Report from Community and Country Level Consultations on GMAP2 “Action and Investment to defeat Malaria (AIM)” in Papua New Guinea 25th - 29th July 2014

Prepared for
Roll Back Malaria Partnership

Submitted by:
Swiss Tropical and Public Health Institute

28 August 2014
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ACT</td>
<td>Artemisinin-based Combination Therapy</td>
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<td>AIM</td>
<td>Action and Investment to defeat Malaria</td>
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<td>BI</td>
<td>Burnet Institute</td>
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<td>CBD</td>
<td>Community Based Distributors</td>
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<td>ENB</td>
<td>East New Britain</td>
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<td>GFATM</td>
<td>The Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GMAP</td>
<td>Global Malaria Action Plan</td>
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<td>HMM</td>
<td>Home Management of Malaria</td>
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<td>IRS</td>
<td>Indoor Residual Spraying</td>
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<td>LLG</td>
<td>Local Level Government</td>
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<td>LLIN</td>
<td>Long Lasting Insecticide Treated Nets</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MCH</td>
<td>Maternal and Child health</td>
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<td>MTWG</td>
<td>Malaria Technical Working Group</td>
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<td>NDOH</td>
<td>National Department of Health</td>
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<td>NGO</td>
<td>Non-governmental Organization</td>
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<td>NHIS</td>
<td>National Health Information System</td>
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<td>NMCP</td>
<td>National Malaria Control Program</td>
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<td>P. falciparum</td>
<td><em>Plasmodium falciparum</em></td>
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<td>PNG</td>
<td>Papua New Guinea</td>
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<td>PNGIMR</td>
<td>Papua New Guinea Institute of Medical Research</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>P. vivax</td>
<td><em>Plasmodium vivax</em></td>
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<td>RBM</td>
<td>Roll Back Malaria Partnership</td>
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<td>RDT</td>
<td>Rapid Diagnostic Test</td>
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<td>Swiss TPH</td>
<td>Swiss Tropical and Public Health Institute</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1. Introduction

The country consultation in Papua New Guinea (PNG) was convened by the country office of Population Services International (PSI PNG) and the Malaria Technical Working Group (MTWG), the body comprising key stakeholders in the National Malaria Control Program (NMCP), chaired by the National Department of Health (NDOH).

The consultation was organised jointly by PSI, NDOH and the RBM consultant Dr. Manuel Hetzel, while further assistance was provided by the Burnet Institute (BI) during the community engagement visit and by the PNG Institute of Medical Research (PNGIMR) during the country-level meeting in Port Moresby.

The consultation process included a one-day engagement visit to East New Britain (ENB) Province. ENB is located in the Islands Region of PNG, the area which continues to exhibit high levels of malaria transmission. The province is also one of three sites in which a Home Management of Malaria (HMM) program is being implemented. Consultations were held with key government representatives, community leaders and health workers involved in the HMM program. The consultation in ENB involved 24 participants. Subsequently, a one-day central meeting took place in the national capital Port Moresby, bringing together national-level stakeholders, including members of the MTWG currently involved in the implementation of the NMCP, representatives from NGOs, the private industry, the PNGIMR and a nursing college. Discussions during the meeting also drew on findings from research conducted previously by PNGIMR.

1.2 Malaria Situation in Papua New Guinea

The patchwork of different ecological zones (ranging from coral atolls and coastal swamps to rainforests and high mountains) inhabited by human populations of exceptional cultural and linguistic diversity (800 different languages) is also reflected in the remarkable complexity of PNG’s malaria epidemiology. While malaria is endemic throughout most parts of the country, transmission intensities, vector and parasite species composition and morbidity patterns vary on different levels.

Since 2004, the malaria control efforts have been intensified with the financial support from the Global Fund. This includes the continuous free provision of long-lasting insecticide treated nets (LLIN) and the introduction of artemisinin-based combination therapy as first-line treatment. Household surveys conducted by the PNGIMR in 2009 and 2011 indicated an increase in ownership and use of LLIN from 65% to 82% and from 33% to 48%, respectively. In parallel, an increase in the use of appropriate antimalarial treatment, from approximately 5% in 2009 to approximately 40% at the end of 2012 was found.

In terms of impact, over the past decade PNG has seen declines in malaria prevalence, cases, and deaths. Between 2009 and 2012, the National Health Information System (NHIS) reported a 39% reduction in the number of reported malaria cases, a 60% reduction in malaria admissions, and a 50% reduction in reported malaria deaths. While the exact figures should be interpreted with caution due to ongoing inconsistencies and changes in the way data is reported, a significant decline was also observed in population surveys of parasitaemia. These achievements were highlighted in the 2012 World Malaria Report as a success story for scale-up of LLIN coverage and associated declines in parasitaemia.

Despite this progress, PNG continues to report the highest number of cases in the WHO Western Pacific Region. Particular challenges relate to outdoor biting mosquitoes, shifts in peak mosquito biting times, the treatment of P. vivax hypnozoites and operational challenges to the sustained implementation of malaria control interventions. Already in 2011, the World Bank has warned of an emerging human resource crisis in the PNG health workforce with critical staff shortages exacerbated by migration of qualified staff to other countries. Within

World Bank, PNG Health Workforce Crisis: A call to action. Port Moresby, 2011
PNG, skilled professionals are often attracted to Port Moresby and other urban areas, or away from the public sector to private enterprises offering better employment conditions. In recent years, severe fiscal constraints required a moratorium on hiring new staff across the public sector, including NDOH, imposed by the Public Service Commission.

2. Community Consultation Visit to East New Britain Province

A site visit to East New Britain (ENB) Province took place prior to the national-level meeting.

ENB is one of 22 provinces of PNG, occupying the eastern half of the island of New Britain. Administratively, the province is divided into four districts (Gazelle, Kokopo, Pomio, Rabaul), each of which comprises several Local Level Government (LLG) areas, which are again divided into wards. Since the destruction of most of Rabaul town by a volcanic eruption in 1994, Kokopo is the province’s new capital. The population of ENB is approximately 330,000⁴.

ENB is PNG’s leading cocoa and copra producer (80% from smallholders)⁵, while oil palm plantations are increasingly gaining importance. Much of the province, particularly the rugged central mountain range, remains covered with tropical rain forest. The more densely populated areas are connected by a well-developed and maintained road network. Colonial and World War 2 history, cultural and diving activities, as well as the active Tavurvur volcano consistently attract a small number of tourists.

The Islands Region, to which ENB belongs, continues to exhibit high levels of malaria transmission. The most recent malaria prevalence survey undertaken by PNGIMR in 2010/11 found a high population prevalence of both *P. falciparum* and *P. vivax* malaria in the Islands Region⁶. In Rabaul and Gazelle Districts of ENB, Burnet Institute (BI) is implementing a Home-Based Management of Malaria (HMM) program under the auspices of PSI. The HMM project in ENB and in two other provinces (in which it is implemented by different partners) is funded by a Global Fund Round 8 grant through the Principal Recipient PSI. An expansion to Kokopo District is currently in planning. Much of the discussions was therefore centred around the HMM concept and its application in ENB.

