CONSULTATIVE IMPLEMENTATION AND MONITORING COUNCIL

NATIONAL DEVELOPMENT FORUM

20th to 22nd June 2017

Crowne Plaza Hotel- Port Moresby.

THEME: Quality Leadership & Community Oversight for Improved Governance.

Sub-Theme: Promoting Leadership to Address Governance Challenges and Delivery of Quality Health Services.

Provincial Presentation: Experiences of Leadership and Rural Health Service Delivery and Management.

By: Mr Albert Bunat, ML.
Executive Manager- Health

Introduction.

The theme of this forum takes me back to the 23rd National Health Conference held at the Gateway Hotel in June of 2016.

A reflection of the theme of that conference was similar and has some relevance; "Effective Leadership & Good Governance:
Key to Progress the Implementation of the National Health Plan (NHP) 2011-2020"

And so in an effort to progress the implementation of the NHP 2011-2020, we in the provinces have done all we can to implement the Annual Activity Plans. However, our planned activities have not been successfully implemented. That is to say that there were impediments in the delivery of quality health services. Selected Provincial presentations in that conference showed similarities in the challenges faced in their leadership roles in trying to have the quality health care services delivered. Likewise, this presentation will also highlight some of the Experiences of a leader facilitating the leadership roles in trying to execute the delivery of quality health services in a political and administrative environment that has many hurdles to overcome.

East Sepik Province Profile.

East Sepik Province (ESP) is located in Mamose Region at the top north-west end of Papua New Guinea. ESP shares boarders with Sandaun to the west, Manus to the north, Madang to the east and Enga and Simbu to the south.

Wewak is the capital of East Sepik Province. It has six districts with 27 LLGs and 627 wards. ESP has an estimated population in 2017 of just over 500,000, and is

unevenly distributed over 43,426km^2 of landmass. With a crude population density of 8 persons per km^2, high population densities are found in the offshore islands owing to smaller land area. In contrast, the greater single population concentration begins from the foothills of the Prince Alexander Ranges to the Torricelli Mountains of Maprik District. Other population concentrated areas are along the coast, the lower Yuat River, and the Lower and the Middle Sepik River areas where large villages do occur.

The terrain is mostly rugged from the costal foothills to the central Torricelli Mountains and towards the south there are lowland grassy-flood plains, swampy areas of the Sepik River to the gradually ascending mountains towards the south into the highlands provinces. Seasonal flooding makes accessibility easier than during dry weather periods in and along the Sepik River area. Accessibility by land transport is dependent on the road conditions and the weather patterns.

East Sepik Provincial Administrative Structure and Functions.

On the outset, East Sepik Provincial Administration has had no permanent appointment of a Provincial Administrator but has had Acting Provincial Administrators' from 2013 to date. This arrangement has had some drawbacks in terms of decision making; discipline, financial powers and employment/recruitment of human resources in sectors with great demand for staff.

Let alone the above, the provincial administrator is the head of the provincial administration. Under him there are three Deputies who are responsible for different functional areas. They are Deputy Provincial Administrator responsible for Corporate Services, Deputy Provincial Administrator responsible for Districts and Local Level Governments and Deputy Provincial Administrator responsible for Advisory and Technical Services. I report to the last of the three deputies where my administrative and management responsibilities and roles terminate.

On the other hand, the district health staff are responsible to the Deputy Provincial Administrator responsible for Districts and LLGs. They report to the District Administrators or the CEOs of the DDA per say. With this administrative arrangement come the funding, supervision and disciplinary responsibilities at the district and LLG level. Likewise, the use of the health funding appropriated for district health services operations remains the responsibility of the District Administrator, District Treasurer and LLG Presidents with or without consultations with the district health managers. The so-call 20 percent of DSIPs

and LLGSIPs for sectors have over the years have not been made available. Additionally the next lot funding which will find its way straight to the ward level still needs to be questioned as to its use.

Funding Allocations to Health as Health Expenditure.-Processes and procedures.

Health Sector Grants or the Health Functional Grants are appropriated to;

1. District Health Services (Operational)
2. LLGs for health facility maintenance,
3. LLGs for water supply
4. Main public health programs including admin. and management,
5. Provincial Hospital,
6. St Johns Ambulance Services
7. Callan Services,
8. Church Health Services, and
9. Samaritan Aviation- (Float Plane)

There has been late disbursement of the functional grants as experiences over the last five years. Funding has come in as late as May/June and there leaves not much time to implement program activities. Large amounts of funds remaining in the last quarter tend to be abused and the residue ends up as Roll over Funds.

The expenditures for first three activities is the prerogative of the District Administrator/CEO of DDA, the District Finance Manager and LLG Presidents. The use of those funds are on many occasions dubious, lacks conformity and not made known to the District Health Managers in each of the districts other than for health facility routine operations.

