ANGLICAN CHURCH of PAPUA NEW GUINEA

ANGLICAN HEALTH SERVICE

Strategy for the Period 2001–2005

The Anglican Church's Health Ministry to the People of Papua New Guinea

Compiled by
Peter Rookes MPH., DHSA., RCNT., FETC., RGN., RNMH.
National Health Secretary, Anglican Health Service.

(original: Jan 2001, version 2: October 2001)

Acknowledgements

1. I would firstly like to thank the Anglican Board of Mission in Australia, the Anglican Missions Board in New Zealand and the Papua New Guinea Church partnership in the United Kingdom for their continued support of our infrastructure costs. Without this, nothing else would be possible.

2. We are very grateful to organisations like the United Thank Offering in the USA; Mothers' Union in the UK; ABM Auxiliary in Australia; Targeted Community Development programme in PNG and many individual churches for supporting specific items and projects.

3. My great thanks to the Anglican Health Board, and in particular the Chairman, Archbishop James Ayong. Despite his heavy workload and many other pressures, continues to give great support to the Anglican health service, and lend his weight to the necessary, and sometimes unpopular measures, which are essential if we are to improve the health of our rural communities.

4. Thank you to the Diocesan Health Secretaries, for their support in implementing the changes; to the Schools of Nursing; the VBA and VHA Coordinators; the VBAs and VHAs themselves; Village Health Promoters; the many OIC who often struggle to improve services in difficult circumstances; and the health Committees, who try to bridge the communication gap between their communities and the health workers.

5. We are also grateful o the Diocesan Bishops. Diocesan Secretaries, Priests, Catechists and the Provincial Council for their faith and support of what we are trying to do,

6. Finally my enduring gratitude to my wife, Jean, who now works as National Coordinator of the Village Health Volunteer programme, but continues to work long hours on the general and financial administration of the Anglican Health Service. She is a great inspiration and support.

The current high levels of sickness and death amongst our rural communities are not inevitable. Thank you to you all for believing that we can make a change.

Peter Rookes MPH., DHSA., RCNT., FETC., RGN., RNMH.
National Health Secretary, Anglican Health Service.

Jan 2001

ANGLICAN HEALTH SERVICE

Strategy for the Period 2001–2005

Contents

Acknowledgements

1.	Forward	1
2.	Introduction	3
3.	Current Situation	4
4.	International Comparisons	7
5.	Trends	12
	Map – Location of AHS Premises	13
6.	Organisation of the Anglican Health Service	14
	Table – AHS Human Resources	16
	Table – AHS Management Structure	17
7.	Mission Statement	18
8.	Major Objectives of AHS	19
9.	Implementing the Objectives	20
9.1	Improving the Management of the Service	20
9.2	Developing a Public Health Emphasis	21
9.3	Taking Services to People where they Live	25
9.4	Improving Diagnosis and Treatment	27
9.5	Developing the Knowledge, Skills and Attitudes of our Staff	30
9.6	Providing the Necessary Equipment and Facilities to Perform Effectively	33
9.7	Improving Communications and Transport	36
10.	Key Results to be Achieved by the end of 2003	37
11.	Finance	43

1. Forward

1.1 This is the first time that the Anglican Health Service has produced a strategy, which sets out clearly its vision of what it is aiming to achieve in the long term. Perhaps, it has never before been so important as now, in the face of deteriorating health trends, particularly in maternal and child mortality and infectious diseases, including the major threat posed by AIDS.

1.2 The Strategy, with its Mission Statement, Objectives and Key Tasks sets the direction we want to travel. This is complemented by our Policy Manual which guides the way we plan and budget our work. If the Objectives are to be fulfilled, we need to take account of our own particular role, our circumstances, and the resources we have available.

1.3 We implement the Strategy in our day–to–day, week by week, month by month and yearly planning, by having objectives to make use of our resources of time, money and people. The Mission Statement sets out the general aim and the objectives say how we are going to meet the aim, making best use of the resources we have.

1.4 The strategy is important in evaluating what we are achieving or have achieved. For example, we recognise that we have certain roles. The AHS Policy Manual states *...Seek continually to improve the quality of our health service...* In the area in which we work we may recognise that there has been little or no improvement over the last year. Before we start thinking that we would do better if we had more staff or better equipment, we should ask ourselves whether we are following the right strategy to meet the needs we have here and now with the resources we actually have.

1.5 The Strategy takes note of a number of important factors. We are part of a National Health Service, which is government led, but in which we can play our own role. Our Strategy, therefore, takes account of the National Health Plan, in which the Churches' Medical Council have taken a part in formulating. After many years of working on five year plans, the current plan covers a ten year period.

1.6 The Department of Health, in developing its National Health Plan, follows closely the principles agreed by the World Health Organisation, which is expressed as the philosophy of Primary Health Care. This is the health care made available to people as close to where they live as possible, particularly for people living in villages very distant from towns and cities. It is a simple form of health care which does not cost people a lot of money, but can assist people with most of the common illnesses which occur.

1.7 An important part of the the training of Primary Health Care workers, is to be able to recognise diseases and provide first aid for the more serious accidents, which cannot be cared for at the local health facility because of the geographic isolation. They know when to send patients on to a larger

hospital, and in certain cases to a referral hospital such as Port Moresby.

1.8 The training of Primary Health Care workers also emphasises prevention. This includes antenatal and post natal clinics, and immunisation and health checks for children. Health Promotion, including Health Education, is most important. This must include education about STDs and HIV/AIDS, and the diseases which people can avoid if they are shown how. Health Promotion also includes encouraging people to develop good clean water supplies and knowledge about hygiene, waste disposal, healthy and unhealthy food.

1.9 The great variety of things which have to be done to make Primary Health Care a success, means very careful planning, and this is where good strategy is important. A good strategy means that, in our planning, nothing gets missed out. We include patient care to everybody, but have special plans for those at risk, and we include prevention programmes and health promotion.

1.10 A good Primary health care worker is not only a doctor, nurse or Community Health Worker, but is a teacher, leader and counsellor, and sometimes, of necessity, a maintenance person or driver. The Primary health Care Worker needs good guidance to do all these things well, by having planned strategies.

1.11 Lastly we are a Church Health Service, which means our service is based on Christian principles, That will mostly be shown in our own personal dedication, but strategy planning will always take special note of people in poverty, at special risk, or with special needs.

This Strategy document, together with our revised Policy Manual, will need to be studied by everyone with an interest in improving the health of our communities.

Archbishop James Ayong
Chairman,
Anglican Health Board

Brother Dr Andrew,SSF
Vice Chairman
Anglican Health Board

2. Introduction

2.1 This draft of the Anglican Health Service (AHS) Strategy has been compiled following:–

a) A questionnaire sent out to AHS staff, Health Board members and Bishops in 1997, seeking their views on the operation and priorities of AHS.

b) Assessment of current service and facilities carried out by the National Health Secretary during his initial round of supervisory visits in 1997.

c) Discussions at the NHS Consultative Committee in 1997, 1998 and 1999.

d) Consultation exercise at the ACPNG Provincial Council in 1998.

e) Exercises and assignments carried out by Community Health Workers during their upskilling workshops in 1998 and 1999.

f) Discussions at the Village Birth Attendant (VBA) and Village Health Aide (VHA) Coordinators' workshop in 1999.

g) Policy decisions made by the Anglican Health Board at its meetings in 1998 and 1999

h) Anglican Church Development Workshop held at Lae in October 1999.

i) Views on the final draft were sought from:–
- The 2000 NHS Consultative Committee
- The 2000 ACPNG Provincial Council
- Our overseas partners.

2.2 Amendments to the final draft were approved by the Anglican Health Board in September 2000

2.3 In preparation of this strategy, it has been important to ensure that it:–

a) Is compatible with the Department of Health National Health Plan 2001–2010 and seeks to work in a spirit of partnership to achieve common goals.

b) Is based on the principle of Primary Health Care as the most cost effective means of ensuring 'health for all'. This was clearly outlined in the 'Alma Ata Declaration' at the International Conference on Primary Health Care sponsored jointly by the World Health Organisation (WHO) and the United nations Children's Fund (UNICEF) as long ago as 1978.

c) Embodies Christian principles of serving and empowering the poor and vulnerable, particularly women and children.

d) Recognises the particular features of PNG's subcultures, traditions, economy and geography, as well as its socioeconomic and demographic characteristics.

3. Current Situation

3.1 There is no legal requirement or official system of registering births and deaths in Papua New Guinea. The system of Village Recorders, introduced by the Government before the last general election, has collapsed in most areas because the recorders had not been paid. As a result the demographic data we have to hand is based on the 1990 census, ad hoc surveys and the Department of Health patient information system.

3.2 **Key statistics** from these sources are as follows:–

a) 42% of the population are under 15 years of age.

b) 52% of the population are male.

c) Life expectancy is 54.6 for males and 53.5 for females,. That is twenty five years earlier than most ‘western’ countries and twenty years earlier than most of our Pacific neighbours.

d) Infant mortality rate deteriorated from 72 per 1000 live births in 1980 to 77 per 1000 in 1996.

e) Overall, 1 in 8 children die before reaching their 5th birthday.

f) 45% of children are malnourished and 65% not fully immunised.

g) 69% of women deliver their babies unsupervised.

h) In rural areas there are 20 maternal deaths per 1000 births.

i) The population growth is 2.3% per annum, thus the urban population will double and the rural population triple every 30 years.

j) The high infant mortality is exacerbated by the fact that 25% of pregnancies occur within 2 years of the mother previously giving birth. (Infant mortality is 3 times higher when there is less than 2 years between births).

k) 85% of the population live in rural areas. The most remote of these are generally served by Church Health Services.

l) The literacy rate is 40.3% for women and 49.5% for men. (There is a strong correlation between literacy and health).

3.3 The Government National Health Plan 2001–2010 states:–

Health Status Indicators

The gains made in the health status indicators prior to independence have not been sustained and some have even deteriorated.

The infant mortality rate stands at 77 per 1000 live births according to the 1966 Demographic and Health Survey, up from 72 per 1000 in 1980. It is the worst in the Pacific region. Over the last 10 years the infant mortality rate has declined in every country in the Pacific except Papua New Guinea.

The 1996 Demographic and Health Survey estimated Papua New Guinea's maternal mortality rate at 370 per 100,000 live births. This is one of the worst in the Western pacific Region.

Papua New Guineans have a life expectancy of only 54 years at birth, which is the worst in the Pacific Region. Unlike other countries, the life expectancy at birth of 53.5 for females is lower than that of males at 54.6 years.

Health Service Coverage

While Papua New Guinea has been acknowledged by the World Health Organisation as having one of the best health service networks in the region, its network of aid posts, health centres, rural hospitals and general hospitals has not performed as well as expected. Contributing factors include poor funding and staff levels, inefficient management, poor role definition and lack of community support.

For the key programmes, the churches provide 45% of total health services and 49% of rural health services.

Of the country's rural health facilities.....46% have no transport, 41% no radio, and 60% require major maintenance. Of the aid posts 22% are currently closed, and this figure may be an underestimate.

In the area of maternal and child care, only 31% of deliveries are supervised.
Coverage rates for key vaccinations under 1 year include 81% for BCG, 60% for triple antigen, 48% for measles and 60% for poliomyelitis vaccine.

In the area of water supply and sanitation coverage, it is estimated that less than 30% of rural communities have safe water supply.

3.4 The **main causes of recorded disease and/or death** are:–

a) Childbirth b) Pneumonia particularly in young children c) Malaria	*These 3 categories account for 40% of all recorded deaths*

d) Other respiratory conditions, particularly Tuberculosis

e) Accidents and violence

e) Skin sores and ulcers. Although these conditions account for very few admissions and deaths, they represent a very high proportion of the outpatients seen.

f) Meningitis

g) Typhoid, Diarrhoea and other intestinal conditions

h) Anaemia, cardiac conditions and Cancer

3.4.1 These figures must be treated judiciously as many deaths occurring in villages are unrecorded and the cause of death unknown.