Discussions took place with key stakeholders of the provincial government and with health workers and community leaders from an area covered by the HMM program. In total, 24 people participated in key informant interviews and focus group discussions (participants list in annex):

**Key informants:**
- Provincial Health Advisor
- Provincial Forestry Officer (acting advisor, Department of Primary Industries)
- Central Gazelle LLG Council President (elected leader)

**Focus group discussions in Gelegele, Kombiu LLG, Rabaul District, included:**
- 6 Staff of Gelegele Health Centre
- 8 Community Based Distributors (CBD) of HBMM program
- 2 Local ward councilors of HMM program area
- 5 ENB division of health and Burnet Institute staff

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⁴ National Census 2011.
⁵ http://www.eastnewbritain.gov.pg/
2.2 Community Consultation Objectives

The main objectives of the community level consultation were to:

- Gain a first-hand understanding of community level priorities and the perception of malaria as a problem
- Better understand the impact of malaria in the context of household vulnerabilities and learn more about family coping strategies
- Create a shared understanding of the contribution of HMM and health care workers to basic health service provision, particularly in the fight against malaria
- Find ways to support HMM / community development workers to play their role more effectively
- Use malaria as an entry point to gain insights on ways to strengthen governance and accountability for the consequences of non-availability of services
- Enable community level stakeholders to set the agenda for the next iteration of the Global Malaria Action Plan

2.3 Summary of key themes emerging from the discussions in East New Britain and implications for AIM

Malaria was recognised a major (but not the only) health problem in the province by government officials, health workers and community members.

Program implementation faces challenges related to human capacity at the implementation level, which is the district. While funding is directed to the district level, human resources and expertise are concentrated at a provincial level. A certain disconnect between these levels may at times hinder program implementation.

Leadership at district level and below is crucial for multi-stakeholder programs. Otherwise, community members may be confused by different partners working in the same field but under no obvious joint umbrella. This challenge applied to the implementation of the HMM program, which required significant advocacy input to gain the trust of community members towards the community-based distributors (CBD, HMM volunteers). In ENB, the HMM program appeared to be implemented as a BI/PSI program rather than a component of the NMCP and the link to the national malaria control efforts may consequently not be apparent to the community (despite the program being funding through the Global Fund grant).

The HMM implementation site visited by the consultation team (Gelegele) is in an area of ENB well connected by roads. The HMM scheme implemented there is now being considered by community representatives and by the consulted government officials to be a useful way of bringing specific health services closer to the community. One of the direct results of the program is a reduction in the workload in the health centre, which employs eight staff members. In order to integrate the HMM program better, one CBD is based at the Gelegele HC every week performing RDT testing and treatment of all suspected malaria patients. While this helped increase acceptability of CBDs in the community, it also deprives community members of any choice from whom to seek treatment. While this was explicitly mentioned as one of the aims of the approach, questions arose as to why the HMM program was being implemented in a well-connected area as this was in contrast to the principal aim of reaching under-served populations. The reason for this situation seems to be the pilot-character of the program and the reliance on a pre-existing network of community workers from a prior project (by Burnet Institute).

At a provincial level, the importance of partners was clearly acknowledged, including current partners such as RAM, PSI, BI and IMR, as well as the potential of non-health stakeholders. However, a need for better partner coordination was expressed and a stakeholder forum may be initiated in the near future by the provincial health office. Having partners located physically under one roof facilitated the collaboration, as exemplified in the collaboration between the provincial health office and BI.
Beyond the HMM, community involvement was considered to have a great potential but it seemed unclear how best to engage communities. Sustainability of volunteer-based programs was clearly a concern and political leadership would be required to make local resources available to sustain such initiatives, including the HMM program. An encouraging example was one LLG which adopted the HMM program as an LLG activity in order to source funding through government channels. At provincial level, an oversight position should ensure sustainability and integration of outreach/community-based programs into the provincial health system. Previous programs had no lasting effect as they were not integrated in the system.

At the level of the ENB Division of Forestry, a clear potential for collaboration was recognised. HIV/AIDS was cited as a topic often integrated into agricultural development projects, but not malaria. Initiatives for collaboration by the provincial health office and guidance from a central level could initiate result in fruitful complementary activities. Uncertainties exist relating to both the “what” and “how” of a collaboration. In general, it was expressed by provincial government officials that guidance on malaria control measures beyond the distribution of LLIN and the treatment of cases was lacking and would be appreciated if not urgently required to increase impact. This would potentially be highly relevant for a partnership with the agricultural sector (vector control, source reduction, environmental management).

There are currently two new oil palm development projects in the province, which are followed by an environmental but not a health impact assessment. This would be a further opportunity for multisectoral collaboration but requires one partner to take the lead and the industry to acknowledge the relevance and benefit of such assessments. The Private Industry Malaria Initiative (PIMI) may be an avenue through which such collaborations could be initiated.

- **Implications for AIM:**
  - Guidance on the potential role of different types of partners (education, agriculture, community development) in malaria control could facilitate the initiation of partnerships at provincial level.
  - Mechanisms for using limited technical expertise and implementation capacity at central level to implement programs at peripheral level should be discussed.
  - The role of volunteers in contributing to the fight against of malaria needs to be discussed, particularly models for long-term financing, transferring of ownership to lower implementation levels and integration into government funding and supervision/support systems. Mechanisms at government level for coordinating different community activities implemented by diverse partners should be discussed.

3. **Overview of the consultative meeting at national level in Port Moresby**

In total, 21 representatives of malaria stakeholders attended the meeting at national level in Port Moresby on 29 July 2014 (participants list in annex). This included representatives of all partners implementing the current NMCP and extended to NGOs, a nursing school and the private sector.

3.2 **Objectives of the national level consultative meeting**

The main objectives of all consultative meetings were to:

- Help set the agenda for the next iteration of the second generation Global Malaria Action Plan “Action and Investment to defeat Malaria (AIM)” – “a PNG-voice”.

"Community-based projects that are not integrated and linked to the government system are like a seed that falls on a rock – and then dies."

Provincial government official
• Create a shared understanding of the current status of the country’s response to malaria
• Identify high priority actions in the fight against malaria (focus on how to)
• Identify areas where the AIM could usefully provide guidance to accelerate action
• Network, build relationships, and identify new opportunities for partnership

3.3 Key national opportunities and challenges prioritized for discussion

During the meeting in Port Moresby, participants were presented key outcomes of the Western Pacific and South East Asia regional consultations, key points emerging from the community consultation in ENB, as well as key findings from a survey with community leaders conducted by PNG IMR in 2010/11. On this basis, the meeting participants discussed priority issues relevant for the implementation of malaria control in PNG with a focus on intensifying current efforts.

Dr. Manuel Hetzel put the AIM and Global Technical Strategy in the context of the recently launched PNG National Malaria Strategic Plan (NMSP) 2014-2018. The vision of the plan is the elimination of malaria from PNG in the long term (from 2025 onwards). The plan includes the expansion of public-private partnerships and strengthening of advocacy, communication and social mobilization. As such, the NMSP is already well aligned with some of the envisaged key priorities of the AIM. With its long-term vision, the NMSP 2014-2018 takes into consideration the extraordinary challenges of the PNG implementation environment.