As a leader of Health Services in the province I am only allowed to sign as a Requisitioning Officer for the expenditure claims for other activities from 4th to 9th. The claims are facilitated through the office of the Deputy Provincial Administrators, the Budget/Finance Manager, and the Provincial Administrator and then to Treasury where they further get delays. Treasury examiners checks for completeness, why this/that queries, needs further justifications etc, are some examples for delay. So claims can get as long as two weeks or more. Even a worst scenario is an example for the claims raised for an epidemic outbreak of pertussis at back of Amboin (Angoram District) where it took so long and before the cheque was raised the epidemic has taken its toll (11 under 5yr) and had subsided without any health patrol into the area.

In a given scenario as such, a leader or manager must use all the knowledge and skills; the protocols and processes to influence, lure or succumb to the government systems and processes and nothing gets done. Example is timely access of funds for routine MCH outreach patrols. Another is for medical emergencies.

Organisation of Health Services and Delivery System.

Health services are provided by the government and Churches with funding from the public sector funds, while other provinces' health services are provided by for example the extractive industries, private sector enterprises, CBOs, and Village Health Volunteers.

Within the public sector, the management responsibility for hospitals and rural health services within provinces is divided. The NDoH manages the provincial hospitals, while provincial governments and LLGs are responsible for "rural health services".

Under OLPG&LLG, districts and level governments are given responsibility to manage and support their health services, each level of government having different powers and functions in relation to health. The passing of the Organic Law exacerbated existing problems in health staff supervision and support. Provincial Health Advisors/Managers lost much of their authority to supervise and discipline district health staff.

Legal Framework for health service delivery.

In health sector, the delivery of health services are govern by the legal framework. There is currently a dual system of health services delivery.
The provincial hospitals deliver through the Public Hospital Act of 1994, while Provincial/rural health services are delivered under the provincial administrations is through the National Administration Act of 1997. There is in place a Provincial Health Authority Act of 2007, aimed to streamline the delivery of health services under a unified system –WAN SYSTEM TASOL. That is the merging of the two entities under one Authority. Ten provinces have rolled it out while ESP is in the final stages for a merger to take place. However this has been postponed until after the 2017 elections.

Current Status of Rural Health Services.

The delivery of primary health services in the province is through the aidposts, health sub-centres, health centres and district hospitals, let alone the provincial hospital which carry out more intensive diagnostic and specialist health care

services. The provisions of quality health care services have been very badly affected /impeded which has resulted in poor health indicators. Two hundred and twelve aid posts out of 280 are closed, leaving on 68 operational. Of the 46 National Health Information System (NHIS) participating health facilities 26 are closed while only 20 are operational.

Management of the Delivery of Rural Health Services -Provincial

Efficient, effective and quality health care services delivery in rural areas is really difficult and challenging. There are many creeks, swamps and mountains to pass through to reach the unreached populations. The weather patterns are unpredictable; the road infrastructure is indescribable, unfriendly and impassable. Community support is absent; possess threats, thefts and vandalism. Nonetheless, at least health services are being provided (to those who seek "health") by what's left of those through retirements and deaths have become more committed health providers, *(government)* working in very tough environments. Where government cannot deliver, the Churches have managed to reach out wider into the remote areas providing almost 50% of health care services in the province. There are other partners involve in health service provision whom as a leader have to collaborate and assist where necessary.

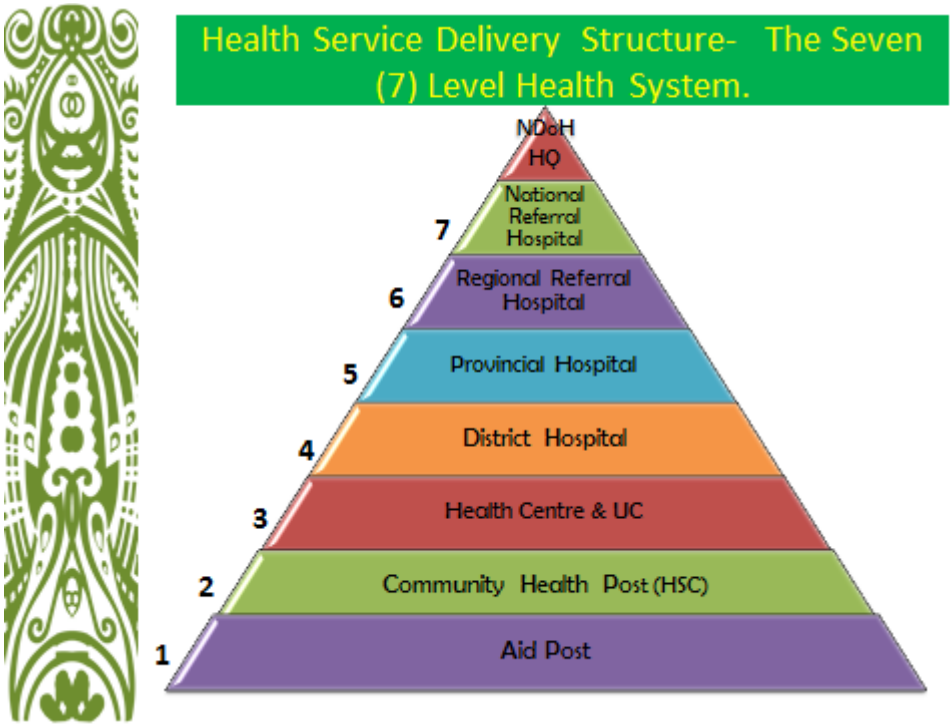
Many health facilities are dilapidated, some are closed, especially the aidposts. There are many aging workforce. Quite a good number (50) were retrenched in 2005 and 41more will leave (retirements) the service in 2017. As of the recent structure review and placements, Health has 199 staff on ceiling. This is total position holders. All six districts have 2-3 staff manning the health facility. As such effective delivery of quality health services have petered down over the past five years owing to number reasons as indicated.