3.4.2 Most of these conditions are infectious and/or nutritional in origin and are, therefore, highly preventable.

3.4.3 At the end of 2000 there were 3,428 confirmed cases of HIV (Human Immuno–deficiency Virus) infection, 1153 confirmed cases of AIDS (Auto Immune Deficiency Syndrome) and 242 patients had died from the disease in PNG. This pandemic is expected to have devastating effects within the next ten years, unless there is a major change in sexual behaviour.

3.4.4 The escalation in the incidence of HIV infection in PNG is very sharp compared with its Pacific neighbours. This trend is expected to continue because of the association of HIV infection with Sexually Transmitted Diseases. The incidence of Syphilis in PNG is the highest in the Asia Pacific region. The incidence of Chlamydia is over twice the average for the region and Gonorrhoea is 15 times higher than the regional average.

3.4.5 The HIV virus is passed from one person to another through body secretions, principally blood and semen. The major route of infection in Papua New Guinea, is believed to be unprotected sexual intercourse with more than one heterosexual partner, ie one male and two, or more, females, or vice versa. Because of this, it is the most sexually active age group, with the highest level of infection. The period between being infected with the virus and when the first symptoms appear may be as long as 10–12 years, thus an infected person can pass on the infection to many other people without knowing.

3.4.6 As the most affected age group are also the most physically active, the effect on the demography and economy of the country could be disastrous, stretching the country’s health services to the absolute limit. In many Sub–Saharan countries in Africa, a whole generation of people has been decimated, leaving grandparents to do the work and care for young children. It is feared that the same could happen here.

4. International Comparisons

The following tables demonstrate Papua New Guinea's (PNG) unfavourable health status compared with both its Pacific neighbours and with other Developing Countries (DCs). In several instances it also compares unfavourably with the average for the Least Developed Countries (LDCs).

Table 1 illustrates that, compared with its neighbours, PNG has:–
The lowest
a) Life expectancy at birth, only just above the average for the LDCs.

The highest
a) Infant and under 5 years mortality per 1000 live births, 10 higher than the next highest and 9 higher than the average for all DCs.
b) Fertility rate, over 50% higher than for all DCs, and almost as high as the average for LDCs.

The 2nd highest
Maternal mortality rate per 100,000 live births, and 114 per 100,000 higher than the next highest.

Table 2 illustrates that, compared with its neighbours, PNG has:–
The 3rd lowest
GNP (Gross National Product).

The lowest
a) Proportion of its GNP spent on health.
b) Expenditure per head of population.
c) Ratio of doctors per population. Only 7 per 100,000 population, which is only 23% of the average for LDCs.
d) Ratio of nurses per population. Only 67 nurses per 100,000 population, which is 48 lower than the next lowest and 11 lower than the average for LDCs.

Table 3 illustrates that, compared with its neighbours, PNG has:–
The lowest
a) Percentage of deliveries supervised by a trained person.
b) Percentage of mothers receiving tetanus toxoid.

2nd lowest
a) Percentage of population with access to safe water and 16% lower than the average for LDCs.
b) Percentage of pregnant women receiving antenatal coverage.

3rd lowest percentage of population with adequate sanitation.
4th lowest contraceptive prevalence, at 26% it is only 4% higher than average for LDCs

Table 4 illustrates that, compared with its neighbours, PNG has:–
4th highest percentage of low birthweight babies.
3rd lowest percentage of children immunised against measles.

Least efficient
Health service overall.
Health service in terms of health attainment.

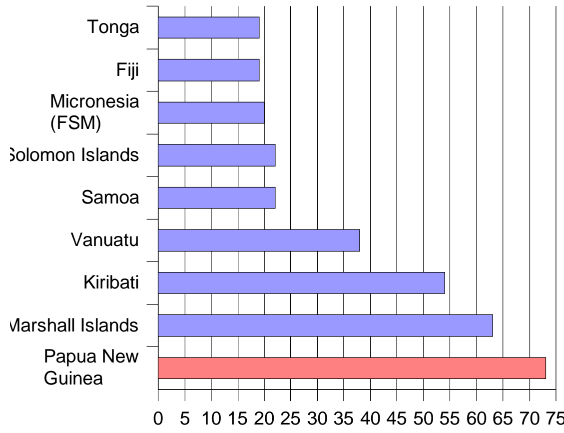
Table 1: Demography

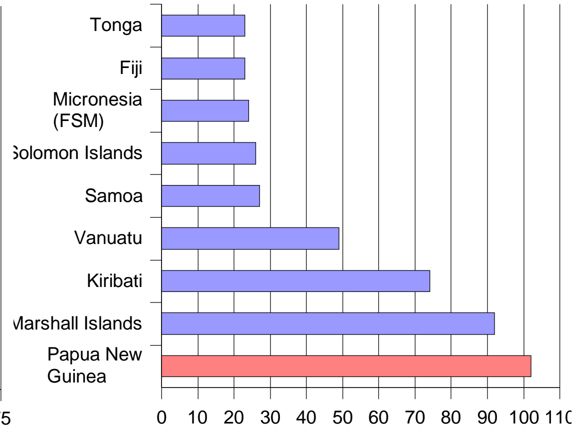
	Life Expectancy at Birh	Infant Mortality Ratio	Under 5 Mortality Ratio	Total Fertility Rate	Maternal Mortality Ratio
Fiji	67	19	23	2.7	27
Kiribati	63	54	74	4.5	225
Marshall Islands	66	63	92	–	–
Micronesia (FSM)	68	20	24	4	226
Samoa	68	22	27	4.1	70
Solomon Islands	63	22	26	4.8	549
Tonga	71	19	23	3.6	197
Vanuatu	61	38	49	4.3	68
Papua New Guinea	54	73	102	4.8	370
High Income Countires	7	6	6	1.6	–
Developing Countries	65	64	93	3	–
Least Developed Countries	52	104	161	5	–
Source of International Data	(1)	(2)	(2)	(2)	(3)
Source of PNG Data	(4)	(4)	(4)	(4)	(4)

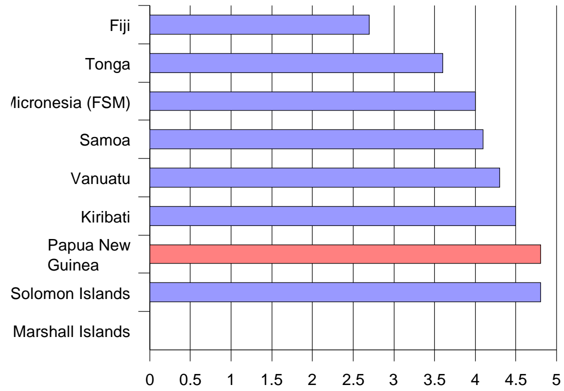
Table 2: Health Resources

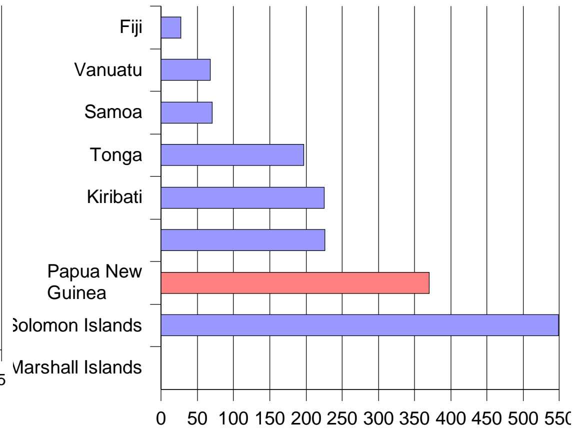
		Inputs to Health Sector			
Resources for Health	GNP 1997	%GNP on health	Expenditure per head	Doctors per 100,000	Nurses per 100,000
Fiji	$2,460	3.50%	$55	37	209
Kiribati	$910	12.70%	$94	15	212
Marshall Islands	$1,610	4.60%	$85	43	290
Micronesia (FSM)	$1,920	9.10%	$171	46	329
Samoa	$1,140	NA	NA	38	186
Solomon Islands	$870	11.60%	$94	11	115
Tonga	$1,810	3.50%	$56	46	331
Vanuatu	$1,340	2.50%	$29	10	239
Papua New Guinea	$930	2.30%	$27	7	67
High Income Countires	$22,273	–	–	252	–
Developing Countries	$5,699	–	–	78	98
Least Developed Countries	$157	–	–	30	78
Source of International Data	(2)	(3)	(3)	(3)	(3)
Source of PNG Data	(2)	(3)	(3)	(5)	(5)

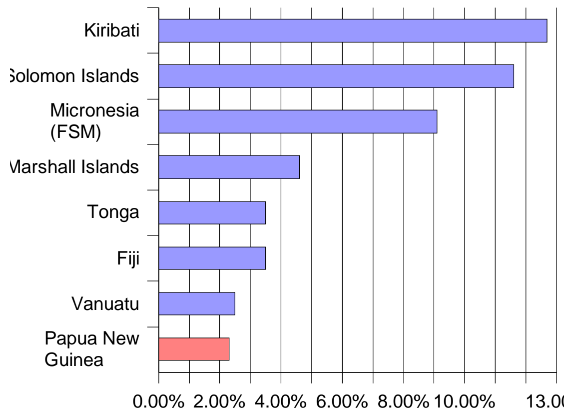
Notes: *i.* *Infant mortality and under 5 mortality ratios are per 1000 births*
ii. *Maternal mortality ratio is per 100,000 births*
iii. *Sources of data:*
(1) World Health Report 2000, WHO Geneva
(2) The State of the World's Children 2000, UNICEF, New York
(3) Country Health Information Profiles 1997, WHO Manilla
(4) Demographic and Health Survey 1996, NSO, PNG
(5) National Inventory of Health Facilities 1998, DoH, PNG
(6) National Health Information Systems, DoH, PNG

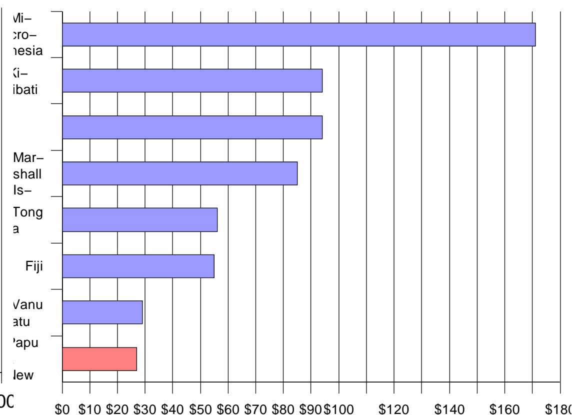

Infant Mortality Ratio
Tonga
Fiji
Micronesia (FSM)
Solomon Islands
Samoa
Vanuatu
Kiribati
Marshall Islands
Papua New Guinea
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75

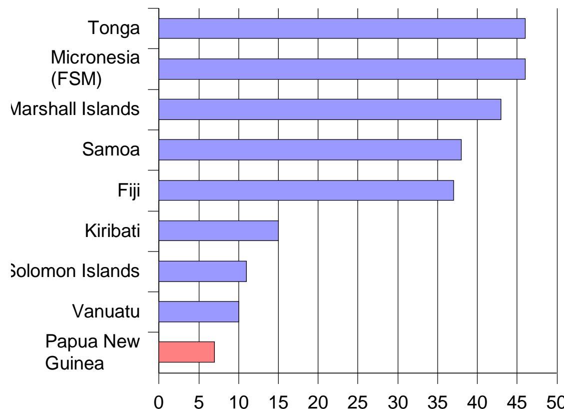

Under 5 Mortality Ratio
Tonga
Fiji
Micronesia (FSM)
Solomon Islands
Samoa
Vanuatu
Kiribati
Marshall Islands
Papua New Guinea
0 10 20 30 40 50 60 70 80 90 100