The following key priority issues were then identified for further discussion:

1) Opportunity to achieve greater community involvement: It was generally acknowledged that communities could and should play a stronger role in sustaining malaria control efforts.

2) Challenges to build partnerships and put multisectoral partnerships into action: The benefits of partnerships with actors from non-health sectors was recognised by all participants but questions arose around how to initiate, implement and sustain successful partnerships.

3) Challenge to use donor driven funding model to create a sustainable country program: The heavy dependence on few major donors and the conditions linked to donor support was seen as challenge to a holistic approach to malaria control.

3.4 Summary of key points emerging from the consultative meeting

Meeting participants worked in three multi-constituency groups, each one discussing one of the identified key priorities. The discussions focused on what was currently being done from their viewpoint and how well it was working. The groups then proceeded to prioritise actions to enable them to move forward on the particular topic. The minutes of the group discussions are provided in the annex, while a summary of key points emerging from the discussions is provided below.

Considering the PNG-context: The National Department of Health and other NMCP implementing partners think that outside collaborators and donor representatives often lack understanding and do not appreciate of the particularities of the PNG context. Particular
points of concern are the distinct epidemiological situation (e.g. Highlands, which can see transmission prompted by movement of people between low-lying valleys and high-altitude villages), the logistics problems faced by any outreach program (particularly the high costs for transport and accommodation, unreliability of infrastructure), the unpredictable security situation, the general modus operandi of the government, difficulties resulting from the degree of decentralization, etc.

A general expectation was that AIM could incorporate an acknowledgement of such special situations and of the need for funders and implementers to consider them in program planning and evaluation. This could help stakeholders from PNG and other complex implementation environments in their negotiations with funding agencies and development partners.

It was felt that at present, the country was not in a position to shape donor expectations in a mutually agreeable manner. There seems to be an absence of an ‘empowerment’ mechanisms which would allow flexibility in the contracting process. It was proposed that an empowerment mechanism, such as a global advocate representing PNG’s interest be created for this purpose. External guidance on this would be appreciated. The national expertise represented by the Malaria Technical Working Group should be better supported.

Community involvement through Healthy Village concept and Village Health Volunteers: A general appreciation for stronger involvement of communities was expressed by many participants. The Healthy Islands concept, which is a holistic approach to improving health, development and well-being of people at a village level⁷, was repeatedly brought up as an approach worth considering for promoting community engagement in malaria control. The concept had been introduced in PNG but not been vigorously promoted. Nevertheless, it was seen as a promising contribution to malaria control and elimination efforts through measures directed at general community development including specific health promoting measures. A high level of participation from communities and their leaders would be required as well as technical assistance and incentives from the Government.

It was expressed that measures aimed at improving household economics in general would also contribute to reduction in health problems. The involvement of community members in carrying out specific malaria control tasks (e.g. vector control activities) was discussed as a way of sustaining activities. However, guidance on the best way to involve communities in routine malaria control would be helpful.

Village Health Volunteers (VHV) could be made a key vehicle to bring malaria control activities into the communities. However, VHVs would have to be linked to the government grant systems. Equally important would be a good partnership among key stakeholders involved in VHV programs in order to ensure integration of the VHVs into the overall program. Political support and ownership at provincial and district levels would be crucial.

Supporting and strengthening existing systems and activities: It was discussed that existing structures should be better used for program implementation. This would include the network of (partly dysfunctional) aid posts. It was considered a challenge that the major donor to the program (Global Fund) would be unlikely to support such structures. There was some hope that AIM could advocate for donors to embrace system-wide approaches in their funding models, if requested by a country.

A key concern by NDOH participants was the question whether the current funding for malaria control had helped the country establish a sustainable structure and mechanisms which could be maintained despite decrease in funding from the current main donor. The current heavy dependence on a single major donor (Global Fund) was another concern raised. With little (explored or existing) donor options, the country was seen at the mercy of the directions from a single donor with little bargaining power. This situation was seen as highly dissatisfactory.

In this context, discussions with key NMCP partners also revealed major concerns related to recent initiatives by overseas partners to push for sub-national malaria elimination on selected islands (Manus, Bougainville, Lihir). The major worry was the diversion of both attention and funding (e.g. Australian Aid) from the main national control program to costly and highly focused elimination efforts. It was generally considered more important to invest particularly development assistant funds to “get the basics right” rather than to showcase the possibility of sub-national elimination. The latter was considered unsustainable if simultaneous to sub-national elimination efforts, funding was diverted away from key NMCP activities resulting in a deterioration of nation-wide control efforts.

**Financing and sustainability of community programs:** Key discussions on community involvement centred on financing of village-based volunteer workers and sustainability of such programs. It was noted that integration into a government structure and oversight by the provincial government would be vital for sustainability. The HMM program was acknowledged as a valuable program.

Guidance from national level on the implementation of community-based activities as well as partnership with non-health actors and the private sector was considered to be crucial. While provincial governments were considered to be responsible for initiating and implementing partnerships for specific program implementation, it was expected that NDOH would provide guidance on what role could be taken on by which partners.

**Building and operationalizing multisectoral partnerships:** Private sector partners would be willing to collaborate with the public sector and that existing opportunities had not yet been fully exploited. It was considered essential, particularly (but not only) by public sector participants, that government would take on a leadership role in PPPs.

Similarly, the potential for involving non-health government departments, such as education or agriculture, was clearly acknowledged. Again, it would require NDOH to take a lead in initiating such partnerships. An assessment of the potential contributions of partners would be very useful.

Guidance to provinces and lower level implementers was also considered important to intensify malaria control to include activities not currently implemented as part of the NMCP. For example technical guidance on and technical assistance for the implementation of complementary vector control interventions (source reduction, environmental management), awareness and education programs would be useful. This would be of particular importance in the context of partnerships with non-health stakeholders.

A challenge might be how to avoid diverting attention from essential key interventions (LLIN, ACT, diagnostics) when introducing complementary measures. Guidance on how, when and where to introduce complementary measures, would be useful.

In order for NDOH to take on a leadership role in multisectoral partnerships, the malaria program should work closely with the recently established PPP office in the Policy & Planning division of NDOH. More allocated time and dedication would be required at the level of the malaria program office of NDOH; a dedicated position should be created if possible. A good coordination between policy and technical levels would be a basis for any multisectoral partnerships.

**Donor requirements:** NMCP implementing partners expressed that the over-burdening of the national level program staff was a limiting factor to exploring and initiating additional partnerships and activities. A major concern was the burden of donor requirements. At the time of this consultation, the national program staff was heavily absorbed in the numerous revisions of the concept note to the Global Fund.
Implications for AIM:

- AIM should help countries in negotiations with funding agencies and developing partners. This is particularly important for small countries with difficult environments and lacking global advocacy power. AIM could provide guidance on how countries can utilize local expertise in negotiations with donors.
- Provide guidance on how malaria control can be integrated in broader community development initiatives.
- Emphasize on the integration of malaria control in existing systems and acknowledge that this may require adaptation of the global standards of “what” and “how” to the local implementation context.
- Provide guidance on incentive mechanisms for community-based activities and explain the economic and social benefit of investing in community-based approaches. Discuss the danger of over-burdening communities.
- Provide guidance on governance mechanisms for multisectoral partnerships and guidance or best-practice examples of what contributions could be most useful from which type of non-health partner.
- Discuss the importance of long-term sustainability of programs and the benefit of long-term funding commitments to maintain all core activities.

