

WASH in Health Care Facilities

Papua New Guinea Situation Analysis

June 2022



Acknowledgement

This report is supported by the Australian Government's Water for Women Fund (WfW). WaterAid would like to acknowledge the National Department of Health, and the Department of National Planning & Monitoring of Papua New Guinea along with the WASH in HCFs fund partners and other stakeholders who provided their insights to the report. The report was written by Penny Dutton in collaboration with ACE Consulting.

Cover Photo:

Piano Sub-Health Center Makis Constituency, Buin LLG, South Bougainville (Plan International)

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Abbreviations and acronyms

ADB	Asian Development Bank
AROB	Autonomous Region of Bougainville
CHP	Community Health Post
CHS	Christian Health Services
CHW	Community Health Workers
DFAT	Department of Foreign Affairs and Trade (Australia)
DH	District Hospital
DNPM	Department of National Planning & Monitoring
DPLGA	Department of Provincial and Local Level Government Affairs
EHO	Environment Health Officer
GEDSI	Gender Equality Disability and Social Inclusion
GoPNG	Government of PNG
HCF	Health Care Facility
HEO	Health Extension Officer
HSC	Health Sub-Centre
IPC	Infection Prevention and Control
JMP	Joint Monitoring Programme
LLG	Local Level Government
MHM	Menstrual Health Management
MIS	Management Information System
NCHS	National Catholic Health Services
NDOH	National Department of Health
NGO	Non-Government Organisation
NHIS	National Health Information System
NHP	National Health Plan
NHSS	National Health Service Standards
PATH	PNG-Australia Transition to Health
PHA	Provincial Health Authority
PLWD	People living with disability
PMGH	Port Moresby General Hospital
PNG	Papua New Guinea
PPE	Personal Protective Equipment
SDG	Sustainable Development Goals
SMO	Senior Medical Officer
UNICEF	United Nations Children Fund
WASH	Water, Sanitation Hygiene
WASH-PMU (DNPM)	WASH-Project Management Unit-Department of National Planning & Monitoring
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

Background

Water, sanitation and hygiene (WASH) in health care facilities broadly refers to the quantity and quality of facilities, and access to water, toilets, waste management, the cleanliness of the environment, availability of hygiene facilities (water, soap or alcohol-based hand rubs), and knowledge and practices of safe hand hygiene (handwashing) in all kinds of public and private sector health care facilities and their surrounding environment or compound.

Access to safe and quality WASH services is fundamental to infection prevention and control in health care facilities, and to good health outcomes. WASH is integrated in the Sustainable Development Goals (SDGs). Adequate WASH in health care facilities is crucial for achieving universal health coverage. It helps ensure safe, high-quality care, minimises the risk of infection for patients, caregivers, health care workers and surrounding communities, and upholds the dignity of vulnerable populations including pregnant women and disabled people.

While there is increasing attention from governments, donors and the international public health community to improving WASH in health care facilities in low- and middle-income countries, WASH services in many facilities are currently poor or absent, compromising the ability to provide safe care and presenting serious health risks to patients and health care providers. Moreover, specific WASH-related policies, standards and monitoring and evaluation systems are lacking. Papua New Guinea is no exception. The country's particular health context, with high maternal and infant mortality, makes WASH in health care facilities in Papua New Guinea more important. When pregnant women make the often-arduous journey to health care facilities in Papua New Guinea, their health should not be compromised further due to lack of WASH facilities.

WaterAid, in support of the National Department of Health and the National Department of Planning and Monitoring, and aided by ACE Consulting, undertook a situation analysis of WASH within health care facilities.

This study aimed to analyse the situation of WASH in health care facilities, in particular within levels 1-4 of the health care system in Papua New Guinea. More specifically, the analysis focuses on: (1) policies and planning, including standards and coverage targets related to WASH in health care facilities; (2) related monitoring and evaluation mechanisms, tools and data; and (3) key actors involved in or working on WASH in health care facilities, and their related roles and responsibilities.

Methodology

Data for the situation analysis was obtained from a desk review of existing policies and reports, interviews with key informants involved in WASH in health care facilities, and meetings with the WASH in Health Care Facilities Working Group. National WASH Monitoring Information System data on health care facilities was analysed against the UNICEF and WHO Joint Monitoring Program indicators. The situation analysis took place between January and May 2022 from Port Moresby.

Findings

PNG lacks basic services in health care facilities across all domains of water supply, sanitation, hygiene, waste management and environmental cleaning. Sanitation and waste management services are the worst. Rural areas have the least access to basic services compared to urban areas and hospitals.

In the past, efforts on WASH in health care facilities have lacked coordination and have been disjointed. The re-formation of the WASH in health care facilities Working Group provides an opportunity to improve sector coordination at the national level between NDOH, the WASH PMU and other stakeholders, and move the WASH in HCF agenda forward.

Provincial Health Authorities (PHA) and provinces have ultimate responsibility for improving health care facilities but are not fully empowered and resourced to do this. Information does not always flow to PHAs or down to individual facilities. NDOH is a clear sector lead, with support from the National WASH PMU of DNPM.

There are some policies and plans available in PNG with relevance to WASH in health care facilities, but they lack detail and definitions, and concentrate on water supply and sanitation and not the five essential domains including hygiene, waste management and environmental cleaning.

There are no comprehensive WASH services standards and guidelines for health care facilities in PNG. Their absence is seen as an impediment to achieving basic levels of WASH in health care facilities and as creating gaps in the National Health Sector Standards.

The National WASH Management Information System (MIS) contains recent and growing records of health care facilities across the five domains. The National WASH MIS provides an opportunity to systematically monitor WASH in health care facilities using the standard SDG domains and indicators, and to provide country updates to the JMP. The number of records in the system currently is a fraction of the number of facilities nationally, and more data is required in order to identify regions or domains or levels of services that should be a priority.

Recent facility assessments have been conducted of individual HCFs in different locations in PNG, particularly by NGOs who are supporting facility improvements through the Australian Government Water for Women program. There is a case for further detailed assessment of facilities to understand the constraints and barriers to effective WASH. Information gaps exist around disability access, safety and security issues, knowledge of staff on WASH, information from and supervision by PHAs, water quality, and WASH behavioural practices including cleaning.

There is insufficient budget for all aspects of WASH in health care facilities. There is no separate budget item or expenditure monitoring on WASH in health care facilities. There are not cost guidelines for WASH in HCF improvements.

The success of WASH in HCF improvements hinges on the knowledge, capacity development and training, and ability of health staff to implement changes. The need for staff awareness and training, including the necessity to build in WASH awareness as part of nursing school and medical school training, is huge and ongoing.

Gender and Social Inclusion mainstreaming is largely overlooked in WASH in health care facilities. Disability accessible facilities are not a high priority and the planning, design and management of WASH services in health care facilities do not consider the variety of users which include women during childbirth; menstruating women; infants and children; older people; people with disabilities; people experiencing injury, illness or incontinence; and female staff.

Conclusion and recommendations

This study provides some useful insights into the situation of WASH in health care facilities in Papua New Guinea in terms of policies and planning – including standards and coverage targets, monitoring mechanisms, and access data and tools. The findings suggest that much

needs to be done to improve the situation of WASH in health care facilities to ensure safe and quality care, especially for mothers and newborn babies during and immediately after birth.

We make the following recommendations:

1. **Strengthen national level coordination** and direction through an effective national WASH in health care facilities Working Group. The Working Group needs to have a formal Terms of Reference with a clear purpose and goals; broad membership with representatives from WASH and health sectors; and regular meetings with accountable actions towards the WASH in health care facilities agenda.
2. **Develop a country roadmap** through a country-led process to review and assess the current WASH in health care facilities landscape, identify strengths and gaps, and plan and prioritise activities, taking into consideration existing capacities and resources as well as potential risks and challenges. The roadmap is a practical framework to help achieve targets) should be an agreed task for the Working Group to guide future efforts.
3. **Develop guidelines on minimum requirements** for WASH in health care facilities which are relevant for PNG's context (especially rural areas) and build on existing policies, standards, and guidelines as well as WHO guidelines. All new facilities and WASH upgrades to existing facilities should follow these guidelines.
4. **Improve monitoring** of WASH in health care facilities to enable data to be used for reporting and planning. This requires the Health MIS to capture WASH in health care facilities information and feed into PNG National WASH MIS. All stakeholders should be encouraged to report health care facility data to the national WASH MIS. Staff training and quality control are essential components of this data system.
5. **Improve budgeting and financing** for WASH improvements by clearly defining responsibilities and processes for financing WASH improvements; setting aside budget for this purpose; and developing WASH cost models to improve planning.
6. **Promote knowledge sharing and build capacity** for all WASH in health care facility stakeholders through sector meetings, workshops and forums, in particular between national and subnational levels. Key areas include: awareness about policies and guidelines; awareness on disability and dignity provisions in WASH services; facility assessment and improvement initiatives for PHAs and health staff; and curriculum on WASH and Infection Prevention and Control in health care facilities.
7. **Ensure health plans and policies** prioritise WASH in health care facilities, include all WASH in health care facilities domains, and use standard terms and targets so that plans, policies, standards and strategies are all aligned. Ensure all related WASH in health care facilities plans, policies, and guidelines are published, disseminated, and available to individual health care facilities.
8. **Use evidence to advocate** to the Health Minister and regularly inform about goals and achievements and sector needs.

1 Background

1.1 What does WASH in Health Care Facilities mean?

The term “WASH in health care facilities” (WASH in HCF) refers to the provision of water, sanitation, hygiene, health care waste management, and environmental cleaning infrastructure and services across all parts of a facility. “Health care facilities” encompass all formally recognized facilities that provide health care, including primary (health posts and clinics), secondary, and tertiary (district or national hospitals), public and private (including church managed), and temporary structures designed for emergency contexts. They may be in urban, peri-urban, or rural areas (World Health Organization 2019). WASH in HCF embraces not only WASH inside the facilities, but also in their surrounding environment or compound.

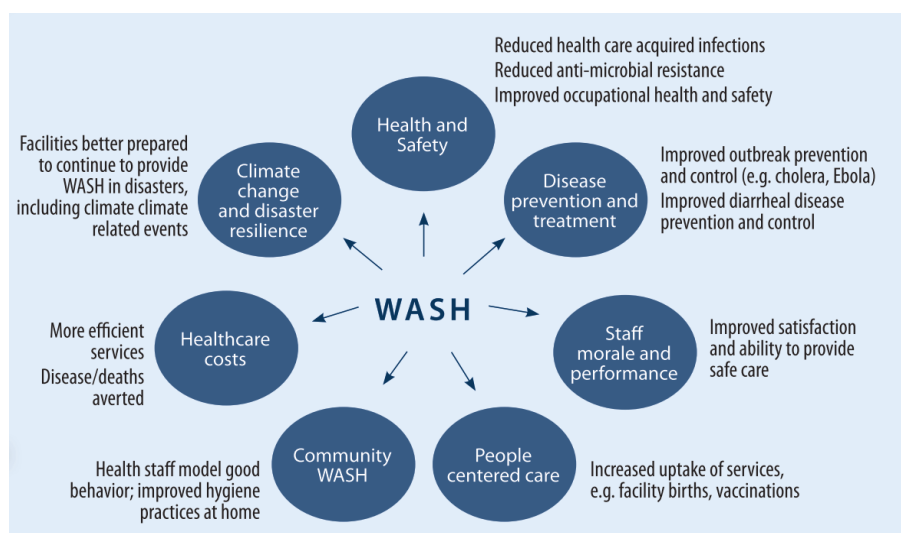
1.2 Why a situation analysis is essential

Water, sanitation, and hygiene (WASH) are essential environmental determinants of health and well-being. Water and sanitation are recognized human rights, and their fulfilment is a focus of the 2030 Agenda for Sustainable Development, specifically under Sustainable Development Goals (SDGs) 6 on water and sanitation and 3 on health and well-being.

The provision of safe WASH services in HCF is an essential aspect of ensuring high-quality health care, preventing infections, and safeguarding maternal and newborn health. Improved WASH in HCF can also prevent disease outbreaks, combat Antimicrobial Resistance; increase trust in and use of health facilities; protect staff and boost morale; increase staff retention; and reduce health care costs (Figure 1).

Conversation 1: WASH in HCF is still a great challenge experienced by our HCFs both in rural and urban settings. There is evidence of disparities in the level of WASH services provided at the HCF. Our HCFs are still collecting water from their yards during patient care. Limited access to basic WASH services connected to the facilities including healthcare waste management. Thus, posing great risk of cross contamination and inhibiting infection control procedures.
Ms Winnie Sagiú – EHO, Boram Hospital (ESP-PHA)

Figure 1 Multiple benefits of adequate WASH in health care facilities



Source: (WHO/UNICEF, Water, Sanitation and Hygiene (WASH) in Health Care Facilities Global Action Plan Factsheet 2015)

On World Water Day 2018, the United Nations Secretary-General issued a global call for action for WASH in all health care facilities. The World Health Organisation (WHO), with the United Nations Children’s Fund (UNICEF), formulated a joint response strategy and a global vision; most recently, resolution 72.27 on WASH in HCF was adopted at the Seventy-second World

Health Assembly (WHA) in May 2019. The resolution stresses the fundamental importance of adequate WASH services in achieving universal health coverage and re-emphasizes attainment of the WASH-related commitments mentioned. Papua New Guinea (PNG) is a signatory to the WHA Resolution on WASH in HCF, which includes targets for access to WASH in HCF but also commits PNG to critical actions on developing standards, monitoring, funding, staffing, and integration of WASH in HCF.

This situational analysis is a step towards refocusing to achieve PNG’s National WASH Policy 2015- 2030, which stipulates a national goal of 100% of HCFs to have access to safe, convenient, and sustainable water supply and sanitation facilities by 2030. This analysis outlines the existing situations of WASH in HCF in PNG, and helps identify the critical actions to be taken to improve WASH in HCF.

This situation analysis was implemented by WaterAid, in partnership with ACE Consulting, and supported by the Australian Government's Water for Women Fund.

1.3 Purpose and objectives of the study

To improve and sustain WASH services in HCF, a set of eight practical steps (Table 1), has been identified, based on global experience (World Health Organization 2019). The first of these steps is to conduct a national situational analysis and assessment of WASH in HCF, which provides the foundation for planning, prioritization, and resource mobilization.

Table 1 Eight Practical Steps to Achieve Universal Access to Quality Care

1.	Conduct Situation Analysis and Assessment
2.	Set Targets and Define Roadmap
3.	Establish National Standards and Accountability Mechanisms
4.	Improve Infrastructure and Maintenance
5.	Monitor and Review Data
6.	Develop Health Workforce
7.	Engage Communities
8.	Conduct Operational Research and Share Learning

Source: (World Health Organization 2019)

This analysis aims to provide a clear picture of the current situation, the efforts made so far, and provide options to where PNG can strengthen and improve WASH in HCF.

Specifically, the situation analysis focusses on:

- Policies and planning, including standards and coverage targets related to WASH in health care facilities.
- Related monitoring and evaluation mechanisms, data and tools, routine data collected through the Health Management Information System (HMIS) and health facility assessments data and tools.
- Key actors involved in or working on WASH in health care facilities, and their related roles and responsibilities.

Also included in this study is gender equality, disability, and social inclusion (GEDSI) considerations which are fundamental to universal health care. It includes gender, disability, and social inclusion. Focus is given to maternal and newborn health, female health care staff, as well as people with disabilities, children, and other vulnerable groups.

2 Methodology

Obtaining data for the situation analysis consisted of a desk review and interviews with key informants involved in WASH in HCFs. The situation analysis took place between January and May 2022, from Port Moresby.

2.1 Data collection

The **desktop review** included a review of the existing research, policies, plans, targets, and guidelines on WASH in HCF PNG. Tools for data collection and monitoring the status of WASH in HCFs were also reviewed.

Semi structured interviews were conducted with various stakeholders responsible for PNG's WASH in HCF, via telephone and face to face interviews using a question guide (Annex D: Question Guide for Semi-Structured Interviews). The interviewees included Government agencies, National Department of Health (NDOH), Department of National Planning and Monitoring (DNPM), WASH Project Management Unit (WASH-PMU), Department of Provincial and Local Government Administration (DPLGA) and Provincial Health Authority representatives. Development partners included UNICEF, WHO, World Vision and the WASH Consortium¹ and Church health care service providers (Christian Health Services (CHS) and the National Catholic Health Services (NCHS)). The semi structured interviews included 1 Provincial Health Authority (PHA) (Level 5), one District Hospital (DH), and two Health Centres (HC) (rural).

Conversations were held with three Health Managers of three Provinces under the National Catholic Health Services (NCHS) who together manage 74 HCFs (Table 2). The conversations were centred around the five domains of WASH.

Table 2 Interviews Conducted for this Analysis

Semi Structured Interviews	Conversations with three Health Managers-(NCHS)				
	Provinces	HC	HSC	UC	CHP
1 PHA (Level 5)	Western Province		7	1	8
1 District Hospitals (Level 4)	Gulf	1	5		26
2 Health Centre (Rural – Level 1-3)	East Sepik Province	2	8		16
	Total	3	20	1	50

PHA=Provincial Health Authority, NCHS=National Catholic Health Services, HC=Health Centre, HSC=Health Sub Centre, UC=Urban Clinic, CHP=Community Health Post

Source: Ace Consulting and Training Interviews

During the preparation of the Situation Analysis report, additional clarification was sought from stakeholders, including the Working Group and in particular NDOH.

All contributors to this Situation Analysis are listed in Annex E.

2.2 Limitations

This situation analysis has been carried out as a desk top review with interviews and therefore relies on the information available from these sources. The major limitation at the time of the situation analysis was Covid-19 restrictions, which did not allow close contact. This meant that, most interviews were conducted via telephone and remote access communication. The resurgence of the COVID-19 (Delta strain) in February, and poor network coverage contributed

¹ The WASH consortium includes WaterAid (PNG), World Vision, Plan International and Live and Learn, who are contracted by the Australian Department of Foreign Affairs and Trade (DFAT) to support specific WASH in HCF activities.

to interview delays. Although attempts were made to consult with a variety of HCFs, government staff were unwilling to be interviewed without NDOH approval.

3 PNG’s WASH and Health Status

3.1 WASH Status

PNG’s estimated 9.2 million people (2022), are amongst those with the least access to safe water supply and sanitation in the world. Nationally there are low levels of basic WASH access for households, and wide disparities exist between rural and urban areas. According to the Joint Monitoring Program (JMP) report (WHO/UNICEF 2021):

- 45% of the population have access to at least basic water supply, (39% in rural areas, and 86% in urban areas),
- 19% of the population have access to at least basic sanitation (15% in rural areas, and 49% in urban areas),
- 30% of the population have access to basic handwashing, (25% in rural areas, and 62% in urban areas).

Clean water, basic toilets and good hygiene practices are essential for the survival and development of children and women. While PNG has made progress in improving access to clean water and sanitation facilities, there is still much work to be done.

3.2 Health Status

Papua New Guinea’s health system is fragile with poor health and immunisation outcomes (Table 3). With an under five mortality rate of 44 per 1000 live births, an estimated 15,400 children or one in 13 children, die each year in PNG, mostly from preventable diseases. The life-time risk of maternal death is eight times higher in PNG than in East Asia and Pacific region average. Inequity is a serious concern with a wide range of disparities - rural children are twice as likely to die before their fifth birthday compared to urban ones. Access to health care is extremely challenging for the urban poor and the rural remote communities. (UNICEF 2022)

Water-borne diseases, such as diarrhoea and acute respiratory infections, are among the principal causes of deaths in children under five years. PNG ranks at the bottom of all Pacific countries for all WASH related health statistics, with over 6,000 diarrheal deaths per year. (UNICEF 2022)

Conversation 2: We struggle with some mothers who prefer to bury their own placenta by taking them home after delivery. This is due to traditional beliefs and we cannot do much but educate them continuously. This also pose another threat on hygiene and environmental cleanliness in the community that the health care facility is located.
 Sr Anna Sanginawa – Manager Catholic Health Services – ESP.

Table 3 Key Health Indicators

Indicator	Figure	Year of data
Maternal Mortality Ratio (maternal deaths per 100,000 live births)	145	2000 - 2017
Neonatal Mortality Rate (Deaths per 1,000 live births, first 28 days)	21	2020
Infant mortality rate (Deaths per 1,000 live births, between birth and 1 year)	35	2020
Under-five mortality rate (per 1,000 live births)	44	2020

Under five deaths (number of deaths)	10,284	2021
% of Children under 5 with Diarrhea	38	2018
Antenatal care 4+ visits - percentage of women (aged 15-49 years) attended at least four times during pregnancy by any provider (%)	54	2018
Skilled birth attendant - percentage of deliveries attended by skilled health personnel (%)	61	2018
Postnatal care for mothers - percentage of women (aged 15-49 years) who received postnatal care within 2 days of giving birth (%)	45	2018
Postnatal care for newborns - percentage of newborns who have a postnatal contact with a health provider within 2 days of delivery (%)	45	2018

Source: UNICEF <https://data.unicef.org/country/png/>

4 PNG Health System

4.1 Health Care Service Delivery

PNG's national health system is a decentralized model (Table 4), based on a primary health care model. It consists of a network of Health Posts (Aid posts), Community Health Posts (CHP), Health Sub-Centres (HSC), Health Centres (HC), District Hospitals, Provincial Hospitals and one national referral hospital (which also operates as a provincial hospital and a teaching hospital). (Grundy J 2019)

Table 4 defines health facilities and levels of care provided, from level 1 to 6, with primary health services covering levels 1-4, and tertiary and specialist services at levels 5-6.

