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The Country Cooperation Strategy (CCS) outlines the country’s strategy to improve the health and well-being of its population while contributing to the achievement of the Sustainable Development Goals over the next five years. It is responsive to the country’s needs and aligns with WHO’s mandate, core functions, global strategic objectives and regional strategies.

The CCS is the result of extensive collaboration and consultation with a wide range of stakeholders, including government agencies, other United Nations agencies, civil society organizations, faith-based organizations, development partners, multilateral and bilateral partners, and the private sector. The success of this CCS will depend on the combined efforts of all stakeholders harnessing their strengths and resources effectively in an integrated and collective approach to ensure a safe, healthy and sustainable country.

While significant challenges and unfinished agendas remain, the CCS intends to address them through innovative approaches and strategic partnerships. The CCS is focused on four strategic priorities: building resilient systems for health; ensuring healthier populations; integrating health services delivery targeted to high-priority diseases; and improving health security.

The CCS reflects the aspirations and priorities of the people of Papua New Guinea and their commitment to building a resilient and sustainable future.

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We would like to express our gratitude to our leadership team comprising Dr Sevil Huseyvona, WHO Representative in Papua New Guinea, and the executive management of the National Department of Health of Papua New Guinea, including Dr Osborne Liko, Secretary for Health, Ms Elva Lionel, Acting Deputy Secretary for National Health Policy and Corporate Services, and Mr Ken Wai, Deputy Secretary for Public Health Services. We are grateful for their visionary guidance, unwavering support and commitment.

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Our sincere thanks also go to our stakeholders, whose valuable insights and feedback have been instrumental in shaping our strategic priorities.

We would also like to thank WHO consultants and staff from the WHO Regional Office for the Western Pacific, whose expertise and strategic insights have enriched the planning process.

This CCS would not have been possible without the collaborative spirit and shared commitment of all these individuals and groups. We look forward to the implementation journey ahead as we collectively work toward realizing our strategic goals.
ABBREVIATIONS

ADB | Asian Development Bank
AMR | antimicrobial resistance
ART | antiretroviral therapy
CCA | Common Country Analysis
CCS | country cooperation strategy
CDC | United States Centers for Disease Control and Prevention
COVID-19 | coronavirus disease
DFAT | Department of Foreign Affairs and Trade (Australia)
DHS | Demographic and Health Survey
EENC | Early Essential Newborn Care
eNHIS | electronic National Health Information System
EOC | emergency operations centre
GBV | gender-based violence
GDP | gross domestic product
GPW | General Programme of Work
HBV | hepatitis B virus
HCV | hepatitis C virus
JICA | Japan International Cooperation Agency
KMC | Kangaroo Mother Care
KRA | key result area
M&E | monitoring and evaluation
MDR-TB | multidrug-resistant tuberculosis
MMR | maternal mortality ratio
NCD | noncommunicable disease
NDOH | National Department of Health
NHIS | National Health Information System
NHSS | National Health Services Standards
NTD | neglected tropical disease
ODA | overseas development assistance
PB | Programme Budget
Penta  pentavalent (vaccine)
PHA    provincial health authority
RDT    rapid diagnostic test
RMNCAH reproductive, maternal, newborn, child and adolescent health
RR-TB  rifampicin-resistant tuberculosis
SD     strategic deliverable
SDG    Sustainable Development Goal
SDH    social determinants of health
TB     tuberculosis
UHC    universal health coverage
UN     United Nations
UNDAF  United Nations Development Assistance Framework
UNICEF United Nations Children’s Fund
UNMSDF United Nations Multi-Stakeholder Development Framework
UNSDCF United Nations Sustainable Development Cooperation Framework
VDI    Vaccine-Preventable Diseases and Immunization unit
VPD    vaccine-preventable disease
WASH   water, sanitation and hygiene
WHO    World Health Organization
XDR-TB extensively drug-resistant tuberculosis
Papua New Guinea lies in the south-west Pacific Ocean, just south of the equator and about 160 kilometres north-east of Australia. The country has a combined surface area of about 741 379 square kilometres and had a population of 9 501 008 in 2022. In recent years, population health has moderately improved, with life expectancy rising from 61.72 years in 2000 to 66.12 years in 2020. From 2006 to 2018, the neonatal mortality rate dropped from 29 to 20 per 1000 live births, the maternal mortality ratio fell from 773 to 171 per 100 000 live births, and the under-5 mortality rate dropped from 74 to 49 per 1000 live births. Nevertheless, progress towards achieving the Sustainable Development Goals has been slow or stagnant, as significant challenges remain, including limited access to health-care services, financial and geographical barriers, and the availability of essential medical supplies. The coverage of essential health services is about 33%, as the health workforce density remains low. The total health expenditure as a percentage of the gross domestic product (GDP) is 2.5%, lower than the recommended minimum level, and the government health expenditure as a percentage of GDP is 1.7%. Several challenges remain with communicable and noncommunicable diseases, mental health, immunization and family health.

The Papua New Guinea–WHO Country Cooperation Strategy 2024–2028 describes how the World Health Organization (WHO) country office will support the implementation of the Papua New Guinea Vision 2050 and the National Health Plan 2021–2030 over the next five years. The development of the country cooperation strategy involved a thorough process of collaboration and consultations with various stakeholders. The process resulted in the identification of four strategic priorities based on the country’s context and needs:

- **Strategic Priority 1. Resilient systems for health** includes ways of improving access to quality services, promoting effective governance, reviewing laws and policies, utilizing data to guide decision-making in the health sector, and fostering partnerships to address health challenges in a comprehensive and coordinated manner.

- **Strategic Priority 2. Healthier populations and NCDs** aims at improving reproductive, maternal, newborn, child, and adolescent health, enhancing immunization coverage, addressing violence (with focus on gender-based violence) and injuries, promoting gender equality, preventing NCDs through healthy lifestyles and addressing risk factors, and fostering community engagement and partnerships to address social determinants of health.

- **Strategic Priority 3. Integrated health services delivery targeted to high-priority diseases** aims at eliminating neglected tropical diseases, managing NCDs, addressing mental health conditions, managing and controlling communicable diseases particularly TB, HIV/ AIDS STI and malaria.

- **Strategic Priority 4. Health security** deals with health emergencies and health security by strengthening preparedness and response to health emergencies, ensuring food safety, addressing the health impacts of climate change, preventing and responding to disease outbreaks, and improving water, sanitation and hygiene practices, including health-care waste management and infection prevention and control.

The complex health challenges in Papua New Guinea require innovative and creative partnerships, both within and outside the health sector, for better health outcomes. Developing high-impact partnerships at regional and national levels will help to achieve national health and development goals.

The Country Cooperation Strategy (CCS) serves as a high-level corporate strategy that defines the work of WHO in and with Papua New Guinea. As a result, it is fully linked with The country’s Vision 2050 and the National Health Plan 2021–2030. It also provides a longer-term perspective and serves as a basis for the Programme Budget and operational planning of the WHO country office. The CCS enables the tracking of progress of the selected strategic priorities and outcome-level strategic deliverables (output-level deliverables are usually captured in Building Management System analytics). It serves as a single, forward-focused vision that translates the Sustainable Development Goals (SDGs), the Thirteenth General Programme of Work (GPW 13) and the priorities of For the Future: Towards the Healthiest and Safest Region to the Papua New Guinea context. It also serves as WHO’s input to the United Nations Sustainable Development Cooperation Framework (UNSDCF) for 2024–2028 and helps to proactively lead Common Country Analysis (CCA) and UNSDCF discussions related to health and development.

The CCS strategic priorities were identified in a series of discussions with the National Department of Health (NDOH), WHO country office staff, WHO regional technical staff, local development partners and other stakeholders. The strategic priorities are based on a critical analysis of the country’s needs and WHO’s comparative advantage in addressing them. The strategic priorities focus on areas in which WHO is best positioned to make an impact and to help make the people of Papua New Guinea the healthiest people in the Pacific region.

Through the CCS, WHO works as “One WHO” to utilize the strengths of all three levels of the Organization – the country office, the Regional Office for the Western Pacific and the global headquarters – along with the WHO Centres of Excellence in various thematic areas and the research and consultancy pool.