4. Assessment of the success of the consultative process

The country consultation brought together two small but very interactive groups during the two consultative meetings. In ENB, 50% of the participants in focus group discussions were community members, the majority being female. The national level meeting in Port Moresby included 21 participants (see chart). The meeting reached out to a number of participants not normally involved in the implementation of the NMCP.

The outcomes of the community consultation in ENB Province provided a good basis for the meeting in Port Moresby; all key issues raised in the province were taken up during discussions at the national level meeting.

The funding available limited the participation of a larger number of stakeholders from around the country due to the high local travel and accommodation costs.

The absence of several invitees from the non-health sector can be seen as a reflection of non-health actors unawareness of their potential roles in a partnership to fight malaria. It may also in part be explained by the rather short notice given for the consultation and the numerous other activities going on almost simultaneously, including the visit of Global Fund representatives in the frame of the concept note development.

While there was no formal evaluation of the country consultation, participants expressed their satisfaction with the participatory approach. In particular, it was noted during the meeting in Port Moresby that the event had prompted key implementing partners of the national malaria control program to think more about the possibility of engaging in multisectoral partnerships.

As an immediate consequence of the consultation, meetings were arranged between a private pharmacy retail chain (City Pharmacy) and NMCP stakeholders, resulting in a joint action plan to increase awareness of malaria guidelines among pharmacists, and corporate as well as private clients. Furthermore, discussions were initiated with the Private Industry Malaria Initiative on best ways the industry could support the NMCP efforts.
5. Conclusion and Recommendations

Overall, the PNG country consultation went very well, with participants actively engaging in all discussions. It was particularly appreciated by meeting participants that this consultation reached out to countries outside of Africa. The high costs of transport and accommodation and the number of other ongoing activities limited the number of participants from outside of Port Moresby.

PSI (and Burnet Institute for ENB) providing administrative and logistical support made it possible to organise the meeting with relatively short notice. However, the support from the malaria program of NDOH was crucial to ensure good attendance from public servants.

The objectives of the consultation were all met. There is a clear expectation from PNG stakeholders that the key findings of the consultation will be reflected in the AIM document.
Annex 1: Meeting Minutes, Community Engagement Visit in East New Britain Province
Kokopo and Gelegele, Friday, 25 July 2014

1. **Consultation Team**
The consultation team travelling to East New Britain consisted of:
- Dr. Manuel Hetzel, Swiss TPH / RBM Consultant
- Mr. Steven Paniu, Technical Advisor Malaria/VBD, National Department of Health (NDOH)
- Mr. Blacklock Sine, Malaria Program Manager, Population Services International (PSI) – PNG

On the ground, the team was assisted by:
- Mrs. Geraldine Wambo, Project Manager, Burnet Institute
- And several project staff.

The logistics for the field visit were facilitated by Burnet Institute and PSI.

2. **Place of visit**
- Kokopo (Since the destruction of Rabaul by volcanic eruption the provincial capital and home to the provincial administration)
  - Mr. Nicolas Larme, Provincial Health Advisor
  - Mrs. Florence Paisparea, Provincial Forestry Officer (acting Advisor, Division of Primary Industries, Livestock and Agriculture)
  - Mrs. Elizabeth Malori, Central Gazelle LLG Council President (elected leader)
- Gelegele in Kombiu Local Level Government (LLG) area, Rabaul District
  - Staff of Gelegele Health Centre
  - Community Based Distributors (CBD) of HBMM program
  - Local village leaders of HBMM program area
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<th>Summary of key points emerging from the discussion with the Provincial Health Advisor:</th>
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<td>Malaria is considered No. 1 priority in ENB, followed by TB, immunization. Human resource constraints are an important challenge to fighting malaria and other health problems / delivering health services.</td>
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<td>Sees the economic impact of malaria at the household level, including indirect impact on food security.</td>
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<td>Strong focus on HIV may have diverted attention from malaria in the past.</td>
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<td>Currently, the fight against malaria in the province focuses on a curative rather than a comprehensive public health approach.</td>
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<td>NHIS data should be reviewed more timely at a provincial level and used for immediate program planning.</td>
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<td>Questions what complementary malaria control measures could be rolled out in addition to what is done through the NMCP at the moment.</td>
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<td>Suggests a stakeholder forum to bring all provincial program implementation partners together; this is currently not in existence. Stresses importance of having implementing partners physically under one roof to improve collaboration. Important to include IMR, Rotarians Against malaria and other national level partners in collaborations.</td>
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<td>Malaria can learn from HIV/AIDS in terms of multisectoral approach.</td>
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<td>Program currently focuses on health partners. There is a need to extend to other partners as well, eg. Dept. of Education, Agriculture (DPI), Commerce. DPI has outreach activities.</td>
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<td>National Program / NDOH should develop proper protocol/guidelines for effective partnership coordination for provinces to use as a guide. Important to define the role of each partner well.</td>
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<td>How can we mainstream and realign some of the malaria control strategies into their programs?</td>
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<td>Strong partnership at the provincial level for home management of malaria (HMM) but feels that it is still not translating into sufficient impact in the reduction of malaria incidence.</td>
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<td>Advocacy of program partnerships/collaborations is necessary at the district level, where implementation happens. Important to see individual partners/programs as being part of the overall NMCP.</td>
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<td>CBDs doing HMM need proper certifications and their roles should extend beyond curative to preventative activities.</td>
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<td>To be sustainable, HMM should become part of the provincial program; this requires integration into the structure, particular oversight.</td>
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Visit to ENB Provincial Division of Primary Industries (Agriculture and Livestock)
Mrs. Florence Paisparea, Provincial Forestry Officer (acting Advisor, DPI)
25.07.2014, Provincial Health Office, Kokopo

Summary of key points emerging from the discussion with the Provincial Forestry Officer:
- Considers that agricultural industries may contribute to malaria risk through standing water bodies
- No collaboration with malaria control program in the past at the provincial level. Only health program is HIV/AIDS with their advocacy program.
- Suggests that malaria control activities could be fit into DPI agenda; for example improved farming methods, drainage systems, etc. to reduce breeding sites
- Health department or provincial health office (PHO) to advocate to the other partners in the province.
- PHO needs to make a submission to the PCMC meeting at the provincial level. This is an ideal forum to advocate to the different partners/stakeholders at the provincial level. Another forum that PHO can utilize to advocate to non-health stakeholders is the Provincial Executive Council.
- DPI is open to collaborate with the malaria program, for example on:
  - Insecticide (IRS) intervention etc.
  - Climate change and VBDs
  - Link of livestock/animal husbandry, malaria vector breeding sites (consider collaboration with National Agriculture Quarantine and Inspection Authority NAQIA)
  - Health Impact Assessments/evaluation on new Oil Palm Planation projects (currently two new developments in ENB province; plots of 500 hectares cleared, then planted, before next 500ha cleared).