Table 4 Levels of Essential Health Services, Papua New Guinea

	NHSS Level	Types of facility	Approximate catchment population	Staffing estimates (minimum)	Description of services
Tertiary or specialist care	Level 6	National Referral Hospital (PMGH)	National (9-13 million).	Multiple medical, surgical, nursing, and allied health specialties.	National tertiary referral role <ul style="list-style-type: none"> • Inpatient and outpatient care, including medical, maternal and child health, and major surgical, public health • Sub-speciality services • Clinical support services
	Level 5	Provincial Hospitals	1 per province (60,000-700,000) (2.7 beds/ 1,000 population)	Dependent on size of province. Some specialist health workers.	Provincial secondary referral role <ul style="list-style-type: none"> • Inpatient and outpatient care, including medical, maternal and child health, and intermediate surgical services, public health • Some sub-speciality services • Clinical support services
Primary Health Care	Level 4	District Hospitals	1 per district (30,000-100,000)	1 Rural Medical Specialist 1+ doctors 1-2 nurses 2 CHW	District primary/secondary referral role <ul style="list-style-type: none"> • Inpatient and outpatient care, including medical, maternal and child health, and minor/intermediate surgical services, public health • Public health, primary health care and clinical support services • Outreach & supervisory programs to Level 3, 2 and 1
	Level 3	Health Centres (Rural)	Local Level Government	1-2 HEOs 1-2 nurses 2 CHWs	LLG primary referral role <ul style="list-style-type: none"> • Outpatient and inpatient care, including core clinical services -

		Urban Clinics	(LLG) jurisdiction (5,000-40,000)	(same approximate staffing for both)	<ul style="list-style-type: none"> medical, maternal and child health, and minor surgical services Public health, primary health care and clinical support services Outreach & supervisory programs to Level 2 and 1 (for Urban Clinics, as above minus inpatient care services)
	Level 2	Community Health Posts (Health Sub-Centres)	<ul style="list-style-type: none"> Multiple wards or small urban centre Grade 1: >10,000 Grade 2: 5-10,000 Grade 3: <5,000 	Nurse CHWs	<ul style="list-style-type: none"> Community primary referral role Inpatient short stay care up to 24 hours Outreach & mobile services Outpatient care, including reproductive and child health, TB DOTS, HIV and malaria prevention, nutrition, school, and dental health
	Level 1	Health Posts	Ward or multiple small villages (1,000-2,000)	1-2 CHWs Village Health Assistants	<ul style="list-style-type: none"> Basic health care and referral (outpatient services) Public health education Basic primary health care Community-based programs and community support

PMGH=Port Moresby General Hospital, CHW=Community Health Worker, HEO=Health Extension Officer, LLG=Local Level Government, TB=Tuberculosis
Source: National Health Plan 2021-2030

4.1.1 Primary Health Care

Levels 1 to 4 provide basic primary health care, outpatient and inpatient services, and limited clinical support services. Where each facility encounters illnesses outside their capability, referrals are made to a higher numbered health care facility.

Level 1 facility: Community aid posts are managed by one health worker, either a community health worker (CHW) or a nurse and covers a population of 500 to 1000 people and focuses mostly on health promotion and minor illnesses and providing referrals that need further management. There are no inpatient services at this level, and, in many cases, the scope of health activities is limited, dealing with basic infectious diseases. Anything that is more complex or requires admission is referred to a level 3 health facility.

Level 2 health facility: Health sub-centres employ about three staff members, usually two nurses and one CHW. They provide all the services by Level 1 facilities with additional services: inpatient short stays, delivery, nutrition programs, TB, HIV and Malaria. The health facility only admits pregnant women for delivery of babies and provides prenatal, postnatal, and newborn services. If pregnant women develop complications, they are referred to the closest level 5 health facility.

Level 3 health facility: Rural and or urban health centre provide medical, obstetric, paediatric, surgery and public health services. Level 3 facilities also conduct primary health care, family planning, disease control, health promotion, nutrition programs and other medical services and referrals and medical consultations. Inpatient services are provided.

Level 4 health facility: District and rural hospitals, must have a Senior Medical Officer and medical officers and provide general admissions and inpatient care. Depending on the employment of a doctor, may provide surgical services if anaesthetic officers and scrub nurses are employed and present in the facility, laboratory services, medical imaging, mortuary services, dental services, medium surgical services, medical consultations, referral point from level 1 – 3 facilities and provide pre-service training for medical students. Complex cases are referred to and administered at level 5 health facilities (or provincial hospitals).

4.1.2 Tertiary Health Care

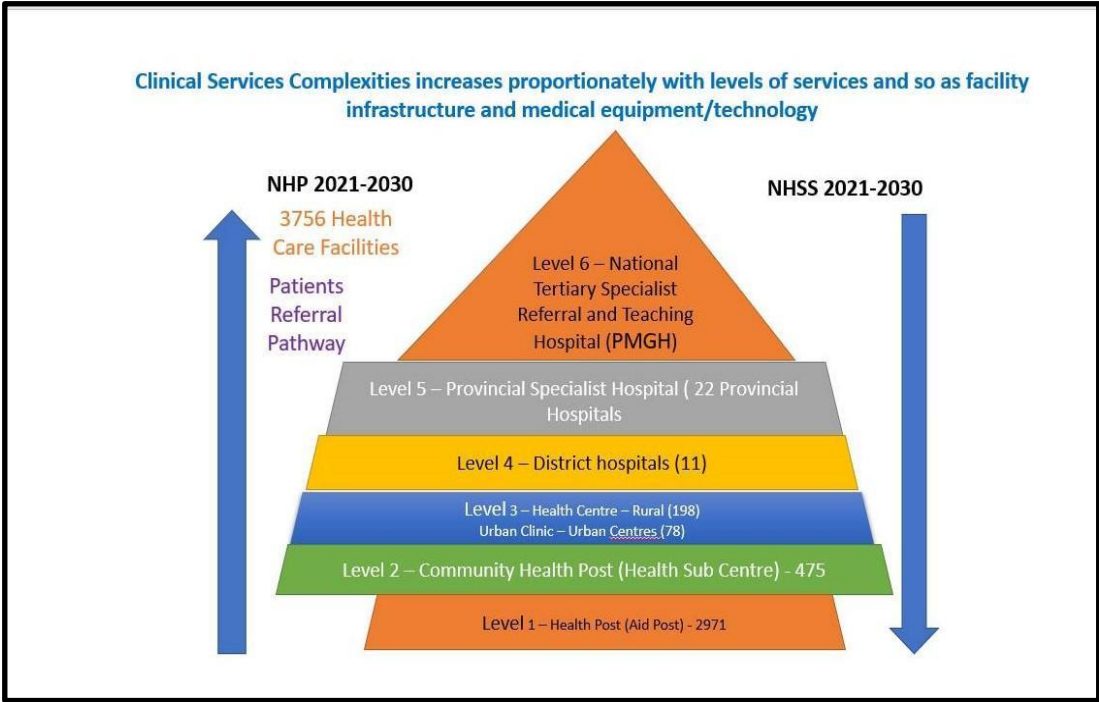
Level 5 health facility: Provide secondary and tertiary health services. The types of services offered on a regular basis are determined by the skill and knowledge of the staff. Level 5 health facilities provide clinical support services, such as pharmacy services, laboratory services, and radiology.

Level 6 health facility: The Port Moresby General Hospital is the most advanced health care facility in PNG and provides comprehensive health care services, including teaching.

4.2 Health Facilities and Numbers of Health Care Facilities

The two major providers of health care service in PNG are the Government and Churches. Primary health care services (Level 1-4) are shared between church and government managed facilities and serve mainly rural populations. District Hospitals (Level 4) and provincial hospitals at level 5-6 serve as referral hospitals and are usually located in district towns and provincial capitals. Figure 2 provides the number of facilities and referral pathways. Church managed HCFs are governed by two separate entities; the National Catholic Health Services (NCHS) and the Christian Health Services (CHS) who manage all other denominations' HCFs.

Figure 2 Number of Health Care Facilities and referral pathways - 2021



Source: Adapted from: World Health Organization and National Department of Health, 2012; National Health Plan 2021-2030

4.3 Church Health Services

The CHS and the NCHS are responsible for more than 70-80% of healthcare services especially rural primary health care (50%) in the country² and receive 80% of their funding through Government grants (World Bank, 2019). Church-based HCFs have a stronger presence in some rural and remote areas than government facilities. Churches have also taken over the management of several Government health facilities. This includes running six nurse training facilities and 14 training facilities for community health workers.

² <https://chspng.org.pg/wp-content/uploads/2019/10/CHS-Information-Handbook.pdf>

Each church health service is responsible for the management of its own facilities, including staffing terms and supervising clinical and administrative activities. Both the NCHS and CHS have their own respective partnership agreements with NDOH.

4.4 Private Sector

Private sector health care providers are mainly based in urban towns and metropolitan areas where there is reliable water supply and access to sanitation and disposal sites for medical waste. As their HCFs are concentrated in urban areas, they serve a smaller percentage of PNG's population compared to the GoPNG and Church managed HCFs. They range from facilities which are comparative to level 6 health facilities, to Level 3 primary health care facilities, with few to no private health care providers observed below Level 3 and none in the rural communities. There is no register of private health care facilities, although the Medical Registration Board is responsible for the licensing of private hospitals in PNG. There is little collaboration with public hospitals and urban clinics.

4.5 Extractive and Agricultural Industries

PNG has eight mines in operation that produce copper, gold, nickel, and silver and has a further eight in exploration stage. Established mines such as Ok Tedi, Porgera and Lihir have legal agreements with landowners and the provincial governments to provide services including health care services. By using public-private partnerships, facilities are built or maintained, and health services funded by industries as part of an agreement with the provincial and national governments. Similar arrangements are made in large-scale agricultural farming for example in New Britain Palm Oil. These industries may also provide funding to government health care facilities in areas around mines, through agreements with provincial governments. For example, in Hela province the PHA has an MOU with Oil search as the main partner supporting WASH activities and health services in health facilities. Data for the number of health care facilities around the extractive industry space remain fragmented and unreliable.

5 Analysis of the Enabling Environment

5.1 Policies, Plans and Targets

There is no single policy document which describes national policies and planning, including standards and coverage targets, on WASH in health care facilities in PNG. A number of guidelines have been developed but are in draft format and their implementation status is unclear. There are gaps in the documentation of policies, targets and standards for WASH in health care facilities.

The **PNG Development Strategic Plan 2010-2030** goal for health is to achieve an efficient health system which can deliver an internationally acceptable standard of health services. The outcomes are to reduce infant, child and maternal mortality and extend life expectancy, as well as minimise diseases such as malaria, TB and malnutrition. Health actions include increasing the number of functioning aid posts to 7,500 by 2030, increasing supervision, increasing the number of physicians to 50 per 100,000 people and nurses to 200 per 100,000 people, and CHWs to 20,000 nationally. 95% of births should be supervised and antenatal coverage goal is 100%.

The Strategy plan proposes to modernise health care facilities and upgrade district health centres to be hospitals. It also recognises the need to improve access to water and sanitation for the general population, however the need for sustainable WASH facilities in HCFs is not part of the strategy.

The **Medium-Term Development Plan III 2018-2022** aims to make quality health services accessible and efficient. The approach is to scale up care and treatment services throughout the country by upgrading DHCs to district hospitals in all 89 districts by 2022, increasing the number of health professionals, rolling out PHAs and strengthening CHPs throughout the country. The MTDPIII has the target of 80% of health institutions have access to safe water and sanitation services by 2022. Water PNG Limited is identified to provide safe water and improved sanitation services to all health institutions in the country. Improved waste management is a strategic investment in all provinces.

The **National WASH Policy 2015-2030** sets a target for 100% of medical centres across the country to have access to a safe, convenient and sustainable water supply and sustainable sanitation facilities, and 100% of medical centres have handwashing facilities with running water and soap. Medical centres include hospitals as well as health centres and aid posts. The policy does not define sustainable services in the context of health care facilities, nor does it provide minimum standards for water and sanitation for HCFs (only households). Strategy 4, point 13 states that all institutions, including health centres, should expect to pay the full cost of their water and sanitation schemes.

The **GoPNG National Water Supply & Sewerage Act 2016** (Amendment 2020) states that Water PNG may operate and maintain a water supply and/or sanitation system in and for any city, town or rural area in a water or sanitation district.

The **National Health Plan 2021-2030** aims to strengthen primary health care and improve access to the rural majority in a “back to basics’ approach, through building capacity of PHAs, and revitalising Village Health Assistants. The Healthy Islands Concept is the health promotion approach. Actions include the establishment of a minimum set of Essential Health Intervention Packages (EHIP) for Levels 1-4 (PHC level) to be delivered by the public health system (both government- and church-run facilities). The EHIP serves as a tool to guide the provision of a minimum set of priority public health and clinical services that must be delivered in the different levels of health facilities and in the community. In terms of WASH in HCF the NHP Strategies include:

5.1.1.1 National level

- Develop and establish National WASH in Health Care facilities standards and guidelines

5.1.1.2 Provincial level

- Ensure all health facilities have readily available clean and safe water, sanitation and hygiene facilities by 2030
- Ensure hygiene and sanitation is promoted and practiced in Institutions such as hospitals

5.1.1.3 Local level

- Improve health through the safe management of water, sanitation and hygiene services in all settings
- Ensure continuous hygiene promotion leading to long term behavioural change
- Ensure WASH in health care facilities standards and guidelines are implemented.

The NHP also includes strategies to develop facility standard designs and guides for infrastructure development in line with the NHSS, develop and conduct auditing of facilities, and upgrade and develop all rural health facilities to meet the required minimum standard from level1 to 6.

5.2 Standards and Guidelines

The **National Guidelines on Infection Prevention and Control for COVID-19 2020** was developed to guide handwashing, hygiene, use of personal protective equipment (PPE) and infection prevention for health staff and communities during the COVID pandemic. The Guidelines, supported by WHO, specifically cover IPC in health care facilities including hand hygiene, use of PPE, disinfection, environmental cleaning, and waste management. WHO global and Western Pacific guidelines and operating procedures are used for hand hygiene practice, (including Pacific examples where there is no water for handwashing), PPE, and cleaning/disinfection in the context of COVID-19.

An **Infection Prevention Policy Guidelines for Health Facilities** which covers handwashing, PPE, hospital cleaning, water supply and drainage, excreta disposal, waste handling and management has been drafted but those guidelines do not exist at HCF level.

National Health Service Standards for PNG 2nd Edition 2021-2030 (2021, 3 Volumes) are a modified version of the previous NHSS developed to support the National Health Plan 2011-2020. The second edition covers the current NHP timeframe. Volume 1 outlines the minimum requirements to be met to ensure safe, appropriate and quality health services delivery. The NHSS have three major purposes:

- To provide a standard set of criteria for 'Levels of Care', and 'Essential Health Services' supported by the core components for health system strengthening that is accessible, equitable, affordable efficient, clinically viable and integrated with evidenced based public health interventions;
- To provide a quality improvement program with a set of National Quality Standards and an Accreditation process to guide health services through self-assessment, periodic review and a 4-year cycle of compulsory accreditation to meet Papua New Guinea National Quality Standards; and
- To provide standards for planning, design, development, commissioning, operation, maintenance and disposal of health facilities infrastructure and medical technology for the public sector in PNG.

The related **National Quality Standards and Accreditation Program for Health Services in Papua New Guinea** (Volume 2) provides a framework, commitment and process for the use of PNG national healthcare standards to achieve continuous improvement, 'to strengthen safe, quality health care by continuously advancing standards and education nationally'. This 2nd NHSS edition builds on the NHSS Volume 2 Quality Standards and addresses the broader National Quality Standards and Compulsory Accreditation Program based on a Package of Integrated Health Services Standards for Provincial Health Authorities.

The 26 quality standards include 7 mandatory requirements and cover the following areas:

- Organisational governance and health systems strengthening
 - Leadership and Management, Governance for Safety & Quality in Health Services:
 - Corporate Governance Systems & Safety (OH&S - Mandatory standard),
 - Clinical & Public Health Systems & Safety (Mandatory standard)
 - Health Workforce Capacity and Performance,
 - Training, Ongoing Professional Development,
 - Essential Medical Supplies Procurement and Supply Chain Management Systems,
 - Health Infrastructure & Improve Facility - Environmental Management (Fire Safety - Mandatory Standard),
 - Financial Resource Management,

- Health Information & Information Communication Technology for Decision Making.
- Quality and Safety in Integrated Health Service Delivery
 - Health service planning
 - Partnerships and collaboration
 - Universal Health Coverage
 - Preparedness for Disease Outbreaks and Emerging Population Threats Including Pandemics (Mandatory standard);
 - Formalised Patient Referral Pathways;
 - Supportive Supervision;
 - Infection Prevention and Control (Mandatory Standards);
 - Waste Management (Mandatory Standards).
- Essential Public Health Services
 - Evidenced based interventions
 - Essential public health services standards implementation
 - Health promotion and prevention
 - Environmental health programs
- Essential Clinical Care
 - Appropriate & Effectiveness of Care & Health Services;
 - Provision and Continuity of Patient Care (Mandatory Standard);
 - Medication Management;
 - Surgical Safety;
 - Blood Products.

To achieve national accreditation, health entities undertake a self-assessment risk-based approach before being assessed by Accreditation Surveyors.

The **Design Standards for Health Facilities in PNG 2021-2030** (Volume 3) aim to inform all stakeholders involved in the planning, design, development, commissioning, operation, maintenance and disposal of health facilities infrastructure and medical technology for the public sector in PNG. Issuing of the standards for the design and construction of new health infrastructure ties in with GoPNG's aim to improve health infrastructure, as outlined in the NHP. It is the policy of NDOH that all new health facilities for the public sector are designed and constructed to the NHSS design standards, and it is expected that all PHAs and other health services providers (i.e., Faith-based organisations, Non-Government Organisations and Private Sector Providers) who are constructing or renovating healthcare facilities comply with the Design Standards.

It is expected that future capital projects will provide amenities consistent with the particular health service's level of care and delineated role (Levels 1-6).

Relevant features of the design standards include:

- The separation of adult male and female patients in general inpatient settings;
- Discrete and separate ablution facilities for clients, guardians and staff;
- All facilities are fully accessible for disabled clients.
- Adequate facilities are provided to control the spread of infection.
- All buildings are constructed in accordance with the Building Code of Papua New Guinea.

The design standards (Annex 1) provide standard components for different types of HCFs such as the type of hand basins, toilets, showers, cleaning room, etc but the number of facilities and their characteristics are not stated. Water supply and quantities, as well as number and location of toilets and effluent management, and waste management are not covered.

The Community Health Post Policy 2013 supports the strengthening of CHPs throughout the country to address access to quality health services by the community and to tackle worsening maternal mortality.

All Community Health Posts in PNG will:

- Provide 24-hour emergency services to the community
- Operate as 'Level 2 Facilities' (as defined by the National Health Services Standards 2011-2020)
- Be staffed by a minimum of three health workers
- Be equipped with a delivery room and may provide a 'waiting house' for expectant mothers
- Be located on a strategic site which will include adequate staff housing, waste disposal facilities and access to reliable and sustainable energy and water supplies.

The Community Health Post Policy includes concept designs for four CHP layout options. While access to water supply and waste disposal is a criteria for CHPs, availability of sanitation facilities and handwashing, and cleaning are not mentioned as criteria. The layouts do include toilets, showers, and utility rooms but the minimum requirement for the patient and staff population is not stated, and the basis for the designs are not known. Accessible sanitation has not been included, for example.

Guidelines for Health Care Waste Management in Papua New Guinea (Draft) circa 2008 contain technical guidelines on segregation, handling, storage, treatment and disposal, and off-site transportation of all types of medical waste and general waste. The Guidelines also include management arrangements such as the healthcare waste management committees at individual health care facilities, and a national health care waste management committee chair. A summary of the relevant policy documents, guidelines, standards, and legislation for WASH in HCF in PNG is depicted in Table 5.