It is the vision of the WHO country office in Papua New Guinea to work for the betterment of the health and well-being of the people and to facilitate the active engagement of all people in global health.
2. COUNTRY CONTEXT

Papua New Guinea lies in the south-west Pacific, just south of the equator and about 160 kilometres north-east of Australia. The country occupies the eastern half of the island of New Guinea, together with the main islands of New Britain, New Ireland and the Autonomous Region of Bougainville, as well as another 600 smaller islands and atolls (World Bank, 2022). Together, they have a combined surface area of about 741 379 square kilometres (Country Reports, 2023). In 2022, Papua New Guinea had an estimated population of 9 501 008 (SPC, 2023), with an annual growth rate of 1.9% (United Nations, 2022).

Economic situation and drivers for growth

In 2020, Papua New Guinea’s gross domestic product (GDP) decreased by 3.5%, according to the World Bank (Piontkivsky et al., 2022). However, in 2021, the Asian Development Bank (ADB) reported a slight recovery with a -0.2% GDP growth rate, attributed to increased export volumes of tea, palm oil and copra (ADB, 2022). The country was projected to experience a positive GDP growth rate of 3.5% in 2022 and 4.9% in 2023 (ADB, 2022).

The total health expenditure as a percentage of the GDP is 2.5%, which is lower than the recommended minimum level, and the government health expenditure as a percentage of GDP is 1.7% (World Bank, 2021).

In terms of international development assistance, the World Bank reported the net overseas development assistance (ODA) received in 2020 was US$ 108 per capita (current US$) (World Bank, 2023). Fig. 1 shows the net ODA per capita over the past decades.

Fig. 1. Net ODA received per capita (current US$), 1960–2020

Source: World Bank, 2023
Population demographics

The population pyramid in Fig. 2 depicts large populations in the younger age groups (for both sexes) and a small productive group, a trend that is likely to take a long time to change. It also depicts a situation with high fertility, high mortality, short life expectancy, greater population growth rates and a low proportion of elderly people. Population health has moderately improved in recent years, with life expectancy rising from 61.72 years in 2000 to 66.12 years in 2020 (United Nations, 2022).

Political situation

Papua New Guinea is a federal constitutional monarchy with three spheres of government: national, provincial and local. Local government is enshrined in the Constitution. The National Parliament constitutes a 118-member unicameral legislature elected for five-year terms by universal suffrage. The Governor-General appoints and can dismiss the Prime Minister based on the proposal of Parliament. The Governor-General also appoints the Cabinet or National Executive Council on the recommendation of the Prime Minister. The Supreme Court, National Court, and local and village courts form an independent justice system (DFAT, n.d.).

Health and equity situation

Papua New Guinea has a complex health and equity situation because of its decentralized system of local governance. Each province and the Autonomous Region of Bougainville are responsible for delivering health and social services, resulting in a fragmented system. Provincial governments manage rural health services, while the NDOH oversees hospital services. The health budget for Papua New Guinea increased from 1.7 billion kina in 2021 to 2.6 billion kina in 2022 (ADB, 2022). Despite this financial boost, challenges persist, including inadequate infrastructure, a shortage of health-care workers and limited financial resources. Most people residing in rural areas face limited access to health-care services. Only 33% of the country’s population is covered by essential health services.
Country context

Although efforts have been made to address this issue by establishing rural health centres and training community health workers, further investments in infrastructure, equipment and health-care worker training are needed to ensure equitable access to high-quality health-care services.

The availability and distribution of health-care workers pose significant challenges in Papua New Guinea, particularly in rural and remote areas, leading to limited access to health services and disparities in health outcomes.

In terms of drugs, pharmaceuticals, health laboratories and technologies, Papua New Guinea faces issues of availability, affordability and reliance on imported drugs. Counterfeit and substandard drugs have also been a concern. The Government has taken steps to address these challenges, such as establishing the National Medicines and Therapeutics Committee and implementing a national medicines policy. Initiatives like the electronic m-Supply system aim to improve the procurement, warehousing and distribution of medical supplies.

The health laboratory system in Papua New Guinea needs more trained personnel, inadequate infrastructure, stock-outs of commodities and limited funding. Laboratories are primarily located in urban areas, limiting access for the general population. The Government has implemented measures to enhance the laboratory system, including the establishment of a national laboratory policy and training programmes for laboratory personnel.

Access to modern health technologies, including diagnostic equipment and telemedicine services, is limited in Papua New Guinea. This hampers the ability of health-care providers to effectively diagnose and treat diseases. To address this challenge, the Government has initiated efforts to improve access to health technologies. These initiatives include the establishment of the National Health Information System (NHIS), the electronic National Health Information System (eNHIS) and the procurement of medical equipment for health facilities.

Several information systems, including the NHIS, have been established to collect data on health service delivery, vital statistics, health outcomes and more. Data reporting has been good, initially through paper-based systems and subsequently through the roll-out of the eNHIS in health facilities across provinces. However, challenges remain, such as a shortage of trained personnel, limited infrastructure and funding constraints.

Disease burden

Noncommunicable diseases

Papua New Guinea is facing an epidemiological transition characterized by the increasing burden of noncommunicable diseases (NCDs). Premature mortality caused by NCDs accounts for 10 million deaths worldwide annually, including 31,400 deaths in Papua New Guinea. NCDs and related modifiable risk factors are prevalent, according to the 2007 STEPS Survey report in Papua New Guinea. Adult risk factor trends include current tobacco smoking, obesity and raised blood pressure. In 2016, NCDs accounted for an estimated 56% of all deaths (24% due to cardiovascular diseases, 12% to cancers, 6% to chronic respiratory diseases, 4% to diabetes and 10% to other NCDs) (WHO, 2018). This figure likely undercounts the true impact of NCDs, as it only considers deaths that occurred in hospitals or clinics. The probability of premature mortality from NCDs in 2018 was 36% (32% for females, 40% for males) (WHO, 2018). It was found that 99.6% of Papua New Guinea’s population was at moderate to high risk of NCDs, with 77.7% classified as high risk (NDOH, 2015).

Many NCDs share common risk factors: tobacco use, betel nut chewing, harmful use of alcohol, physical inactivity and unhealthy diet. Papua New Guinea has one of the highest smoking rates in the
world, with 44% of adults aged 16–64 (60.3% of men, 27.3% of women) identifying as current smokers (NDOH, 2007). Smoking is also prevalent among young people, with 33.3% of those aged 13–15 (40.1% of boys, 28.3% of girls) found to be current smokers (WHO, 2016). Betel nut (or buai) chewing is highly prevalent, with 79% of the population (80.3% of men, 77.8% of women) having chewed betel nut in the last 12 months; the average age of first consumption is 11.7 (NDOH, 2007). More recent evidence shows that Papua New Guinea ranks among the top 10 nations globally in terms of tobacco consumption, with approximately 40% of its population using tobacco. This poses a significant development challenge and places a heavy burden on households, especially those economically disadvantaged, since tobacco expenditure can account for 3–7% of household total expenditure (World Bank and Australian AID, 2015).

Mental, neurological and substance use conditions continue to escalate in Papua New Guinea. The disability-adjusted life years attributed to mental disorders is 1389.6 per 100 000 population, and the age-standardized suicide mortality rate is 3.57 per 100 000 population (WHO, 2020). The most common causes of admissions are cannabis use, induced psychosis, depression, schizophrenia and post-traumatic stress disorder.

Major challenges include a lack of government funding (total government health expenditure on mental health being 1.0%) and limited human resources and capacity to provide human-rights-based and people-centred mental health services in the country. There is a lack of national data and information to guide policy and planning, measure impact and drive change for the mental health programme. Social determinants of health are major contributing factors to mental health and substance use conditions in the country.

**Maternal and child health**

Maternal and child health is a major issue in Papua New Guinea, particularly in rural and remote areas and among disadvantaged populations. Maternal mortality is high because of postpartum haemorrhage and sepsis, while newborn mortality is primarily caused by low birth weight, prematurity, sepsis and asphyxia. Limited access to quality maternal and newborn health services in many parts of the country, as well as low health literacy, traditional beliefs and practices, and gender-based violence (GBV), further hinder access to health care.

Missed opportunities for family planning within the system are prevalent. The maternal mortality ratio (MMR) in Papua New Guinea is one of the highest in the Region. In 2018, the MMR was 171 per 100 000 live births, the under-5 mortality rate was 49 per 1000 live births, the newborn mortality ratio was 20 per 1000 live births, and the infant mortality rate was 33 per 1000 live births (National Statistical Office, 2019). Rates have improved since 2006, but they remain high (National Statistical Office, 2009).