Visit to Mrs. Elizabeth Malori, Central Gazelle Local Level Government (LLG) Council President
25.07.2014, Provincial Health Office, Kokopo

Summary of key points emerging from the discussion with Mrs. Malori:
- Considers malaria a priority to address. Has noticed reduction in malaria cases in the ward in which HMM was piloted. Is considering enabling the extension of the HMM program to other wards in her LLG.
- Acknowledges the benefits of the program in her community and wants to support the program by providing incentives to the CBDS, including:
  - Working with DPI and NARI to provide piglets, chicken to be raised and farming for the CBDS.
  - Building semi-permanent buildings for the CBDS to use as their “treatment house”. CBDS want a place to test/treat patients that is not their own home.
  - Include CBDS on government funding. More political commitment from the LLG for the sustainability of the program.
- Plans to approach NARI, OFARA (food security program) to come on board the HMM program as well and to use some of their programs as a source of incentive for the CBDS.
- Other areas including adult literacy program and to integrate into malaria advocacy program and tie it into the HMM programs
- Suggestion of using PEC meeting at the provincial level to showcase the HMM program to other LLG President in the province.
- Important to increase awareness of CBD work at the district level. Awareness should be done by ward members/councillors
- CBDS should be an extension of the nearest HF outreach program.
- Needs coordination and support from the PHO and the partners to assist the CBDS and the HMM programs.
Focus Group Discussions in Gelegele, Kombiu LLG area, Rabaul District
25.07.2014

A site visit was done to Gelegele, an area in which the HMM program is being implemented by Burnet Institute under the supervision of PSI, with Community Based Distributors providing malaria testing and treatment services in the community. Many of the discussions focused on this HMM program.

a) Staff of Gelegele Health Centre (M. Hetzel)

Gelegele Health Centre staff consider malaria to be an ongoing major health issue and expressed general appreciation for the HMM program to be implemented within their catchment area.

They particularly appreciate the reduction of their work load as malaria diagnosis and treatment has been taken over by HMM CBDs. Particularly cases occurring after hours would now be taken care of by CBDs. Only malaria-negative fever cases, or those with danger signs, are referred to health facility staff. Health workers received (refresher) training on the use of RDT and ACT together with the CBDs, which was considered useful.

Initial reluctance of community members to seek help from CBDs was addressed by increased awareness activities. Every week, one CBD (on rotation) is based at the health centre, testing and treating all malaria cases. This way, the CBDs are recognized as part of the system. Health workers also expressed that this was a good approach to make it impossible for community members to avoid the CBDs. The general stand of health workers was that they should now not have to worry about malaria any longer, as this would be taken care of by CBDs.

Health workers expressed some concern as to the training and certification status of CBDs. They felt that it was very important for CBDs to be officially certified and to receive adequate training in biosafety as they were handling human blood. It was also felt that CBDs should have clearly defined tasks and they have to limit themselves to these tasks. They should not be seen as treating illnesses other than malaria. Adequate training and refresher courses were considered important to make CBDs feel comfortable in their role. For the same reason, community awareness activities were considered crucial, so that community members would understand that CBDs were qualified to provide malaria services.

Gelegele Health Centre was currently serving outpatients only, as the eight employed health centre staff were not sufficient and not specialized to provide inpatient and specialized services. The health centre was renovated and extended several years ago, including inpatient and maternity wards; however, these had not been operational since.

Health workers reported to be doing outreach activities, including MCH, school medicals, supervisory visits, follow-ups on TB and HIV cases. The recognized this also as an opportunity to talk more about malaria.

In the area of Gelegele, LLIN had been distributed by RAM, but not sufficient nets were provided, according to health centre staff. The health centre also provides LLINs to pregnant mothers during their first ANC visit. CBDs were considered a good vehicle to spread messages on malaria prevention and on the importance of compliance.
b) Community Based Distributors (CBD) of HBMM program (S. Paniu)

1. What are the most pressing concerns/priority issues in this village?
   - Law and order in the community
   - Poverty; unemployment; lack of farming /gardening land (Gelegele is a re-settlement area for people affected by the volcano eruption 1994 in Rabaul).
   - Poor living conditions, no proper housing and overcrowding in many families.
   - No proper water source and poor sanitations; swampy areas

2. What are the implications of the mentioned problems for families? How do households try and cope with the problems?
   - Church Groups, (Seventh Day Adventist, Catholic, United are the major Christian denominations in the area)
   - LLG members
   - Most of the times are the family themselves through selling food etc.

3. How much of a concern is malaria for families in this village?
   - Main issue is still malaria; there are still a lot of cases. Gelegele health centre is not fully operational: offering outpatient services only; admissions, MCH, dental services dysfunctional due to no staffing)

4. What actions are ongoing at community level to provide basic services, build a safety net to stop households falling further into poverty and to fight malaria?
   - None

5. Which other people or organizations support you in this work? If so, how and how could they support you more effectively?
   - Apart from RAM, PSI and LLG, there is none. There is a new fisheries project just started by Fisheries Department.

6. If someone here falls sick what are the possibilities to get help quickly?
   - CBDs (HMM program)
   - Transport to nearest HF (Church Car/private car)
   - Bush doctor
   - Hire HF ambulance

7. What needs to happen to increase access to basic services in this village?
   - Make Gelegele health centre functional
   - Provide staffing for specialized inpatient services (STI, VCT, Dental)

8. What role do you expect your local politicians and village leaders to play? What further steps could you take as a community? What would need to happen to be able to take those steps?
   - Political leaders not interacting with the community to identify social issues affecting the community.
   - Ward Members not transparent, no feedback from council and community meetings.

9. Are you consulted by ward/district concilors when they undertake their planning for eg. community development, health etc? How extensively are community representatives involved in the governance of nearby health facilities, schools and other public institutions?
   - Yes, but no proper feedback from the council/ward members
   - Meetings every Wednesday; a lot of community issues raised to the attention of the political leaders; however, no proper feedback.

10. Do you think sufficient resources are allocated to tackling community concerns? Where would you like to see more ‘investment’ (of attention, funds and other resources)?
    - No, been neglected by the Governor/political leaders on most social issues in their
community.

- Investment should be placed into health and social issues, housing, sanitation, water supply etc.

11. Do you have any lessons learned on any aspects discussed (positive or negative) that could be shared with other villages or communities?

- Positive
  - Job satisfaction of CBDs; opportunity to be trained.
  - CBDs well acknowledged by the community

- Areas that needs improvements
  - Provide sanitation/sterile consumable to the CBDs
  - Rubbish bin, gloves
  - Working furniture: tables, chairs, basic lighting, (lamp etc.)

c) Local village leaders of HBMM program area (B. Sine)

1. What are the most pressing concerns/priority issues in this village?

   The most pressing issues at the moment is population increase due to resettlement. The population in Gelegele is originally from Rabaul, which was destroyed by the volcano eruption. People were relocated here and the land is getting scarcer when more people arrive in the coming years.