Total Fertility Rate
Fiji
Tonga
Micronesia (FSM)
Samoa
Vanuatu
Kiribati
Papua New Guinea
Solomon Islands
Marshall Islands
0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5


Maternal Mortality Ratio
Fiji
Vanuatu
Samoa
Tonga
Kiribati
Papua New Guinea
Solomon Islands
Marshall Islands
0 50 100 150 200 250 300 350 400 450 500


%GNP Spent on Health
Kiribati
Solomon Islands
Micronesia (FSM)
Marshall Islands
Tonga
Fiji
Vanuatu
Papua New Guinea
0.00% 2.00% 4.00% 6.00% 8.00% 10.00%


Expenditure on Health per Head
Fiji
$0 $10 $20 $30 $40 $50 $60 $70 $80 $90 $100 $120 $140 $160


Doctors per 100,000
Tonga
Micronesia (FSM)
Marshall Islands
Samoa
Fiji
Kiribati
Solomon Islands
Vanuatu
Papua New Guinea
0 5 10 15 20 25 30 35 40 45 50

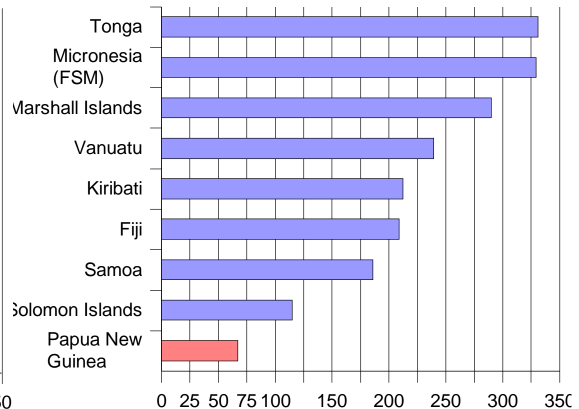

Nurses per 100,000
Tonga
Micronesia (FSM)
Marshall Islands
Vanuatu
Kiribati
Fiji
Samoa
Solomon Islands
Papua New Guinea
0 25 50 75 100 150 200 250 300

Table 3: Water, Sanitation, Antenatal and Deliveries

	Population with access to:					
	Safe Water	Adequate Sanitation	Contraceptive Prevalence	Antenatal Coverage	TT	Deliveries Supervised
Fiji	77%	92%	32%	100%		96%
Kiribati	76%		28%	88%	74%	72%
Marshall Islands	82%	88%	37%			
Micronesia (FSM)	22%	39%		90%		82%
Samoa	68%		21%	52%	99%	52%
Solomon Islands	65%		25%	92%	55%	85%
Tonga	95%	95%	39%	95%	93%	94%
Vanuatu	77%	28%	15%	98%	78%	79%
Papua New Guinea	41%	83%	26%	77%	69%	51%
Industrialized Countries			72%			
Developing Countries	72%	44%	56%		50%	
Least Developed Countries	57%	37%	22%		48%	
Source of International Data	(2)	(2)	(2)	(3)	(2)	(3)
Source of PNG Data	(5)	(5)	(5)	(5)	(5)	(5)

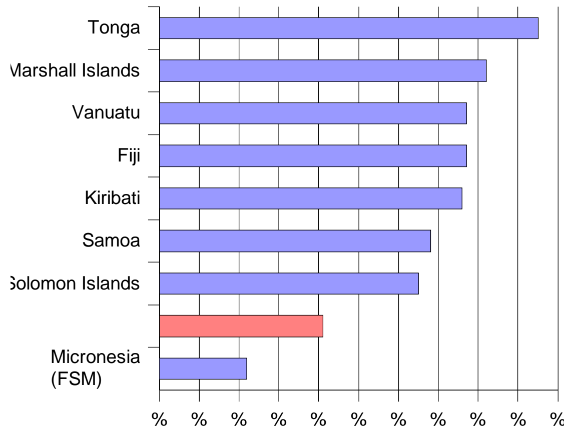
Table 4: Infant Health and Health System Efficiency

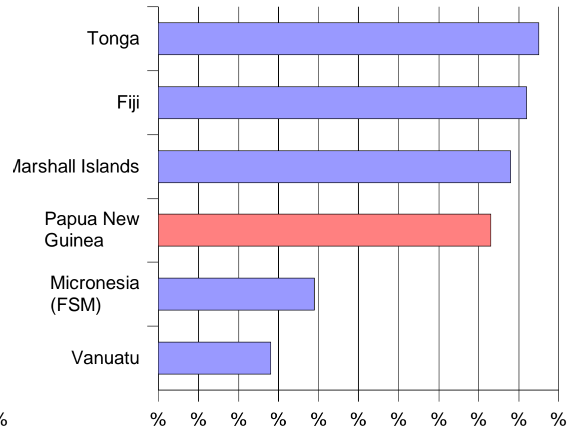
		% < 5yrs	Immunisation Coverage		Health System Efficiency	
	% Births < 2500g	Severely Maln'shed	3rd dose TA	Measles	Health Attainment	Overall
Fiji	12%	1%	86%	75%	63%	65%
Kiribati	3%	–	88%	77%	55%	49%
Marshall Islands	14%	–	86%	93%	58%	50%
Micronesia (FSM)	9%	–	80%	82%	68%	58%
Samoa	6%	–	100%	100%	60%	59%
Solomon Islands	20%	4%	69%	64%	89%	71%
Tonga	20%	–	97%	96%	68%	61%
Vanuatu	7%	–	93%	94%	66%	56%
Papua New Guinea	10%	2%	47%	76%	55%	47%
Industrialized Countries	–		94%	89%	–	–
Developing Countries	–	44	75%	72%	–	–
Least Developed Countries	–	37	55%	54%	–	–
Source of International Data	(2)	(2)	(2)	(3)	(1)	(1)
Source of PNG Data	(6)	(6)	(5)	(5)	(1)	(1)

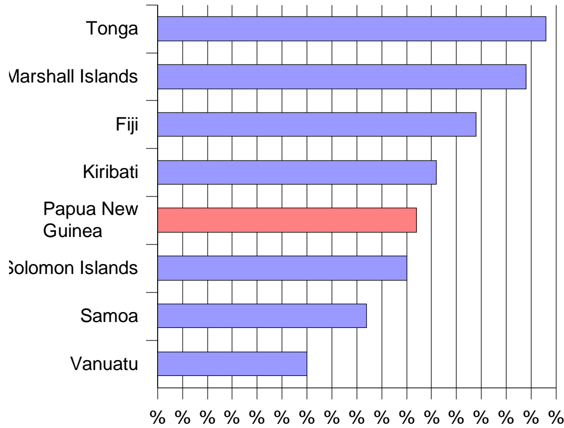
Notes: *i.* *Efficiency of Health Sector estimated by WHO as the ratio between actual health status achieved and that expected with the most efficient health system. Overall performance also considers equity in the distribution of health and health financing, and the health system responsibeness as well as health attainment.*

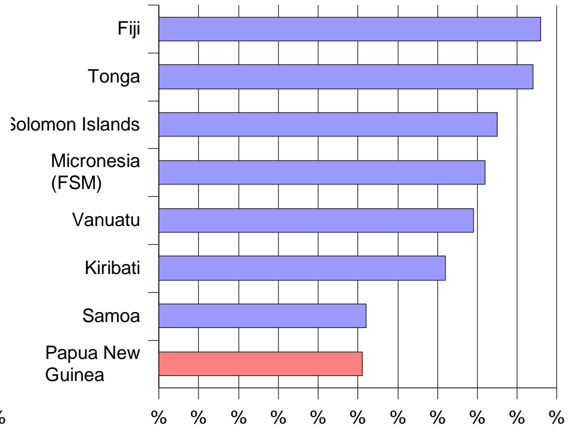
ii. *Sources of data:*

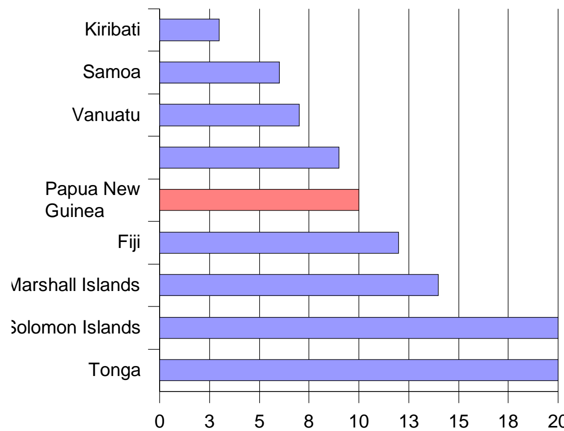
(1) *World Health Report 2000, WHO Geneva*
(2) *The State of the World's Children 2000, UNICEF, New York*
(3) *Country Health Information Profiles 1997, WHO Manilla*
(4) *Demographic and Health Survey 1996, NSO, PNG*
(5) *National Inventory of Health Facilities 1998, DoH, PNG*
(6) *National Health Information Systems, DoH, PNG*

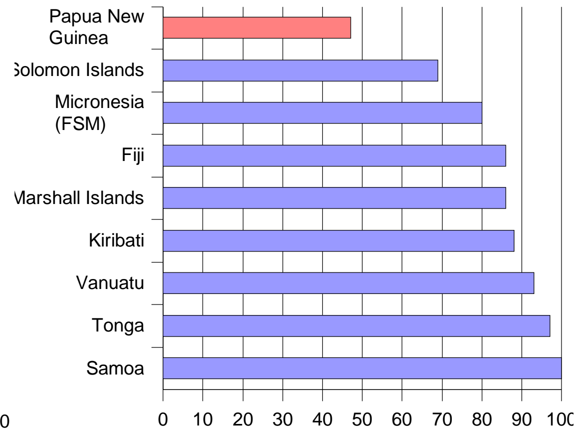

Population with Safe Water
Tonga
Marshall Islands
Vanuatu
Fiji
Kiribati
Samoa
Solomon Islands
Micronesia (FSM)
%

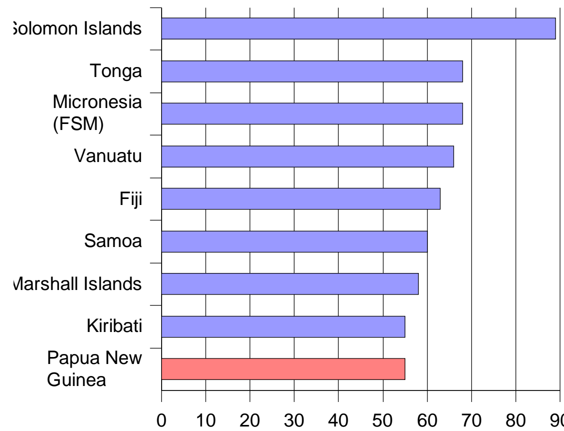

Pop. with Adequate Sanitation
Tonga
Fiji
Marshall Islands
Papua New Guinea
Micronesia (FSM)
Vanuatu
%