Among women aged 15–19, 12% have started childbearing (that is, they have already given birth or are pregnant with their first child). Adolescents who are sexually active or living with HIV often encounter stigma and discrimination, which can deter them from accessing health services. This issue is particularly challenging for girls who must contend with GBV, early marriage and pregnancy.

Despite the Government’s prioritization of improving reproductive, maternal, newborn, child and adolescent health (RMNCAH) service coverage, access to quality services remains a challenge because of supply-and-demand side barriers. Based on eNHIS 2019–2021, the coverage of antenatal care and supervised deliveries is less than 50%, and the number of family planning acceptors is declining, particularly for intrauterine devices (by 5%), implants (by 15%) and injectables (by 5%). Sexual and reproductive health issues have been overshadowed by other health issues, such as the coronavirus disease (COVID-19) pandemic. Economic inequities also persist, exacerbating the disparities in access to RMNCAH services.
**Immunization**

Routine immunization services have been a major component of primary health care in Papua New Guinea for several decades despite still remaining suboptimal. Most of the districts have DPT3 (Penta 3) coverage of less than 50%. The scarcity of human resources for health, such as doctors, nurses and community health workers, vaccine shortages, poor vaccine management, insecurity and inadequate financial support, all combine to make routine immunization service delivery a challenge. Population immunity against vaccine-preventable diseases (VPDs) is low, and the risk of VPD outbreaks is high. In 2022, national coverage for three doses of pentavalent vaccine, or Penta3, protecting against diphtheria, tetanus, pertussis, Haemophilus influenza type B and hepatitis B, was 39%, while coverage for the first dose of measles–rubella vaccine was 38%. (eNHIS, 2022) The provincial and district Penta3 coverage levels vary widely across the country, from less than 20% to 76%, with most districts under 50%. There have been small focal sporadic outbreaks of measles and pertussis in recent years. Family health issues will be dealt with under Strategic Priority 2 – Healthier populations and NCDs.

**Communicable diseases**

Papua New Guinea has a high burden of infectious diseases, including HIV/AIDS, tuberculosis (TB), malaria, respiratory diseases and diarrhoeal diseases. Marginalized populations, including women, children and those living in poverty, are disproportionately affected. Limited access to prevention, diagnosis, and treatment services exists in rural and remote areas.

**HIV, sexually transmitted infections and hepatitis B**

Papua New Guinea faces challenges related to HIV, with varying prevalence rates among different population groups. About 72 000 people are living with HIV, 70% know their HIV status, about 87% are on treatment, and 87% of those tested are on viral suppression. The rate of vertical transmission of HIV from mother to child is about 22.6% at 12 months (UNAIDS, 2021). In 2022, HIV prevalence was around 1.8% among pregnant women and about 1.0% among the general population. The epidemic is driven by sexual transmission and affects key populations, including female sex workers, men who have sex with men, and transgender women.

HIV prevalence is higher than 1.00% in 13 of the 23 provinces, including the National Capital District. Among the provinces with the highest HIV prevalence are Jiwaka Province (1.49%) and Enga Province (1.36%) in the Highlands Region and Oro Province (1.34%) in the Southern (Papuan) Region. The Momase Region has an average prevalence of 1.30%. As of 2020, only 54 of the 164 antiretroviral therapy (ART) sites provided paediatric HIV care. Paediatric HIV transmission typically occurs during early pregnancy, labour or breastfeeding (NDOH, 2021). Efforts are underway to provide treatment and reduce new HIV infections, but testing and treatment coverage need improvement. About 3500 children aged 0–14 years are living with HIV, with about 65% on treatment. A similar percentage of those above 14 years are on ART.

The national prevalence of hepatitis B is 10% and hepatitis C is 1%. The programme is in an embryonic stage due to fiscal constraints. In 2020, the hepatitis B surface antigen prevalence was 6.7% in the general population and 2.8% in 5-year-olds. Less than 5% of the population had been diagnosed, with very few patients treated for hepatitis B virus (HBV). Nearly all treatments occurred in the context of HIV/HBV coinfection. In 2020, the prevalence of hepatitis C virus (HCV) RNA was 1.2%, with approximately 10% of patients diagnosed for HCV. No patients are currently treated for HCV in Papua New Guinea.

**Tuberculosis**

TB is a major public health threat and a leading cause of death in Papua New Guinea. The TB mortality rate is 49 per 100 000 population, resulting in about 5100 deaths each year. The estimated total TB incidence is 42 000 cases, with a rate of 424 cases per 100 000 population, one of the highest rates globally and the second highest in the Western Pacific Region (WHO, 2021). Among the TB cases, 4600 are estimated to be HIV-positive, with a rate of 46 cases per 100 000 population.

Drug-resistant TB is becoming increasingly common, and extensively drug-resistant tuberculosis (XDR-TB) is also being reported in the country. The incidence of multidrug-resistant tuberculosis (MDR-TB) or rifampicin-resistant tuberculosis (RR-TB) is estimated to be 2400 cases, with a rate of 24 cases per 100 000 population. The estimated number of HIV-negative TB deaths is 5100, with a rate of 51 deaths per 100 000 population, while the estimated number of HIV-positive TB deaths is 370, with a rate of 3.7 deaths per 100 000 population (WHO, 2021). The estimated proportion of TB cases with MDR-TB/RR-TB in 2021 was 4% for new cases and 23% for previously treated cases. The TB treatment coverage for notified/estimated incidence in 2021 was 68%, while 34% of TB patients face catastrophic total costs as of 2019. The TB case fatality ratio in 2021 is estimated to be 13% based on estimated mortality/estimated incidence. In 2021, there were 481 laboratory-confirmed cases of MDR/RR-TB, and 415 patients started on treatment for MDR-TB/RR-TB. Additionally, there were three laboratory-confirmed cases of pre-XDR-TB or XDR-TB, and three patients started on treatment for pre-XDR-TB or XDR-TB (WHO, 2021).

**Malaria**

The incidence of malaria was 92 cases per 1000 population in 2021. While the overall incidence has declined, it remains relatively high in the coastal areas (NDOH, 2022). Reported malaria cases fell by 33% from 1.5 million in 2010 to around 1 million in 2022, and malaria-related deaths declined by 57% from 653 in 2010 to 283 in 2022. In the WHO Western Pacific Region, Papua New Guinea accounted for nearly 87% of the malaria burden and over 94% of malaria-related fatalities in 2021 (WHO, 2022). The country adopted WHO’s Test, Treat and Track policy by introducing a nationwide roll-out of rapid diagnostic tests (RDTs) to detect malaria in 2012. Since then, RDTs have increasingly been used to detect malaria. As a result, the percentage of laboratory-confirmed malaria among all reported cases has increased from 10% in 2011 to over 90% in 2022, and the detection rates of laboratory-confirmed malaria cases are still high.³

Challenges in the malaria programme include limited access to remote communities, rapid detection, risk assessment, slow response to malaria outbreaks, poor compliance with treatment, stock-outs of essential supplies, reduced effectiveness of insecticidal nets procured since 2013, and high parasitaemia levels despite declining cases. Addressing these challenges is crucial for effective malaria control.

**Neglected tropical diseases**

Papua New Guinea is affected by various neglected tropical diseases (NTDs), including yaws, leprosy, Buruli ulcer, trachoma, soil-transmitted helminthiases, dengue fever, lymphatic filariasis, snakebite envenoming and scabies. Lymphatic filariasis and yaws are prevalent in the country, requiring focused attention and integration of surveillance and management at the primary health-care level.

Papua New Guinea has one of the highest burdens of lymphatic filariasis in the world, with some sites reporting more than 70% prevalence in baseline surveys. About 16 of the 22 provinces are suspected of being endemic with lymphatic filariasis, and all 22 provinces are endemic to one or more NTDs.

Papua New Guinea also has reported the highest number of clinically suspected yaws cases in the world, and these have come from health facilities. In 2021, 92,856 cases were reported. In 2000, leprosy was eliminated as a public health problem at the national level, but at the subnational level, cases have been found in six provinces (National Capital District, Central, Gulf, Western Pacific, West South Pacific and East New Britain). For sustainability, there is the need to integrate NTD surveillance and case management at the primary health-care level and increase efforts to combat these NTDs and ensure their elimination.

**Emergencies**

Emergencies continue to be an issue in Papua New Guinea and must be tackled purposefully and proactively. There are emergencies almost every year, as shown in Fig. 3. In light of the realities described below, emergency preparedness and response are of major importance.