   - There is water in the ground making impossible for us to make gardens and other productive sustainable living.
   - Population increases and land mass decreases.
   - Basically, it’s about daily sustenance which is challenging every day.

2. What are the implications of the mentioned problems for families? How do households try and cope with the problems?

   Economic pressure on daily livelihoods is challenging; facing some level of poverty in the community. People are in the process of going back to their original land to plant cocoa and copra; DPI (Department of Primary Industry) had provided some cocoa seedlings to start the process. Beginning 2012, people have been travelling back and forth from their original land to start agricultural activities with support from the Government.

3. How much of a concern is malaria for families in this village?

   Malaria is a big problem here because of stagnant water where mosquitoes breed. Malaria is one of the leading causes of illness in the area. When there is rain, there are many people who are affected by malaria.

4. What actions are ongoing at community level to provide basic services, build a safety net to stop households falling further into poverty and to fight malaria?

   Ward members do community awareness to dig holes and drain stagnant waters. Also mobilise community to cut grasses and other minor activities to prevent mosquito breeding sites.

5. Which other people or organizations support you in this work? If so, how and how could they support you more effectively?

   Community based Distributors trained by PSI and Burnet Institute helping those who are sick; Rotarians Against Malaria with PHO distributing mosquito nets. Provincial Health promised to build kit toilets. This is still ongoing, depending on the Government.
6. If someone here falls sick what are the possibilities to get help quickly?
Estimated that about 50% go to the health facility, 30% resort to herbs, traditional medicine or witch doctor, while others go to a CBD, buy medicine at Chinese stores, pharmacy etc.

7. What needs to happen to increase access to basic services in this village?
Local ward members have plans to build a big hall to incorporate those practising medicine at the community levels to practise in these common community hall. The hall should incorporate CBD, TB DOTS, women and children health etc. These different practitioners should provide access to health services at the ward level. CBD also do community engagement activities; awareness on malaria and other staff which is very helpful in the community. Also planning to upgrade the main health centre to maintain its status so that it provides efficient service to the community. Ward members consider this to provide better access to the community – even though it is unclear how this would relate to the existing health infrastructure. All plans are still awaiting funding.

8. What role do you expect your local politicians and village leaders to play? What further steps could you take as a community? What would need to happen to be able to take those steps?
As the local politicians, they appreciate the work the CBDs are doing; there is understanding that community volunteers cannot continue to work free. Incentives are dependent on National Government to distribute funds. At a local level, community fundraising is being done. Australian Aid is supporting some community projects with NGOs.

9. Are you consulted by ward/district councilors when they undertake their planning for eg. community development, health etc? How extensively are community representatives involved in the governance of nearby health facilities, schools and other public institutions?
Ward members bring ward plans to the executive meetings that includes the LLG President. The LLG President then brings this up to the LLG meetings (full council- all Presidents); the main development agendas are brought forward to full council. However, this process is lengthy and can take up to a year or two depending on how Government is responding. The community reflects their needs to a person called ward committee. Ward members consider their communication and interactions to be well developed.

10. Do you think sufficient resources are allocated to tackling community concerns? Where would you like to see more ‘investment’ (of attention, funds and other resources)?
National Government is not distributing sufficient resources to tackle issues affecting the communities. Health should be a priority. Ward members believe that the District Office is not performing and they should be delivering services at the LLG level. They suggest to dismantle the District office and move all activities to the LLG levels.

11. Do you have any lessons learned on any aspects discussed (positive or negative) that could be shared with other villages or communities?
CBD are doing a fine job in the community. LLG (Ward Members) make commitments but depend on the funds allocated by the Government. Some LLGs have internal revenues which they can use to support their local volunteers; other LLGs (eg. Kombiu) does not have any internal revenues and hence depends entirely on the Government grants.
### Official welcome & opening remarks

**Topics & Discussion**
- Official welcome by Dr. Lucy John, Manager Disease Control & Surveillance, NDOH, on behalf of the Secretary of Health
- Welcome remarks by Mr. Leo Makita, Program Officer Malaria, NDOH
- Both express appreciation of country consultation and emphasize that this process should give PNG a voice in the development of AIM.

### Orientation to AIM (Dr. Manuel Hetzel)

**Topics & Discussion**
- Overview of the AIM Development Process
- Link to the Global Technical Strategy for Malaria
- Purpose & objectives of Country Consultation
  - Importance of raising key country priorities for incorporation in AIM document
  - Link to National malaria Strategic Plan 2014-18 which highlights many priority issues (what rather than how).
  - Selected key objectives are to expand PPPs for malaria control, to strengthen social mobilization, strengthen surveillance and program management capacity
  - Put into context of current “control” phase in PNG and reduced support from Global Fund.

### Presentation of key findings from WPRO Regional Consultation (Dr. Manuel Hetzel)

**Topics**
- Putting people (communities/civil society) at the centre is key for further progress
- Challenges to putting multisectoral action against malaria into practice
- Persistence of bottlenecks that hinder an efficient response
- Challenges to addressing malaria in mobile migrant populations
- Changes in development partners funding policies will lead to shortfalls in funding elimination of malaria

### Summary of findings from community engagement visit in ENB (Mr. Steven Paniu)

**Topics**
- Need for harmonization of activities within province, communication and advocacy between province and district/LLG/ward levels
- Bringing on board non-health partners: guidance is required.
- There may well be interest from non-health sectors (e.g. agriculture) to engage in malaria control
- Sustainability of short-term projects (such as HMM). Need for adequate resources (e.g. from LLG) and integration in provincial structure
- Guidance on (complementary) malaria control measures to be implemented at province level required
- Home management of malaria (HMM) program can reduce workload in health facilities but needs to be well integrated and awareness at community level is crucial
- HMM volunteers require incentives to be sustainable.
**Session topic & discussions**

**Summary of findings from PNG IMR village leader survey 2010/11 (Dr. Justin Pulford)**

**Topics**

- Majority of village leaders consider malaria a problem; in the lowland provinces, malaria is more often considered a priority issue.
- Few malaria-related community activities are ongoing, except distribution of mosquito nets. More is happening for other conditions, particularly HIV/AIDS.
- Most ongoing village activities relate to cleaning of the village environment.
- The Government should improve health services, implement malaria control measures, incl. mosquito nets, insecticide spraying and awareness activities.
- Communities themselves should maintain a clean and healthy environment, participate in health promoting activities, adopt healthy habits and use prevention and curative services provided.
- Community leaders should organize awareness and community services and organize assistance to tackle the community’s problems.