Table 5 WASH in HCF Acts, Policies, Standards and Guidelines in PNG

Acts and Policies	WASH Related Content	WASH in HCF
Development Strategic Plan 2010-2030	National Health Outcomes, community water and sanitation goals.	No
MTDP 2018-2022	Goal 3.2 Improve health service and outcomes, upgrade health centres strengthen CHPs Target of 80% of health institutions have access to safe water and sanitation services by 2022	No all domains, targets only, service levels not defined
WASH Policy 2015-2030	100% of medical centres have access to safe, convenient, and sustainable water supply and sanitation, and handwashing facilities with soap by 2030	Not all domains, targets only, access to services not defined
GoPNG National Water Supply & Sewerage Act 2016-Amendment 2020	Provisions of water and sanitation to any city, town or rural area	No
National Health Plan 2011-2030	Importance of community WASH as a prevention strategy	Identifies need to develop national WASH in HCF guidelines
National IPC Guidelines (COVID-19) 2020	Guidance on hand hygiene, environmental cleaning, waste management in context of COVID-19	Includes HCF settings eg. environmental cleaning, hand hygiene, waste

		management. Not all domains covered
Infection Prevention Policy Guidelines for Health Facilities	Not sighted	Understood to include handwashing, PPE, hospital cleaning, water supply and drainage, excreta disposal, waste handling and management
National Health Service Standards 2021-2030	Quality Standards for Health Care including toilets, handwashing, water, IPC, waste	Types of infrastructure outlined but WASH service levels are missing
Community Health Post Policy 2013	CHPs include waste disposal facilities, access to reliable and sustainable energy and water supply and sanitation	Leads into WASH actions, standard designs but no minimum requirements, no accessible WASH
Guidelines for Health Care Waste Management in Papua New Guinea (Draft) circa 2008	Guidelines on segregation, handling, storage, treatment and disposal of medical and general waste, management and reporting	Healthcare waste management

5.3 Institutional Arrangements

The 1998 Organic Law on Provincial and Local level Governments significantly decentralized responsibility for delivering health services to the provinces and districts (National Health Plan 2021-2030, Vol1b). However, the law did not address *how* to implement the changes.

Governance of health care lies with the provincial government. The Provincial Health Authorities Act, passed in 2007, allows 'provincial governments to establish Provincial Health Authorities (PHA) to be responsible for both primary and secondary health care (hospitals) in the province (World Bank 2011).

PHAs are now the main driver of health systems in the country. With the sole responsibility of improving the health outcomes in the province, the PHA is structured to build its system based on cohesive approaches to national health priorities. The PHA mandated functions are;

- Provide curative health care services in the province;
- Promote, protect, and maintain the health of the community;
- Encourage the local community to participate in planning and in the decision-making process in relation to health;
- Deliver public health services appropriate and acceptable to the local community;
- Harness Partnerships;
- Resource Management.

Each PHA is accountable to manage its resources and support relating to health performance outcomes in the province. This fiscal responsibility also provides the option for PHAs to generate internal revenues to support the operations of health services.

PHAs are responsible for coordinating partner activities in provinces through partnership arrangements with PHAs. Churches have signed agreements with PHAs and the NDOH to run health care facilities. PHA's also enter into agreements with private sector partners, NGO's and churches to provide funding. This is managed by their own committees and boards at the provincial level. Similarly, national agencies such as CHS have legal agreements with the NDOH directly.

WASH Programs are implemented through PHAs and are responsible for collaborating with development partners on WASH activities in their health facilities in their provinces under the overall coordination and support of NDOH.

5.4 Financing Mechanisms

The Government of PNG remains the largest financier of health services in Papua New Guinea and subsidises most costs associated with operating health care facilities. Development partners also contribute to the health system through systems strengthening.

While operational responsibilities in the health sector have been devolved to PHAs, capital investments remain centralized in the public investment program. Provinces are allocated a percentage of net government revenue in staffing and health sector function grants, which cover operational but not capital investment costs. As a result, resources, authority, and competency are poorly matched to decentralized responsibilities. (ADB 2014)

Reasonable health financing has proven to be a major impediment to the provision of health services in PNG. Conversely successive PNG governments have struggled to translate investments in health systems into improved performance. A large health survey conducted across PNG showed that health services had declined against a range of indicators despite large increases in recurrent and development health budgets over the decade to 2012 (Howes 2014). Since 2013, the health financing context has shifted, in large part due to declining national revenue affected by falling commodity prices and broader economic and budgetary challenges. Since then, the health sector has shown continuous stagnation and decline against key performance indicators (NDOH 2019).

It is through partnership arrangements with PHAs that church organizations and other NGOs receive direct grants from National and Provincial Governments to conduct health care activities. For WASH in HCF, despite the formal overarching arrangements and provincial autonomy, activities are conducted only when prioritized or reacting to an urgent need, and where funds are available.

Current funding arrangements for WASH in HCF are through the PHAs whose responsibility is to manage budget allocations to achieve overall health outcomes. Donors and other INGO operating in specific Provinces also contribute to the funding pool and most provincial WASH activities are implemented by INGOs and donor agencies. WASH programs are implemented reactively without fiscal guidance from PHAs and National WASH agencies. Currently there is no specific budget line for WASH in HCF for most provinces. Funding is allocated in a lump sum to PHAs whose responsibility is to allocate proportion to WASH Programs. WASH funding is provided on an ad hoc basis and based on other competing priorities within specific PHAs. Funding is used for maintenance of facilities to ensure WASH standards are met and practices able to be conducted. However, this is done more when recognized by relevant health officials in provinces as opposed to a rolling asset management program.

Conversation 3: What WASH? I need a southern cross tank in Oro Bay to cater for my health facility. We at the facility improvise on all the WASH activities. No Water, we go to the river or the tank. Not enough toilets we go home, no soap we bring our own. I don't want the bucket projects anymore. - Mr Jeff Ubin – SNO, St. Margaret's District Hospital, Oro Bay

A contemporary approach to funding is being trialled in Hela Province and a handful of other provinces. The Hela PHA uses facility-based budgeting, where money is allocated based on the data collected through the NHIS. Requests can be made on a monthly basis for improvements such as tanks, pipes, with technical people to support upgrading. The Hela PHA also works closely with Churches and supports them through grants from PHA when the NDOH budget is inadequate. This additional budget support for operations includes WASH activities.

There have also been instances where local communities assist to do maintenance of health facilities where government programs do not reach rural areas (eg. in Hela Province).

During the COVID pandemic provinces received government and donor funds to provide handwashing facilities in HCF. The value of that funding and the number of HCFs benefitting are not known, however health workers reported the facilities were only provided in hospitals not in aid posts or health centres where most people seek health care.

5.4.1 Donor financing to the health sector

Major donors are contributing millions of dollars in loans and grants to improve primary health services in PNG in support of national development plans.

The Asian Development Bank (ADB) is currently funding the Health Sector Support Services Program (US\$145m) to improve service delivery for essential health care to the mainly rural population. The implementing agency is NDOH. The program supports policy actions and investment nationally and sub-nationally. Output 3 project activities will support health facility upgrades in selected provinces at district levels 3 and 4. PHA's must request for new facilities/upgrades and satisfy selection criteria. The project will also support training in (i) health facility management and maintenance at civil works sites, periodic assessment of facilities to ensure they meet the National Health Service Standards, (ii) gender-based violence awareness training including with construction staff, the community, and health workers. Civil works for new health facilities at district level amounts to US\$45 million. The importance of clean water to the facilities is emphasised but sanitation, hygiene, cleaning and waste management are not mentioned.

Conversation 4: Funding is the main barrier for WASH in HCF and COVID 19 has given the health system a challenge in terms of effectiveness and efficiency in providing the basic health to every individual during the COVID 19 lockdown
Mr Michael Inabiyu – HEO,
Drekikir Health Centre, ESP.

The project will also support training in (i) health facility management and maintenance at civil works sites, periodic assessment of facilities to ensure they meet the National Health Service Standards, (ii) gender-based violence awareness training including with construction staff, the community, and health workers. Civil works for new health facilities at district level amounts to US\$45 million. The importance of clean water to the facilities is emphasised but sanitation, hygiene, cleaning and waste management are not mentioned.

The Australian Government's Department of Foreign Affairs and Trade (DFAT) is funding the PNG-Australia Transition to Health (PATH) Program - 5-year program budget of A\$183m. This program targets strengthening of PHAs and improving service delivery. There is no commitment to facility upgrading however the funding is flexible. DFAT is also contributing additional funding to the ADB HSSP to expand the number of health care facilities that will be upgraded.

The World Bank is currently providing US\$30 million for the [IMPACT Health](#) project which aims to address primary health care delivery challenges by increasing the quality and use of essential health services through direct province-level funding at Provincial Health Authorities (initially in Enga and East New Britain).

5.5 Human Resources

Papua New Guinea suffers from a critical shortage of human resources for health. Most recent estimates of health worker densities in 2019 reflect 0.1 physicians per 1,000 population and 5 nurses per 1,000 population (World Bank 2022), and 1.1 health professionals (doctors, HEOs, nurses and CHWS) per 1,000 population in 2019, well below the target of 4.5 (NDOH 2020). In the last decade, the health sector has experienced a decline in the number of skilled health workers, a disproportionately low number of skilled workers in rural areas resulting in inequitable access to health services, low productivity of health workers and uncompetitive conditions of service. The human resource management challenges facing the sector stem from years of underfunding by government and neglect of human resources issues and has resulted in an overall decline in the quality of health services delivered and the poor health

status of PNG citizens (GOPNG 2014). PNG health sector human resources is characterized by:

- an aging workforce
- low numbers of critical cadres, such as midwives and community health workers
- a demotivated workforce due to poor working conditions including low wages and poor physical infrastructure
- insufficient training capacity to produce the number of health workers to meet population needs
- maldistribution of specialist clinical and technical skills, where 30% of skilled health professionals occupy administrative and management positions.

The focus of the NDOH Human Resources Department leans toward personnel administration as opposed to health sector wide integrated approaches that address all aspects of workforce issues including planning workforce supply, liaising on education and training, management of performance and improving work conditions. Over time this has resulted in an unbalanced and inequitable distribution of health staff between remote and isolated areas and urban areas. Major challenges are due to a fragmentation in institutional and fiscal relationships between national, provincial, and lower levels of government (Human Resources for Health, 2022). In turn, affecting the depth in which to select and employ qualified workers to maintain, practice and promote consistent WASH practice in HCFs in provincial Primary Health Care facilities. Planning for WASH activities in health care facilities is left to under-trained staff in terms of expertise, numbers, and general knowledge, particularly among health workers that are not specialists in WASH-related fields (such as Environmental Health Officers - EHO).

Conversation 5: Our mothers are very strong. They can walk for days to the nearest Health Centre to deliver. Usually they come with a guide, a relative to mind her, to find food, do laundry and general help the mother may need. This helps us so we are thankful and the little we have, we provide. –
 Ms Dorothy Hailaravilla- Manager- NCHS, Gulf Province.

GoPNG plans to increase the health sector workforce, if implemented, will also increase demand for WASH facilities in HCFs, for example the need for separate staff toilet facilities, and increased waste for disposal. Improved WASH facilities may help attract and retain staff in rural areas, however there are other factors that impact on human resources such as a lack of incentives in pay, recognition, and motivation to continue their work in rural settings with challenges of patient attitudes and beliefs settings, safety and security.

5.5.1 Current Training and Development Status

The implementation of health workforce education and training has been poorly coordinated. This is a direct result of the lack of training needs analysis and plans, insufficient data to verify training needs. Poor quality control of pre-service training curricula for many of the health cadres has resulted in inadequately trained staff that do not have the relevant skills to match PNG’s health service delivery requirements. In the case of in-service and postgraduate training, there has not been strict adherence to any systematic processes due to the absence of appropriate policies, plans and guidelines. Training and providers in PNG are shown in Table 6.

Table 6 Number of Training and development in PNG

Training	Number of Schools	Provider
Community Health worker (Certificate)	12	Churches and 12 Provinces

Nursing - General (Diploma)	7	Church and Govt located in 8 Provinces
Nursing (Degree)	1	Church (Pacific Adventist University)
Specialist/Allied - Rural Health, Environmental Health, Health Management (Degree)	1	Church (Divine Word University)
Specialist - Medical and Surgery (Degree)	1	University of Papua New Guinea, School of Medicine and Health Sciences)

Source: Grundy J, Dakulala P, Wai K, Maalsen A, Whittaker M. *Papua New Guinea Health System Review*. Vol. 9 No. 1. New Delhi: World Health Organization, Regional Office for South-East Asia; 2019.

5.6 Monitoring and Information Systems

5.6.1 Health Information Systems

There are four core national data collections in the PNG health and management information system. Many of these have been in operation since at least the 1990s and have undergone several reviews and updates.

- 1) The National Health Information System (NHIS): This is the “flagship” data collection instrument and contains a monthly record (four A4 pages) from every health centre and public hospital in the country. Its focus is PHC, but it does contain basic counts of inpatient discharges. Data collection is largely manual, using a daily aid post tally sheet and in person submission to information officers who report to the NHIS monthly. Implementation of an electronic national health information system (eNHIS) started in 18 districts across 5 provinces under the ADB funded Rural Primary Health Services Delivery Project and will be rolled out nationally under the Health Services Sector Development Program. (ADB 2018)
- 2) The Discharge Health Information System (DHIS): This contains a record for every inpatient discharged from every public health facility in the country, from health centres to tertiary hospitals.
- 3) The National Inventory of Health Facilities (NIHF): The NIHF is a yearly census of all health facilities in the country. This includes regular availability of “core” medical supplies, basic information on the presence of water and sanitation, power sources, staffing levels and status of the infrastructure. It uses the National Health Services Standards to inform this survey tool.
- 4) Management information systems data are primarily from the pharmaceutical branch and human resources branch. The m-Supply system is being rolled out to manage medical supply procurement, warehousing, and distribution functions, with installation completed in 2017.

Both CHS and NCHS report technical and clinical data through the NHIS in line with overall health system reporting requirements.

The health information system does not include full WASH in HCF information. Currently the information system that captures all five WASH domains is implemented by the Department of National Planning and Monitoring (DNPM).

5.6.2 WASH Management Information System

The WASH-PMU operates a [WASH database](#) for households, schools and health care facilities, using mWater data collection and presentation software platform.

The WASH MIS includes data on the relevant JMP indicators. For WASH in HCF this includes information on the five WASH domains, service levels against the JMP SDG indicators, the location and level of the facility, number of births per month, with photographs and geolocation

tags. Data is not systematically collected but obtained through baseline surveys from district planning exercises, and provided voluntarily by NGOs and other implementing organisations to the MIS. Currently there are 235 HCFs recorded in the data base, and therefore represents a small, but important, sample of PNG's more than 3,000 HCFs.

5.7 Roles and Responsibilities of Stakeholders

Agencies responsible for WASH in HCF encompass different sectors in the GoPNG bureaucracy, state-owned enterprises, NGOs and Faith Based Organizations.

The DNPM plays an overall coordination role and has more direct control as the department responsible for managing donor and multilateral funding arrangements particularly from donor partners.

Health focused custodianship of WASH in HCF is NDOH as a sector coordinator for health services. NDOH has a role in advocacy, policy and guidelines development and standards, and works with other sectors and levels of government to coordinate activities (Grundy, et al 2019). NDOH is legislatively mandated through the National Health administration Act (1997) to develop national policy, set health service standards and provide funding, human resources and technical assistance where necessary.

Provincial Health Authorities and Non-Government Service providers, particularly faith-based church health services, are directly involved in the service delivery aspects of WASH in HCF. Outreach, health promotions, general health facility standards are monitored and implemented at this level of the PNG decentralised service delivery system.

Overall, the health sector cuts across various sectors including agriculture, education and the resources sectors, including the extractive industry, involving them as direct actors, financiers and collaborators. Without having legitimate authority this can be challenging. All players within the WASH sector legitimise their state of responsibility and accountability through respective agreements as discussed previously.

Table 7 Roles and responsibilities for WASH in health care facilities in PNG

Key Actors	Involvement in/work on WASH in health care facilities	Key contact
Minister for Health	Set the agenda for key priorities in the health sector. Responsible for performance of the health sector	Honorable Jelta Wong, MP Minister for Health and HIV/AIDS
DNPM: WASH PMU	Oversee and coordinate all WASH in HCF along with other WASH services providers, monitoring of WASH in HCF	Mr John Nokue Planner - WASH
NDOH: Public Health Division, Environmental Health Section	WASH Program coordination, environmental health	Ms Rose Kavanamur, Manager Environmental Health Mr Ray Kangu, WASH Program Officer
NDOH: Strategic Policy Division	Planning improvement of WASH in HCF, policy and guideline development, water quality improvement, monitoring and evaluation and research	Mr Ken Wai Mrs Agnes Pawiong
NDOH: Medical Standards Division	Curative standards and audits, workforce standards, health facilities	Dr. Dora Lenturut Acting Manager

NDOH: Medical Standards Division, Health Facilities Section	Construction of WASH facilities, water quality testing, waste management facility improvement	Mr Ambrose Kwaramb Manager – Standards and Services
DPLGA	Decentralised functions to the Provincial Authorities	Ms Lyn Pokam
Water PNG	Broadly the custodian of Water Authority in PNG, provide water supply and sanitation in declared areas	Dr Fifaia Matainaho – Strategy and Technical Advisor
Provincial Health Authorities	Improvement of primary health care facilities, financing through NDOH. Management of the health care systems in the provinces. Management of constructing new facilities	Provincial Health Manager
District Health Authorities	Oversee health delivery in district including management of HCFs; plan and mobilise resources	District Health Manager
Church health services	Deliver health services under contract	National Catholic Health Services, Christian Health Services
Private sector	Provide health services, run private clinics and hospitals	Various
Resources and extractive industries	Provide health services and facilities in resource (often remote) areas, including supporting local government to deliver health services	Company representatives
UNICEF	Technical assistance to WASH in HCF including monitoring, implementation of WASH projects which include HCFs	Mr Martin Worth - Chief WASH Ms Isabella Warre – WASH Specialist
WHO	High level Technical Assistance in WASH in HCF, SOPs	Ms Nola NDrewei
Development agencies (ADB, DFAT, World Bank, EU)	Funding and implementation support for WASH and health projects with sector strengthening and WASH in HCF infrastructure.	Country Directors/Representatives, Project officers
INGOs – WASH in HCF (WaterAid, Live and Learn, Plan International, World Vision)	WASH in HCF Program activities including systems strengthening to support national progress on WASH in HCF, technical advice, HCF infrastructure upgrading and staff training, support to national monitoring of WASH in HCF	Ms Navara Kiene Programs Director - WaterAid PNG
INGOs – WASH and/or Health (ChildFund, Oxfam, ADRA, Anglicare, Caritas)	Implementation of WASH and/or health programs in selected provinces and districts.	Country Directors/Representatives

Source: compiled by Ace Consulting and Training

5.7.1 Development Agencies and NGOs

There are a number of development agencies and NGOs working in WASH sector and specifically WASH in HCF.

WHO has committed to provide technical assistance and will work with the WASH in HCF working group as an interested aid agency within the WASH sector to provide the following as depicted in Figure 3.

Figure 3 WHO Technical Assistance to WASH Sector

- | |
|--|
| <ol style="list-style-type: none"> 1. Developing WASH Sector, Standards and Guidelines. 2. Assistance in training especially in Technical Assistance specialist for WASH through Monitoring and Evaluation. 3. To assist in mobilizing WASH Specialist Conferences etc to stimulate interests and including WASH Sector Agenda at the Higher Strategic level. 4. To action the Eight Practical Steps to Achieve Universal Access to Quality Care |
|--|

WHO globally provides high level technical assistance and international guidelines for WASH in HCFs. For PNG there needs to be a strategy in place or a road map in order to access the technical assistance.

The UNICEF WASH Strategy (2016-2030) and the UNICEF Strategy for Water, Sanitation and Hygiene (2016–2030) articulate the organizational thinking and approach to WASH in health care facilities. WASH in institutions – consisting of WASH in schools (WinS), WASH in health care facilities (WinHCFs) and WASH in early childhood care centres – is one of UNICEF’s five strategic results areas.

Currently, UNICEF in partnership with the European Union and the Government of PNG, is implementing a project called, ‘Klinpela komuniti projek (KKP)’. This project is focused on four districts in PNG; Nawae (Morobe Province), Goroka Urban (Eastern Highlands Province), Mt Hagen Central (Western Highlands) and Central Bougainville (AROB). The project includes 36 HCFs in levels 1-3 in the 4 districts. Facilities that included birthing facilities were improved, those HCFs that did not have the facilities were constructed. Agencies assisting in this project are detailed in Table 8.

Table 8 Partners in the Klinpela Komuniti Projek

District	Coordinating Agency	Implementing Agency
Goroka Urban 9 HCF	Oxfam /District Development Authority	Touching the Untouchables Anis Foundation Appropriate Technology Project
Nawae 9 HCF	District Development Authority	World Vision
Mt Hagen Central; 9 HCF	District Development Authority	Infra Tech
Central Bougainville 9 HCF	District Development Authority	Plan International

Source: Internet Readings on UNICEF Projects

WHO and UNICEF are working closely with PMU on the National WASH MIS database and a number of INGOs including WaterAid (PNG) to increase the scope, and coverage of the database.

WASH in HCF is a core program for WaterAid, globally and in PNG to improve health outcomes. WaterAid is funded through the DFAT Water for Women program to support the WASH in HCF working group, undertake the situation analysis of WASH in HCF in PNG, support the development of a Road Map for progressing WASH in HCF in PNG, and developing minimum WASH standards and guidance for HCFs. As well as working at the national level, WaterAid is implementing infrastructure improvements at health care facilities in Wewak district with the East Sepik PHA.