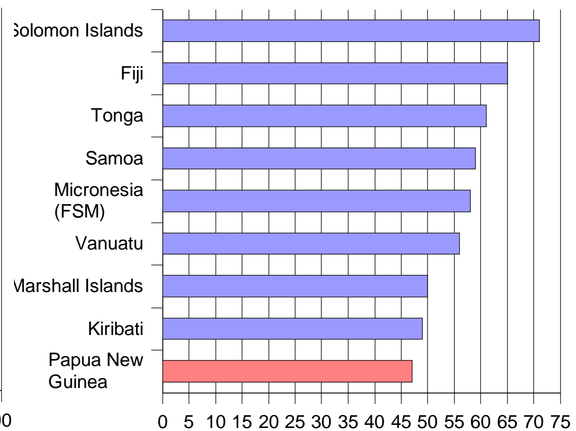

Contraceptive Prevalence
Tonga
Marshall Islands
Fiji
Kiribati
Papua New Guinea
Solomon Islands
Samoa
Vanuatu
%


% Deliveries Supervised
Fiji
Tonga
Solomon Islands
Micronesia (FSM)
Vanuatu
Kiribati
Samoa
Papua New Guinea
%


% Births < 2500g
Kiribati
Samoa
Vanuatu
Papua New Guinea
Fiji
Marshall Islands
Solomon Islands
Tonga
0 3 5 8 10 13 15 18 20


TA Immunisation Coverage
Papua New Guinea
Solomon Islands
Micronesia (FSM)
Fiji
Marshall Islands
Kiribati
Vanuatu
Tonga
Samoa
0 10 20 30 40 50 60 70 80 90 100


Efficiency in Health Attainment
Solomon Islands
Tonga
Micronesia (FSM)
Vanuatu
Fiji
Samoa
Marshall Islands
Kiribati
Papua New Guinea
0 10 20 30 40 50 60 70 80 90


Overall Efficiency
Solomon Islands
Fiji
Tonga
Samoa
Micronesia (FSM)
Vanuatu
Marshall Islands
Kiribati
Papua New Guinea
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75

5. Trends

5.1 Sadly, the general trend in most sectors in PNG, is one of decline and lack of development. This is perhaps most conspicuous in the health sector in which PNG compares so unfavourably with its Pacific neighbours, and presents a general pattern of deterioration rather than improvement.

5.2 At the time our initial assessment visits of the Anglican Health Service were conducted in 1997, we observed the results of a major under investment in the capital and manpower of the service over a protracted period of time. This underinvestment caused an accelerated decay of the buildings and equipment; caused low motivation amongst the staff; and contributed to the sub–optimal standard of service being provided in many locations.

5.3 The Department of Health statistics for health services nationally, demonstrate this general regression during the last 20 years:–

a) Increase in infant mortality compared with a decrease in other Pacific countries

b) Decrease in the proportion of births, which are supervised by a trained person

c) Decrease in the proportion of pregnant women receiving trained antenatal care

d) Decrease in the number of village health patrols carried out by health workers

e) Decrease in the number of mothers taking their infants to the Well Baby Clinic for growth and developmental checks

f) Increase in the proportion of underweight children

g) Virtually every indicator shows a widening gap between the allocation of resources and consequential development in urban areas and the continued decline in rural areas.

Location of AHS Health Facilities

WABAG
Enga
MENDI
Southern Highlands
Western Highlands
Aiome
Tsendiap
Togban
Koinambe
MADANG
KUNDIAWA
Simbu
Movi
GOROKA
Eastern Highlands
Morobe
LAE
ACPNG National Office
Gulf
KEREMA
DARU
Sagsag
Aisega
Aurio
Iangpun
Kumbun
Maklo
Urin
West New Britain
KIMBE
Au
Manau
Korisatu
Gona
St. Margaret's School Of Nursing
Martyr's School
Newton College
POPONDETTA
AHS National Headquarters
Oro Bay
Northern (Oro)
Sakarina
NCD
PORT MORESBY
Central
Wanigela
Biniguni
Agaun
Taiakwaruru
Ikara
Gadovisu
Alotau
St. Barnabus' School Of Nursing

6. Organisation of the Anglican Health Service

6.1 The Anglican Church is one of twenty different church denominations which manage rural health services in Papua New Guinea. In some provinces there is just one denomination. This is the case in Oro Province where the Anglican Church is the only church health service, whereas in other provinces there may be as many as six denominations.

6.2 The Anglican Health Service employs 126 staff and is responsible for:–

a) Recruitment and appointment of staff.
b) Setting conditions of service.
c) Managing, training, supporting and guiding staff
d) Reviewing the performance of staff.
e) Applying disciplinary procedures, when appropriate.
f) Ensuring that staff receive their correct salaries.
g) Arranging leave, transfers, retirements, promotions, etc.
h) Ensuring that staff work to the policies and financial procedures approved by the Anglican Health Board.

All of this requires a significant input of managerial time

6.3 The Anglican Church Health Service provides services across four diocese and operates:–

Health Centres, (small rural hospitals)	3
Health Sub Centres (inpatient and outpatient facilities)	12
<u>Aid Posts</u> including;	18
• recently transferred from the West New Britain Provincial Government	3
• in the process of transferring from the West New Britain Provincial Government	3
• professionally supervised located in educational establishments	3

6.4 Health workers based at AHS centres provide the following services both at their health facility and at 400 village clinic points, which they visit during their monthly or bi–monthly patrols:–

Antenatal examinations	Family planning
Child growth monitoring	Immunisation
Health education	Treatment of sick patients

Family planning advice is offered to both sexes and the method of choice is prescribed free of charge.

6.5 The Anglican Church also manages 2 educational institutions:–

a) St Margaret's Community Health Worker Training School, located in Popondetta, Oro Province, for training Community Health Workers. All CHW training in PNG is conducted by church health services.

b) St Barnabas School of Nursing, located in Alotau, Milne Bay Province, for

training nurses. This is jointly managed by the Anglican, Catholic and United Churches.

6.6 The Anglican Church also manages a number of development programmes, including:–

Village Birth Attendant	Village Health Aide
Village health promotion	Rural Water Systems
Health Worker Upskilling	

These involve preparing project proposals, supervising the projects and coordinating the work of the 400 village health volunteers.

6.7 The National Health Secretary, based in Popondetta, is responsible for the overall management of the Anglican Health Service, for which he is accountable to the Anglican Health Board. The Board in turn, chaired by the Archbishop, is accountable to the Anglican Provincial Council for the policies and performance of the Health Service.

6.8 The day to day management of the service in each diocese is carried out by the Diocesan Health Secretaries (DHS), who are managerially accountable to the National Health Secretary.

Traditionally there have been 2 DHS, one each in Popondota and Dogura diocese. An additional DHS is in the process of being appointed for Aipo Rongo diocese, and 'in principal' approval has been given for a further DHS post in New Guinea Islands in 2001. These two diocese have previously been managed directly by the NHS.

6.9 There is an annual meeting of the NHS' Consultative Committee, which comprises the Health Secretaries, School Principals, and staff representatives. This has the role of formulating policy for approval by the Health Board; monitoring service provision; deciding on staff postings; and dealing with other management issues.

6.10 Liaison between church health services and the National Government is conducted through the Churches' Medical Council, who have a coordinative role. This arrangement is in the process of being replicated at Provincial level where more than one denomination is involved.

6.11 The Church Health Services are provided by the churches as an agent of the Government for which the Government is expected to pay staff salaries and institutional running costs. The Churches' Medical Council is in the process of drafting a model Memorandum of Agreement to clearly specify and formalise this arrangement. This is seen as a first stage in the direction of properly costing the 'agency contract' between the Church Health Services and the Government.

6.12 Church Health Secretaries are expected to be members of the statutory Provincial Health Boards to facilitate partnership with the Provincial Government and to ensure that the Church Health Service perspective is taken into account when provincial health services are being planned and priorities determined.

ANGLICAN HEALTH SERVICE

Management Structure – Human Resources

Delivery of Service – Paid Employee Costs

Position	Dogura Diocese	Popondetta Diocese	Aipo Rongo Diocese			NGI Dioceses	NHQ	Total
National Health Secretary							1	1
VHV National Coordinator							1*	1
Water System Officer							1*	1
Diocesan Health Secretary	1	1	1			1*		4
			WHP	**Simbu**	**Mad'g**			
Doctor	1	1	1					3
Officer In Charge	5	5	3	1		1		15
Nursing Officer	14	10	5	1		1		31
Community Health Worker	25	21	7	3	1	10 (inc3*)		67
Ancillary Staff	4	5		1			1	11
Total	50	43	17	6	1	13	4	134

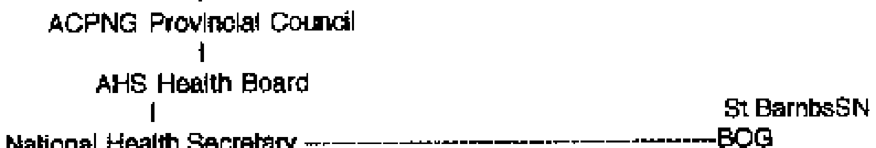
Delivery of Service – Voluntary Workers (unpaid)

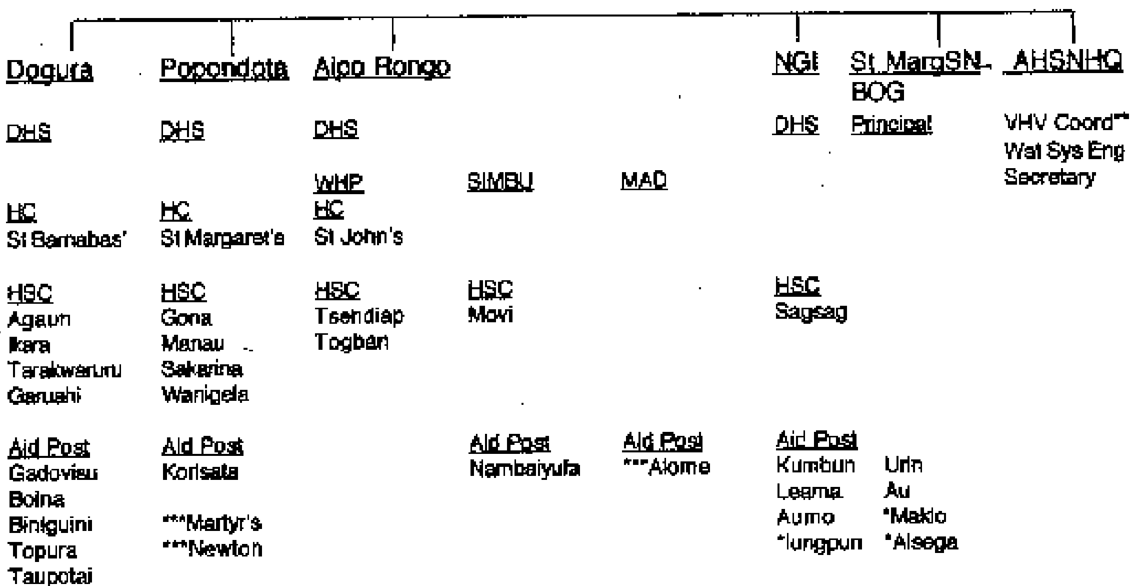
Village Health Aide	55	34	55	36		7		187
Village Birth Attendant	104	14	14	8				140
Village Health Promotors	24	23	24	22				93
Total	183	71	93	66		7		420

Schools of Nursing

	St Margarets's School of Nursing	St. Barnabas' School of Nursing	Total
Principal	1	1	2
Tutors	3	5	8
Students	41	57	98
Ancillary Staff**	1	1	2
Total	46	64	110

* *to be funded in 2001*
** *Ancillary Staff (secretarial, maintenance, drivers etc...)*


ANGLICAN HEALTH SERVICE
MANAGEMENT STRUCTURE - HEALTH FACILITIES
ACPNG Provincial Council
AHS Health Board


National Health Secretary
St BarnbsSN BOG
Dogura
Popondota
Aipo Rongo
NGI
St MargSN BOG
AHSNHQ
DHS
DHS
DHS
DHS
Principal
VHV Coord**
Wat Sys Eng
Secretary
WHP
SIMBU
MAD
HC
St Barnabas'
HC
St Margaret's
HC
St John's
HSC
Agaun
Ikara
Tarakwaruru
Garuahi
HSC
Gona
Manau
Sakarina
Wanigela
HSC
Tsendiap
Togban
HSC
Movi
HSC
Sagsag
Aid Post
Gadovisu
Boina
Biniguini
Topura
Taupotai
Aid Post
Korisata
***Martyr's
***Newton
Aid Post
Nambaiyufa
Aid Post
***Alome
Aid Post
Kumbun
Leama
Aumo
*Iungpun
Urin
Au
*Makio
*Aisega
Clinic Points
Clinic Points
Clinic Points
Clinic Points
Clinic Points = 400 in total
*To be transferred from Prov Gov
** 420 volunteers trained
***Professionally supervised but not managed by AHS

7. Mission Statement

The mission of the Anglican Church Health Service is to improve the physical, psychological, social and spiritual health and wellbeing of everyone in the communities we serve, irrespective of religious denomination; clan; status; age; gender; or ability to pay, and thus reduce the distress and suffering associated with the current high levels of morbidity and mortality.