**Fig. 3. Health emergencies, 2009–2022**

Source: National Health Services Standards, Papua New Guinea

**Health system and service delivery**

Papua New Guinea’s system of local governance is highly decentralized. Each province and the Autonomous Region of Bougainville are responsible for delivering health and other social services, resulting in a fragmented health delivery system. Provincial governments are responsible for delivering primary health-care services, and the NDOH manages hospital services.

The National Health Services Standards (NHSS) outline seven levels of health service delivery, ranging from aid post to the national referral hospital. Health-care providers at the seven levels of care have six roles and varying responsibilities, as shown in Fig. 4.

Health service delivery in Papua New Guinea faces many challenges, including inadequate infrastructure, a shortage of health-care workers and limited financial resources. Most of the population lives in rural areas, where access to health-care services is limited. The creation of rural health centres and the training of community health workers are some steps the Government has put in place to increase access to health-care services. To significantly improve access to health-care services, there is still a significant need for investment in infrastructure, equipment and training for
health-care workers to ensure that the population has access to high-quality health-care services. There is some disconnect in the service delivery in the regions, and this will be reviewed in the CCS.

Fig. 4. Health-care providers and their responsibilities

<table>
<thead>
<tr>
<th>National</th>
<th>Policy development and coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial</td>
<td>Management of delivery and services</td>
</tr>
<tr>
<td>District</td>
<td>Management and service delivery at district level</td>
</tr>
<tr>
<td>Health centres and aid posts</td>
<td>Direct service delivery</td>
</tr>
</tbody>
</table>
| Non-state actors | • Rural areas (50–80% service delivery)  
• Traditional healers |
| Private sector | Clinics in cities, towns, urban areas & mining sector |

Source: National Health Services Standards, Papua New Guinea

3. NATIONAL HEALTH AND DEVELOPMENT AGENDA

The Papua New Guinea National Health Plan 2021–2030 aims to prevent ill health, identify and address health risks and emerging diseases, and provide accessible and affordable quality health care for all. The Plan details 22 specific objectives and strategies across five key result areas (KRAs): KRA1 – Healthier communities through effective management; KRA2 – Working together in partnership; KRA3 – Increased access to quality and affordable health services; KRA4 – Address disease burdens and targeted health priorities; and KRA5 – Strengthen health systems.

The Plan sets the 2030 indicators based on the Papua New Guinea Vision 2050, which includes increasing life expectancy from 65 to 70 years, reducing under-5 mortality from 45 per 1000 to less than 20 per 1000 live births, and reducing the MMR from 171 per 100 000 to less than 100 per 100 000 live births. The KRAs of the National Health Plan relate to other national health policies, such as the National Population Policy 2015–2024, National Nutritional Policy 2016–2026, Water Sanitation and Hygiene Policy 2015–2030, and Gender Equity and Social Inclusion Policy. Vision 2050 focuses on seven strategic focus areas or pillars: human capital development, gender, youth and people empowerment; wealth creation; institutional development and service delivery; security and international relations; environmental sustainability and climate change; spiritual, cultural and community development; and strategic planning, integration and control. It is pertinent to note that health is linked to all seven pillars.
4. PARTNERSHIP ENVIRONMENT

WHO’s work is supported by government and development partners, including United Nations (UN) agencies, multilateral and bilateral partners, government agencies beyond health and nongovernmental organizations. The UN system in the country has established the “Delivering as One” mechanism with the intent of bringing together UN agencies to work coherently in support of the Government. The current *United Nations Development Assistance Framework* (UNDAF) for 2018–2022 has been extended to the end of 2023, and the development process for the UNSDCF has started as well. Under this UNDAF, working groups have been formed to facilitate smooth joint implementation and monitoring among UN agencies. WHO and the United Nations Children’s Fund (UNICEF) co-chair the PEOPLE working group, which is responsible for the delivery of inclusive social services. WHO maintains active membership and participation in the working group on PLANET (for climate change and disaster preparedness). It should be noted that the timing and alignment with the new UNSDCF is one of the major considerations in the development of this CCS.

Key partners include the NDOH, the United Nations Country Team, the World Bank, ADB, Australia’s Department of Foreign Affairs and Trade (DFAT), the Japan International Cooperation Agency (JICA), the New Zealand High Commission, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the European Union, the United States Agency for International Development (USAID) and the United States Centers for Disease Control and Prevention (CDC), which funds the CDC STOP team at the subnational level, and GAVI, The Vaccine Alliance.

5. COLLABORATION BETWEEN WHO AND THE COUNTRY

The WHO country office collaborates with Papua New Guinea on a range of health-related initiatives and programmes aimed at improving the health and well-being of the population. This collaboration involves various aspects of health-care and public health, including:

- **Health policy and planning**: WHO works with the Government to develop and implement policies and strategies that align with international health standards and best practices. This includes areas such as health system strengthening, disease prevention and health promotion.

- **Disease control**: WHO supports efforts to control and manage infectious diseases such as malaria, TB and HIV/AIDS. This involves providing technical assistance, capacity-building and resources for disease surveillance, prevention and treatment programmes.

- **Immunization**: WHO supports immunization efforts to ensure that children and vulnerable populations have access to life-saving vaccines. This includes support for vaccination campaigns and strengthening immunization systems.

- **Emergency response**: In the event of health emergencies, such as disease outbreaks or natural disasters, WHO collaborates with health authorities to provide rapid response and assistance. This includes the mobilization of resources and expertise to address urgent health challenges.

- **Capacity-building**: WHO provides training and capacity-building opportunities for health-care workers and public health professionals. This helps strengthen the country’s health-care workforce and improve the quality of health-care services.
Health data and research: WHO supports Papua New Guinea in collecting and analysing health data, essential for evidence-based decision-making. This includes research on health trends, epidemiology and health system performance.

Health promotion: WHO promotes health education and awareness campaigns on various health issues, including nutrition, maternal and child health, and the prevention of NCDs.

Access to essential medicines: WHO assists in ensuring the availability and accessibility of quality essential medicines and health-care technologies.

Health security: WHO collaborates with Papua New Guinea to strengthen its capacity to detect, respond to and mitigate health security threats, including those related to infectious diseases and pandemics.

Policy advocacy: WHO advocates for health policies that prioritize the well-being of the country’s population and align with global health goals.

The collaboration between WHO and Papua New Guinea is guided by the country’s health priorities and needs, and it is aimed at achieving better health outcomes for the people of Papua New Guinea. This partnership involves technical expertise, financial support and knowledge sharing to address the country’s health challenges and promote sustainable development in the health sector.

Personnel situation in the WHO country office

As part of the collaboration to provide technical assistance, the WHO country office in Papua New Guinea employs three categories of staff: international professional, national professional officer and general service. Notably, the country office continues to use many short-term engagements with short-term consultants and special service agreements, particularly during emergencies such as earthquakes, poliomyelitis outbreaks and the COVID-19 pandemic. With outbreaks becoming more common, there is the need to review staff strengths and the skills mix to deal with emergencies on a continuous basis. WHO is working to strengthen staff capacity through the establishment of new Core Predictable Country Presence positions, which aim to ensure that the country office has the necessary core capacities required at the country level in a sustainable manner.

Financial situation in the WHO country office

Regarding WHO’s funding, voluntary funds constitute a significant proportion of the Papua New Guinea budget centre’s total budget. Australia’s DFAT remains the largest donor, particularly among the resources mobilized in country. Currently, a DFAT–WHO partnership is supporting six international professional staff who are handling essential programmes.