Other NGOS working in WASH or health include:

- ChildFund provides WASH infrastructure in the Central Province including WASH programs.
- Oxfam working in Goroka with the DDA on water infrastructure
- ADRA in Lae and New Ireland as well.
- Anglicare (PNG) in all 5 dioceses of the Anglican Church.
- Caritas (Australia) in PNG working under the 'can do' projects, in disaster prone areas, where WASH is a concern for the community.

5.8 Coordination and Sector Leadership

NDOH is the lead agency for the majority of health sector and national health related initiatives, projects and policy related matter. For WASH in HCF, this means design of facilities, funding for WASH programs and training health workers. However, the latter has been somewhat absorbed by Department of Higher Education, Research, Science and Technology.

Since the inception of the National WASH Policy a National WASH Coordination group was established to provide secretariat and administrative support for the implementation of government and development partner WASH activities. The group comprises NDOH as the implementing agency for WASH in HCF, WASH PMU (DNPM) who act as custodian of the National WASH Policy, and WaterAid (PNG), currently performing secretariat functions. Department of National Planning & Monitoring plays an important role as the national agency responsible for pooling, allocating and coordinating donor funding and development assistance in PNG. The WASH Coordination group purpose is to lead collectively and organizes and prioritises WASH activities in PNG and provide some strategic direction.

The NHP key result area for aid coordination advocates for collaboration with all partners to implement a single national health sector plan for PNG. Strategies to achieve this include: at the national level: increase engagement with all resource partners and stakeholders in planning; strengthen Aid-Coordination mechanisms to improve resource mobilization for health sector, increase accountability and transparency for relevant stakeholders to meet their funding requirements. The provincial level has the responsibility for overseeing and coordinating all support coming into the province for health service delivery.

5.9 Community Perspectives/Social Context

Medical personnel are held in high regard in PNG communities especially in the rural communities, particularly midwives. Communities rely upon these health workers when a health issue arises in the community.

An example of the influence of health staff is evident during the COVID-19 pandemic. In a rural setting, one nursing officer doing a routine immunisation roll out, also planned to do the COVID-19 vaccination program and awareness. Community perception of COVID-19 was negative, filled with doubt and uncertainty, referring to myths and rumours. Out of respect for the medical officer to do their job, the community assisted in providing water and cleaning where possible and remained neutral on the subject of COVID-19. An example of community respect for a medical officer is presented in Figure 4.

Figure 4 Statement depicting community respect

Around the catchment area of Oro Bay, the health officer is away overnight and visits five villages at any one time. Following the original immunisation trail, he merges his conversation on COVID-19 in his routine job.

I realise that when I tell them (villagers through their ward councillors) ahead of time, that I will speak on COVID-19 as well, (when doing my normal routine round), I receive 2-10 'patients'. When I do my normal immunisation rounds, I receive on average 30-40 mothers per village, and when I visit the villages and because I know them and they know me, I am left to do my work and they respect me and I respect them. If it was someone else or an outsider, they would retaliate with knives and chase me out. The major challenge we face is that there is not enough information being given or disseminated to the people thus creating confusion and fear of COVID-19.

Community Perception of COVID-19 was one of fear and concocted with the fallacy of the 666 and the beast.

5.10 Equity and Access

An effect of PNG's economic stagnation has stretched household's health care seeking behaviour. Poorer households are more likely to seek medical care from a level 3 and 4 health facilities than other facility type (World Bank 2017). This is because there are more level 3 and 4 facilities relative to the rural population. The demand for health care in PNG is thus skewed towards primary health care providing facilities that are more accessible from the rural majority and low-income families. However, these primary facilities are less likely to have reliable water supply and WASH facilities.

Women who are pregnant in remote rural PNG face major difficulties in seeking out HCFs, particularly due to lack of transportation. In parts of PNG, women walk 3-5 days before reaching the nearest health facility. They are usually accompanied by a minder whose job is to provide meals and fetch water from the available source, whether a tank, well or nearby streams. The most recent Health Sector Performance Annual Review indicates that the percentage of pregnant women that attended at least one antenatal visit at hospital, health centre or outreach clinic during the pregnancy in 2019 was only 51% (NDOH 2020). Many women are not attending antenatal services. Nationally, only 36% of births occur in a hospital or health centre (NDOH 2020).

5.11 GEDSI Mainstreaming

Gender and gender mainstreaming, although captured in most of PNG's policy documents, including the Health Sector Gender Policy 2014, is poorly conceptualised and implemented (Lamprell G 2015). Gender disparities are apparent in employment patterns or personnel composition (World Bank, 2017). In the PNG Health Sector, a World Bank Survey of health

facilities in eleven provinces found that females comprise 26% of all medical officers. Even among residents, only about 34% were female, implying that the male-to-female ratio of doctors will improve in the future but by a relatively small amount. Overall, about 60% of all health facility personnel were female and most were nurses, CHWs, midwives, and kitchen staff.

Culturally, it is more suitable for women to seek assistance from female health workers. However, the safety of female health workers in rural settings does not always create incentives to work in those settings. This is corroborated by findings that there are more females in the preventative and curative care and more males in public health care. It is also stated that the remote and rural facilities are better stocked with supplies including soap and cleaning agents as a male health worker will frequent a PHA central medical store for supplies more often than a female who may consider safety, and family obligations before travelling to these medical stores.

The health sector employs a large proportion of women; however, women still have fewer opportunities than their male counterparts to occupy leadership positions within the health sector. There is a need to create a conducive environment that tolerates, encourages and supports women to apply for other types of health professions and management positions. It is essential to have a monitoring framework for gender equity to monitor the outcomes of the Health Sector Gender Policy, including the integration of gender into health programs, equal access to health services, and gender equity in recruitment.

Specifically, for WASH in HCFs there needs to be a particular focus on improving facilities for pregnant women, delivering women, and new mothers, and providing accessible and female friendly WASH facilities, e.g., including menstrual hygiene management.

Providing facilities for people with a disability, or for those in pain, elderly people, and pregnant women or anyone else with physical mobility issues is significantly overlooked in existing infrastructure, in the design of new infrastructure and WASH facilities, and in the thinking of health planners.

6 Assessment of WASH services in HCFs

6.1 Global WASH in HCF indicators

Current benchmarks for assessing WASH in HCFs come from UNICEF and WHO through the Joint Monitoring Program (JMP). The JMP provides five core indicators for monitoring WASH in HCFs globally: water supply, sanitation, handwashing, waste management, and environmental cleaning. The five WASH Core Indicators and definitions are explained in Annex B. WHO also provides key definitions of WASH in Health Care Facilities (Annex B).

6.2 Assessment of HCFs in PNG

Few assessments of WASH have been conducted in HCFs in PNG, resulting in limited data. Sources of data to provide a picture on the current situation of WASH in HCFs are shown in Table 9. Only the most recent data from the National WASH MIS includes all five WASH domains in accordance with JMP indicators.

Table 9 WASH in HCF Assessment Data Sources

Survey/Assessment/Data source/date of data	Number of facilities	Method
1. Survey of health facilities 2012	142	Facility surveys

2. NDOH/WHO survey of water supply and sanitation in Health Care Facilities including Maternity Wards/Labour Wards 2015	87	Survey of facilities
3. Survey of level 3 and above HCFs 2015	73	Survey of facilities
4. NDOH Inventory Data 2021	432 HCFs	Self-report by HCF
5. JMP data report on WASH in HCFs	22 provinces	Compilation of data and estimates at national level
6. Surveys of HCFs in National WASH MIS 2020-22	220 (currently 235)	NGO and PHA supported surveys using DNPM National WASH MIS data collection and standard indicators

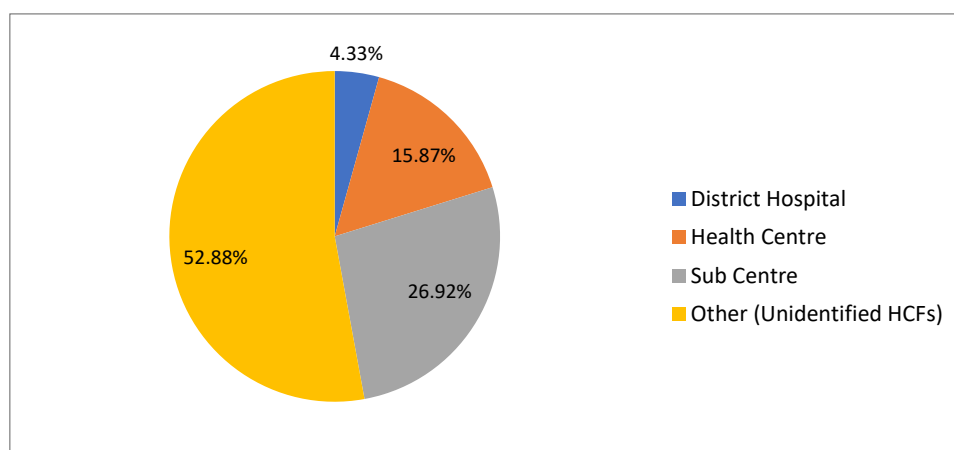
Source:

- Howes, S, Mako, AA, Swan, A, Walton, G, Webster, T and Wiltshire, C 2014, *A lost decade? Service delivery and reforms in Papua New Guinea 2002-2012*, The National Research Institute and the Development Policy Centre, Canberra.
- NDOH Environmental Health Branch. 2015. *Water Supply and Sanitation Accessibility into Health Care Facilities Especially for Maternity Ward / Labour Wards*. NDOH: Port Moresby
- World Bank, 2017. *Service Delivery by Health Facilities in Papua New Guinea*. World Bank: Washington
- NDOH HCF inventory data
- WHO and UNICEF, 2019. *WASH in health care facilities: Global Baseline Report 2019*, WHO and UNICEF, Geneva
- DNPM National WASH MIS, [mWater](#)

The National WASH MIS on mWater, implemented and coordinated by DNPM-WASH-PMU in partnership with the NDOH and its stakeholders, contained records for 227 HCFs at the time of data analysis for this report (currently 235). Seven records were removed from the analysis as they were duplicates, leaving 220 unique values remaining. The unique values of 220 were from 14 districts; Central Bougainville, Goroka, Henganofi, Kavieng, Markham, Mt Hagen, Namatanai, Nawae, North Bougainville, Rigo, South Bougainville, South Fly, Wapenamanda and Wewak.

The distribution of HCFs analysed is shown in Figure 5. A greater proportion of HCFs in the districts are Sub Health Centres. Approximately 84% are located in rural areas, 10% in urban areas, and 6% in peri-urban areas. Nearly 60% of the facilities cover levels 1-3.

Figure 5 Distribution of 220 HCFs in 14 Districts



Source: National WASH MIS, DNPM

6.3 Health care facility status in general

A 2012 health facility survey of 142 facilities found that 67% of clinic rooms and 77% of health worker accommodation needed rehabilitation, and only 40% of clinics had electricity (Howes 2014). Just 33% of facilities had the capacity to support patient referral. In 2012, 68% of facilities indicated that they had no maintenance in the past year, and only 40% had received

a supervision visit in the last year. Only 23% of health clinics (health centres and aid posts) had functional transport, 20% had beds with mattresses and 23% had a kitchen (good or adequate) (Howes 2014). The same study confirmed that the availability of essential medicines and supplies had declined over the previous 10 years (2002–2012).

The Facilities Branch of the NDoH has undertaken a national assessment of infrastructure and equipment needs, and found that in rural areas, there were shortages of running water and energy, and that cold chain systems were very limited.

The current data on HCFs in the National WASH MIS shows that at least 20% of HCFs have never had any maintenance on the building.

There are variations in the condition of HCFs across the country. For example, infrastructure at church-run health clinics is in better condition than at government ones. The 2012 survey of 142 HCFs found that 28% of government aid post clinic rooms needed rebuilding, compared to 14% for church aid post rooms. 54% of staff housing attached to government health centres needed complete rebuilding compared to just 26% for church health centre housing.

There is also a huge provincial variation in services such as access to transport or electricity. There are also wide disparities between rural HCFs such as aid posts and urban clinics, with aid posts being poorly equipped.

It is in this context that the status of WASH in HCFs should be considered.

6.4 Water Supply

The 2012 survey of 142 HCFs found that 79% of health clinics had access to water but only 55% had year-round water supply (Table 10).

Table 10 Health clinic water availability (%) 2012

Percentage of Health Clinics with...	Access to water	Water working at time of survey	Water working all 2012	Water connected to delivery room
Overall	79	70	55	47
East New Britain	89	85	62	31
West New Britain	64	64	38	39
Morobe	79	61	39	33
Sandaun	79	79	68	78
Eastern Highlands	83	83	47	28
Enga	73	48	48	69
Gulf	68	65	50	40
NCD	94	81	81	56
Health Centres	82	76	55	46
Aid Posts	76	66	48	NA
Government (HC+)	82	71	49	48
Church (HC+)	82	82	58	44
Government (AP)	68	61	45	NA
Church (AP)	84	59	37	NA

Note: Figures in final column 'connected to delivery room' only reports results for health centres because it is not common for aid posts to have a delivery room.

Source: Howes et al, 2014

NDOH's 2015 survey found that 77% of HCFs had availability of water in the health facility, while 23% had no constant water available for the health facility. The difference is due to many

reasons such as: rainfall pattern, number of tuffa tanks installed, number of patients and mothers attending the facility, leakage from the connected tanks and pipes. 90% of HCFs had rainwater catchment as their main water source, 3% had a deep well and pump, and 2% were connected to the town water supply. For the facilities using rainwater systems, all tuffa tanks were located near the buildings and less than 50 meters away (<50m). Water used in most facilities (except town water) was not treated.

Similar findings were made by the World Bank survey of 73 HCFs in 2015 (Table 11).

Table 11 Service provision 2015

Readiness indicator	Level 3 and 4				Level 5 and 6		Level 7	
	Public (N)	%	Church (N)	%	N	%	N	%
Water from main line	2	6.90	3	12.00	15	83.33	1	100.00
Water shortage last year	18	62.07	11	44.00	7	38.89	0	0.00
Water available for use by health care providers	24	82.76	21	84.00	18	100.00	1	100.00
Water available in delivery room	13	44.83	18	72.00	18	100.00	1	100.00

Note: At the time of the survey the health system had 7 levels
Source: World Bank, 2017

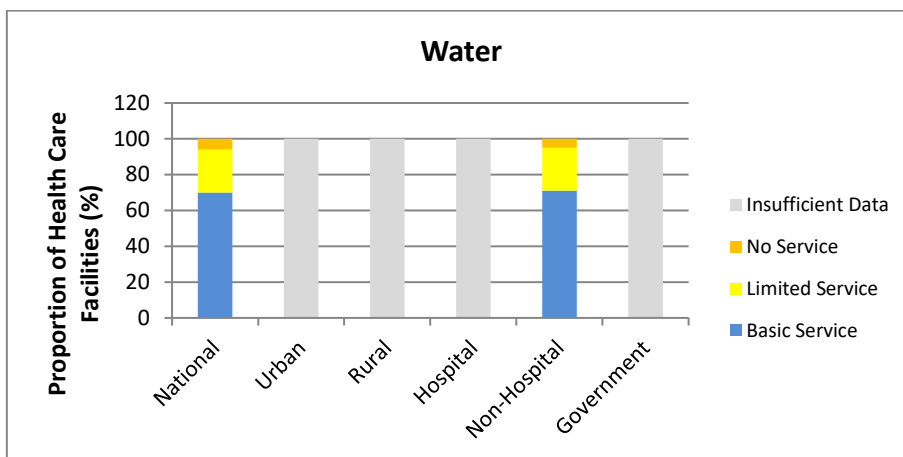
About 62%, 44%, and 38 %of level 3 and 4 public, level 3 and 4 church, and level 5 and 6 facilities, respectively, experienced water shortages in 2014. The survey asked facility respondents whether the facility was responsible for maintaining the water supply system. About 45% of facilities were responsible for maintaining the water supply system, while it was 64% for church-run level 3 and 4 facilities and 68% for level 5 to 7 facilities.

Most level 3 and 4 health facilities require better clean water supply, however, over half of the level 3 and 4 health facilities surveyed required repairs to their water supply systems. The overall infrastructure condition is much better for level 5 and level 6 facilities; the level 7 health facility required no infrastructure, electrical, or plumbing repairs.

The NDOH survey found that 55% or 48 of the 87 HCFs had water connected at the maternity ward/delivery room. The National Inventory of Health Facilities reports that nationally the figure is only 49% of HCFs that have running water to the delivery room, with the lowest rate in Manus province (31%) and highest in NCD (100%) (NDOH 2020).

JMP data from 2019 indicates that even at the hospital level, most water supply is basic (Figure 6). 70% of national and 71% of non-hospital health care facilities deliver **basic water** services, while 24% of national and 24% of non-hospital health care facilities had **limited water** services, and 6% of both National and non-hospital health care facilities have **no service**.

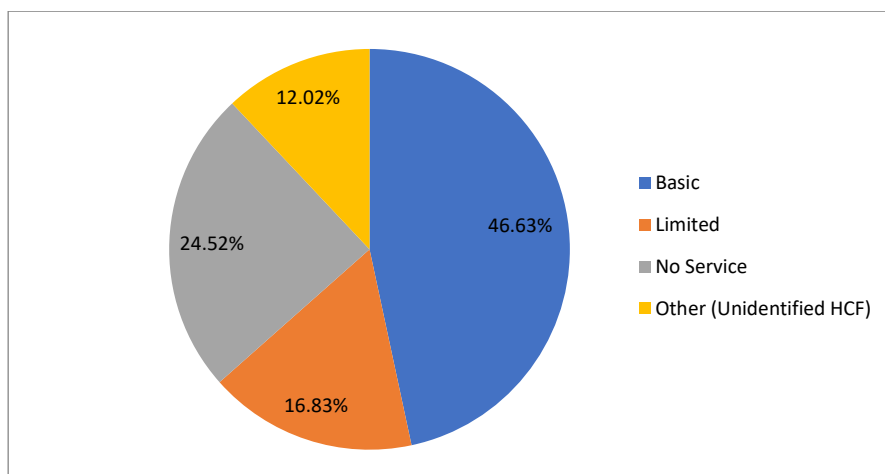
Figure 6 JMP Water Services in Health Care Facilities in 2019



Source: WHO/UNICEF Joint Monitoring Program (JMP) (2020) data for 2019.

Records from 220 HCFs show that fewer than half the HCFs (46.63%) have a basic level of water supply service, that is, water is available from an improved source on the premises. 24.52% of HCFs reported no service – water is taken from unprotected dug well.

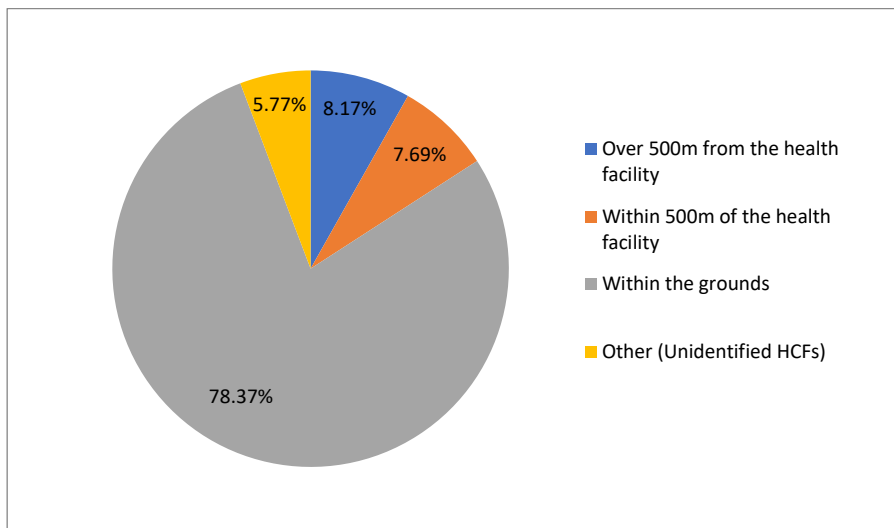
Figure 7 Water supply SDG service level for HCFs



Source: National WASH MIS, 2022

78.37% of HCFs have water supply located within the grounds while 8.1% of HCFs get their water over 500m from the health facility (Figure 8).