This is the general aim and philosophy of the Anglican Health Service.

8. Major Objectives of the Anglican Health Service

In order to achieve this mission, seven specific objectives have been identified, which in essence, constitutes our Development Programme:–

1. **Improving the management of the service**

2. **Developing a public health emphasis**

3. **Taking services to people where they live**

4. **Improving diagnosis and treatment**

5. **Developing the knowledge, skills and attitudes of our staff**

6. **Providing the necessary equipment and facilities to perform effectively**

7. **Improving communications and transport**

9. Implementing the Objectives

This section sets out the detailed implementation of the Anglican Health Service Development Programme under each of our seven objectives.

Many items included in the programme have already been initiated and, where necessary, additional funds sought and allocated. Implementation of these will continue during the next 3–5 years. Other items will be implemented as staff are prepared and funds become available

9.1 Improving The Management Of The Service

9.1.1 It was stated in Section 3 that there had been a general deterioration in the standard of health services during the last 20 years, eg decline in the frequency of village health patrols; antenatal attendances; supervised deliveries and well baby clinic attendances. Some of the factors involved could be due to a shortage of resources. Others are more to do with the management and motivation of the Officer in Charge (OIC) of the particular health facility.

9.1.2 This is obviously an unacceptable trend, and one which needs to be reversed. OICs of health facilities play the key role in terms of the quality of service provided and the motivation of their staff. Most of the OICs have had no management training and are, therefore, ill prepared for their role.

9.1.3 To remedy this deficiency, an **OIC Upskilling** workshop was arranged in July 2001 to improve the management skills of our OICs and prospective OICs.

Upskilling topics include:–

- National Health Plan
- Planning
- Quality improvement
- Use of workload statistics
- Patrol programme
- Financial accounting
- Village health volunteer programmes
- Conducting meetings
- Managing & motivating staff
- Anglican Health Service Strategy
- Problem solving
- Nursing care planning and recording
- Health centre management
- Aid post supervision
- Health Promotion
- Communication skills
- Staff development
- Management of change
- Maintenance of buildings, equipment and supplies
- Working with the community and public relations
- Administration, records and reports
- Developing the mother and child health services
- Reducing the incidence of infectious diseases, including HIV/AIDS
- Developing the public health programme
- Improving diagnostic and treatment services

The course will be followed up with workplace assignments

After being given additional help, OICs who are not able to perform at the required level will need to be replaced.

9.1.4 It is essential that the service has policies and procedures, which are well understood by staff, a clear sense of direction and firm management. This **Anglican Health Service Strategy** will affirm the direction. The **AHS Policies and Procedures Manual** which has been re–issued in 2001, incorporates all of the new policies, and is fully indexed for easy reference.

9.1.5 As a result of the policy introduced by the Health Board in 1998, Anglican health facilities are now receiving more frequent **supervisory visits**. It is essential that Diocesan Health Secretaries make at least one structured visit annually to each health facility at which the following items are assessed:–

Clinic programme	Standards of care
Record keeping	Patrol programme
Staff management	Availability of equipment
Financial accounts	Maintenance of buildings
Community liaison	Village Health Volunteer programme

Any issues requiring further action are identified and recorded for follow up.

9.1.6 It is important that each member of staff understands what is expected of them. To this end '**Model job descriptions'** for each grade of staff, have been approved by the Health Board. These will be used as a basis for compiling and issuing individual job descriptions to each employee.

9.1.7 New staff are appointed for a 6 month **probationary period**, following which the OIC prepares a report on the individual's performance, and a recommendation of whether he/she should be offered a permanent position. The new employee then signs a declaration that he/she has received their job description and has read and understood the AHS Policy and Procedures Manual.

9.1.8 All staff who have been in post for more than one year are in the process of having an **appraisal** from their supervisor to give them feedback on their performance, and identify the aspects of their work which require some improvement. This will be repeated on an annual basis and is a useful opportunity to review the job description and to identify future training needs.

9.1.9 At the year 2001 NHS Consultative Committee, it is intended to discuss introducing a system of each Health Secretary and OIC formulating a series of **management objectives** to be achieved in the year ahead. This will assist both them and their staff in identifying their sense of direction and setting their own specific targets.

9.1.10 During our assessment visits in 1997, we detected that the majority of accounts kept by OICs were inadequate and contained discrepancies. Furthermore three Diocesan Health Secretaries and a School Principal have been dismissed for misappropriation of funds.

9.1.11 Following this, the **auditing of accounts** has been included in the supervisory visit structure and guidelines were issued in March 1999. It is necessary now to ensure that financial audit of all accounts is carried out on an annual basis.

9.2 Developing A Public Health Emphasis

9.2.1 Experience in other developing countries has shown that the major improvements in health have not been brought about by the building of large and expensive hospitals, but by **simple public health measures** such as:–

a) Pure drinking water
b) Efficient sanitation
c) Improved nutrition
d) Improved housing
e) Immunisation
f) Community based health programmes
g) Improved economic power
h) Improved education, particularly of women

9.2.2 The majority of our rural communities have no access to clean, pure water, and mostly rely on water from the creek. The safety of this water for drinking is highly suspect, as it is being used further upstream for bathing, washing clothes and by animals. There is little doubt that this is a major cause of gastrointestinal and skin conditions. We are, therefore, giving high priority to the development of **rural water systems**.

9.2.3 The Anglican Church Water Strategy was approved by the Health Board in May 99. The following points should be particularly noted:–

a) Two pilot projects were successfully carried out at Movi and Fikanbaro in the Siane District of Aipo Rongo diocese, as well as a Rotary project at Dogura.

b) At least one 'technical volunteer' has been trained in each rural diocese to give local communities assistance with designing their system, calculating volumes of water, and with the actual construction.

c) A Water Systems Officer has been recruited through VSO to give further technical assistance and to give the programme further impetus.

d) In order that the community has 1ownership' of their water system, the initiation and planning must come from them. They should also provide free labour and make a financial contribution towards the total cost. The level of this contribution is to be decided by the Diocesan Bishop.

9.2.4 **Village Health Promotion Workshops** are being organised to train Village Health Promoters in each village, who will help our isolated communities improve their general health and reduce their current high level of sickness.

9.2.5 The workshop comprises five modules:

a) Before and after Village Childbirth, including antenatal health, and care of the mother and baby

b) Malaria, Pneumonia and Diarrhoea

c) Child Growth and Development, including child nutrition

d) Sexual Health, including family planning and sexually transmitted diseases. High prominence is given in this module to HIV and AIDS.

e) Healthy Families, Happy Communities including environmental health, housing and personal hygiene)

9.2.6 Each module is supported with a flipchart, worksheets, games and other materials. A training manual is currently being written.

9.2.7 Participants in the workshops include schoolteachers, priests, catechists, youth workers, members of the Mothers Union and other women's organisations, and members of the local Health Committee, who keep sets of materials for using in their own communities. It is stipulated that at least half of the participants must be female.

9.2.8 The intention of the workshops is to strengthen community understanding of the causes of ill health and take ownership of their own programmes to improve the health and wellbeing of its village people

9.2.9 Two pilot workshops were held at Taupota in Dogura diocese, a coastal location, and at Movi in Aipo Rongo diocese, a highland location. Each pilot included an evaluation of the materials and the methods used, following which the materials were modified and reprinted, incorporating new ideas. It is intended that workshops will now be available throughout PNG.

9.2.10 The initial workshop is followed up by refresher days and sending updating materials. The workshop is most beneficial when a local health worker is designated to liaise with, encourage and support the village health promoters.

9.2.11 We continue to highlight the importance of **Family Planning** and **Child Immunisation** at our health facilities and during our MCH patrols. Family planning aids are available at all of our centres. There were a number of National Immunisation Days in 1998 and 1999, when universal Immunisation took place. The World Health Organisation declared PNG 'Polio Free' in the year 2000.

The programme continues to be disrupted by vaccines and gas cylinders for refrigerators not being available. The AusAID Womens and Childrens' Health Programme is attempting to address these problems.

9.2.12 Infants and young children are regularly weighed to monitor their growth patterns, but very little attention is given to developmental screening. Some initial work was carried out by Dr Kate Owen at Dogura in 1999. This needs to be pursued further in the future.

9.2.13 Most communities have adequate pit **toilets** or sea toilets, but in a few areas it is still common for defaecation to take place in the bush. This practice is being discouraged both by Community Health Workers during their patrols, and by village health promoters following attendance at the health promotion workshops.

9.2.14 We have purchased and distributed **mosquito nets** and Permethrin to each of our Diocesan Health Offices, to be made available at each of our health facilities. Each facility is being encouraged to organise sessions for treating the nets every 6 months. The nets are sold at a subsidised price and the chemical treatment is provided free. The programme was taken up by the Scouts in Lae. It is hoped that other youth and voluntary groups can be encouraged to pursue this programme as a community service in other provinces.

9.2.15 Increasing emphasis is given to public health measures in the training of nurses and community health workers. Improving community health will be given even greater prominence in the new curricula for training both groups of health workers. Particular importance is given to the prevention of infectious diseases especially malaria, pneumonia, tuberculosis and diarrhoeal conditions, as well as to the increasing incidence of the '**lifestyle diseases'** such as diabetes; cardiovascular disease; tobacco, alcohol, drug and betel nut related conditions, and sexually transmitted diseases. Particular prominence is given to HIV and AIDS.

9.2 16 There is great concern at the increasing incidence and geographical spread of **HIV infection**. Extrapolation of current trends present a horrific picture of a decimation of the economically active section of the population, which will have a disastrous effect on the efforts of the country to develop.

9.2.17 The need to reduce the spread of HIV infection is regarded as so important that it is emphasised throughout the training of our student nurses and student community health workers. This includes teaching the skills to run awareness campaigns and community education.

9.2.18 All of our Village Health Aides and Village Birth Attendants are trained in HIV/AIDS. Our Village Health Promoters are trained in HIV/AIDS and equipped with materials to carry out awareness and health education in their communities.

9.2.19 HIV/AIDS is included in all inservice training, upskilling programmes and refresher courses. We regularly receive updates from International, National and Local agencies dealing with HIV/AIDS, which are reproduced to keep all of our staff informed.

9.2.20 To be successful, the improvement of all aspects of health should be tackled on a multisectorial basis. This is particularly so in the case of HIV infection, because of the essential need for behaviour change. Priests; Catechists; Mothers Union and other Womens' Group Leaders; Teachers; Members of Religious Orders; and Youth Leaders are all included in our Village Health Promotion Workshops, at which HIV/AIDS is prominently dealt with. It has been agreed that the workshop will be carried out at Kerina and Newton Colleges, when the respective principals have agreed suitable dates.