In the Programme Budget (PB) 2020–2021, the funding available for base programmes totalled about US$ 15.3 million, slightly lower than that in PB 2018–2019 (US$ 24.8 million). Of important note is the almost three-fold increase of funds managed by the budget centre from PB 2016-2017 (US$ 16.2 million) to PB 2018–2019 (US$ 51.2 million) because of additional funding for the polio campaign. In PB 2020–2021, the budget centre had US$ 24.7 million in funds, including US$ 9.4 million in Outbreak, Crisis Response & Scalable Operations funds for the COVID-19 response. The unpredictable fluctuating budgets make it very difficult for the country office to plan ahead. Hence, more stable, predictable resources are needed.
6. STRATEGIC PRIORITIES

Strategic Priority 1
Resilient systems for health

<table>
<thead>
<tr>
<th>SD1</th>
<th>SD2</th>
<th>SD3</th>
<th>SD4</th>
<th>SD5</th>
<th>SD6</th>
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</thead>
<tbody>
<tr>
<td>Strengthened human resources for health</td>
<td>Improved access to quality essential medicines, vaccines, diagnostics and devices</td>
<td>Accelerated fight against antimicrobial resistance (AMR)</td>
<td>Strengthened use of multi-source strategic information including research</td>
<td>Improved availability of and access to essential health services at primary level</td>
<td>Strengthened governance &amp; partnerships</td>
</tr>
</tbody>
</table>

Outcome-level strategic deliverables (SDs)

- Systems approach
- Data-driven actions
- Working beyond health & strategic partnerships
- Working across teams in WHO
- Strategic communication
- Community engagement

Ways of working & approaches
To ensure a resilient health system in Papua New Guinea, it is necessary to focus on a few key areas. These include strengthening the health-care workforce, improving access to quality essential medicines and health services, addressing antimicrobial resistance (AMR), and promoting effective governance and partnerships.

Investing in the health workforce is necessary to alleviate shortages, especially in remote and rural areas. Training, retention, strategic deployment and continuous professional development of health-care professionals contribute to a resilient health system.

Equitable access to health products is a national priority, and the availability, accessibility, acceptability and affordability of health products of assured quality need to be addressed in order to achieve the SDGs and universal health coverage (UHC). Every disease management strategy requires access to health products for prevention, diagnosis, treatment, palliative care and rehabilitation in Papua New Guinea.

The National Action Plan on Antimicrobial Resistance 2019–2023 outlines six pillars for addressing AMR: national coordination mechanisms, surveillance and laboratory capacity, access to quality essential medicines, rational use of medicines, infection prevention and control, and research and development.

The availability and use of health data from different sources, such as routine health information systems, surveys and research studies, is critical for measuring and driving impact in the health sector. This requires enhancing governance and coordination, developing health information-related strategies, guidelines and tools, building capacities in data management, analysis and use at all levels of the system, strengthening the digital health environment, and improving research governance and capacities.

A resilient health system in Papua New Guinea should effectively respond to the burden of diseases, including communicable and noncommunicable diseases like TB, malaria, HIV/AIDS and cardiovascular diseases. It should ensure availability, accessibility and high-quality health-care services for disease prevention, diagnosis and treatment.

Addressing health inequalities is another important aspect. Ensuring equitable access to health-care services, particularly in underserved areas, improving infrastructure in remote regions, and addressing barriers like transportation and affordability are essential steps towards reducing disparities in health outcomes.

Sustainable health financing mechanisms are vital to support the system. Strengthening health financing systems, efficient resource utilization, and exploring innovative financing methods can ensure a financially sustainable health system that provides essential services to the population.

Health governance, stewardship, and partnerships are increasingly regarded as salient themes on the health development agenda. They involve ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, and attention to system design. The involvement of both state and non-state actors should be guided by national health priorities and targets.
### Strategic Priority 2

**Healthier populations and NCDs**

<table>
<thead>
<tr>
<th>Outcome-level strategic deliverables (SDs)</th>
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<tbody>
<tr>
<td><strong>SD1</strong> Improved reproductive, maternal, newborn, child and adolescent health (RMNCAH) through gender-responsive people centered strategies</td>
</tr>
<tr>
<td><strong>SD2</strong> Improved immunization coverage</td>
</tr>
<tr>
<td><strong>SD3</strong> Improved actions for gender equality, prevention of gender-based violence and addressing other social determinants of health</td>
</tr>
<tr>
<td><strong>SD4</strong> Reduced morbidity and mortality due to violence and injuries</td>
</tr>
<tr>
<td><strong>SD5</strong> Prevention of noncommunicable diseases and promoting mental health</td>
</tr>
</tbody>
</table>

#### Ways of working & approaches

- Systems approach
- Data-driven actions
- Working beyond health & strategic partnerships
- Working across teams in WHO
- Strategic communication
- Community engagement
To ensure a healthier population in Papua New Guinea, addressing disparities in health outcomes between rural/remote areas and disadvantaged populations is crucial. Factors such as poverty, limited health-care access and cultural practices contribute to these disparities. By focusing on the social determinants of health (SDH), which have a significant impact on health outcomes, Papua New Guinea can improve health and reduce inequities. This requires collaboration across sectors and civil society.

To foster equitable access and stimulate demand for health-care services among people of all ages and genders, it is critical to employ community-centred prevention and health promotion initiatives led by proficient personnel and collaborative partners. This comprehensive approach involves the development of effective communication materials, the active involvement of fathers, male partners, village chiefs, and influential opinion leaders to reshape societal norms, alongside the delivery of patient-focused, high-quality services at all levels with rigorous infection prevention and control measures and seamless referrals. It is equally important to prioritize the strengthening of health-care worker capacities across all levels and engage with partners from diverse sectors to ensure the delivery of quality and timely services, alongside the provision of a consistent supply of essential RMNCAH resources, such as equipment, medicines, commodities and supplies. There is a need to establish incentive mechanisms to motivate both patients and health-care professionals and enlist the support of prominent female and male leaders and decision-makers to drive mindset shifts and garner backing for RMNCAH programmes. Data must drive planning, prioritization, and targeted investment. It is critical to sustain the implementation of Early Essential Newborn Care (EENC) and Kangaroo Mother Care (KMC) in all health-care facilities, offering tailored capacity-building for health-care personnel, and delivering comprehensive counselling to mothers on breastfeeding and nutrition practices through a combination of community and hospital-based interventions. Furthermore, community-based preventive measures to promote optimal nutrition, empower health-care workers for effective counselling, collaborate with the education sector, deploy nutritionists within primary health-care areas, and advocate for progressive policies to facilitate inclusive breastfeeding practices. Noting that health through the life-course is the basis of all health programmes, it is imperative to ensure cross-programme collaboration through a linked response on the elimination of parent-to-child transmission of HIV, sexually transmitted infections and hepatitis, as well as the prevention and control of VPDs, malaria, TB, NCDs, including cancer, NTDs and violence.

Improving immunization coverage and effectively detecting and responding to VPD outbreaks are critically important. Key strategies and actions include ensuring vaccine availability; improving staff capacity in microplanning, data management and demand generation; integrating immunization with other maternal and child health services; and improving laboratory-based VPD surveillance.

Actions should also focus on promoting gender equality, preventing GBV, addressing other social determinants of health, expanding the Family Support Centre to districts, training health-care workers, and partnering with the education sector and civil society organizations.

Furthermore, stronger community engagement and strategic communication are essential. Developing tailored communication materials and tools that consider the cultural context can effectively convey health-related information and promote healthier communities.

By implementing these actions, Papua New Guinea can ensure a healthier population by addressing disparities, improving RMNCAH, enhancing immunization coverage, promoting gender equality and GBV prevention, and engaging communities through strategic communication.
Strategic Priority 3

**Integrated health services delivery targeted to high-priority diseases**

**SD1**
Reduce burden of high-priority diseases including HIV, TB, malaria, sexually transmitted infections and hepatitis to accelerate progress towards their elimination at national and subnational levels

**SD2**
Reduce transmission and eliminate NTDs in endemic communities

**SD3**
Management and control of NCDs including mental health

Outcome-level strategic deliverables (SDs)

Ways of working & approaches

- Systems approach
- Data-driven actions
- Working beyond health & strategic partnerships
- Working across teams in WHO
- Strategic communication
- Community engagement
Integrated health services delivery contributes to the development of primary health care-based health systems and thus to health services delivery that is more accessible, equitable, efficient, and of higher technical quality, with a connected network of various services providing a single continuum of care and one that better fulfils citizens’ expectations.

Integrated health services delivery is crucial for addressing high-priority diseases in Papua New Guinea. The country faces significant challenges related to NCDs, mental health, HIV/AIDS, TB, malaria and NTDs.

