Australian Doctors International

Response to independent 2018-19 Evaluative Report of ADI Programs in Western Province, Papua New Guinea

May 2019

ADI welcomes the independent evaluation of its integrated primary health care patrols in under-serviced remote areas of Western Province, PNG and the supporting health worker capacity building that together constitute ADI's 'Strengthening Western Province Health Services' program.

The report and our responses to it, will make a significant contribution to improvement in our provision of primary health care services in rural and remote areas of PNG and is part of our own efforts towards continual improvement.

Whilst some small corrections of fact have been included in the Ms Kitchener's evaluation report as published, we thank her for her diligence in seeking and obtaining the information necessary to provide such a thorough assessment of our work in Western Province.

Specific follow-up responses to Ms Kitchener's evaluation report

Many of the recommendations provided by Ms Kitchener are already beginning to be addressed by ADI and others are will be considered in forward planning.

Addressing specific points raised, in the sequence in which they appear in the evaluation report, we offer the following comments.

Section 3b (ii) Tuberculosis

ADI will:

1. Consult with Dr Bernie Hudson, an ADI consultant and infectious diseases specialist with expertise in TB in PNG
2. Contact scientific staff from Burnet Institute, who have worked in the South Fly region with TB patients, particularly those with MDR-TB
3. Contact World Vision staff who are working in North Fly region with local staff, including Catholic Health staff, on community education relating to TB.

Section 3b (iv) Vaccinations

ADI is acutely aware that immunisations are specifically funded by the PNG NDoH to those that are responsible for Health Centres (in Western Province Government health services (Kiunga Hospital), Catholic Health and EC PNG, through the Rumginae Hospital). As the Provincial Health Authority in Western Province gains operational strength they should become a significant part of the provision of both drugs and vaccines for planned health patrols and vaccination schedules.

At the recent invitation of Australia's Department of Foreign Affairs & Trade (DFAT), ADI in partnership is seeking funds to conduct a 3-year 'catch-up' immunisation program across Western Province. Our outreach model provides the much needed mechanism in order to reach those communities yet to be immunized.

Section 3d. Focus on disability and Section 3e. Focus on gender equity

As reflected in ADI's policy and procedures manual and in briefings to field staff, ADI takes very seriously its commitment to inclusive provision of health care services to people in rural and remote areas who have a disability, as it does to enhancing gender equity both within teams providing services and more broadly.

These are matters explicitly included during the development of projects with in-country partners and increasingly they are monitored as part of our routine provision of services.

With regard to gender equity, ADI has consistently included family planning as part of its ongoing rural and remote health services where we can. In PNG, ADI has recently employed an in-country family planning expert to work towards ~~a~~ more comprehensive family planning strategies including 'birth-spacing' when appropriate, within the provinces in which we currently work and expanding to other provinces.
ADI has also included a local family violence professional on Western Province patrols and as part of future in-service training.

Section 3f. Organisational issues

ADI doctors on patrol consistently strive to provide advance notice of the arrival of each patrol so that best use can be made of patrol team staff and patients from outlying areas can come to the clinic provided. However, even in areas supported by funding partners such as Horizon Oil, communications rely heavily on the 'tok save' system which is often only partially successful due to technological and other constraints. This is a matter of ongoing challenge, which may be better addressed as telecommunications across the province improve.

<u>Lack of time to see all patients on patrols</u>

The majority of recommendations made by Ms Kitchener in relation to these challenges are very much part of ADI's core model. The one potential exception being the inclusion of medical students from Griffith University to support ADI doctors. The capacity of ADI doctors to provide appropriate supervision to students working in what are often challenging situations at inadequately maintained and equipped health centres and aid posts has to be balanced against the other demands on the doctor's time in such situations.

<u>Role of the ADI doctor whilst not on patrol</u>

Since 2001, ADI volunteer doctors have been instructed during induction and as part of their job description that when they were not on patrol they should work either at the Kiunga clinic (in the grounds of the Catholic Mission) or at Kiunga Hospital. On arrival, ADI doctors present to the Hospital Administrator as soon as possible and leave their mobile phone number so that they could be contacted in an emergency, when within mobile range.

Over the years, ADI doctors have provided hours of consultation, teaching and have assisted in complex surgical procedures at Kiunga Hospital saving many lives. This is a relationship that continues to strengthen over time.

<u>Delayed, cancelled or reduced quality of patrols</u>

As recorded in the independent evaluation, the reasons for delays and cancellations are numerous and varied.
ADI is currently negotiating with new partners and funding providers to expand the coverage of rural and remote patrols. However, the recommendation that reliance on government funding be reduced by ADI providing necessary funds to make a patrol happen requires careful balancing against the desire to ensure that our role is to enhance local capacity for health service provision of local organisations and their staff while delivering

public and primary health care into the district. ADI's role should not be to replace local responsibility of health service provision, but strive to make that happen under the partnership banner.

Inadequate facilities

ADI's experience in Western Province since 2001, suggests that those health centres and aid posts in poorest condition are likely government facilities.

While the inclusion of a carpenter and plumber in patrol teams is a useful recommendation, the size of each patrol is significantly limited by the costs and transport options available (often river boat or helicopter), with priority for ADI's patrol model being to include a diversity of ancillary health services, such as physiotherapy, ophthalmic services etc.

As partnerships with the emerging Provincial Health Authority are strengthened, it may be possible for ADI to work with Provincial Health to lead separate patrols to update and repair these facilities.

Lack of medication

ADI doctors, and in particular Dr Bruce Slonim, have had extensive consultations with DFAT over some time in relation to the medications distributed to health centres and aid posts in PNG. As part of ADI efforts to assist in advocating for improved supply of medications appropriate to rural and remote areas of Western Province, we will consult with Dr Slonim. Aside from the appropriateness of medications supplied, it is also of concern to ADI that it not become a substitute supplier for medications that should properly be the responsibility of PNG health services.

In the case of medications for TB and leprosy, these are only provided with confirmation of diagnosis by laboratory testing. They are supplied by the WHO in the National Department of Health (NDOH). ADI will liaise with Leprosy Mission Australia and Leprosy Mission PNG about ways of ensuring that the full 6 or 12 month supply can be obtained so that patients do not default or miss out due to lack of medication.

In the case of TB medications, the provincial government infectious diseases officer is responsible for the ordering and shipping of drugs from Port Moresby.

In summary

As stated at the beginning of this short response, ADI welcomes the evaluation report provided by Ms Kitchener and will generally use the recommendations contained within it to improve our programs in Western Province. The particular responses above are by way of clarification, or inclusion of additional perspectives in relation to some of the report's recommendations.