9.2.21 We are in the process of providing Posters on the prevention of HIV infection to each of our health facilities to display in a prominent place.

Condoms are also issued free from each health facility.

9.2.22 Health Workers must be made aware, in all of their clinical procedures, of the need to take precautions against the spread of infection. This is particularly important when dealing with blood products and sharp instruments which have been in contact with blood products, to avoid the risk of HIV and Hepatitis infection. All clinical areas must be issued with sharps boxes

9.2.23 A positive diagnosis of HIV is an extremely traumatic experience, because of its inevitable outcome and its effect on family relationships. It is essential, therefore, that health workers are provided with additional counselling skills to support patients and their families through this process. This should commence with one nurse at our 4 main centres of Dogura, Oro Bay, Koinambe and Sagsag receiving training and acting as a referral point. This will later be extended to one nurse in each of our sub centres.

9.3 Taking Services To People Where They Live

9.3.1 Frequently people living in rural communities must walk several kilometres over rough terrain to the nearest health facility. This will often involve crossing one or more mountains, and wading through rivers, which is clearly an unreasonable expectation for a pregnant women, or for a mother with young children. We are making our services more accessible in the following ways:–

9.3.2 **Improving the frequency of Village Health Patrols.** A new policy is being implemented, which requires health workers to carry out patrols at least every two months. This is being reinforced through a new system of health workers submitting patrol reports. Although there has been some improvement, the frequency of carrying out patrols is still unacceptably low and we will continue to work at some of the difficulties.

9.3.3 Recent experience shows that there is great variation in the number of patrols currently carried out. In 2000, Agaun carried out 16 and Ikara 11 compared with Oro Bay, Sakarina, Manau, Gona and Wanigela, who all did 1 or less. This is completely unrelated to difficulty of terrain or numbers of staff.

9.3.4 **In each village**, **training and supporting a Village Birth Attendant,** who is able to give antenatal support, carry out simple deliveries, and refer complicated deliveries to a trained health worker. The programme is well established in Dogura diocese with a total of 104 VBAs. Three courses have been run in Aipo Rongo with 21 VBAs trained, and the programme has recently commenced in Popondota. The programme will continue to be extended in these diocese, and is planned to commence in New Guinea Islands in 2001.

9.3.5 **In each village, training and supporting a Village Health Aide**, who is able to give first aid, provide simple treatments and to refer more serious conditions to a trained health worker. This programme also commenced at Dogura, which now has 55 VHAs. 95% of the patients seen have been diagnosed with Malaria, Coughs, Diarrhoea and skin infections.

The programme extended in 1998 to Aipo Rongo, which now has 55 VHAs in the Jimi District and 36 in the Siane. The programme commenced in Popondota and New Guinea Islands in 2000.

9.3.6 It is essential for **VBAs and VHAs to attend upskilling courses** every two years, and for Coordinators also to have refresher workshops every two years. The first of these workshops was held in April 1999, and provided an opportunity to determine our future programme and revision of training materials.

9.3.7 There is a need for a VBA Trainers Guide, similar to the one produced for VHA Trainers. Also to develop VBA reports using a graphic format, recognising their low level of literacy.

9.3.8 The National Inventory of Health Facilities carried out by the Government in 1998 showed that a total of 367 **aid posts were closed** nationwide. This represents 18% of the total. In individual provinces the percentages are:–

Milne Bay (Dogura)	5.00%
Oro (Popondetta)	17.00%
Western Highlands (Aipo Rongo)	33.00%
Chimbu (Aipo Rongo)	26.00%
West New Britain (New Guinea Islands)	25.00%

9.3.9 These closures represent an absence of health provision for the most vulnerable and deprived communities in Papua New Guinea. For these people there is no alternative. They live in the most difficult terrain and in the most isolated locations. There is no way of getting to the nearest health facility other than walking for at least a day, often 2 or more days. They are largely forgotten and have no voice.

9.3.10 The Government has stated in the National Health Plan, that the reopening of these Aid Post is a priority. The Anglican Health Service is keen to assist with this process, and to open aid posts in other areas of need. 3 Aid Post in West New Britain have been transferred to AHS management in Wrest New Britain, 1 more is due to be transferred and 2 new aid posts to be opened. In the Jimi District, of Western Highlands Province, we have carried out a survey of the closed aid posts and will negotiate their reopening with the Provincial Health Advisor

9.3.11 It is important for the community to be able to collectively communicate their needs and their views to the health workers through the medium of a functioning **Health Committee**. A committee should be set up for each area served by an AHS facility representing all sections of the community, and must have at least 2 women amongst its members. The committee does not

have a management role, but a support role, acting as a communication bridge between the community and the health service.

9.4 Improving Diagnosis and Treatment

9.4.1 For many years, Milne Bay Province has funded a **Doctor** post at Dogura, which has been filled reasonably continuously by VSO (Voluntary Service Overseas).

9.4.2 Both Western Highlands and Oro Provinces have funded doctors, for which we have only recently been able to recruit. There are insufficient doctors trained in PNG to serve both urban and rural needs, and national doctors tend to seek urban locations when considering development of their skills and their future careers. VSO recruit to 60 developing countries worldwide, most of whom have acute demands for doctors, resulting in the demand outstripping the supply.

9.4.3 Our traditional mission recruiting agencies, ABM (Australia), PNGCP (UK), and AMB (New Zealand) have experienced difficulty in recruiting to these posts, until recently when PNGCP assisted the UK agency Christians Abroad in recruiting Dr Suzanne Alzinger from Switzerland.

9.4.4 We have recently been advised by VSO that they will in future be only working in 6 provinces, which excludes Milne Bay. This will necessitate us having to pursue other channels of recruitment as these posts are crucial to the future development of our health services.

9.4.5 For the vast majority of people living in rural areas, the only medical service they will have access to are Nurses and Community Health Workers. It is essential, therefore, that they are able to competently diagnose, treat and refer either when they are not sure of the diagnosis, or when the condition is beyond their competence to treat.

9.4.6 The National Department of Health has compiled 3 **Standard Treatment Guides**: One each for Illnesses of Children, Illnesses of Adults and Obstetric and Gynaecological Conditions. Each health worker should have their own personal copies, which they refer to when diagnosing and treating a patients condition.
These guides contain sound advice and should be adhered to whenever possible.

9.4.7 As members of a profession, nurses and community health workers should ensure that they constantly **review their own practice**, and ensure that it is kept up to date. This is not always easy to do in isolated rural facilities and requires health workers to reread textbooks; question colleagues, particularly

those with specialist expertise; read patients' notes, attend upskilling courses and carry out set assignments; and study distance learning material, eg the distance learning course on HIV/AIDS.

9.4.8 We refer in the next section to the need for AHS to run regular **upskilling courses**, and the need for specialist and post basic skills. This is particularly important in areas where there is no doctor.

9.4.9 The Government introduced a system of Child Health and Adult **Treatment Books**, which the patients keep themselves and bring with them to the health facility during each visit. This is a commendable system, as it keeps each patient informed about their own treatment. It is, however, no substitute for the health facility keeping their own records.

9.4.10 In addition to the patients' own records, each health facility should keep their own **record for each outpatient** on which is recorded their history, clinical observations, diagnosis, treatment prescribed, treatment carried out, and the result (evaluation).

9.4.11 Because health workers are performing the role of both doctor and nurse, and because of the immediacy of the medical needs, there is a tendency in some centres for the nursing care to be overlooked, particularly as this is usually carried out by the guardians.

9.4.12 International experience has clearly demonstrated that competent nursing care can have a crucial effect on recovery, therefore, it is necessary for health workers to record the care required for each patient on a **nursing care plan**. Health Workers will identify and record each patient's nursing needs and plan the care to meet these needs. Health Workers should work with the guardians in providing care. They will also record the care actually given.

9.4.13 There is a high correlation between high levels of morbidity with poverty associated with low rates of literacy, low standards of hygiene and poor nutrition. Thus, those people most likely to be sick are least able to pay. As a means of improving access to treatment for everyone, according to their need, we have introduced a **free treatment** service for children up to the age of 15 years, the elderly, and the handicapped. All preventive services are now free, including deliveries in AHS facilities.

9.4.14 As a further means of encouraging patients to seek early diagnosis and treatment, it is essential to create a **welcoming** atmosphere, where patients

are treated in a courteous and sympathetic manner, and where they can be dealt with confidentially and in privacy.

9.4.15 Other issues to improve the effectiveness of diagnosis and treatment are:–

a) Avoiding the unnecessary use of antibiotics and ensuring that when they are prescribed, patients take the full course.
b) Similarly, ensuring that patients suffering from Tuberculosis complete the full course.
c) Wherever appropriate, diagnosis is confirmed by laboratory test. This will also require the development of laboratory facilities in our centres and training staff.
d) Whenever necessary advice is sought by radio contact with a specialist nurse or doctor, or by referring the patient.
e) Whenever necessary patients are admitted for treatment and care.
f) Health facilities provide a suitable place for food to be prepared for inpatients.
g) That sick patients are sought out during patrol, diagnosed and treated.
h) That discharged patients and their guardians are given advice on continuing care and rehabilitation at home. These patients should be followed up during patrols.

9.4.16 Reference is made elsewhere in this document to the need for training specialist health workers in eye care, midwifery, paediatrics, laboratory skills and mental health. Such health workers should work peripatetically within their diocese, and beyond if necessary, and be prepared to assist with referred patients from other health facilities.

9.4.17 There is a clear need for additional specialist posts:–

a) Dogura is the only diocese with a dentistry service. This needs to be extended to other diocese to assist with the improvement in oral health and to treat dental caries. We will attempt to seek funding for such posts in the future.
b) There is no physiotherapy service anywhere in the Anglican Health Service. Such a post is necessary to assist patients directly and to train other health workers.

9.5 Developing the Knowledge, Skills and Attitudes of our Staff.

9.5.1 The health workers themselves, are undoubtedly the most important resource in providing health services. It is a concern that we are experiencing difficulty in identifying from within the Anglican Health Service, individuals with the necessary skills and experience to fill the posts of Health Secretary and OIC.

9.5.2 Many of our health workers are highly committed to improving the health and welfare of their communities, but some show little concern for the suffering experienced by people with chronic illness or disability. This is most evident with the poorest and most vulnerable members of the community.

9.5.3 As a Church Health Service, it is essential to constantly restate and reinforce the **Christian values** which permeate everything we do. The Mission Statement refers to the importance of the spiritual health and wellbeing of our communities. Church health workers must work alongside the priests and other church workers to pursue this and to set a good example by their own religious observance and personal behaviour.

9.5.4 The Mission Statement also refers to our services being provided irrespective of religious denomination, clan, status, age, gender or ability to pay. We have already referred to the greatest burden of ill health falling on the poor, many of whom live in the most remote areas. It is thus part of our Christian mission to strive to ensure that our services reach these people.

9.5.5 It is essential, that clear **policies** are in place to **develop, equip and motivate** staff to provide a high quality service to our communities. The importance of good management practice, including the issue of job descriptions and performance appraisal, was mentioned in the previous section.

9.5.6 The training of health workers with the required knowledge, skills and attitudes starts with our Schools of Nursing. It is essential that students are trained with an appreciation of the importance of primary health care, a commitment to delivering a high standard of service to our communities, and the skills to perform competently in a rural situation

9.5.7 **St Barnabas' School of Nursing**, in common with other General Nursing Schools is in the process of introducing a diploma level curriculum. This is a move, which we welcome, to prepare nurses more able to analyse the causes of ill health and more able to negotiate improvements in lifestyle.