To tackle these challenges, comprehensive approaches are needed:

1. **Enhance NCD and mental health services.** Advocate for increased government funding and resources, and build capacities to improve NCDs and mental health services.
2. **Scale up HIV/AIDS interventions.** Expand HIV testing, treatment and prevention services, particularly among key populations. Focus on paediatric HIV care, ensuring comprehensive care for HIV-positive children and pregnant women.
3. **Strengthen TB control.** Improve TB detection, treatment coverage and drug-resistance management. Invest in laboratory infrastructure, health-care workforce training and patient-centred care approaches.
4. **Improve malaria services.** Enhance accessibility to malaria services in remote areas, strengthen surveillance systems and ensure an adequate supply of medications and insecticidal nets. Promote compliance with treatment regimens and target vector control strategies.
5. **Integrate surveillance and case management for NTDs.** Strengthen primary health-care systems to effectively manage NTDs such as yaws, leprosy and lymphatic filariasis. Enhance diagnostic capacity and treatment accessibility.

Addressing these health challenges requires increased funding, improved infrastructure, capacity-building, and strong partnerships between the government, health-care providers with an integrated network of services and communities. By implementing these comprehensive approaches, Papua New Guinea can ensure integrated health services delivery and effectively tackle the high-priority diseases affecting its population.
### Strategic Priority 4: Health security

#### Outcome-level strategic deliverables (SDs)

<table>
<thead>
<tr>
<th>SD1</th>
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<th>SD5</th>
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<tbody>
<tr>
<td>Enhanced capacity for preparedness and response to health emergencies</td>
<td>Strengthened food safety measures</td>
<td>Strengthened mitigation, response and adaptation measures to address the health impacts of climate change and environmental hazards</td>
<td>Prevent, detect and respond to disease outbreaks to minimize morbidity, mortality and socioeconomic impact</td>
<td>Improved water, sanitation, and hygiene (WASH) including health-care waste management and infection prevention and control</td>
</tr>
</tbody>
</table>

#### Ways of working & approaches

- Systems approach
- Data-driven actions
- Working beyond health & strategic partnerships
- Working across teams in WHO
- Strategic communication
- Community engagement
Health emergencies and health security in Papua New Guinea are influenced by various factors such as natural disasters, disease outbreaks, climate change and environmental hazards. Papua New Guinea regularly experiences concurrent emergencies of different intensities, including the recent COVID-19 outbreak with community transmission and significant impact.

To address these challenges, the following measures are important:

1. **Enhance capacity for preparedness and response.** Increase health-care worker training, strengthen core capacities for International Health Regulations (2005), integrate COVID-19 measures into the national health system, emphasize risk communication and community engagement, and prepare for VPD outbreaks.

2. **Strengthen food safety measures.** Support the implementation of a new food safety policy, strengthen the food control system, and enhance a risk-based approach, with auditing and enforcement.

3. **Strengthen mitigation, response, and adaptation measures for climate change and environmental hazards.** Support the implementation of the national adaptation plan in collaboration with the climate and health sectors and promote climate-resilient and environmentally sustainable health-care facilities.

4. **Prevent, detect and respond to disease outbreaks.** Strengthen national and provincial emergency operations centres (EOCs) and rapid response teams, improve disease surveillance for early detection, and enable swift and targeted interventions to control and mitigate the spread of infections.

5. **Improve water, sanitation and hygiene (WASH) practices including health-care waste management and infection prevention and control.** Support the implementation of the National WASH in Health-care Facilities Road Map and a new health-care waste management policy.

These measures aim to enhance Papua New Guinea’s capacity to effectively respond to health emergencies, reduce morbidity and mortality and minimize the socioeconomic impact. By strengthening preparedness, enhancing response systems and addressing environmental and climate-related challenges, Papua New Guinea can improve health security and protect the well-being of its population.

In order to effectively implement the strategic priorities outlined in the CCS, a comprehensive set of actions will be undertaken, specifically designed to address the identified challenges and gaps in health-care delivery and advance the goals and priorities set forth in the CCS. This is aimed at enhancing access to quality health-care services, strengthening health-care systems, promoting health equity, improving health outcomes and fostering sustainable development. Annex 2 shows how the strategic directions are going to be achieved.

**Cross-cutting issue – One Health**

The major components of One Health include human, animal and environmental health, and all three are closely intertwined. The scope of One Health includes zoonotic diseases, AMR, food safety and security, vector-borne diseases that come from insect bites, environmental contamination and other health threats shared by people, animals and the environment. As such, One Health is a necessary collaborative, multisectoral and transdisciplinary approach – working at the local, regional and national levels – with the goal of achieving optimal health outcomes and recognizing the interconnection between people, animals, plants and their shared environment. Interventions such as information, education and communication on safe food practices, improved sanitation and veterinary
public health measures should be implemented to decrease transmission rates and reduce the risk of infection.

In Papua New Guinea, WHO and its partners collaborate to implement the One Health approach, as described below:

1. **Multisectoral coordination.** WHO facilitates multisectoral coordination among key stakeholders, including the NDOH and relevant government agencies, the Department of Agriculture and Livestock, environmental agencies and other partners involved in human, animal and environmental health.

2. **Joint policy development.** WHO collaborates with its partners to develop joint policies and strategies that integrate human, animal and environmental health considerations. This includes aligning priorities for disease surveillance, outbreak response and health promotion efforts.

3. **Disease surveillance and outbreak response.** WHO supports the establishment and strengthening of integrated disease surveillance systems that monitor and detect potential disease outbreaks in both humans and animals. Rapid response mechanisms are put in place to address any emerging health threats promptly.

4. **Zoonotic disease control.** WHO and partners work together to control and prevent zoonotic diseases through vaccination programmes, disease monitoring, and education on safe animal handling and food practices.

5. **Capacity-building.** WHO provides training and capacity-building initiatives for healthcare workers, veterinarians and environmental personnel. This ensures a skilled workforce capable of addressing health issues at the human–animal–environment interface.

6. **Environmental health protection.** The One Health approach recognizes the impact of environmental factors on human and animal health. WHO and partners collaborate on environmental health initiatives, including safe water supply, sanitation and waste management to mitigate health risks.

7. **Health promotion and education.** WHO and partners engage in health promotion and education campaigns to raise awareness about zoonotic diseases, hygiene practices, responsible pet ownership, dairy farming and fostering a culture of health and well-being.

8. **Research and data sharing.** Collaborative research efforts are undertaken to better understand the relationships between human, animal and environmental health. WHO facilitates data sharing and evidence-based decision-making to inform policies and interventions.

9. **Emergency preparedness and response.** WHO and its partners develop joint contingency plans and response strategies to address health emergencies that may have implications for humans, animals and the environment.

10. **Engagement with communities.** WHO recognizes the importance of involving communities in One Health initiatives. Community engagement activities are undertaken to promote active participation and ownership of health and environmental interventions.

By working together in the One Health approach, WHO and its partners contribute to a more comprehensive and effective response to health challenges in Papua New Guinea, such as resistance to known antibiotics, access to safe water and waste management, among others. This collaborative effort ensures that health interventions are better integrated, sustainable and responsive to the complex health needs at the human–animal–environment interface.
7. IMPLEMENTATION

Working as “One WHO” in a decentralized manner

WHO works as “One WHO” across the three organizational levels – country offices, regional offices and headquarters – to provide technical and operational support to Papua New Guinea to address public health issues and develop innovative solutions that benefit everyone. To ensure successful implementation and delivery of the CCS strategic agenda, new ways of working need to be incorporated.

A centralized WHO country office can work in a decentralized manner within a country by adopting a collaborative and coordinated approach that respects Papua New Guinea’s governance structure and health system. This approach allows WHO to engage and support various levels of the country’s health system, including national, regional and local levels. Some of this can be achieved through the following mechanisms:

1. **Collaboration with partners.** The WHO country office collaborates with international and local partners operating in the country at the various levels of health care. This coordination not only helps to entrench working right up to the provincial and district levels, but also prevents duplication of efforts and promotes a more comprehensive and harmonized approach to health interventions.

2. **Technical assistance and capacity-building.** WHO provides technical expertise and capacity-building to strengthen the country’s health system. This may include training health-care professionals, enhancing disease surveillance, improving health-care infrastructure and supporting health workforce development. The training should involve people from all levels of the health-care system so that all levels benefit from the capacity-building.

3. **Data and evidence-based decision-making.** WHO assists in ensuring disaggregated data are collected, analysed and fed back to all pertinent levels of the health system. The information will form the basis of evidence-based decision-making in the districts, provinces and country. This helps to identify health trends, challenges and areas that require targeted interventions.