**Discussion regarding country-specific priorities** (Discussion moderated by Dr. Manuel Hetzel)

**Discussion**

Current challenges & opportunities identified for PNG (grouped by theme)

**Community involvement**

1. Reconsider malaria not as a clinical issue, but a development issue.
2. Importance to focus on families / households; importance for «ownership» of malaria control.
3. Challenge is how to get communities/villages/LLGs involved? Whom to engage can partly be a political issue.
4. NDOH requires active participation from provincial (health) offices to engage communities.
5. Identify what is already being done to control malaria at community level and then identify gaps where they could utilise existing programs/community initiatives rather than introduce all new ideas.
6. Opportunity to use/re-introduce Healthy Islands concept to promote malaria control.
7. Non-functional services at peripheral levels create demand-driven communities. This can make it easier to engage the community; can be used by malaria control program to roll-out interventions, but requires real community involvement.
8. Opportunity to involve schools in preventative and curative (T3) activities.
9. It is acknowledged that provinces need partners; health services not functioning in all areas.
10. Opportunity to work with the education sector to spread messages on malaria / ensure appropriate training of teachers & health workers on questions related to malaria.
11. Challenge to empower families and improve economic situation of households (money is key to everything).

**Special risk groups / additional control activities**

12. Human movements; village vs towns; people’s behaviours (pop. At special risk)
13. Challenge to reach remote populations, e.g. without road access, where most government services are dysfunctional. Why are HMM CBDs currently in health facilities? Inconsistent with original intention.
15. Consider the environment as source of malaria. How to incorporate environmental management into malaria control program especially in private sector development projects.
16. Opportunity to apply complementary malaria control measures beyond standard interventions by national program; but little guidance on who could do what and...
Session topic & discussions

**Partnerships / Coordination / Governance / Leadership at central level**

17. Involving partners is appropriate but what is the platform for involving partners? Must involve housing, agriculture & education.

18. There have been attempts to engage wider community/private sector in NMCP initiatives. Potential partners respond well to the idea of partnership, but uncertainty on how to form and conduct partnerships (both sides). Opportunities exit but haven’t been exploited well.

19. Need/opportunity to incorporate malaria into partners’ activities

20. Take a pro-active, holistic approach to initiate partnerships

21. Provincial health offices should initiate partnerships. Do they have the time and capacity?

22. Guidance on partnership needs to come from a central level: Opportunity through the PPP office in NDOH/Policy & Planning. It is often unclear what the potential of different partners is. Technical expertise should come from central level.

23. Challenge to identify partners and define their role within a partnership (particularly PPP)

24. General challenges of multisectoral approach

25. There is a need for local leadership to drive partnerships

26. Recognition of role of private pharmacies; challenge to provide guidelines to pharmacies

27. Coordination of different malaria initiatives, e.g. Manus/Bougainville, private sector (PIMI); need for good governance and clear leadership. MTWG should play this role

28. Rational use and quality of medicine: challenge of private industry health services not adhering to national treatment guidelines and ordering ineffective treatments

**Implementation capacity / Sustainability**

29. Dominance of one donor (GFATM), restrictions imposed by donor, little support for components not supported by GFATM; little bargaining power

30. Not sufficient complementary funding from Government

31. Burden of donor requirements to capacity of implementing partners

32. Ageing workforce; lack of manpower; Public service human resource may not improve for a long time, so need to use other existing resources, e.g. VHV’s, foster community engagement and empowerment.

33. HR issues at national/provincial level very different to district level issues. Implementation is at district level so there is a need for dedicated staff at that level. People in these roles are the least trained of all levels, so need to build district capacity.

34. Money is at district level, manpower at provincial level

35. Information systems: do we capture everyone? How do we measure malaria in people who get sick but don’t seek treatment?

36. Use of public service /public HR: do we make best use of their capacity?

37. Operation of peripheral health services is often difficult. Many remote facilities are not operational.

38. How to direct resources / capacities at lower levels?

39. Private industry has access to a range of technical experts. These could be used to support public initiatives.

40. Distinguish between ‘doing something’ and ‘doing something effectively’. A need for technical guidance.

41. Challenge to be inclusive in context of PNG; difficult to get everyone at the same time to the same place for example to discuss strategies
**Session topic & discussions**

**Identified three priority issues:**

1) Opportunity to achieve greater community involvement
2) Challenges to build partnerships and put multisectoral partnerships into action
3) Challenge to use donor driven funding model to create a sustainable country program

**Discussion of priority issues in three groups** (Facilitated by Mr. Blacklock Sine, Mr. Steven Paniu, Dr. Justin Pulford)

**Topics & Discussion**

- What are you currently doing to address this challenge or take advantage of this opportunity and how well is it working?
- Having heard what all stakeholders are doing about this issue, what future actions do you now see to be necessary for progress towards your malaria reduction or elimination goals?
- Looking across the list of actions identified, which ones can you (as a country) begin to take action on immediately with the resources you have available?
- Which actions would benefit from guidance, best practices, or other resources that could be included in AIM?

**Group 1: Opportunity to achieve greater community involvement** (B. Sine)

*What is currently being done:*

**Prevention:**

- Rotarians Against Malaria (RAM): LLIN distributions
  - Net use not always optimal
  - Distribution model should be more participatory
- Home Management of Malaria, Inter-personal communication
  - Equip HMM CBDs with IEC materials at community level
- Need to strengthen leadership at provincial and district levels
- IRS
  - Training of locals to spray (Industry)
  - Fogging (mainly done in NCD)
- IEC
  - Support school children with IEC materials
- Healthy Island Concept

**Curative:**

- HMM: community investment in CBD selection
- Haus Marasin
- Challenge: district/LLG support lacking; community participation

**ACT/RDT:**

- Availability of ACT/RDT in every health facility
- Capacity building
- Treatment compliance
- Quality Assurance

**Way forward:**

Use of ward members in the distribution of mosquito nets
IRS / vector control as activities with community participation
Healthy Islands concept
Home based management: needs political support for sustainability
Session topic & discussions

**Actions:**

- Use the Healthy Islands concept and integrate Malaria prevention
  - Currently a “sleeping” program, needs to be woken up.
  - Requires high level of community participation, including local politicians and community leaders
  - Assistance could be provided by the Government
- Coordination & leadership in program implementation: key stakeholders implementing programs, communities, local governments; program ownership
  - Involve all key stakeholders in implementing the program
  - Participation of other government departments, provincial governments and administrations
  - Share responsibilities and take ownership
  - This may benefit from external guidance.
- Strengthen Village Health Volunteer (VHV) concept
  - Make this a key vehicle to bring program into the communities
  - Link it to government grant systems
  - Establish partnership among key stakeholders for integration of activity
- Systems strengthening
  - capacity building of local staff
  - quality assurance
  - availability of treatment at community level

**Group 2: Challenges to build partnerships and put multisectoral partnerships into action (S. Paniu)**

- Identify partners that can make an impact
- Identification of what partners can contribute, e.g.
  - Awareness about existing guidelines
  - Implement policies of NDOH (components of National Strategic Plan)
- Establish long-term relationship

Need to identify key partners (non-exhaustive list):
- Global Fund, PIMI, PSI, RAM, Save the Children Fund

*Private sector:*
- Agri, Pharmaceutical distributors
- Private health service providers
- Retailers
- Banking & financial
- Communication / media
- Mining, oil & gas

*Public sector:*
- NDOH
- Educations
- Primary Industries (Agriculture & Livestock)
- Works
- Transport
- PNG water board