9.5.8 Other changes must be introduced to meet the requirements for the new curriculum:–

a) Nurse Tutors must be qualified to graduate level. The Principal currently studying for a Bachelor Degree in Australia, and 2 other tutors are studying

for a Bachelor degree using the mixed mode approach, which is a combination of distance learning and class based modules. It is intended that the other tutors will also have the opportunity during the next 2–3 years.

b) The school must be affiliated to a Higher Education Institution for accreditation purposes. Application has been made to Divine Word University in Madang for this, together with St Mary's school of Nursing, Vunapope and the Madang Lutheran School of Nursing.

c) There needs to be some improvement in the classroom capacity and library facility. A new library and classrooms have almost been completed at the time of writing.

9.5.9 The Anglican Health Service has been very successful, during the last few years, in recruiting high quality graduates from St Barnabas SON to work in all geographical areas. Most of these have not been Anglican, but they have been well accepted into their respective communities, and are at the forefront of initiatives to improve our standard of service.

9.5.10 **St Margaret's School of Nursing**, on the other hand, continues to be constrained by uncertainty and sub–standard facilities:–

a) Since the school moved, several years ago, from its previous location at Oro Bay, it has been housed in temporary diocesan buildings. Whilst this enabled the school to continue to function, it is far from ideal, as the residential accommodation is cramped and the males do not have a separate cooking and eating area.

The diocese has always been very helpful and cooperative, but there is always a feeling of insecurity, in that the diocese may wish to use the buildings for their own purpose. An example of this occurred in 1999, when the diocese reallocated a house previously used for a nurse tutor, to a diocesan ancillary worker. This caused a great difficulty for the school and is clearly unsatisfactory.

b) A second cause of uncertainty is the doubt over the future location of the school. The Anglican Health Board conducted a review and resolved that the school would not return to its former location at Oro Bay.

There are 3 main alternatives currently being explored:

1. Moving to the Christian Training Centre when the Melanesian Brothers vacate the premises.
2. Building a new self–contained school on a designated piece of land on the diocesan site.
3. Building on state owned land in Popondetta town

All 3 alternatives will require substantial capital funds, which have yet to be identified.

c) A further source of anxiety is the National Government's rationalisation of schools of nursing. A data collection exercise has been carried out, but no final conclusions have yet been reached. The school is strategically important, because it is the only institution training community health

workers in Oro Province, and potentially an important source of recruitment to AHS. There is also some pressure for the 'viable' schools to increase their intakes to meet the future manpower needs of implementing the National Health Plan.

9.5.11 Against this background of uncertainty, it is not surprising that the performance of the school has inevitably been adversely affected, and the standard of the graduates not as high as we would wish. It is, therefore, a high priority to establish a more secure and acceptable future for the school.

9.5.12 A start was made in 2000, with the replacement of 3 teaching staff. A new Principal will be appointed in 2001. Revised student guidelines will be approved in 2001 and with the development of a School Strategy.

9.5.13 It is also important to establish a programme of visits to High Schools, with a view to publicising health work as a career and encouraging high calibre students to apply to our schools of nursing for training.

9.5.14 Many of our staff have worked in the same location for over 10 years, and in a few cases 15 or more. The Health Board policy requiring all staff to **change location** every five years was first implemented in 1999. This was a difficult year because of the large number of staff involved, but this has now eased and there is a general recognition that the policy is assisting in the process of avoiding stagnation and ensuring that staff can respond to new challenges.

9.5.15 Health is a dynamic topic and new ways of delivering health care are being continuously developed. It is essential that our health workers have the opportunity of **updating their skills** and learning new ways to improve their practice.

9.5.16 Our tutors from both schools of nursing, who do not hold the Diploma in Education, attended a **Teaching and Assessing workshop** organised by the Anglican Health Service at St Barnabas School of Nursing. This was to improve the quality of their teaching and assessing practice. Following the workshop they carried out a number of teaching and assessing assignments.

9.5.17 All 60 of our **Community Health Workers** attended one of two **Upskilling Workshops** organised in Popondetta by the Anglican Health Service. They were required to work on assignments at their workbases, following which they received a certificate authorising them to carry out the full range of Mother and Child health activities, including antenatal examinations, family planning, child growth monitoring and immunisation.

This is of particular importance to community health workers working in Aid Posts, because they are able to provide these services without having to wait for a nurse to visit, thus improving accessibility.

9.5.18 OICs of health facilities play the key role in terms of the quality of service provided and the motivation of their staff. Funds have been received from ABM in Australia to run an **OIC Upskilling** workshop in July 2001 to improve the management skills of our OICs and prospective OICs.

9.5.19 It is intended that upskilling will be provided for other **nursing officers** in 2001. ABM have made application to AusAID for the funds to do this. At this point all of our staff will have attended upskilling within the last 3 years. It is important that this programme is repeated, ensuring that all health workers are upskilled every 5 years.

9.5.20 Village Birth Attendant Coordinators and Village Health Aide Coordinators attended an upskilling workshop in March 99. This will need to be repeated every 2 years. VBAs and VHAs will also need to attend refresher training every year.

9.5.21 It is necessary for some of our staff to be trained in **post–basic** and specialist skills. It is our aim to have in each diocese, at least one health worker trained in the following skills:–

Midwifery	Eye Care
Paediatrics	Laboratory Skills
Mental Health	

These health workers will have responsibility for sharing these skills with other health workers, as well as providing specialist referral services

9.6 Providing the Necessary Equipment and Facilities to Perform Effectively

9.6.1 Our initial assessment, conducted in 1997, revealed the following results:–

a) Of our then 25 facilities, 12 required either extensive or very extensive repair and/or renovation.

b) Another 8 needed a significant amount of work.

c) Over half needed additional or replacement staff accommodation

d) The majority were in need of some essential pieces of equipment such as refrigerators, primus stoves, sterilisers, weighing scales, beds and mattresses.

9.6.2 The Demographic and Health Survey carried out by the government in 1996 illustrated a similar picture of deprivation in other health services.

9.6.3 Thus, at many locations high standards are made more difficult to achieve by the absence of the **necessary facilities and/or equipment** to do the job.

9.6.4 The Health Board has now agreed a list of essential equipment which should be available in our Aid Posts, Health Sub Centres and Health Centres. An inventory is currently being carried out to quantify current deficiencies and assess the standard of equipment in use.

9.6.5 Once the inventory is complete, it will then be our intention to supply each facility with the necessary equipment. Some progress has already been made: we are particularly grateful to Rotary in Australia, who have sent 2 consignments of used equipment and to AusAID, who have supplied vaccine carriers and scales.

9.6.6 Sadly, theft of equipment, is proving to be an increasing problem in some areas, which is very demotivating for staff. It will, therefore, be necessary to improve security and staff vigilance.

9.6.7 Some **refurbishment of health facilities** has commenced:–

a) The refurbishment of the student hostel at Dogura was completed in 1991, and a number of staff houses built.
b) At Koinambe a new Outpatients' Department has been built and the main ward cubicalised and refurbished.
c) The main ward has been cubicalised and refurbished at Movi.
d) A new ward has been built at Sagsag.
e) A new aid post has been built at Kumbun

9.6.8 This maintenance programme is necessarily long term because of the high costs involved. Our immediate priorities are:–

a) The rebuilding of **St Margaret's School of Nursing** was referred to in the

previous section. In the interim, a low cost shower facility has been built so that the male students no longer need to wash in the local stream. We intend to provide facilities for them to store and cook their food and provide better facilities for the female students.

b) Refurbishing the Paediatric ward and building the doctor's house at **Koinambe**.

c) Resiting the Inpatients' Ward at **Tarakwaruru.** The ward is currently located on the sea front, but is in a poor state of repair and is subject to flooding from the sea, causing much discomfort to the patients. There is a need to rebuild the ward on higher ground, adjacent to the outpatients' department.

d) Rebuilding the Maternity Ward at **Dogura.** Some funds have already been raised by a number of churches in the UK through the auspices of the Papua New Guinea Church Partnership. We have applied to the British High Commission for the remainder of the funds.

e) Refurbishing the buildings at **Oro Bay, Manau and Sakarina**, which are all in a deplorable state of disrepair.

f) Rebuilding of the Aid Posts at **Boianai, Topura,** and extension to the aid posts at **Korisata** and **Au.**

Other building and maintenance works will be carried out as funds become available.

9.6.9 We are hoping to interest Rotary Australia in assisting us with some of these building projects.

9.7 Improving Communications And Transport

9.7.1 The lack of transportation and communications are major problems throughout the Anglican Health Service because of the remoteness of so many of our Anglican communities. In the Aid Posts our Community Health Workers have to cope single handed and, at times, need to be able to seek professional advice and treatment for sick patients quickly when there is an emergency.

9.7.2 Four of our facilities now have **vehicles**, and four have **dinghies**, which is a great improvement during the last 2 years. The vehicles at Movi and Oro Bay are both in a poor state of repair and will need to be replaced. For many other locations, transport of sick patients is still a major problem. This is not always easily resolved for two main reasons:–

a) Absence of a navigable road.

b) The cost of purchasing the vehicle, paying the driver, fuel and maintenance.

9.7.3 OICs experience difficulty in ensuring that these vehicles and vessels are used only for their intended purpose of transporting sick patients, health workers on patrol and medical supplies. There is understandable pressure from the communities concerned to transport other different types of cargo, which cause additional depreciation of the vehicle/vessel and causes it to be unavailable when a medical emergency occurs. Their is also a problem in paying the driver or operator and paying for fuel and maintenance.

The Health Board has approved a policy to assist OICs in regulating the use of these vessels/vehicles.

9.7.4 **Radios** were installed at seven of our Aid Posts in 1999 enabling the Community Health Worker to seek professional advice and support when necessary. Some of the older radios are now obsolete and need to be replaced. The new radios will need to have a ‘call facility’ enabling them to be used outside of Sked times. Priorities are Koinambe and Oro Bay to enable the doctors to be contacted, and also at Gona. Some of the new aid posts in West New Britain will also need radios.

9.7.5 **Staff Circulars** are issued 4 times a year by the National Health Secretary to each facility to keep staff informed. A system of **Quarterly Reports** has also been introduced for OICs and Aid Post CHWs to keep Health Secretaries informed of their activities, and for the Diocesan Health Secretaries to inform the National Health Secretary.

10. Key Results to be Achieved by the End of 2005

Key Result	Latest Date	Risk to Achievement
Improving Management		
1. AHS Strategy:–		
a) Formulated	Dec 99	None.
b) Consulted upon	May 2000	None.
c) Approved	Oct 2000	Lack of agreement.
d) Distributed	July 2001	Not returned from printers.
e) Implemented	Dec 2005	Lack of will or funds.
2. Administration Manual rewritten & issued	Aug 2001	Lack of time.
3. OIC Upskilling and all workplace assignments	June 2002	Lack of funds or accommodation Lack of motivation.
4. All facilities had structured supervisory visit within last year	Dec 2001	Lack of time or transport.
5. Financial accounts of all DHS and OICs audited within last year	Dec 2001	Lack of time or transport.
6. All new staff completed probationary period and signed declaration re job description and Policy Manual	June 2001	Probation Reports and declarations not returned.
7. All staff issued with job description	Jan 2001	Lack of time. Delivery problems.
8. All staff had appraisal within last year	Dec 2001	Lack of time or transport
9. All DHS & OICs written objectives for their unit	June 2002	Lack of motivation or supervisory time.
10. Diocesan Health Secretaries appointed to all 4 rural diocese	Dec 2001	Lack of funds. Unable to appoint suitable person.
Increasing Public Health Emphasis		
11. Water Systems Officer in post Does not settle.	Jan 2001	Does not arrive from UK.
12. Yandime water system completed Community doesn't assist	May 2001	Transport problem.