4. **Subnational support.** The governance arrangements brought about by decentralization have shown significant implications for the health sector in Papua New Guinea. The aim of decentralization was to increase the role and participation of subnational governments in the decision-making and management of health services. The implementation, however, has been varied across the provinces. The extent to which local health needs are being addressed depends on governance work cultures of the different provincial governments as well as their technical capacity. The role of the NDOH, on the other hand, has shifted to policy formulation, technical advice and programme monitoring. WHO must find innovative ways to provide appropriate advice, particularly on health governance, at both the central and subnational levels.

5. **Emergency response and preparedness.** In times of health emergencies, WHO supports the country’s preparedness and response efforts, right down to the community in need. This includes providing technical expertise, mobilizing resources and coordinating international assistance, if necessary.

By working in a decentralized manner, WHO can effectively contribute to strengthening the country’s overall health system, addressing health challenges at various levels and promoting sustainable improvements in public health outcomes.
Leveraging partnerships, including beyond health, for enhanced results

By working with partners, WHO can harness their expertise, resources and networks to address complex health challenges comprehensively. This collaborative approach fosters synergies, prevents duplication of efforts and promotes the efficient use of resources.

The WHO country office can further leverage partnerships by actively engaging in strategic dialogues. These dialogues pave the way for a long-term agenda for health system transformation, involving social, economic and environmental actors who are indirectly responsible for determinants of health. This entails forging high-impact partnerships at the regional and country levels, bringing together a diverse array of stakeholders to realize national health and development objectives and build synergies. The work of WHO in Papua New Guinea is part of the UNSDCF, presenting an opportunity to maximize its impact and contribution to the broader development agenda. As part of the sector-wide approach, it is crucial to build networks with the education, transport, telecommunication and agriculture sectors and the regional health authority, among others.

Working across teams to deliver more efficiently and effectively

A collaborative approach across teams, including those at the country and regional levels, facilitates the exchange of information and sharing of best practices. This approach will amplify innovations in technology, social entrepreneurship and service delivery. By encouraging inter-team cooperation, it leverages their expertise and strengths to achieve shared objectives, ultimately reducing costs and eliminating duplication. These cross-team collaborations will empower the development and implementation of grassroots solutions. For instance, collaboration between health and agriculture can manifest as the use of agriculture extension officers to promote health by distributing condoms in the hinterland areas, which are seldom visited by health officers. These officers can then relay information regarding the extent of health needs of the remote villages, enabling health officers to plan village outreach efforts.

Incorporating the For the Future operational shifts and lens to facilitate implementation of the strategic deliverables

Incorporating the operational shifts of driving and measuring country impact and promoting health beyond the health sector – which are at the core of For the Future: Towards the Healthiest and Safest Region, the Western Pacific Region vision for WHO’s work with Member States and partners – will strengthen implementation of strategic deliverables in Papua New Guinea. To facilitate driving and measuring country impact, measurable targets and indicators will be set to track progress, and monitoring and evaluation support will be provided. Promoting health beyond the health sector involves engaging with other sectors, addressing social determinants of health, and integrating health considerations into their decision-making processes.

This approach creates supportive environments and contributes to the long-term sustainability of strategic deliverables. This shift enables the integration of services and addresses the broader determinants of health. Taking advantage of the power of strategic communication as a health and development intervention will also ensure effective dissemination of information to partners and collaborators, raise awareness and mobilize support for the strategic deliverables. Additionally, a gender and equity lens should be applied throughout all levels to ensure that everyone benefits equally from regional progress towards better health.
Support required from all levels of the Organization

To implement the strategic deliverables, all levels of the Organization need to provide support. At the country and regional levels, WHO can provide support for strategic dialogue, partnership development and the establishment of information exchange platforms. Technical advisory groups on thematic priorities can be formed, involving countries and experts in shaping the agenda and ensuring its implementation. The Department of Country Strategy and Support, based within the Office of the Director-General at WHO headquarters, monitors and oversees this commitment and is responsible for providing clear strategic direction to strengthen substantively WHO’s work in countries.

Biennial workplan alignment

The CCS serves as the foundation for a bottom-up planning process, enabling the identification of a targeted and cohesive set of priorities that align with the country’s specific needs. It plays a crucial role in developing the biennial Programme Budget of the WHO country office. Using the CCS, WHO’s programmes and resources are strategically aligned with the country’s requirements, facilitating effective planning and implementation of interventions to address health challenges and promote better health outcomes.

8. MONITORING AND EVALUATION

The CCS will be monitored throughout the implementation of the Programme Budget biennial workplans, and through a midterm and end-of-term CCS review. The lessons and recommendations from the final evaluation will be shared within WHO and with the NDOH and other stakeholders. Monitoring and evaluation will focus on reviewing the CCS priorities and strategic focus areas and will support technical staff to assess the progress and reflect on the need to review and update the workplans and resource needs.

Results framework

The results framework is a monitoring surveillance tool that enables the country office to measure progress on a yearly or half-yearly basis and compare trends for the last five years (see Annex 4). To the extent possible, targets for the various indicators were taken from the NHIS, utilizing the baseline statistics to determine the targets.

Data for the indicators in the results framework will be collected routinely or periodically depending on the type of indicator and data source. Input, process, output and selected outcome indicators that are reported through the framework will be corroborated with the NHIS or annual NDOH reports. Data collected will be reported semi-annually by each technical officer to the WHO Representative.

There will be very close collaboration with all NDOH departments, provincial health authorities (PHAs), development partners and other key stakeholders, as well as with the national e-Health Steering Committee, the e-Health Technical Working Group, the NDOH Monitoring and Evaluation Technical Working Group and the Medical Research Advisory Committee in terms of data gathering, data consistency and integrity checks.
**Midterm evaluation**

The midterm evaluation should focus on identifying and highlighting best practices and lessons learnt from the first half of the CCS, so that they can be shared, adopted and built upon for the remainder of the CCS and future CCSs. It also aims to determine the progress made in implementing the strategic priorities, whether the expected achievements are on track, and to identify challenges and areas for improvement that need to be addressed in the remaining period of the CCS. Evaluation criteria to be used can take into consideration the relevance, effectiveness, efficiency and sustainability of the country office’s work and its input towards improving the health outcomes of the population, or data could be taken from the Building Management System that is to be rolled out. For this purpose:

- relevance evaluates the CCS’s alignment with national priorities, policies and needs, international and regional commitments, and the United Nations Multi-stakeholder Development Framework (UNMSDF);
- effectiveness refers to progress made against financial commitments, targets and deliverables, taking into consideration factors that led to success under the gender lens and successful partnerships;
- efficiency looks at how well the limited resources are being used to deliver results economically and on time; and
- sustainability examines the extent to which the net benefits of the intervention continue or are likely to continue.

**Final evaluation**

A final evaluation will be carried out at the end of the CCS cycle. It will be more comprehensive than the midterm review. The final evaluation will identify critical success factors, impediments and lessons learnt. The final evaluation report will describe the main achievements, gaps and challenges, noting the lessons learnt and appropriate recommendations. These insights will be used to inform and improve the next CCS cycle.
9. FUTURE DIRECTIONS

In summary, the WHO country office in Papua New Guinea will utilize the CCS implementation and accountability frameworks described above to work as “One WHO” by utilizing the strengths of all three levels of the Organization, vis-à-vis the country office, the Regional Office for the Western Pacific and the global headquarters, and this includes the use of all the WHO Centres of Excellence in various thematic areas as well as the research and consultancy pool.

The WHO country office will also lead the health aspects of the One UN family with respect to the UNMSDF to address health issues across the various sectors, civil society, faith-based organizations and others. Bringing various health groups, entities and partners together in a formidable partnership to contribute to health with regard to the human capital at the subnational and national levels contributes to the health architecture at the regional and global levels.

With the CCS, the WHO country office will continue to lead and assist in the promulgation of transformative evidenced-based health policies for all sectors at both the national and subnational levels using various mechanisms such as public health communication to influence social norms, advocacy for healthy public policy, provide public alerts, and helping increase individual and community knowledge and awareness, thereby promoting behaviour change.
REFERENCES


ANNEX 1. REVIEW OF PAPUA NEW GUINEA–WHO COOPERATION, 2016–2020

The Papua New Guinea–WHO Country Cooperation Strategy 2016–2020 was developed and implemented within the evolving global context of agreements made at meetings of the World Health Assembly and in agreed United Nations agendas, specifically those set out in the United Nations Development Assistance Framework (UNDAF). In terms of its relevance, even though it was developed during the roll-out of the Twelfth General Programme of Work (GPW 12), it remained relevant to the Thirteenth General Programme of Work. It also is aligned with the priorities of For the Future: Towards the Healthiest and Safest Region, which was developed in 2019. Nationally, the Country Cooperation Strategy 2016–2020 was relevant to most of the key result areas (KRAs) of Papua New Guinea’s National Health Plan 2011–2019. However, there were major areas not specifically included in the CCS 2016–2020, such as malaria control, ageing and noncommunicable diseases, which are a major concern for premature deaths.