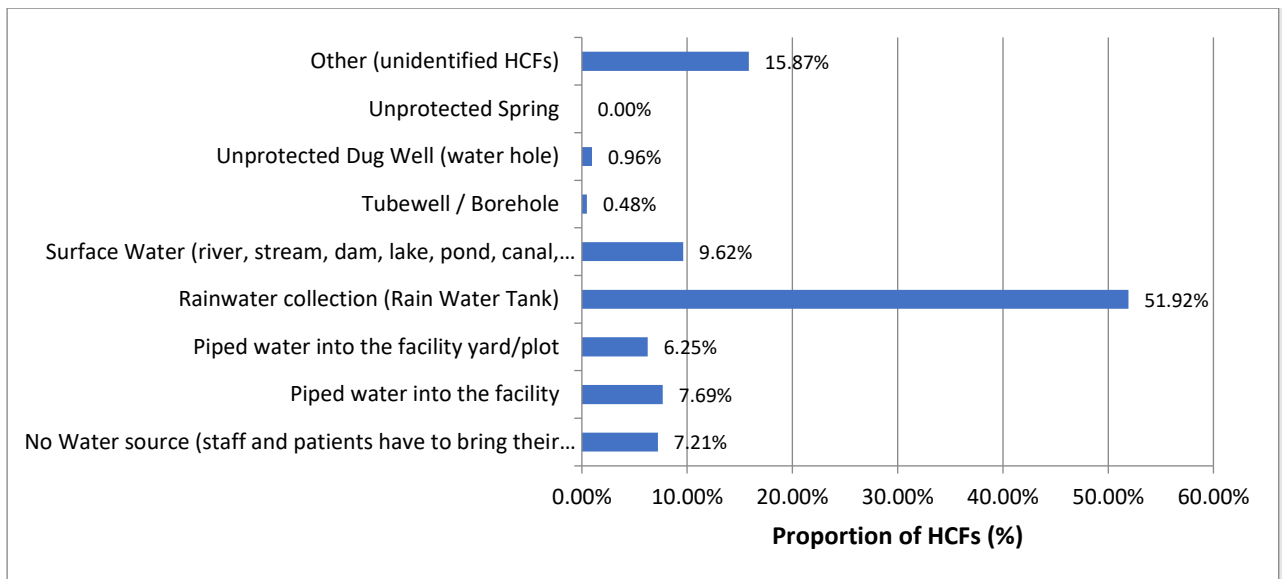
Figure 8 Location of water supply



Source: National WASH MIS, 2022

There is a high reliance on rain water for water supply (51.92%), with 9.62% of HCFs using surface water and nearly 14% accessing piped water supply.

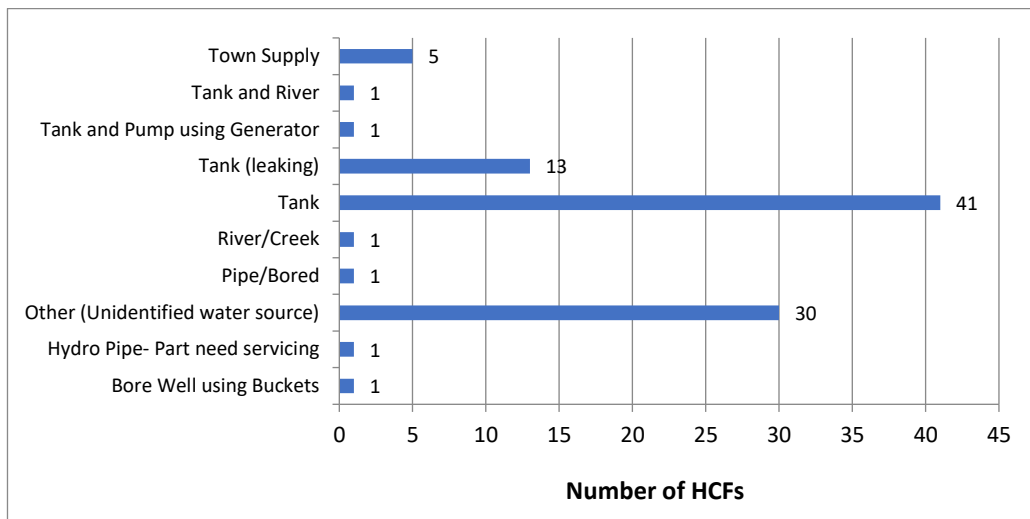
Figure 9 Water Supply Type



Source: National WASH MIS, 2022

Feedback from interviews representing 95 HCFs showed a similar reliance on rainwater stored in tanks (Figure 10).

Figure 10 Water Source of Health Facilities Interviewed (95 HCFs)



Source: Key informant interviews and reports on 95 HCFs

District Hospitals (Level 4) and provincial hospitals, located normally in district towns and provincial capitals, have comparatively greater access to consistent water and electricity supply. Provincial towns are gridded within a certain radius and do not reach outside those town areas. It is also worth noting that the Provincial capitals have a main town water supply source that is piped. Some districts may have a piped water source however most do not. Level 1-3 HCF in the rural areas rely on tank (rain catchment), underground water, either pumped or manually filled in buckets. Level 3 facilities in an urban setting are accommodated by the town water supply. A pump is relevant to an extent where there is reliable electricity fuelling the pump, which is another impediment to water supply.

Figure 11 Rainwater tanks at RSHC



This rainwater tank system at a rural sub health centre at Moreland Rural LLG in South Fly District, Western Province, is typical of many HCFs in rural areas. (photo by World Vision)

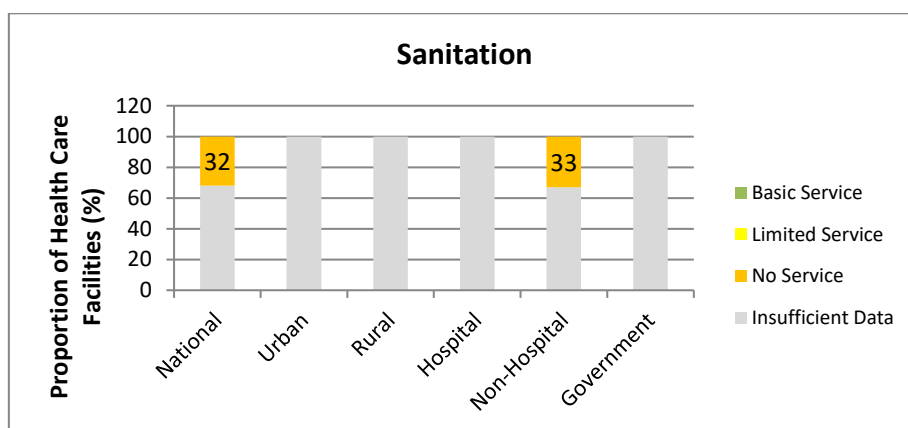
6.5 Sanitation

The 2012 survey of 142 health centres and aid posts found that only 50% had access to toilets. The most common type of toilet facility was a pit latrine and there were rarely separate male and female toilets.

The NDOH surveys from 2015 also indicate that the most common and preferred type of toilet facility was the simple pit latrine (62%) which is less expensive, easy to construct by any person and does not need water. Other toilets included septic tanks system (20%) and Ventilated Improved Pit latrine (17%).

Data from JMP reporting indicates 32% of HCFs nationally do not have access to sanitation services, with these all being in non-hospital HCFs (Figure 12).

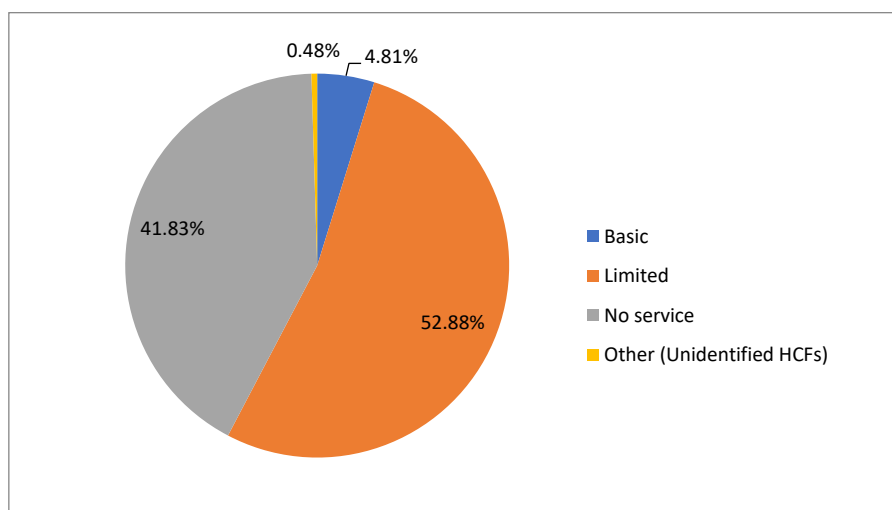
Figure 12 Sanitation services in health care facilities in 2019



Source: WHO/UNICEF Joint Monitoring Program (JMP) (2020) data for 2019

Records from 220 HCFs show that 52.88% of HCFs provide limited sanitation services, that is, at least one improved sanitation facility is available, but not all requirements for basic service are met. 41.83% of HCFs do not provide sanitation service – toilet facilities are unimproved (e.g. pit latrines without a slab or platform, hanging latrines, bucket latrines) or there are no toilets (Figure 13).

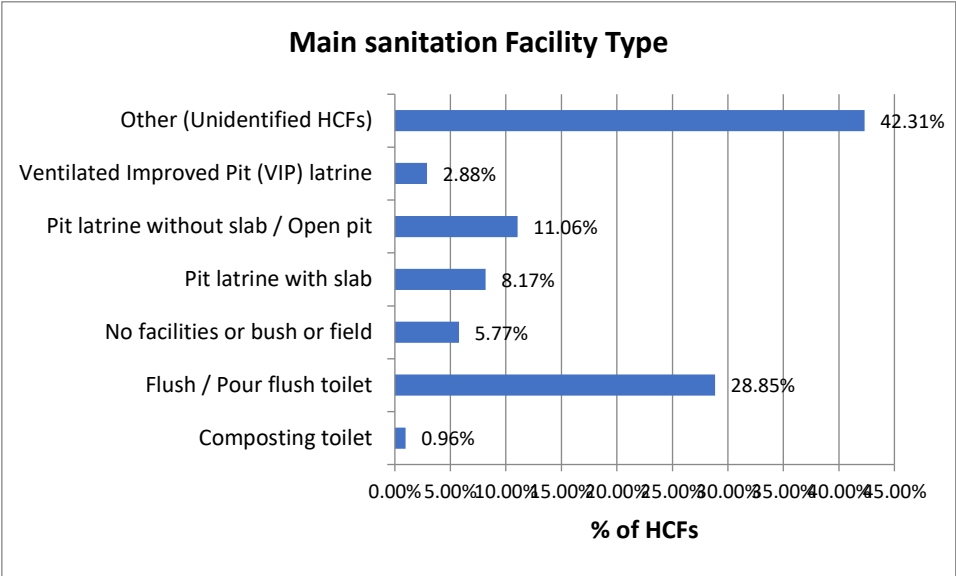
Figure 13 Sanitation SDG service level for HCFs



Source: National WASH MIS, 2022

The main type of sanitation facilities in HCFs was flush/pour flush toilet at 21.85%, although a large proportion are not reported (Figure 14).

Figure 14 Main Sanitation Facility Type



Source: National WASH MIS, 2022

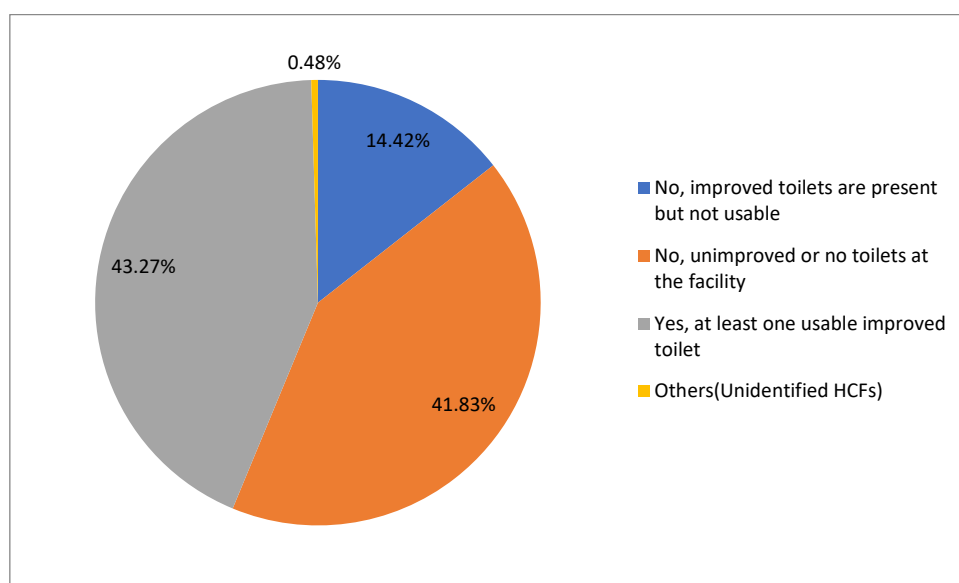
Figure 15 Toilet facilities in HCFs



L to R: Health Sub Centre, Aid Post, Aid Post, Sub Health Centre (photos by World Vision, Plan International)

Data shows that even if toilets are present, they are not always usable. 43.27% of health care facilities had at least one usable improved toilet, while 14.42% had improved toilets present but these were not useable (Figure 16).

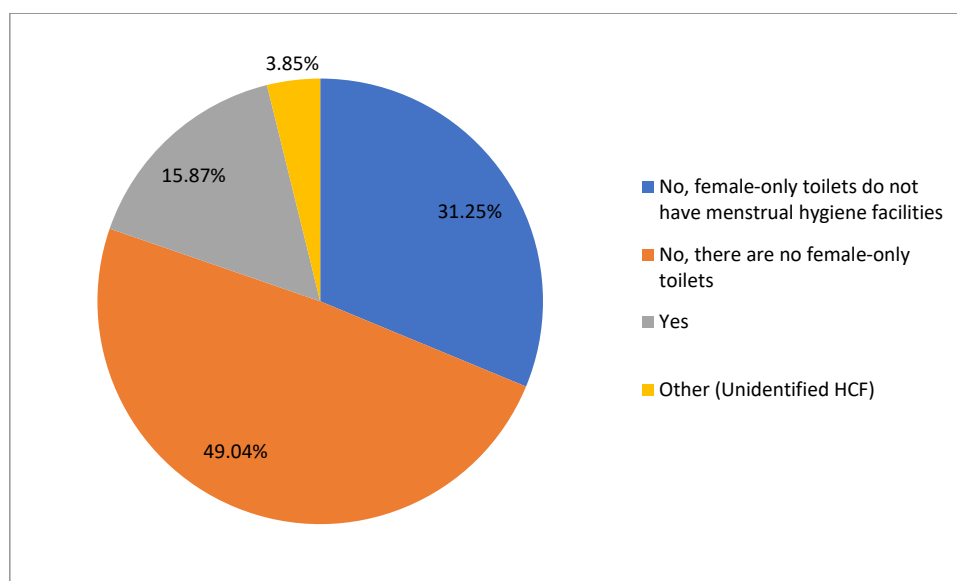
Figure 16 Sanitation at Least one Useable Toilet



Source: National WASH MIS, 2022

A survey from 2015 found that more than 60% of level 3 and 4 facilities did not have an adequate number of toilets (for level 5 and 6, the percentage was 40%) (World Bank 2017). WASH MIS data indicates that 49.04% of health care facilities do not have female-only toilets, and where these existed 31.25% do not have menstrual hygiene facilities (Figure 17).

Figure 17 Sanitation at Least one Useable Toilet for MHM



Source: National WASH MIS, 2022

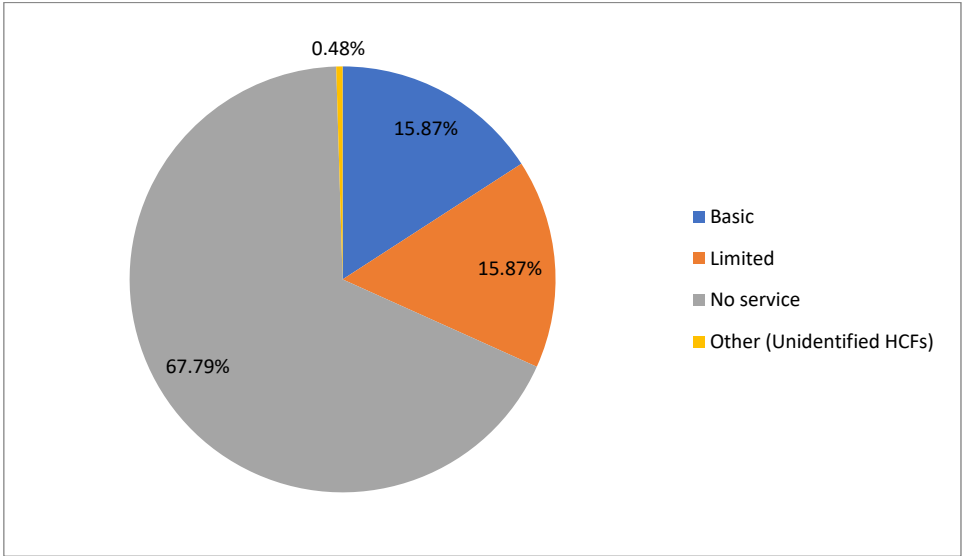
The data shows a difference in access to sanitation between urban and rural facilities. Urban facilities are more likely to have some kind of sanitation facilities. 84% of urban HCFs had improved services compared to 36.7% of rural HCFs, meaning that the toilets were useable. 16% of urban health facilities had basic sanitation (improved, useable, designated for women and MHM) and 77.8% of hospital facilities met needs for people with limited mobility. Rural HCFs lacked basic sanitation and did not accommodate users of MHM, women and people with limited mobility.

6.6 Hygiene

The 2020 JMP report contains no data for hygiene services in HCFs.

Data from the National WASH MIS shows that only 15.87% of HCFs had a basic hand hygiene service level, meaning there were functional hand hygiene facilities (with water and soap and/or alcohol-based hand rub) available at points of care, and within five metres of toilets. 67.79% of health care facilities had no hand hygiene service (Figure 18).

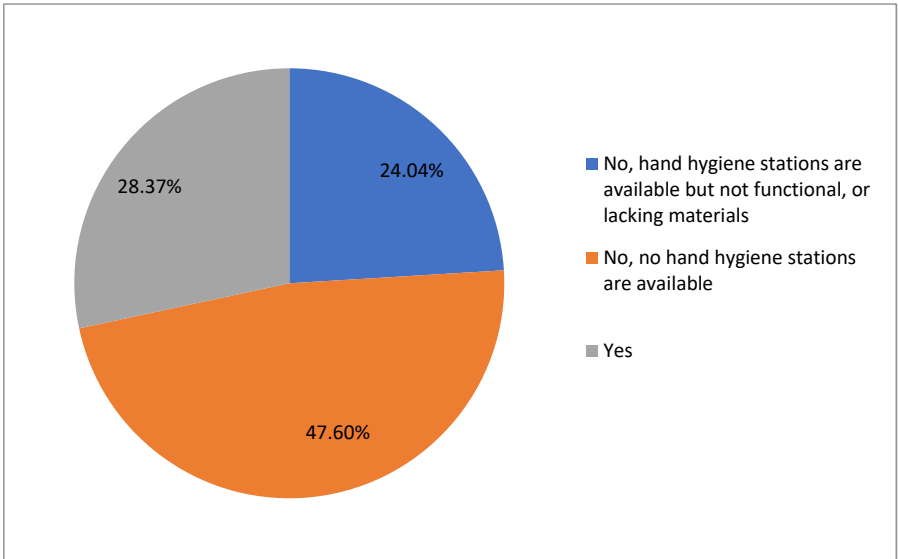
Figure 18 Hand Hygiene SDG Service Level



Source: National WASH MIS, 2022

Only 28.37% of HCFs have functional hand hygiene stations at points of care. 24.04% of HCFs have hand hygiene stations but these are not functional, and 47.60% of HCFs do not have hand hygiene stations at points of care (Figure 19).

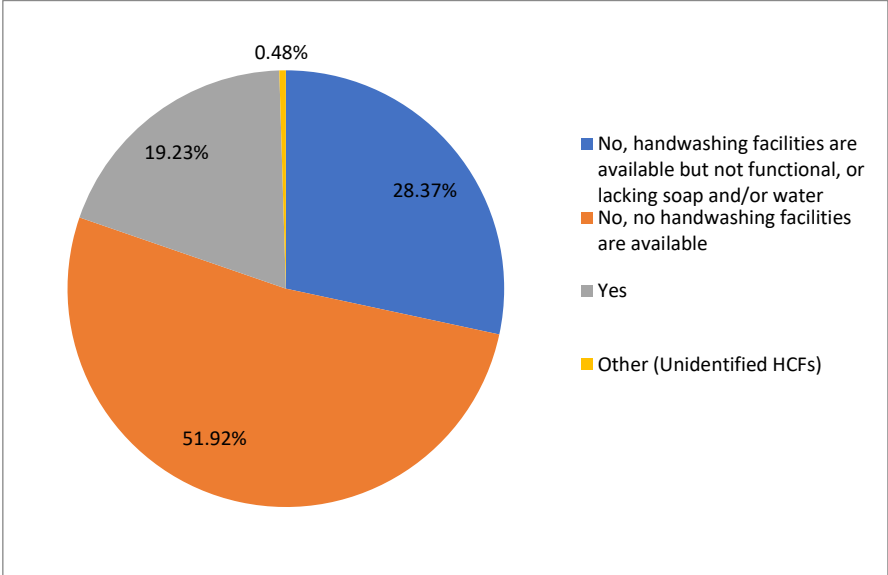
Figure 19 Functional Hand Hygiene Stations at Point of Care



Source: National WASH MIS, 2022

Only 19.23% of HCFs had handwashing facilities at toilets. 28.37% of HCFs have handwashing facilities available but these are not functional, while 51.92% of HCFs do not have handwashing facilities available at toilets (Figure 20).