13. 1 other Siane water system completed	July 2001	Community doesn't collect contribution. community doesn't assist Transport problem.
14. 2 other Siane and 2 Jimi water systems surveyed, costed & submitted for funding	Aug 2001	Lack of transport. Lack of community cooperation.
15. 4 water systems completed Community doesn't assist	Nov 2001	Community doesn't collect contribution. Transport problem.
16. 6 water systems completed Community doesn't assist	Feb 2002	Community doesn't collect contribution. Transport problem.
17. New Guinea Islands surveyed, costed and submitted for funding	Oct 2001	Transport, Lack of community cooperation.
18. Each rural diocese has active Water Development Programme Unable to prepare bids in required form.	Dec 2002	Lack of interest from villages. Lack of transport.
19. Village Health Promotion programme established in all rural diocese & all involved parishes identified 1 Health Promoter	Dec 2001	Lack of time. Lack of funds. Lack of female participants. Lack of motivation to change.
20. All AHS areas have participated in a VHP workshop and each village has identified a Health Promoter.	Dec 2003	Lack of time. Lack of funds. Lack of female participants. Lack of motivation to change.
21. All AHS facilities implemented mosquito net programme	June 2002	Difficulty in obtaining supplies, Lack of funds to start up.
22. Majority of villages in each diocese have access to treated mosquito nets	June 2003	Organisational difficulties. Security of funds. Lack of interest. Unwillingness to organise.
23. Child development screening established in 1 health facility	Dec 2001	Lack of interest or motivation.
24. Child development screening extended to 1 facility in each diocese	Dec 2002	Lack of interest or motivation.
25. Child development screening extended to all AHS facilities	Dec 2005	Lack of interest or motivation.
26. HIV/AIDS prominently	Dec 2001	Lack of cooperation.

incorporated into all training for all health workers, health volunteers, priests and catechists		
27. Posters, leaflets and other information on HIV/AIDS prominently displayed in all health facilities	Dec 2001	Difficulty in obtaining materials, reluctance to display.
28. Condoms are available from all AHS health facilities and use encouraged	June 2001	Not supplied by Area Medical Stores.
29. All health workers aware of referral system for testing and counselling	Dec 2001	Facilities not available.
30. All clinical procedures reviewed to avoid cross infection, particularly HIV and Hep B	Dec 2001	Lack of time, Lack of cooperation .
31 All clinical areas to be issued with sharps boxes	Dec 2001	Lack of availability.
32. 4 nurses receive training in counselling skills	Sept 2002	Lack of funds. Lack of a suitable course.
33. An additional 12 nurses receive training in counselling skills	Sept 2004	Lack of funds. Lack of a suitable course.

Taking Services to people where they live

34 All clinic points received health patrol within last 2 months.	Dec 2001	Lack of motivation. Bad weather. Lack of fuel.
35. All villages served by AHS have VBAs & VHAs	Dec 2002	Lack of funds. Lack of interest.
36. All VBAs & VHAs refreshed within last year	Dec 2003	Organisational difficulties. Lack of funds. Coordinator leaves or not motivated.
37. VBA & VHA Coordinators upskilled within last 2 years	Dec 2001	Organisational difficulties. Lack of funds. Lack of motivation to organise.
38. 70% of births supervised in last year	Dec 2002	Reluctance of mothers to use VBA. VBAs. Not well motivated.
39. 80% of births supervised in last year	Dec 2004	Reluctance of mothers to use VBA. VBAs. Not well motivated.

40. 85% of births supervised in last year	Dec 2005	Reluctance of mothers to use VBA. VBAs. Not well motivated.
41. Trainers Guide produced for VBA Trainers	June 2002	Lack of time. printing difficulty.
42. Pictorial records produced for VBAs	June 2002	Lack of time. printing difficulty.
43. A health committee should be set up for each area served by an AHS facility, representing each section of the community	Jan 2002	Lack of interest from the community. Misunderstanding of role. Lack of agreement. HWs feel threatened. Priest not supportive.

Improving Diagnosis and Treatment

44.Doctors in post at :–		
Oro Bay	Feb 2001	Unable to find suitable candidate.
Koinambe	Oct 2001	Unable to find suitable candidate.
45.There is a programme in place for doctors in training overseas to come for 'electives'	Jan 2001	No applicants. Unable to arrange professional supervision.
46.Communities are able to access 'competent treatment' from all AHS facilities	Dec 2001	Lack of motivation. Resistance to change.
47. Free treatment is readily offered to:– a) Children < 16 years b) The elderly and handicapped.	Feb 2001	Resistance to giving free services. Resistance to change. no running costs received.
48. Nursing Care Plans used for all inpatients	Sept 2001	Printing and distribution problems. Lack of motivation and/or supervision.
49 Record of diagnosis & treatment made for each outpatient	Feb 2001	Obtaining stationary, Resistance to change
50. Koinambe and Oro Bay have laboratory facilities	Jan 2002	Lack of funding, unable to obtain equipment
51. All health facilities have suitable area for guardians to prepare food for inpatients	Jan 2003	Lack of interest, Lack of cooperation
52. All inpatients being discharged have written continuing care advice	June 2002	Lack of interest, Lack of cooperation

Developing Staff

53. All tutors at St Barnabas' SON studied to Bachelor level	Dec 2003	Lack of funds. Lack of places. Pressure of other duties
54. Submission made to Divine Word University for affiliation	Mar 2001	Lack of agreement
55. Course submission made to Divine Word University	Dec 2001	Lack of time. Lack of agreement. Lack of commitment
56. Diploma level curriculum implemented at St Barnabas' SON	Mar 2003	School does not meet all requirements. Lack of funds
57. Decision made on site for rebuilding St Margaret's SON	Aug 2001	Lack of agreement.
58. Funding bids submitted to rebuild St Margaret's SON	Oct 2001	Lack of time. Information not available.
59. Construction of new buildings at St Margaret's SON commence	Oct 2002	Funds not available.
60. Principal appointed to SMSON	Aug 2001	Lack of suitable candidate.
61. Tutors at SMSON commence upgrading of qualifications	Jan 2002	Lack of funds. Lack of interest.
62. Strategy produced for SMSON	Oct 2001	Lack of time. Lack of interest.
63. New Student Guidelines issued at SMSON	July 2001	Lack of time. Lack of agreement
64. Additional books and teaching aids purchased	Dec 2001	Lack of funds.
65. All Health Workers –		
a) Upskilled in last 3 years	July 2002	Lack of funds or accommodation.
b) Been in the current location for less than 5 years	Nov 2001	Difficulty with making necessary moves. Logistical matching problems.
66. At least 1 HW in each diocese with post basic training in:–		
a) Midwifery	Dec 2005	Insufficient funds. Unable to obtain course places or to release staff to train.
b) Paediatrics	Dec 2005	
67. At least 1 HW in each diocese with specialist training in:–		

a) Laboratory skills b) Eye care	Dec 2004 Dec 2004	Courses not run. Releasing staff to train.
68. Visits to High Schools carried out annually to publicise health work as a career	Dec 2003	Lack of time. Lack of interest. Lack of cooperation. Organisational difficulties.

Providing facilities and equipment

69. Inventory of basic equipment carried out	Mar 2001	Inventory not correctly completed or not returned.
70. All facilities have basic sets of equipment in working order	Dec 2002	Lack of funds. Unable to obtain supplies. Inadequate maintenance. Theft.
71. All facilities have had some essential maintenance carried out	Dec 2002	Lack of funds Organisational and transport difficulties. Unavailability of skills.
72. At least 2 major capital schemes carried out	Dec 2002	Lack of funds Organisational and transport difficulties. Unavailability of skills.
73. 2 further major capital schemes carried out	Dec 2004	Lack of funds Organisational and transport difficulties. Unavailability of skills.

Improving communications and transport

74. Radios purchased and installed at Oro Bay and Koinambe	July 2001	Lack of funds. Organisational difficulties.
75. Radios purchased and installed at Gona and Urin	Jun 2002	Lack of funds. Organisational difficulties.
76. All facilities have a functioning radio	Dec 2001	Lack of funds. Difficulties with supply or repair.
77. All facilities have access to some means of transport for carrying sick patients	Dec 2005	Lack of funds. Organisational difficulties Lack of maintenance Unavailability of vehicle.
78. All health facilities have submitted a report of their activities within last 3 months	Dec 2001	Lack of motivation. Poor postal system.
79. All Diocesan Health Secretaries have submitted their activity report, financial statement and patients statistics within the last 3 months	Sept 2001	Lack of motivation. Poor postal system.

11. Finance

11.1 It was stated in section 5, that the poor state of the Anglican Health Service at the time of our assessment visits in 1997, was the result of major underinvestment in capital and manpower over a protracted period of time. This underinvestment was both on the part of the Government and the Anglican Church.

11.2 Church Health Services are funded from a number of sources. Between 1996–9, the salaries of Church Health Workers were paid from a computer operated payroll system operated by each Provincial Government. This system was abandoned in August 1999, when it was found that substantial sums of money appropriated by the National Government for church health workers' salaries had been misappropriated by Provincial Governments for other purposes. Salaries are, once again paid direct to Diocesan Health Secretaries through the Churches' Medical Council.

11.3 Although it is a very time consuming activity, it has the advantage that Church Health Secretaries have control over the payment of allowances and increments, and ensure new staff are added and terminating staff are deleted.

11.4 Provincial Governments also pay institutional running costs for Churches to provide health services to their respective communities. Frequently the sums received are much less than the appropriation made by the National Government to the respective Provincial Government, and there is no legal commitment on the Province to pay the appropriation. These funds are allocated to be spent specifically in the respective province.

11.5 Oro Province paid no running costs at all in 1997, and in 2000 only paid K76,000 out of an appropriation of K276,000. West New Britain paid running costs for the first time in 1999, and paid none again in 2000. Milne Bay have started paying the running costs to the OICs, which limits the control and flexibility of the Health Secretary. Chimbu pay to the Catholic Health Secretary without designating funds for specific church health services.

11.6 The situation is so unsatisfactory that the Churches' Medical Council are pressing for these funds to be paid through CMC in the same way as the salaries are paid. It is also intended that a formal agreement, stipulating the relationship between the Government and the Church Health Services, will be considered at the National Health Conference in August 2001.

11.7 As Church Health Services own most of the buildings, it is their responsibility to maintain them. Historically very little has been allocated by the Anglican Church for this purpose. Consequently, most of the AHS buildings are in great need of repair or replacement. Funds may be allocated on an ad hoc basis by Provincial and Local Level Governments for some renovation and Members of Parliament may also contribute from their Rural Development Funds. These sources are generally inadequate and unpredictable.

11.8 Historically, the funds paid to the Anglican Health Service from the grants provided by ABM–A, AMB–NZ and PNGCP have been relatively small and used mainly to cover infrastructure costs. However, the change in the approach of ABM–A to project funding has resulted in AHS attracting funds for a number of development projects.

11.9 Funds for our development projects have come principally from the following sources:–

a) United Thank Offering (USA)
b) Mothers' Union (UK)
c) Targeted Community Development Programme
d) ABM–A
e) ABM Auxiliary
f) British High Commission
g) Ad hoc gifts

11.10 This also is an unpredictable source, but a welcome one. It does mean, however, that we need to be increasingly innovative in our approach, searching out new sources of funding and spending more time acquitting funds to donor agencies

Peter Rookes
National Health Secretary

Jan 2001

Disclaimer: Material has been edited prior to release on the internet. E & OE.
If in doubt, contact AHS for an approved and signed printed copy of this document.