	CSSP Office	EX
Feb-95	VCR-Unit VT-M348E(SW)S	41113387		K389	\$412	CSSP Office	EX
Feb-95	VCR-Unit VT-M348E(SW)S	41113790		K389	\$412	CSSP Office	EX
Mar-95	Stallion Prefabricated House			K57,715	\$50,789	CSSP Office	EX
Mar-95	Stallion Prefabricated House			K57,715	\$50,789	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022588		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022480		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022529		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022482		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4H021845		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022478		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4H021787		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022478		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022485		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022583		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022523		K429	\$455	CSSP Office	EX
Mar-95	TV-Unit CMT2055-781-192	S4J022500		K429	\$455	CSSP Office	EX

OVERSEAS PROPERTY LOG

DATE	DESCRIPTION (make, model, & etc.)	SERIAL NUMBER	USAID ID NUMBER	LOCAL COST	US\$	LOCATION	CONDITION
Mar-95	VCR-Unit VT-M348E(SW)S	40909881		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	41113763		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	41113778		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	40909639		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	41113373		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	40910035		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	41113347		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	41113361		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	41113785		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	40909805		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	40909736		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	41113391		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	40909979		K389	\$412	CSSP Office	EX
Mar-95	VCR-Unit VT-M348E(SW)S	40909866		K389	\$412	CSSP Office	EX

2288
 KING CSSP