Figure 20 Functional Hand Washing Stations at Toilets



Source: National WASH MIS, 2022

Figure 21 Handwashing facilities in HCFs



46.8% of rural facilities had no hand washing stations at points of care or within 5m of toilets and less than 29% of urban and rural facilities provided basic hygiene services.

6.7 Waste management

JMP data in the 2020 report indicates that 10% of national and 9% of non-hospital HCFs have access to basic waste management services (Figure 22).

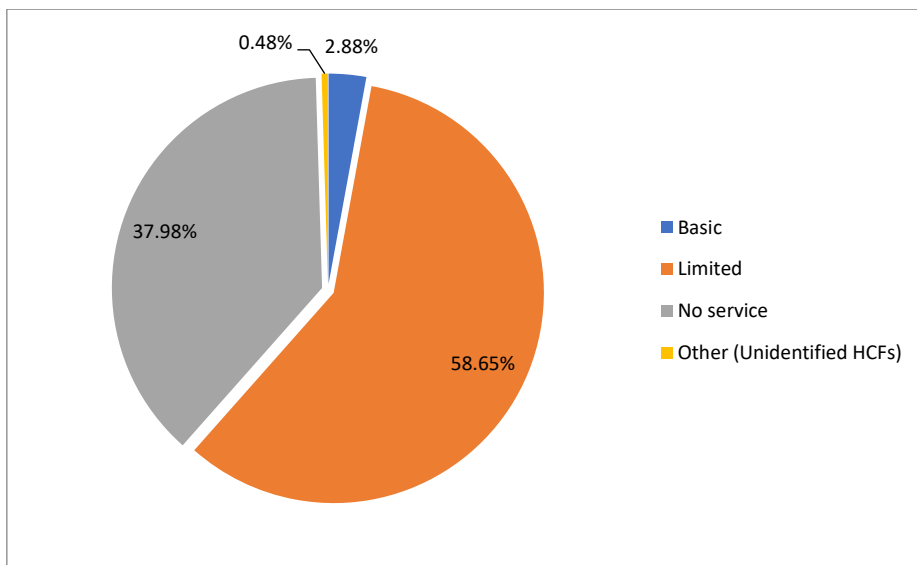
Figure 22 Waste management services in health care facilities in 2019



Source: WHO/UNICEF Joint Monitoring Program (JMP) (2020) data for 2019

Data from the National WASH MIS provides more insight into waste management in HCFs. 58.65% of HCFs had limited service meaning there is limited separation and/or treatment and disposal of sharps and infectious waste, but not all requirements for basic services are met. 37.98% of health care facilities had no service meaning there were no separate bins for sharps or infectious waste and/or sharps or infectious waste are not treated/disposed of safely (Figure 23).

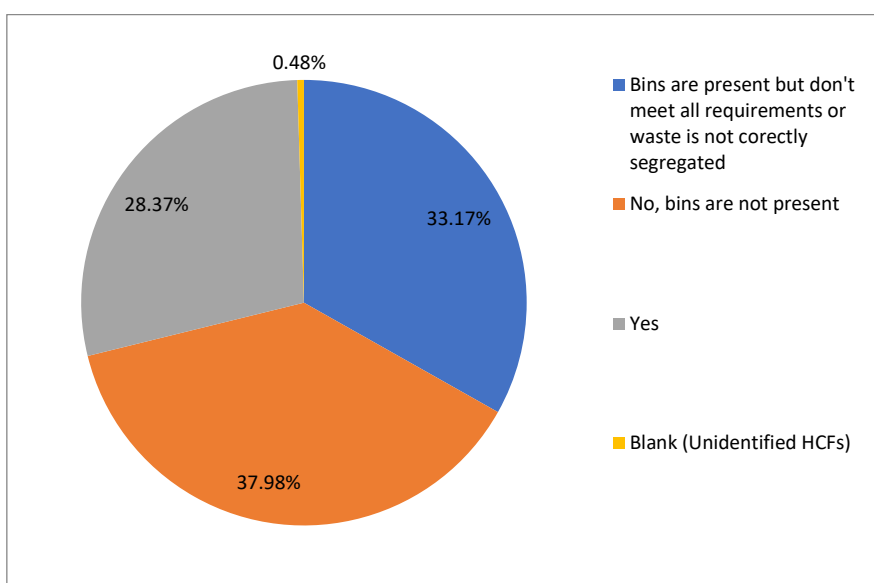
Figure 23 Health Care Waste SDG Service Level



Source: National WASH MIS, 2022

Less than a third of HCFs (28.37%) are segregating healthcare waste into three bins. 33.17% of health care facilities reported bins are present but do not meet all requirements or waste is not correctly segregated. 37.98% of health care facilities do not have bins to segregate waste (Figure 24).

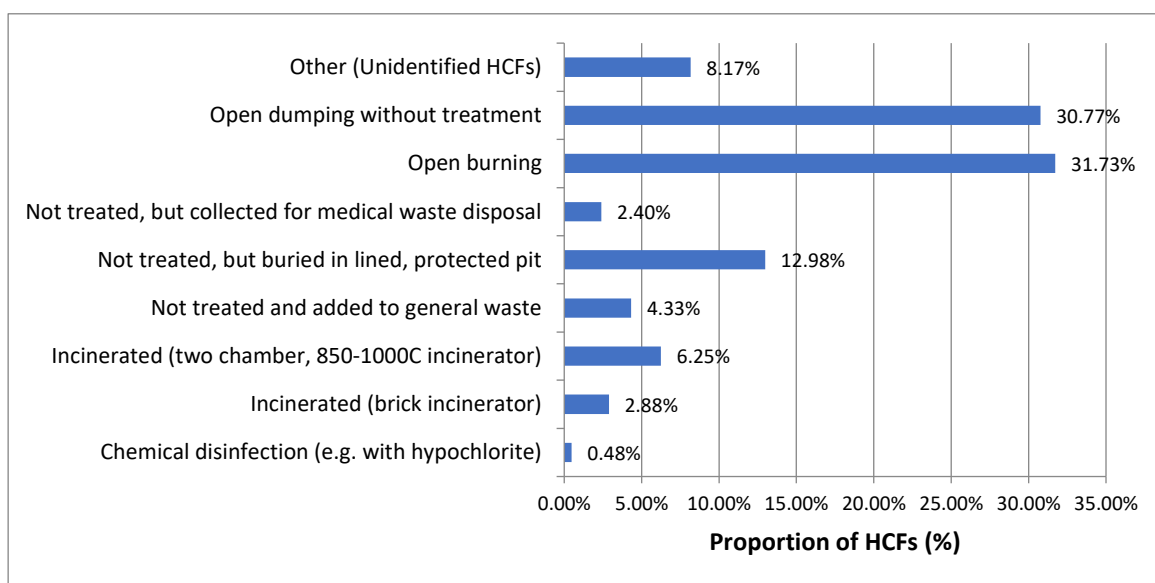
Figure 24 HCF Waste Segregated into at Least 3 Bins



Source: National WASH MIS, 2022

Open burning and open dumping without treatment are the main ways that HCFs treat/dispose of sharps waste.

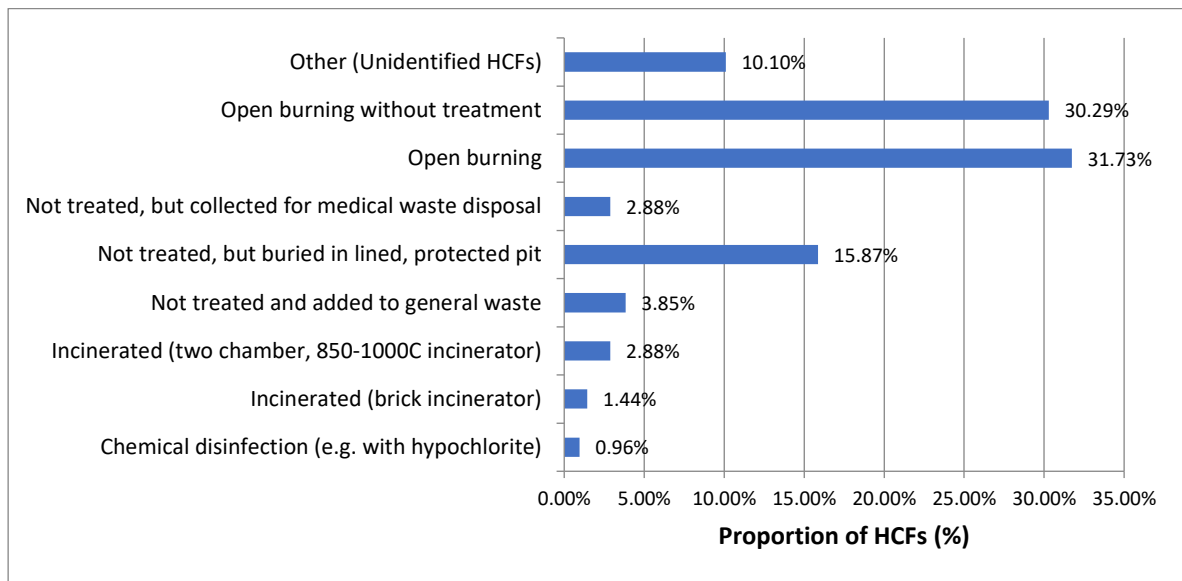
Figure 25 How Does a Facility Treat/Dispose of Sharp Waste



Source: National WASH MIS, 2022

Open burning and open dumping without treatment are also the common ways HCFs treat/dispose of infectious waste (Figure 26). Burying infectious waste in a pit is also common (12.98%) however it is likely that many pits are unlined as Figure 27 shows.

Figure 26 How Does a Facility Treat/Dispose of Infectious Waste



Source: National WASH MIS, 2022

Figure 27 Waste Management Facilities in HCFs



Waste disposal pits and low temperature incinerators at Western Province and Bougainville. (photos by World Vision and Plan International)

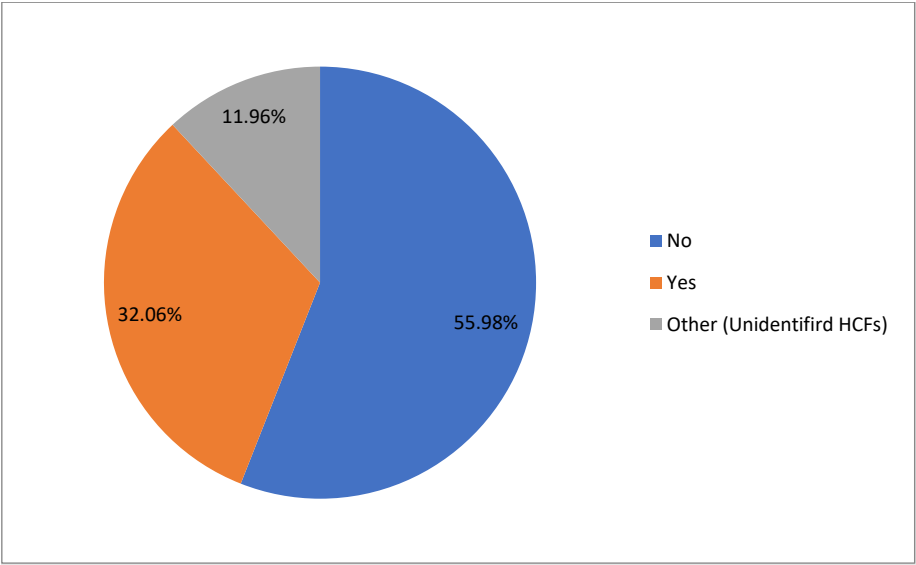
6.8 Environmental cleaning

JMP indicators for environmental cleaning include information about whether HCFs have cleaning protocols available and whether staff responsible for cleaning have been trained in cleaning protocols.

The 2020 JMP report contains no data for environmental cleaning services for HCFs in PNG.

Data from the National WASH MIS shows that at least 55.98% of health care facilities do not have cleaning protocols available (Figure 28).

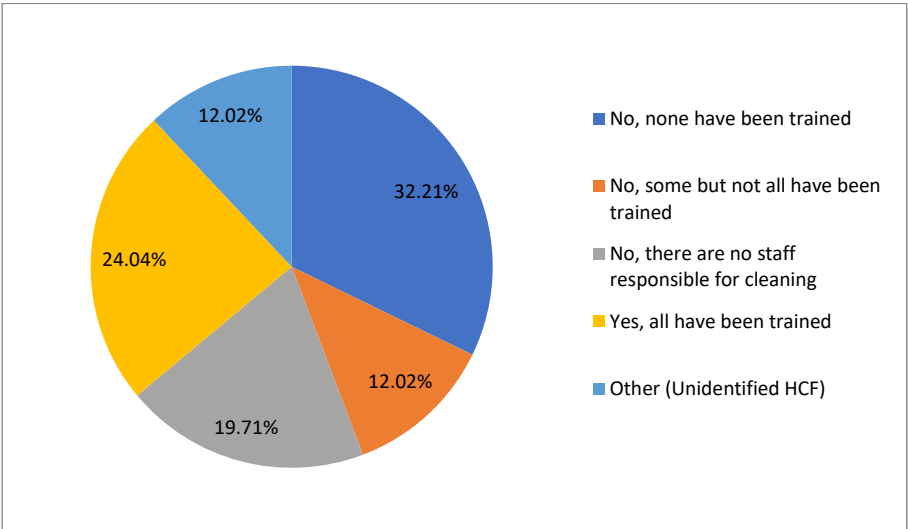
Figure 28 Are HCF Cleaning Protocols Available



Source: National WASH MIS, 2022

32.21% of health care facilities whose staff are responsible for cleaning have not been trained. Importantly, 19.71% of HCFs have no staff responsible for cleaning (Figure 29).

Figure 29 All HCF Staff Responsible for Cleaning Received Training



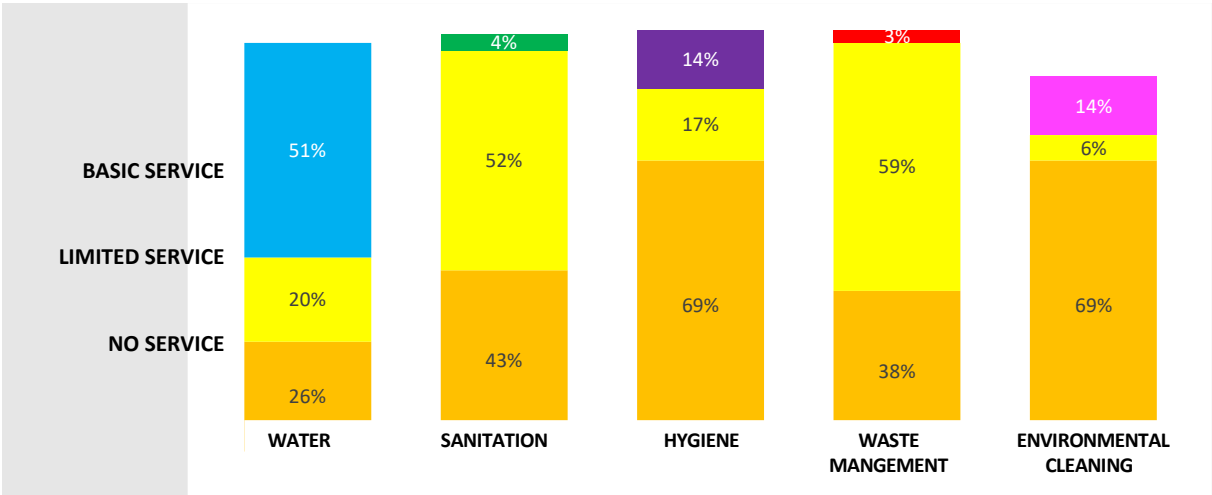
Source: National WASH MIS, 2022

6.9 WASH Summary

The data available indicates that PNG has very low levels of achievement of basic service levels for WASH in HCFs (Figure 30).

Water supply has the highest level of a basic service, however there is a reliance on rainwater which is often not available for all of the year. A reliable supply of water is fundamental to providing health care and also impacts on the other WASH in HCFs domains such as, hygiene, environmental cleaning and sanitation. PNG has few HCFs which have basic levels of service for sanitation, hygiene, health care waste management and environmental cleaning.

Figure 30 PNG WASH SDG levels



Source: National WASH MIS, 2022

Urban HCFs, including hospitals, appear better equipped and more likely to have effective WASH such as running water and toilets. Rural primary health care facilities, which serve the majority of Papua New Guineans, are failing to provide a basic level of WASH service. The reality of the situation in rural health centres was articulated during data collection for this Situation Analysis (Figure 31).

Figure 31 Statement on the reality of WASH in a Rural Health Centre

There are no guidelines with the specification about how many toilets, number of hand basins, what type of toilet facilities, number of tanks, the directions on environmental cleaning and solid waste management on WASH at HCF. There was one policy or guideline on IPC formulated during COVID 19 but we have no copies at the health centre as there were no copies circulated to HCFs. No specific IPC procedures are followed in the health centre.

We have no waste segregation on where to dispose of medical waste and non-medical waste, no incinerator or the guideline on how to make one. We have no pit for throwing rubbish. There are no running taps, no toilet facilities for staff and patients to use and no hand washing basins for patients and staff. Even if we have some hand washing basins, there are no clear guidelines on how the constant supply of hand sanitizer will be provided and the funding where we will access and purchase those hand sanitizers. We have no supply of hand washing materials like soap, paper towels, hand towels etc. In terms of menstrual hygiene, there are no proper bathrooms for female staff and patients for a shower, and no clear guidelines.

Health staff at Rural Health Centre

7 Discussion and Recommendations

7.1 Summary

PNG lacks basic services in HCFs across all domains of water supply, sanitation, hygiene, waste management and environmental cleaning. Sanitation and waste management services are the worst. Rural areas have the least access to basic services compared to urban areas and hospitals.

Poor quality WASH services in HCFs affects staff, patients and the wider community. Without WASH services, the ability of health care workers to carry out their health care functions, and the proper infection prevention and control measures is limited, with implications for the quality of care of neonates, under-fives and their mothers. Patients are at risk of infection from being in a setting that should be improving health, and the most vulnerable patients – pregnant women, children, elderly, infirm – are not able to have the dignity of basic WASH facilities.

Some of the main barriers or challenges to raising the priority of and implementing WASH in HCF which have been mentioned by people consulted, include:

- Current level of poor infrastructure
- Lack of funding for WASH
- Lack of awareness of WASH policy and implementation at the District level.
- No strategic Framework for improving WASH in HCF
- Lack of guidelines and standards on WASH in HCF
- Tribal fights which disrupt the ability to consistently deliver health services
- Sparsely populated provinces or districts where people are isolated and hard to reach with health services (except by air)
- Weather-related challenges to accessing health care facilities e.g. flooding, landslides.

In the past, efforts on WASH in HCFs have lacked **coordination** and have been disjointed. The re-formation of the WASH in HCF working group provides an opportunity to improve sector coordination at the national level between NDOH, the WASH PMU and other stakeholders, and move the WASH in HCF agenda forward. However, to sustain the Working Group there needs to be a clear objective and an agreed path forward for which the Working Group is responsible and accountable.

It is apparent that there is a gap in the **institutional responsibilities** between national level coordination and the provincial health authorities in guiding WASH in HCF standards and guidelines. PHAs and provinces have ultimate responsibility for improving HCFs but are not fully empowered and resourced to do this. Information does not always flow to PHAs or down to individual HCFs. Clear delineation, fiscal management, and collaborative work between agencies responsible for WASH in HCF is inadequate. The opportunity for WASH in HCF to encompass and benefit from the diverse communities and partners in PNG, starting with users and patients, wider communities, public (including church) and private service providers, local government, women and youth organisations, policy institutes, NGOs and INGOs, community-based organisations and landowner groups, is not yet realised.

There are some **policies and plans** available in PNG with relevance to WASH in HCF, but they lack detail and definitions, and concentrate on water supply and sanitation and not the five essential domains including hygiene, waste management and environmental cleaning. The National Health Plan 2021-2030 envisions the renewed effort towards implementing the “back to basics” approach will place greater emphasis on engaging communities, health promotion and prevention, at a primary health level. This shift in focus should inherently include basic WASH concepts and guidelines pushing forward prevention, promotion approach to health care in health facilities.

There are no comprehensive WASH services **standards and guidelines** for health care facilities in PNG and their absence is seen as an impediment to achieving basic levels of WASH in HCFs.³ Existing standards and guidelines e.g. solid waste management in HCFs, sit in isolation. There is an opportunity to supplement gaps across other domains with WHO global guidelines in order to provide a comprehensive guide on minimum requirements for WASH in HCF in PNG, which support the National Health Sector Standards.

The COVID pandemic in the last two years (2020-2021), presented increased focus on WASH. Worldwide, the effects of the pandemic have seen an increase in health messages for hand washing and basic sanitary and protective care in health facilities. The spotlighting of the WASH sector by the pandemic led to the drafting in PNG of the Infection Prevention and Control Policy and Guidelines (COVID-19) – (2020). This momentum can be built on to bring about the development of WASH in HCF guidelines.