*Key donors:*
- Global Fund
**Session topic & discussions**

- **WHO**
- **USAID**
- **DFAT (Australia)**
- **BMGF**

**Academia:**
- All universities

**Civil Society:**
- Civil Society Groups
- Women groups
- Churches
- NGOs

**Opportunities identified for selection of key partners:**

**Private pharmacies:**
- Create more awareness at the private sector level
- Information & directives for sale of products need to come from NDOH
- Product registration

**Department of Primary Industries (Agriculture and Livestock):**
- Extension officers to advocate for vector control measures
- Awareness with key malaria messages
- Use of insecticides in agriculture

**Department of Education:**
- School Health Program
- Health classes
- Health masters
- Strengthen health curriculum
- Cleaning and eliminating breeding sites (schools and homes)
- Awareness programs through schools

**Faith-based organizations:**
- Awareness, sermons
- Community mobilization

**Actions:**

- What can be done immediately:
  - Implement policies
  - Clear guidance from NDOH
- Requires more allocated time and dedication from NDOH (PPP office at Policy & Planning, NDOH)

**Challenges / Barriers:**

- Requires specific people in country to facilitate partnerships: Time to dedicate to building partnerships and putting them into action
  - Opportunity to create a position dedicated to partnership
Session topic & discussions

- Coordination between technical and policy levels
- Recognition and prioritization of partnerships. What are potentials of different partners?
- > Experience from other countries with similar partnership
- > Make use of existing experience / expertise in-country

Group 3: Challenge to use donor driven funding model to create a sustainable country program (J. Pulford)

**Current activities:**

1. NMSP guides donor involvement.
2. Collective dialogue at country level.

However, the above is insufficient for country to shape donor expectations in a mutually agreeable manner. There currently seems to be an absence of ‘empowerment’ mechanisms to shape donor expectations (allow flexibility in the contracting process).

**Actions:**

So, what empowerment mechanisms could be created?

- To identify a global advocate(s) to represent PNGs interests with existing/potential donors (RBM support needed)
  - External guidance would be helpful
- Target a CCM member as a malaria champion (internal, TWG to lobby)
- Greater promotion of TWG to donors and international partners as a collective pool of expertise & experience
  - supported by quarterly technical meetings (internal)
- Strengthen NMCP gap analysis and actively lobby additional donor and government input (internal)
- Diversify donor and government input/contribution (internal).
### PNG Country Planning Committee & Consultant Team

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<th>Name</th>
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<tr>
<td>1</td>
<td>Manuel Hetzel</td>
<td>Swiss TPH</td>
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<td>2</td>
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<td>Dilnesash Defar</td>
<td>PSI PNG</td>
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### Community Consultation Visit in East New Britain Province (25.07.2014)

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<td>1</td>
<td>Nicholas Larme</td>
<td>ENB Division of Health</td>
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<td>2</td>
<td>Florence Paisparea</td>
<td>ENB Division of Primary Industries</td>
<td>Provincial Forestry Officer (acting Prov. Advisor DPI)</td>
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<td>3</td>
<td>Elizabeth Malori</td>
<td>Gazelle Central LLG</td>
<td>LLG Council President</td>
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<td>Sharon Turavai</td>
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<td>Lydia Tarum</td>
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<td>Hamilton Isimel</td>
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<td>Michaelyn Boboko</td>
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<td>Ronnie N. Mandarip</td>
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<td>Volly Gereson</td>
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<td>Joselyn Moses</td>
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<td>Terral Lavuvur</td>
<td>Matalau Ward</td>
<td>Ward Member/Councilor</td>
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<td>Andrew Garama</td>
<td>Nordup Ward</td>
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<td>21</td>
<td>Elsie Peneri</td>
<td>Burnet Institute</td>
<td>EHO</td>
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<td>Rebecca Gabong</td>
<td>Burnet Institute</td>
<td>CBD Supervisor</td>
</tr>
<tr>
<td>23</td>
<td>Sakora Luana</td>
<td>Burnet Institute</td>
<td>Field Monitor</td>
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<tr>
<td>24</td>
<td>Paula Tobang</td>
<td>Burnet Institute</td>
<td>CBD Supervisor</td>
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### National Level Meeting in Port Moresby (29.07.2014)

<table>
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<tr>
<th>No.</th>
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<th>Organization</th>
<th>Position</th>
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<tbody>
<tr>
<td>25</td>
<td>Pradeep Panda</td>
<td>CPL Group</td>
<td>Category Manager (Pharmacy)</td>
</tr>
<tr>
<td>26</td>
<td>Conrad Kambi</td>
<td>East Sepik Province Division of Health</td>
<td>Disease Control Officer</td>
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<tr>
<td>27</td>
<td>Saidi Lani</td>
<td>Goroka Nursing College</td>
<td>Acting Principal</td>
</tr>
<tr>
<td>28</td>
<td>Lucy John</td>
<td>National Department of Health (NDOH)</td>
<td>Manager Disease Control &amp; Surveillance</td>
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<td>29</td>
<td>Joel Kolam</td>
<td>National Department of Health (NDOH)</td>
<td>Environmental Health</td>
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<td>Leo Makita</td>
<td>National Department of Health (NDOH)</td>
<td>Program Officer Malaria</td>
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<tr>
<td>31</td>
<td>Anna Maalsen</td>
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<td>Public Health Management Adviser</td>
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<tr>
<td>32</td>
<td>Steven Paniu</td>
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<td>Technical Advisor Malaria</td>
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<td>Mary Yohogu</td>
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<tr>
<td>34</td>
<td>Marlene Be’eu Lohia</td>
<td>National Department of Health (NDOH), Pharmaceutical Services</td>
<td>Medicines Assessor</td>
</tr>
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<tr>
<td>John Gelua</td>
<td>Central Public Health Laboratory (CPHL)</td>
<td>OIC Malaria</td>
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<tr>
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<tr>
<td>Annette Coppola</td>
<td>OilSearch Health Foundation (OHSF)</td>
<td>M&amp;E Advisor</td>
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<tr>
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<td>Oro Province Division of Health</td>
<td>Provincial Health Advisor</td>
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<tr>
<td>Gordon Manub</td>
<td>PNG Industry Malaria Initiative (PIMI)</td>
<td>Deputy Project Director</td>
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</tr>
<tr>
<td>Justin Pulford</td>
<td>PNG Institute of Medical Research (IMR)</td>
<td>Head, Population Health &amp; Demography Unit</td>
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<tr>
<td>Carrie M. Gheen</td>
<td>PSI</td>
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<tr>
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<tr>
<td>Riven Johnston</td>
<td>Save the Children</td>
<td>Director PG</td>
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<tr>
<td>James Wangi</td>
<td>World Health Organization</td>
<td>NPO NTDs &amp; Malaria</td>
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</tbody>
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**Group Discussion on country-specific priorities during meeting in Port Moresby:**

(*moderator)

**Group 1: Opportunity to achieve greater community involvement**

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**Group 2: Challenges to build partnerships and put multisectoral partnerships into action**

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**Group 3: Challenge to use donor driven funding model to create a sustainable country program**

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Meeting participants, East New Britain

Meeting participants, Port Moresby