As a leader/ manager for health in the province, management of rural health services at the provincial level can be very exciting but at the same time challenging. Bear in mind that the action takes place at the district and LLG level where health care services are provided by the district staff. At the helm of the health services, the roles and responsibilities of a leader is to ensure that the enabling resources are made available for the district staff to deliver. This includes the provincial level public health Program Managers, who also have to supervise the implementation of the TEN HEALTH program activities in the province- EPI, Maternal Health, Disease Control (TB, Leprosy), Water Supply and Sanitation and Malaria programs.

Attachments.

The Ten Health Programs

- General Administration
- Rural Health Facilities
- Urban clinics
- Family Health Services
- Environmental Health and Water Supply
- Disease Control
- Health Promotion and Education
- Medical Supplies and Equipment
- Human Resource Development
- Support Services



Current State of Affairs

- ❖ Short supply of skilled manpower- PHQ, Districts, & LLGs level.
- ❖ Escalating law and order issues-
- ❖ Provincial Treasury delaying processing of claims to implement planned program activities-
- ❖ Late release of Health Functional Grants to provinces. Funds not released in full to implement

- ❖ Over 20% of HFG released towards closure of accounts. Activities NOT implemented- Funds end up as rollovers.
- ❖ Budget Not reflecting Ten (10)
- ❖ Lack of coordination between District administrations and LLG to administer delivery rural health services- including flow of information.
- ❖ BSP becoming another compliance agent to clear government cheques. Also an impediment to program
- ❖ Politicians assuming the roles Public Servants in implementing Minimum Priority Activities Funds.

Factors affecting Service Delivery

- Geographical Locations- Accessibility issues
- Breakdown in existing road infrastructure- lack of maintenance
- Appalling state of health infrastructure- decline in health care service delivery.
- Poor / lack of proper housing for district health workers- affects performance; commitment to work.
- Aging health workers / workforce- poor performance outputs.
- Declined health staff ceiling- no replacements
- High cost of living and high cost of service delivery- district level.
- Recurrent Funds not released on time.
- Accessing timely funds is cumbersome.

Manpower Issues

- The East Sepik Province is currently facing the following issues and challenges in regard to manpower.
- Shortage of manpower
- Aging workforce
- Delay in recruitment for retrenched officers
- Staff not at workplace due to factors such as schools for children, no good road system, housing problems and others
- Staff patient ratio unacceptable
- 50health workers retrenched in 2005 and 41 will be retrenched in 2017.

Challenges in Service Delivery. 2. The Health Infrastructure.

- 100% of existing clinical services buildings non compliant with new HF Design Standards

- 80% of health service buildings and staff houses in dilapidated conditions including lack of running water and sustainable power supply
- Out-dated, non-functioning and inadequate medical equipment / items
- Inadequate medical waste disposal facilities including incinerator
- Lack of regular PPM of infrastructure
  Lack of Asset Register

Challenges in Service Delivery

- Human Resource -Provincial supply store

  poor drug management
- Infrastructure

  Storage practices inadequate and no compliance
- Inventory Management System

  Over & Understocking, excessive wastage, disposal
- Contracting of medical supplies Distributors

  Not actually delivering at Door-steps of health facilities

Successes

1. Improved service delivery through partnerships.
   - Samaritan Aviation
   - CSO – Out Reach International,
   - NGO –
   - Extractive /Resource developers.(logging, Oil Palm)
   - Save The Children, PNG
   - YWAM- Medical Ship

2. Health Infrastructure Projects (NDOH/DPs- RPHSDP)
   4 Community Health Projects under construction
   2 Wewak district and 2 Maprik district
3. Re-introduction of Health Training Institutions.

   Community Health worker Training School.
   ESP College of Nusing (Boram)
4. Assist to Establish New Kreer Height Urban Clinic (Church run-AOG)

WAY FORWARD

- Implement the roll out of Provincial Health Authority

- Infrastructure audit and development
- Health Promotion/advocacy
- Integrated outreach patrols
- Human resource – recruitment
- Improved Health Information reporting
- PPP /Stake holder /Resource developers