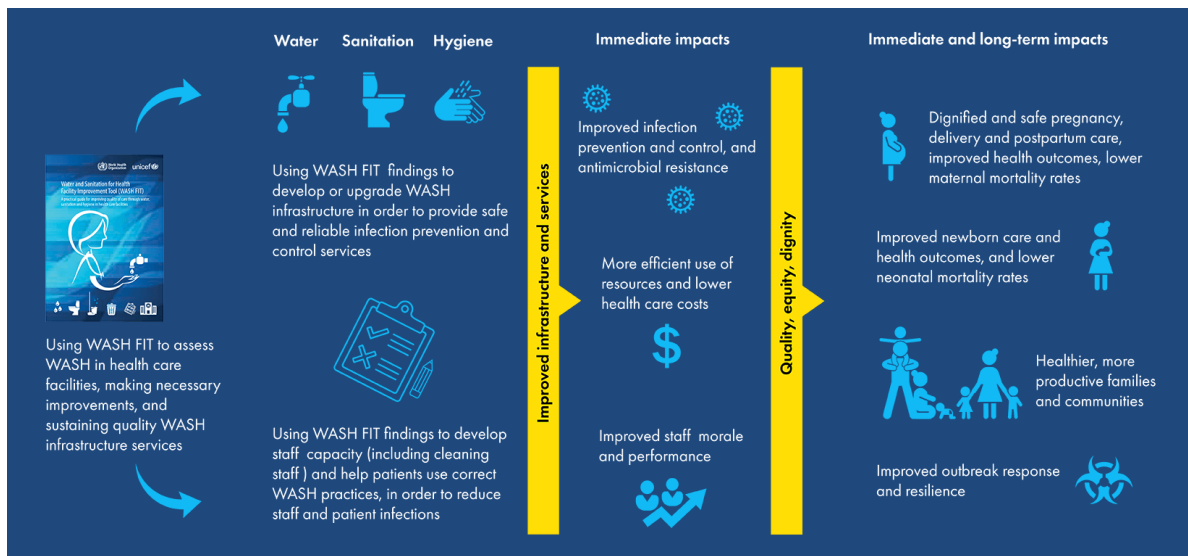
In the past there has been no **monitoring** and evaluation mechanisms to capture reliable data on WASH in HCFs. The National WASH MIS system contains recent and growing records of HCFs across the five domains. The National WASH MIS provides an opportunity to systematically monitor WASH in HCF using the standard SDG domains and indicators, and to provide country updates to the JMP. The number of records in the system currently is a fraction of the number of HCFs nationally, and more data is required. Collecting more, quality, HCF data can help planning where targeted interventions may be needed – for example areas of the country where conditions are poorest, or types of HCFs with the worst WASH indicators, or priority domains which are currently neglected.

Recent **facility assessments** have been conducted of individual HCFs in different locations in PNG, particularly by NGOs who are supporting facility improvements through the Australian Government Water for Women program. There is a case for further detailed assessment of HCFs to understand the constraints and barriers to effective WASH, not just the access to WASH. Information gaps exist around disability access, safety and security issues, knowledge of staff on WASH, information from and supervision by PHAs, water quality, and WASH behavioural practices including cleaning.

Tools exist which can provide facility information and create bottom-up ownership and change. [WASH FIT](#) (Facility Improvement Tool) is being used by some NGOs to work with health staff to conduct facility assessments, identify WASH in HCF needs, and implement changes in these facilities step by step. WASH FIT is a risk-based, quality improvement tool for health care facilities, covering key aspects of WASH services: water; sanitation; hand hygiene; environmental cleaning; health care waste management; and selected aspects of energy, building and facility management (Figure 32). The goal is to improve the quality of care in individual HCFs over time (to national standards). WASH FIT is used in more than 40 countries and is typically adapted for local use. There are opportunities to learn from and expand the use of WASH-FIT in PNG to help with facility level assessments and improvements.

³ Interview with NDOH, Environmental Health Section

Figure 32 WASH FIT Impacts



There is insufficient **budget** for WASH in HCF, and health services in general. Any budgets that exist which can be used for WASH in HCF are fragmented, and have a low visibility as they are not recorded separately. Funding arrangements, governance and the administrative responsibilities and accountabilities for WASH in HCF are devolved to the PHAs. Other fragmented funding comes from the DDA, INGOs, and donor agencies. Spending on WASH in HCF is not tracked, and therefore cannot be monitored. There are no cost guidelines for WASH in HCF improvements.

The success of WASH in HCF improvements hinges on the knowledge, **capacity development and training**, and ability of health staff to implement changes. The need for staff awareness and training, including the necessity to build in WASH awareness as part of nursing school and medical school training, is huge and ongoing.

Gender and Social Inclusion mainstreaming is largely overlooked in WASH in HCF. In PNG infrastructure at level 5 and 6, does have some consideration of gender, however at Level 1-4 it is not clearly stated, and given the poor status of WASH services, gender is close to insignificant. There are more females in the primary health care sector. Disability accessible facilities are not a high priority and the planning, design and management of WASH services in HCFs do not consider the variety of user needs. Users include women during childbirth; menstruating women; infants and children; older people; people with disabilities; people experiencing injury, illness or incontinence; and female staff.

7.2 Recommendations

The following section describes the recommendations for PNG to begin improving WASH in HCF. Much of the overall responsibility for setting the direction for WASH in HCF in PNG lies at the national level, particularly the NDOH.

7.2.1 National Level

1. **Strengthen national level coordination** and direction through an effective national WASH in HCF Working Group:
 - Develop a formal Terms of Reference for the WASH in HCF Working Group which sets out a clear purpose and goals
 - Ensure Working Group membership is representative of and contributes to WASH in HCF improvements. For example, members should include those with interests in WASH and health: public health practitioners, utilities, church

- service providers, NGOs working in the sector, and global sector leaders WHO, UNICEF and WaterAid.
 - Ensure regular meetings with accountable actions to drive improvements in WASH in HCF.
- 2. **Develop a country roadmap** through a country-led process to review and assess the current WASH in HCF landscape, identify strengths and gaps, and plan and prioritise activities, taking into consideration existing capacities and resources as well as potential risks and challenges. The development of a costed WASH in HCF roadmap (a practical framework to help achieve targets) should be an agreed task for the Working Group to guide future efforts.
- 3. **Develop guidelines on minimum requirements** for WASH in HCF which:
 - Build on existing policies, standards, and guidelines
 - Use WHO guidelines to fill any gaps
 - Include gender, disability and child friendly design elements
 - Are highly relevant to PNG's context, particularly for rural HCFs at level 1-4
 - Offer practical suggestions for how to improve WASH conditions.
- 4. **Improve monitoring** of WASH in HCF to enable data to be used for reporting and planning:
 - Adapt health data collection system and Health MIS tools to capture WASH in HCF information and feed into PNG National WASH MIS.
 - Encourage all stakeholders (including development agencies and NGOs) to contribute information which is aligned with the national monitoring formats and data requirements.
 - Provide staff training and ongoing support to maintain the monitoring system.
 - Assist PHAs to take responsibility for data collection and updating.
 - Ensure quality control on data in WASH MIS database – some records have data missing, and the levels of HCFs has changed from 7 to 6 but this is not reflected in the MIS.
- 5. **Improve budgeting and financing** for WASH in HCF improvements:
 - Clearly define responsibilities and processes for financing WASH in HCF improvements.
 - Set aside GOPNG budget for rehabilitation of facilities through PHAs.
 - Redirect donor funds to improving WASH facilities in HCFs (to a standard compatible with new WASH in HCF Guidelines).
 - Develop cost models for components of WASH in HCF and use these for planning improvements and budget requests.
- 6. **Promote knowledge sharing and build capacity** for all WASH in HCF stakeholders:
 - Organise sector meetings, forums and training workshops, technical exchanges and field visits to HCFs.
 - Facilitate the communication, coordination and support between the local and national actors in WASH in HCF.
 - Document and disseminate good practices and lessons learned on WASH in HCF in various levels of health facilities.
 - Promote awareness in the planning, design and management of HCFs on the accessibility, safety, privacy, social appropriateness, and the comfort of different users when using WASH facilities.
 - Organise learning sessions and sharing experiences in implementing WASH-FIT facility improvement tool.
 - Develop a module on WASH/IPC in HCF to be included in the curricula of medical and nursing schools.
 - Provide support and resources for PHAs to provide training to health care workers.
- 7. **Ensure health plans and policies** prioritise WASH in HCF, include all WASH in HCF domains and use standard terms and targets so that plans, policies, standards and strategies are all aligned. Ensure all related WASH in HCF plans, policies, and guidelines are published, disseminated, and delivered to individual HCFs.

8. **Use evidence to advocate** to the Health Minister and regularly inform about goals and achievements and sector needs.

7.2.2 Provincial level

1. Coordinate with National level, District Development Authority, and HCFs to plan improvements to HCFs.
2. Participate in consultation processes and provide constructive feedback on proposed guidelines on minimum requirements of WASH in HCF.
3. Disseminate relevant policies and guidelines to PHA staff, Church service providers, DDAs, and individual HCFs.
4. Conduct staff awareness and training on WASH in HCF at all levels of HCFs.
5. Increase the number of trained environmental health officers and positions within structures of PHAs.
6. Include requirements to improve WASH in HCF in church contracts for health services.
7. Ensure all upgraded and new HCFs are built to the standard for WASH in HCF, regardless of funding source.
8. Disaggregate and record expenditure on WASH in HCF improvements separately from provincial budget.
9. Ensure data on WASH in HCF is collected within the province, and facilitate the transfer of data to the appropriate channels.

7.2.3 District level

1. Participate in consultation processes and provide constructive feedback on proposed guidelines on minimum requirements of WASH in HCF.
2. Include WASH in HCF improvements in District Five Year WASH Plans.
3. Provide budget to support WASH in HCF improvements.
4. Ensure all new HCFs are built to the standard of at least the minimum requirements for WASH in HCF.
5. Disaggregate and record expenditure on WASH in HCF improvements separately from district budget.
6. Ensure data on WASH in HCF is collected within the district and facilitate the transfer of data to the appropriate channels.

7.2.4 Facility level

1. Participate in consultation processes and provide constructive feedback on proposed guidelines on minimum requirements of WASH in HCF.
2. Participate in staff awareness and training on WASH in HCF.
3. Conduct facility assessments using tools such as WASH-FIT.
4. Follow IPC and WASH guidelines and implement WASH improvements or request support from others.
5. Submit monitoring data on WASH in HCF to the appropriate channel.

8 Annexes

8.1 ANNEX A: References

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8.2 ANNEX B: Global Standards for Monitoring WASH in HCF and Definitions

Global indicators for monitoring WASH in health care facilities SDG 6 – via targets 6.1 calls upon Member States to achieve, by 2030, “universal and equitable access to safe and affordable drinking-water for all” and 6.2 calls for “access to adequate and equitable sanitation and hygiene for all”. According to the normative interpretation of the targets, “universal access” means in all possible settings, including schools, health care facilities, workplaces, and public spaces.

To monitor progress towards these targets, the Joint Monitoring Program (JMP) developed a set of core questions and indicators for basic services for health care facilities, for use in outpatient facilities. Separate ladders are proposed for each indicator. The core service ladders include three levels: no service, limited service and basic service. Each level is defined in Table 12.

According to the JMP terminology, a ‘basic service’ corresponds to the minimum acceptable set of WASH services. For countries where “basic” service is not an ambitious aim, an additional “advanced” service level should be defined. Countries are encouraged to define their own national criteria for the “advanced” service level which may vary significantly according to the country, context and type of facility.

Table 12 JMP Global Monitoring Ladder for WASH in Health Care Facilities

Water	Sanitation	Hygiene	Health Care Waste	Environmental Cleaning
Advanced Service To be defined at national level	Advanced Service To be defined at national level	Advanced Service To be defined at national level	Advanced Service To be defined at national level	Advanced Service To be defined at national level
Basic Service Water is available from an improved source located on premises	Basic service Improved sanitation facilities are usable with at least one toilet dedicated for staff, at least one sex-separated toilet with menstrual hygiene facilities, and at least one toilet accessible for people with limited mobility.	Basic service Functional hand hygiene facilities (with water and soap and/or alcohol-based hand rub) are available at points of care, and within 5 meters of toilets	Basic service Waste is safely segregated into at least three bins and sharps and infectious waste are treated and disposed of safely.	Basic service Basic protocols for cleaning available, and staff with cleaning responsibilities have all received training.
Limited service An improved water source is within 500 meters of the facility, but not all requirements for basic service are met.	Limited service At least one improved sanitation facility, but not all requirements for basic service are met.	Limited service Functional hand hygiene facilities are available at either points of care or toilets, but not both.	Limited service There is limited separation and/or treatment and disposal of sharps and infectious waste, but not all requirements for basic service are met.	Limited service There are cleaning protocols, or at least some staff have received training on cleaning.
No service Water is taken from unprotected dug wells or springs, or surface water sources; or an	No service Toilet facilities are unimproved (pit latrines without a slab or platform, hanging latrines and	No service No functional hand hygiene facilities are available at either	No service There are no separate bins for sharps or infectious waste, and sharps and/or infectious	No service No cleaning protocols are available, and no staff have received training on cleaning.

improved source that is more than 500 m from the facility; or the facility has no water source.	bucket latrines), or there are no toilets or latrines at the facility.	points of care or toilets.	waste are not treated/disposed of.	
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Notes:

1 Improved water sources are those which by nature of their design and construction have the potential to deliver safe water. These include piped water, boreholes, or tube wells, protected dug wells, protected springs, rainwater, and packaged or delivered water.

2 Improved sanitation facilities are those designed to hygienically separate human excreta from human contact. These include wet technologies – such as flush and pour flush toilets connecting to sewers, septic tanks, or pit latrines – and dry sanitation technologies – such as dry pit latrines with slabs, and composting toilet.

Source: WHO and UNICEF

Table 13 WHO's Key Definition of WASH in Health Care Facilities

<ul style="list-style-type: none"> Improved sources of water include piped water, tube well or borehole, 	<ul style="list-style-type: none"> Functional hand hygiene station may consist of a basin/pan with water and soap for washing hands, or an alcohol-based hand rub dispenser. If the latter is used, health staff may carry a dispenser around between points of care.
<ul style="list-style-type: none"> protected dug well and protected rainwater collection 	<ul style="list-style-type: none"> Points of care are any location in the outpatient setting where care or treatment is delivered
<ul style="list-style-type: none"> Improved toilets include: Flushed toilets, Pit latrines with slab or ventilated improved pit latrines (VIP). 	<ul style="list-style-type: none"> consultation/examination room). For facilities with multiple consultation rooms, one is randomly selected from the area where most general outpatient services occur to check for hand hygiene stations.
<ul style="list-style-type: none"> Usable or functional toilet means that it has a door – which is unlocked or for which a key is available at any time and can be closed from the inside – is not blocked, and has no major holes in the structure 	<ul style="list-style-type: none"> Waste safely segregated in the consultation area means there are at least three bins in place to separate sharp waste, infectious waste and non-infectious general waste and the bins should be clearly labelled (either in colour coded, written labels or signs), no more than three quarters (75%) full and each bin should not contain waste other than that corresponding to their label.
<ul style="list-style-type: none"> Menstrual hygiene facilities refer to a bin with a lid on it within the cubicle or water available in a private space for washing. 	<ul style="list-style-type: none"> Sharps waste is treated and/or disposed of safely when it is autoclaved and/or incinerated with high capacity incinerator at 850-1,000oC or buried in lined and protected pit.
<ul style="list-style-type: none"> Toilet meeting the needs of people with limited mobility should be accessible <ul style="list-style-type: none"> without stairs/ steps, have handrails for support attached to the floor or side walls, the door is at least 80cm wide, the door handle and seat within reach of people using wheelchairs or crutches/sticks. 	<ul style="list-style-type: none"> Infectious waste is treated and/or disposed of safely when is autoclaved and/or incinerated (with high or low capacity), buried in lined and protected pit, and appropriately collected for medical waste disposal.

JMP has also developed draft indicators for monitoring WASH and related IPC in delivery rooms (Table 14).

Table 14 JMP Basic service levels for monitoring WASH and IPC in the delivery room

Water	Sanitation	Hygiene	Health Care Waste	Environmental Cleaning
Advanced Service To be defined at national level	Advanced Service To be defined at national level	Advanced Service To be defined at national level	Advanced Service To be defined at national level	Advanced Service To be defined at national level
Basic Service Running water is available in the delivery room	Basic service Usable (available, functional, private) and single sex toilets are accessible to women	Basic service Hand washing facilities (with soap and water) and equipment for clean births are available in the delivery room and women have access to a bathing area	Basic service Waste is segregated into bins for sharps, infectious and other waste are segregated into labelled bins in the delivery room, and placentas are disposed of safely	Basic service Basic protocols exist for cleaning the delivery room, and staff with cleaning responsibilities have all received training
Limited service Water is available in the delivery room in a storage container but without a tap.	Limited service There are toilets but not all requirements for basic service are met.	Limited service Hand washing facilities (with water and soap) or equipment for clean births or showers are not available in the delivery room.	Limited service Either waste is not segregated or placentas are not disposed of safely.	Limited service Cleaning protocols are absent, or not all staff have received training.
No service No water available in the delivery room.	No service There are no toilets available for women in the delivery setting.	No service Hand washing facilities (with soap and water) are absent.	No service Bins are not used for waste segregation and placentas are not disposed of safely.	No service No protocols exist and no staff have received training.

8.3 ANNEX C: Core questions for monitoring WASH in HCF service provision

The following provides a list of questions on WASH in health care facilities, adapted for a survey format, which could be used in an assessment of service provision. They are adapted from the WHO/ UNICEF Joint Monitoring Programme's Core questions for monitoring WASH in health care facilities in the Sustainable Development Goals.

1. Main water source (select one):

<input type="checkbox"/> Piped	<input type="checkbox"/> Tube well/borehole	<input type="checkbox"/> Protected dug well
<input type="checkbox"/> Unprotected dug well	<input type="checkbox"/> Protected spring	<input type="checkbox"/> Unprotected spring
<input type="checkbox"/> Rainwater	<input type="checkbox"/> Tanker truck	<input type="checkbox"/> Surface water
<input type="checkbox"/> No water source		
<input type="checkbox"/> Other:		

2. Main water source is on premises:

<input type="checkbox"/> Yes, m	<input type="checkbox"/> Off premises but up to 500 m	<input type="checkbox"/> More than 500
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3. Water from main source is currently available:

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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4. Number of usable (available, functional, private) toilets for health care facility: (insert number)

5. Type of toilets/latrines (select one – most common):

<input type="checkbox"/> Flush/pour-flush to sewer	<input type="checkbox"/> Flush/pour-flush to tank or pit	<input type="checkbox"/> Flush/pour-flush to Bucket
<input type="checkbox"/> Pit latrine with slab/covered	<input type="checkbox"/> Pit latrine without slab/open	
<input type="checkbox"/> Hanging toilet/latrine	<input type="checkbox"/> None	

6. Toilets separated for staff and patients:

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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7. Toilets separated for male and female patients:

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

8. Female toilets have facilities to manage menstrual hygiene needs (covered bin, and/or water and soap):

Yes No

9. At least one toilet accessible to people with limited mobility:

Yes No

10. Soap and water (or alcohol-based hand rub) currently available in consultation rooms:

Yes Partially (e.g. lacking materials) No

11. Soap and water currently available at toilets:

Yes, within 5 m of toilets Yes, more than 5 m from toilets No, no soap and/or no water

12. Sharps, infectious and general waste are safely separated into three bins in consultation room,

Yes Somewhat (bins are full, include other waste, or only 1 or 2 available) No

13. Treatment/disposal of sharps waste:

Autoclave		Incinerator
(2 chamber, 850–1000 °C) Incinerator (other)	Burning in protected pit	
Not treated, but buried in lined, protected pit	Not treated, but collected for medical waste disposal	
Open dumping without treatment	Open burning	
Not treated and added to general waste		
Other:		

8.4 ANNEX D: Situation Analysis: Questions Guide

Question Guide

For the Situation Analysis, we will be using Question Guide and not a questionnaire.

This allows for more probing into what is in existence

The Questions are based on the TOR to determine the review.

1. **Standards and technical guidelines applicable to WASH in HCF.**

Q1: Is there a National Standard or guidelines to WASH in HCF?

Q2: Are there any technical guidelines or standards or standards for the number of toilets, water supply, environmental cleaning, and solid waste management, including COVID-19 facets, that are relevant to health care facilities?

Q3: Are there any gaps in these standards or guidelines that you have identified? Please elaborate on these identified gaps.

Q4: Does the health sector have clearly defined Infection Prevention and Control Guidelines or standard operating procedures for Health facilities at all levels? If yes, what do they cover?

Q5: Are there any guidelines on the operation and maintenance of WASH facilities eg. water supply; hand hygiene and sanitation facilities

2. **Existing monitoring and evaluation mechanisms, tools, and data**

Q6: Is there a register of all the HCFs (public/private) in PNG? If yes, what information does it contain? When was this register last updated?

Q7: How is the data collected and who collects the data?

Q8: How often are the data/information collected?

Q9: How are these data reported?

Q10: What types of data are collected for HMIS?

Q11: Does the HMIS include data on WASH in HCFs?

a) If yes, how is this data reported?

b) b) If no, is it feasible to collect data on WASH in HCFs through the HMIS

Q12: Are all HCFs (public and private) reporting into the HMIS from across the country?

Q13: Is there a register of all health care facilities?

a) If yes, what information does it contain?

b) Is the information up to date?

c) How often are the data/information collected?

Q14: Are there WASH services provided at HCFs?

Q15: Are there indicators in the HMIS that measure WASH activities/services?

Q16: Is there a Monitoring & Evaluation system in place to collect WASH data & monitor the progress of WASH?

3. **Status of WASH in HCF in PNG, with updated figures on WASH in HCF with reference to current WASH in HCF Joint Monitoring Program (JMP) indicators. Disaggregate WASH infrastructure by health care facility type.**

4. **Describe institutions/organisations involved in or working on WASH in HCF in PNG and their related roles and responsibilities. Include administrative, capacity development, and coordination processes.**

Q17: *In your view, does the existing policies/legislations assign responsibility/custodianship of WASH in Health Care Facilities considered or is a feature of Public Health?*

- How effective are existing policies/legislation that governs your responsibility, Please explain
- *How effective do you engage with your stakeholders (in terms of responsibility and custodianship with WASH in HCF.*
- *How effective is the WASH implementation plans in relation to policies and legislation framework available? Considering;*
 - *With roles and responsibilities*
 - *Custodianship*
 - *Administrative capabilities*
 - *Development capacity*

Q18: What and where is the relationship between NDOH, Government and Church Health Facilities in operations and monitoring of WASH in Health care facilities?

17 Status of WASH in HCF in PNG, with updated figures on WASH in HCF with reference to current WASH in HCF Joint Monitoring Program (JMP) indicators. Disaggregate WASH infrastructure by health care facility type.

18 Describe institutions/organisations involved in or working on WASH in HCF in PNG and their related roles and responsibilities. Include administrative, capacity development, and coordination processes.

Q17: In your view, does the existing policies/legislations assign responsibility/custodianship of WASH in Health Care Facilities considered or is a feature of Public Health?

- How effective are existing policies/legislation that governs your responsibility, Please explain
- How effective do you engage with your stakeholders (in terms of responsibility and custodianship with WASH in HCF).
- How effective is the WASH implementation plans in relation to policies and legislation framework available? Considering;
 - With roles and responsibilities
 - Custodianship
 - Administrative capabilities
 - Development capacity

Q18: What and where is the relationship between NDOH, Government and Church Health Facilities in operations and monitoring of WASH in Health care facilities?

Q19: Are there any formal arrangements or directives from NDOH/GoPNG with Church, NGO and Private Sector Health Care Facilities with regard to WASH?

Q20: Please briefly describe any links (e.g. networks/connections both formal and informal) that you currently have with anyone that provides initiatives for WASH in HCF?

Links (Who link between? What used for? Anyone else involved?) Provide <u>only one</u> example in each response box.	Existing Inquiry? (Use E or I)
Link1	
Link2	
Link3	
Link4	
Link 5	

19 Broadly describe the available funding streams for WASH in HCF.

Q21: Tell us how you are funded? (This is a general question that may be answered differently by various types of organization, from National to Subnational to INGO, churches etc)

Q22: Broadly describe the available funding streams for WASH in HCF.

20 Identify the opportunities and barriers to prioritizing and improving health system activities to better support WASH in HCF.

Q23: What are the main barriers or challenges exist in raising the priority of WASH in HCF?

Q24: What opportunities were presented during the pandemic to promote WASH in HCF?

(Q25: NDOH- **Do you have systems in place for regulation and surveillance of WASH services?**

Q26: Briefly describe the representation of;

- a) Female to male workers in the HCF?
- b) Specialist roles occupied by females in HCF?

Q27: Where can we find other indicators relating to Gender distribution in HCF?

Q28: What percentage of healthcare facilities have improved toilets, which are separated for females and allow for menstrual hygiene management?

Q29: What percentage of healthcare facilities have improved toilets, which are accessible to those with limited mobility?

Q30: What percentage of healthcare facilities have soap and water at the toilets?

Extra Guiding Questions

Are there adequate financial resources and systems for WASH? No

Are there adequate financial resources for WASH? No

Are there systems in place to track financial flows for WASH? No

Are the funding availability increasing the availability of funds for WASH? No

What are the main sources of financing for WASH? Donor funding

Are systems in place for drinking-water regulation and surveillance? Yes

Are systems in place for sanitation regulation and surveillance, including wastewater treatment and FSM (ODF? No

How effective is the regulation and surveillance system of WASH in Health Care Facilities? And Explain? No surveillance systems

8.5 ANNEX E: People who contributed to the Situation Analysis

NAME	POSITION	ORGANISATION
Mr John Nokue	Manager-WASH	WASH Project Management Unit – Department of National Planning and Monitoring(DNPM)
Ms Rose Kavanamur	Environmental Health Manager	Public Health Division, NDoH
Mr Raymond Kangu	WASH Program Officer	Public Health Branch, Environmental Health Section, WASH Program coordination, NDOH
Mr Peter Pindan	National IPC Lead and Manager Curative Standards & Audit	Medical Standards Division, NDOH
Dr. Nora Dai	Acting Chief Anesthetist	National Health Standards Compliance, NDOH
Dr Desmond Aisi MBBS. DA. MMed EM - UPNG	Consultant Emergency Physician, Acting Chief Emergency Physician, Honorary Lecturer and Director of Emergency Medicine Training	NDOH
Dr. Dora Lenturut	Acting Executive Manager	Medical Standards Division, NDOH
Dr. Roland Barnabas	Chief Pediatrician	NDOH
Dr. Scotty Kandelyo	Executive Manager, Curative Health Standards	Medical Standards Division, NDOH
Ms Issabelle Warre	WASH Specialist	UNICEF
Ms Nola Ndrewei	Technical Advisor	WHO
Ms Lyn Pokam		DPLGA
Ms Navara Kiene	Programs Director	WaterAid PNG
Ms Turea Wickham	WASH Consortium Lead	World Vision
Mr Graham Apian	Projects Director	National Catholic Health Service
Sr. Anna Sanginawa	Manager (East Sepik Province)	National Catholic Health Service
Ms Dorothy	Manager (Gulf Province)	National Catholic Health Service
Ms Eileen Liborius	Manager (Western Province)	National Catholic Health Service
Mr Leviticus Taghobe	Secretary	Anglican Health Services (Under Christian Health Services)
Mr Jeff Ubin – SNO	Vaccination Surveillance Team Leader	St Margaret's District Hospital-Oro Bay, Oro Province
Ms Winnie Sagi	EHO	Boram General Hospital Wewak (PHA)- East Sepik Province
Ms Angelique Hosea	EHO	Maprik District Hospital Wewak - East Sepik Province
Mr Michael Inabiyu	HEO	Drekikir Health Centre - East Sepik Province
Ms Mondi Sowi	SNO	Bereina District Health Centre- Central Province

8.6 ANNEX F: Acts, Policies, Standards and Guidelines Analysis

1. POLICY NAME: Global Water 2020: Water, Sanitation, and Hygiene in HCFs

Stakeholder Commitments

What relevance, if any, does this policy have to WASH in HCF in Papua New Guinea

<p>Comments:</p> <ul style="list-style-type: none"> • RELEVANT • Of the 73 organizations that made a commitment to WASH in HCF as at 17 June 2019, numerous provide their commitments to global geographies. 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Of the 73 or so Organisations who have made stakeholder commitments to WASH in HCF, how many of these organisations have their commitments reaching Papua New Guinea?
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What concerns or implementation issues have been identified throughout the life of the policy?

<p>Comments:</p> <ul style="list-style-type: none"> • Of the 73 or so Organisations who have made stakeholder commitments to WASH in HCF, how many of these organisations have their commitments reaching Papua New Guinea? 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Questionnaire to identify listed Organisations who are currently committed to WASH in HCF in PNG.
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2. POLICY NAME: IPP

Stakeholder Commitments

What relevance, if any, does this policy have to WASH in HCF in Papua New Guinea

<p>Comments:</p> <ul style="list-style-type: none"> • RELEVANT • Of the 73 organizations that made a commitment to WASH in HCF as at 17 June 2019, numerous provide their commitments to global geographies. 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Of the 73 or so Organisations who have made stakeholder commitments to WASH in HCF, how many of these organisations have their commitments reaching Papua New Guinea?
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What concerns or implementation issues have been identified throughout the life of the policy?

<p>Comments:</p> <ul style="list-style-type: none"> • Of the 73 or so Organisations who have made stakeholder commitments to WASH in HCF, how many of these organisations have their commitments reaching Papua New Guinea? 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Questionnaire to identify listed Organisations who are currently committed to WASH in HCF in PNG.
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3. POLICY NAME: Water and Sewerage Act 2016 Ammended

Stakeholder Commitments

What relevance, if any, does this policy have to WASH in HCF in Papua New Guinea

<p>Comments:</p> <ul style="list-style-type: none"> • RELEVANT • Of the 73 organizations that made a commitment to WASH in HCF as at 17 June 2019, numerous provide their commitments to global geographies. 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Of the 73 or so Organisations who have made stakeholder commitments to WASH in HCF, how many of these organisations have their commitments reaching Papua New Guinea?
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What concerns or implementation issues have been identified throughout the life of the policy?

<p>Comments:</p> <ul style="list-style-type: none"> • Of the 73 or so Organisations who have made stakeholder commitments to WASH in HCF, how many of these organisations have their commitments reaching Papua New Guinea? 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Questionnaire to identify listed Organisations who are currently committed to WASH in HCF in PNG.
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4. POLICY NAME: Papua New Guinea National Department of Health Plan (2021-2030)

What relevance, if any, does this policy have to WASH in HCF in Papua New Guinea

Comments:	Specific points to note from policy analysis:
<ul style="list-style-type: none"> RELEVANT 	<ul style="list-style-type: none"> The Healthy Island Concept (HIC) – a participatory approach that covers a wide range of health and social issues, such as water, sanitation and waste management, hygiene promotion, leadership training as well as gender and social inclusion in decision making The HIC and the HP are tied to the NHSS All PHAs to develop a model of care, reflective of the essential NHP principles and values, and support the range of essential clinical, primary health care and public health interventions and services.

What concerns or implementation issues have been identified throughout the life of the policy?

Comments:	Specific points to note from policy analysis:
<ul style="list-style-type: none"> The Plan is not as effective as stated. M& E is lacking to track outcomes yearly. 	<ul style="list-style-type: none"> The Plan does not make specific reference to WASH in HCF, however the HIC is as close to WASH in HCF.

Is this policy consistent with external and /or regulatory requirements?

Comments:	Specific points to note from policy analysis:
<ul style="list-style-type: none"> Existing relevant Legislation include: <ul style="list-style-type: none"> Public Health Act 1973 GoPNG National Water and Sewerage Act (Amended 2016) National Health Administration Act 1997 1998 Organic Law on Provincial Governments and LLGs Environment Act 2020 	<ul style="list-style-type: none"> Yes. WASH in HCF through the HIC. If reviewed it must make specific reference to WASH in HCF and make reference to the DNPM -WASH PMU MWater data base. The relevance of KRA in WASH in HCF is necessary for a lead into the WASH in HCF. Currently not reflected.

5. POLICY NAME: Papua New Guinea National Department of Health: National Health Service Standards(2011-2020)

What relevance, if any, does this policy have to WASH in HCF in Papua New Guinea

Comments:	Specific points to note from policy analysis:
<ul style="list-style-type: none"> RELEVANT A Standards Guide towards 	<ul style="list-style-type: none"> Although there are Clinical Guidelines, Health Standards and Facility Designs standards that are basically outlining what is, there are no specifics or specific mention of WASH in HCF. To support the NHP, the NDOH to work towards the establishment of KRA to achieve outcomes in the mentioned areas of Clinical, Health Standards and Facility Design Standards. Currently it is ambiguous. The NHSS is outdated

What concerns or implementation issues have been identified throughout the life of the policy?

Comments:	Specific points to note from policy analysis:
<ul style="list-style-type: none"> How effective has this Service standards been in maintaining standards in the HCFs. How effective is the tracking and monitoring of this standards? 	<ul style="list-style-type: none"> The Service standards does not capture WASH in HCF.

Is this policy consistent with external and /or regulatory requirements?

<p>Comments:</p> <ul style="list-style-type: none"> • Existing relevant Legislation include: <ul style="list-style-type: none"> ➢ Public Health Act 1973 ➢ GoPNG National Water and Sewerage Act (Amended 2016) ➢ National Health Administration Act 1997 ➢ 1998 Organic Law on Provincial Governments and LLGs ➢ Environment Act 2020 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Yes – At national level, the NHSS is currently outdated and needs reviewing and updating. And should include KRA of the different Standards Guide to ensure clarity when implanted.
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6. POLICY NAME: PNG WASH Policy (2015-2030)

What relevance, if any, does this policy have to WASH in HCF in Papua New Guinea

<p>Comments:</p> <ul style="list-style-type: none"> • RELEVANT in so far as it relates to WASH overall in PNG 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • While the WASH Policy is overarching there is no specific to WASH in HCF. • The strategic direction of WASH Policy covers; <ul style="list-style-type: none"> • Improve sector coordination and leadership • Increase WASH sector funding • Develop and Implement an Effective Management Information System for the WASH Sector • Improved and Consistent Approaches to WASH Service Delivery • Appropriate Technology Promotions • Enhanced Private Sector Participation and Partnerships • Increase Sector Capacity Building and Training
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What concerns or implementation issues have been identified throughout the life of the policy?

<p>Comments:</p> <ul style="list-style-type: none"> • Policy captures overarching WASH sector issues and challenges • Implementation plan has not been successful. • No M& E plans to track performance of the WASH Policy. 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Nothing covering WASH in HCF, however WASH in HCF is not mutually exclusive of the WASH Policy.
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Is this policy consistent with external and /or regulatory requirements?

<p>Comments:</p> <ul style="list-style-type: none"> • Existing relevant Legislation include: <ul style="list-style-type: none"> ➢ Public Health Act 1973 ➢ National Water and Sewerage Act 1986 ➢ NCD Water and Sewerage Act 1996 ➢ National Health Administration Act 1997 ➢ 1998 Organic Law on Provincial Governments and LLGs ➢ Environment Act 2020 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Yes – Whilst there is an M&E Framework it lacks continuity and sustainability. • Yes – this M&E Framework exists to guide and improve national development planning, decision making, accountability, and learnings associated in the PNG National WASH Policy (2015). •
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7. POLICY NAME: Papua New Guinea Department of National Planning and Monitoring: *Monitoring and Evaluation Framework for Water, Sanitation and Hygiene (WASH)*

What relevance, if any, does this policy have to WASH in HCF in Papua New Guinea

<p>Comments:</p>	<p>Specific points to note from policy analysis:</p>
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<ul style="list-style-type: none"> • RELEVANT in so far as it relates to WASH in HCF Joint Monitoring Program (JMP) indicators. • M&E Framework dated October 2020. 	<ul style="list-style-type: none"> • Effective National M&E can drive evidence-based decisions and accountability, informing planning, budgeting and resource allocation, while tracking investment and interventions for corrective action associated to the rollout of the PNG National WASH Policy (2015). • The Report provides an overview of national data flow and reporting arrangements for WASH in PNG. • The National Department of Health (NDOH) operates a national health management information system (HMIS). Reporting of HCF inventory including WASH infrastructure is undertaken on an annual basis. However, inventory data is not aligned well with JMP WASH in HCF indicators.
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What concerns or implementation issues have been identified throughout the life of the policy?

<p>Comments:</p> <ul style="list-style-type: none"> • Policy to be used by WASH stakeholders in order to work towards PNG Gov Development Strategic Plan target of 70% accessibility to water supply and sanitation by 2030. 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • There is currently limited analysis of WASH data and most visualisation is focused on key health indicators such as births, mortality and patient numbers. • Human Resources are needed for WASH M&E and for effective and timely transfer, processing and use of WASH related data. • Current staffing levels for both national and sub-national M&E functions are inadequate. Refer Table 2: Summary of Known M&E related positions.
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Is this policy consistent with external and /or regulatory requirements?

<p>Comments:</p> <ul style="list-style-type: none"> • Existing relevant Legislation include: <ul style="list-style-type: none"> ➤ Public Health Act 1973 ➤ National Water and Sewerage Act 1986 ➤ NCD Water and Sewerage Act 1996 ➤ National Health Administration Act 1997 ➤ 1998 Organic Law on Provincial Governments and LLGs ➤ Environment Act 2020 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • Yes – At national level, the WASH PMU within the DNPM are responsible for tracking PNGs progress its development agenda and reporting at the policy level • Yes – this M&E Framework exists to guide and improve national development planning, decision making, accountability, and learnings associated in the PNG National WASH Policy (2015). • The Report provides the National WASH M&E Framework that focuses on the uses and users of data. The aim of the Framework is not to focus on technical aspects of the WASH monitoring data but to look at what decisions have to be made, by whom and under what context. • Yes – The Report provides a look into WASH in HCF Indicators. Refer Table 7 at Page 23.
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8. POLICY NAME: Papua New Guinea Department of National Planning and Monitoring, September 2020, '*Water, Sanitation and Hygiene Sector Monitoring Manual*, Papua New Guinea

What relevance, if any, does this policy have to WASH in HCF in Papua New Guinea

<p>Comments:</p> <ul style="list-style-type: none"> • RELEVANT 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> • To support the WASH sector decision making, the Department of National Planning and Monitoring (DNPM) and WASH Program Management Unit (PMU) have developed a WASH Management
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<ul style="list-style-type: none"> Monitoring Manual dated 2020 	<p>Information Systems (MIS) to house, manage and use data from across PNG. The establishment of a reliable information system is vital to enable monitoring of policy targets and improving service delivery.</p> <ul style="list-style-type: none"> This WASH monitoring manual is designed to guide WASH sector stakeholder through the process of registering and contributing to the national WASH MIS. This manual should be used in conjunction with the WASH sector M&E framework. Interview/Questionnaire Prompts - Use of the WASH in HCF Survey is said to have been useful for district level planning and project implementation - . WASH in HCF Survey covers specific categories: Type of HCF, Water Source Details, Seasonality (which months have less water from the main water source), Water Quality, Sanitation Details, Sanitation Accessibility (discusses GESI: access to female hygiene needs, disabled persons needs), Sanitation O&M, Hygiene, Waste Separation (Sharp waste, infectious waste and non-infectious general waste), Waste Disposal, Cleaning Protocols, Cleaning Training, O&M, and Finance.
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What concerns or implementation issues have been identified throughout the life of the policy?

<p>Comments:</p> <ul style="list-style-type: none"> How effective has the DNPM MIS been in registering new WASH in HCF Projects and allowing for tracking of annual service delivery targets? 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> How popular and effective has the WASH in HCF Survey been in tracking PNGs progress towards the Sustainable Development Goals.
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Is this policy consistent with external and /or regulatory requirements?

<p>Comments:</p> <ul style="list-style-type: none"> Existing relevant Legislation include: <ul style="list-style-type: none"> ➢ Public Health Act 1973 ➢ National Water and Sewerage Act 1986 ➢ NCD Water and Sewerage Act 1996 ➢ National Health Administration Act 1997 ➢ 1998 Organic Law on Provincial Governments and LLGs ➢ Environment Act 2020 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> Yes – At national level, the WASH PMU within the DNPM are responsible for tracking PNGs progress its development agenda and reporting at the policy level
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9. POLICY NAME: PNG National Guidelines on Infection Prevention and Control for COVID-19, Dec 2020

What relevance, if any, does this policy have to WASH in HCF in Papua New Guinea

<p>Comments:</p> <ul style="list-style-type: none"> RELEVANT in so far as the Guideline provides evidence based guidelines to deliver safe and quality health services on high standards of IPC practices in the context of COVID-19. 	<p>Specific points to note from policy analysis:</p> <ul style="list-style-type: none"> Health workers must ensure that hand Washing facilities and appropriate PPE are available when handling deaths caused by COVID-19. Key concepts in this Guideline: <ol style="list-style-type: none"> Limit transmission of COVID-19 into and throughout HCF Isolate symptomatic patients as soon as possible Protect health care workers by emphasising hand hygiene.
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What concerns or implementation issues have been identified throughout the life of the policy?

<p>Comments:</p>	
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- The Guideline provides WHO Handwashing alternatives if no running water or soap is available. For e.g., For water use drained rice water, clean river or sea water, laundry or dishwater, water from boiled vegetables. For soap use instead coffee grounds, ash, salt, sand, coconut husk or bark, leaves or berries.

- Regular Hand Hygiene is one of the most effective actions health care workers can take to reduce the spread of COVID-19 and for safe waste management.

Is this policy consistent with external and /or regulatory requirements?

- **Comments: Yes-**
- **SUMMARY:** The Guideline is intended for public health and infection prevention and control (IPC) Teams, health care managers and HCF and community-based health workers in PNG.

The Guideline provides guidance on infection, prevention, and control requirements for the management of patients with suspected or probable or confirmed COVID-19.