Human resource issues were highlighted, including vacant staff positions and short-term consultants. This, coupled with the coronavirus disease (COVID-19) pandemic, made it difficult to provide support to the provincial level, specifically during the 2020–2021 biennium. Additionally, frequent staff movement and reassignments, coupled with delayed replacements, affected the efficiency and effectiveness of the Organization, noting considerations such as the achievement of a full staffing complement and budgetary requirements to maintain current priorities and address new strategic priorities.

The CCS 2016–2020 targeted four strategic priorities with various focus areas, as shown in the illustration on this page.

Despite achievements in areas such as tuberculosis (TB) and HIV, other areas were identified for improvement, such as low national immunization coverage coupled with a vaccine-derived polio outbreak in 2018 and a measles outbreak in 2019. The Special Integrated Routine EPI Strengthening Program (SIREP), introduced in 2015, aimed to address the low national immunization coverage by enhancing routine immunization services and improving immunization coverage across the country while placing focus on implementing the Vaccine-Preventable Diseases Integrated Surveillance (VDI) system, particularly for the polio eradication and measles elimination programmes.

The complexity of implementing the CCS involves working with the National Department of Health (NDOH) and national counterparts as well as other partners to strengthen national capacity and increase the Government’s assumption of responsibilities for health service delivery.
ANNEX 2. STRATEGIC PRIORITIES AND KEY DELIVERABLES

Strategic Priority 1 – Resilient systems for health

The following deliverables are intended under this priority area:

Strengthened human resources for health

- Improved capacities of the National Department of Health (NDOH) and provincial health authorities (PHAs) to optimize workforce motivation, retention, equitable distribution and performance
- Strengthened capacities of NDOH and PHAs for effective public policy stewardship, leadership and governance for human resources for health
- Strengthened health-care workforce data for monitoring and accountability of the National Human Resources for Health Strategic Plan 2021-2030 implementation
- Strengthened capacities of health training institutions and regulatory systems to adapt their institutional set-up and modalities of instruction to respond to transformative educational needs

Improved access to quality essential medicines, vaccines, diagnostics and devices

- Government enabled to manage a sustainable regulatory framework and responsive guidance and standards on quality, safety, efficacy and rational use of medical products
- Strengthened Government capacity for an efficient, effective, functioning and transparent procurement and supply system, inventory management and monitoring system to improve equitable access, availability and affordability of medical products

Accelerated fight against antimicrobial resistance (AMR)

- Government enabled to establish and ensure governance, sustainable investment and actions to combat AMR
- Improved awareness and understanding of AMR through effective communication, education and training
- Strengthened surveillance, diagnostic capacity and research on AMR

Strengthened use of multi-source strategic information including research for evidence-based decision-making

- Improved quality and use of data from routine health information systems, with a focus on the National Health Information System (NHIS), hospital reporting and the civil registration and vital statistics system
- Strengthened digital health environment with a focus on working towards the interoperability of health information systems
- Enhanced institutional arrangements to identify and undertake research of high standards

Improved availability of and access to quality essential health services

- PHAs enabled to provide people-centred health services based on primary health care
- Strengthened primary health-care renewal through policy leadership, advocacy and strategic partnerships with governments, nongovernmental and civil society organizations, and other stakeholders
- Strengthened subnational levels of governance to support primary health care
• Strengthened governance and policy frameworks that reflect and promote all primary health-care components

Enhanced action and innovation for health through effective governance, partnerships and intersectoral coordination

• Enhanced capacity of NDOH to develop and implement equitable health financing strategies and reforms towards universal health coverage
• Enhanced capacity of NDOH to develop evidence-based policy briefs, regulations and laws
• Strengthened health sector and aid coordination for better implementation of the National Health Plan 2021–2030
• Enhanced capacity of NDOH and PHAs to produce and analyse information on financial risk protection, equity and health expenditures to track progress and inform decision-making

Strategic Priority 2 – Healthier populations and NCDs

The following deliverables are intended under this priority area:

Improved reproductive, maternal, newborn, child and adolescent health (RMNCAH) through people-centred strategies

• Enhanced community-centred prevention and health promotion actions
• Improved capacities at all levels for essential RMNCAH
• Cross-programme collaboration and linked response on the elimination of parent-to-child transmission of HIV, sexually transmitted infections and hepatitis and the prevention and control of vaccine-preventable diseases (VPDs), malaria, tuberculosis (TB), noncommunicable diseases (NCDs), including cancer, and violence.

Improved immunization coverage

• Country enabled to provide high-quality immunization service across the life-course
• Health workforce equipped with the knowledge and skills to deliver immunization service
• Improved laboratory-based VPD surveillance and timely detection of and response to VPD outbreaks

Improved actions for gender equality, prevention of gender-based violence and addressing other social determinants of health

• NDOH enabled to integrate social determinants of health into health plans and policies
• Increased awareness of health workforce on the social determinants of health; gender, equity and human rights; and violence against women

Reduced morbidity and mortality due to violence and injuries

• Enhanced capability of health providers to respond to violence and injuries
• Enhanced capacity of PHAs to address gender-based violence

Prevention of non-communicable diseases and mental health

• Implement comprehensive tobacco control measures, promote healthy lifestyles, and raise awareness about the risks associated with NCDs and unhealthy behaviours.
• Public health campaigns, education and targeted interventions can play a vital role in this regard.
Strategic Priority 3 – Integrated health services delivery targeted to high-priority diseases

The following deliverables are intended under this priority area:

- Reduced burden of high-priority diseases including HIV, TB, malaria, sexually transmitted infections and hepatitis to accelerate progress towards their elimination at national and subnational levels
  - Technical support provided for the development of strategies, policies and guidelines in line with WHO recommendations for TB, malaria and other programmes, including the adoption of targeted interventions and elimination of the vertical transmission of HIV, syphilis and malaria at the subnational level
  - Strengthened implementation of a strategic plan at the national level and operational plans at the subnational level
  - Enhanced capacities of health-care workers and officers at national and provincial levels to provide quality prevention, diagnosis and treatment of priority communicable diseases
  - Strengthened monitoring and surveillance to understand disease patterns, service delivery and treatment efficacy, quality improvement of service delivery, and the integrated disease control strategy

- Reduced transmission and elimination of neglected tropical diseases (NTDs) in endemic communities
  - NTDs eliminated through the adaptation of WHO guidelines, capacity-building, partnerships, integrated disease surveillance, resource mobilization and support for innovative approaches such as post-exposure prophylaxis of leprosy

Prevention, management and control of NCDs including mental health

- Enhanced national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response to the prevention and control of NCDs strengthened
- Strengthened integration and implementation of the package of essential noncommunicable (PEN) disease interventions at the primary care level

Strategic Priority 4 – Health security

The following deliverables are intended under this priority area:

Enhanced capacity for preparedness and response to health emergencies

- Potential health emergencies rapidly detected and risks assessed and communicated
- Enhanced capacity in the country to prepare and respond to health emergencies

Strengthened food safety measures

- Country enabled to strengthen access to safe, healthy and sustainably produced foods through a “One Health” approach
- Country enabled to address food-related risk factors through multisectoral actions for food control system
- Increased capacity of Government to implement and monitor food safety measures
Strengthened mitigation, response and adaptation measures to address the health impacts of climate change and environmental hazards

- Country enabled to address environmental determinants including climate change
- Strengthened capacity of NDOH to advance towards climate-resilient and environmentally sustainable health-care facilities

Prevent, detect and respond to disease outbreaks to minimize morbidity, mortality and socioeconomic impact

- Strengthened national and provincial emergency operation centres and rapid response teams
- Strengthened effective surveillance for early detection of disease outbreaks, enabling swift and targeted interventions to control and mitigate the spread of infections

Improved water, sanitation and hygiene (WASH) including health-care waste management and infection prevention and control

- Strengthened capacity of Government to implement WASH measures in health-care facilities
- Increased capacity of Government to implement health-care waste management
## ANNEX 3. KEY TO THE LINKAGES FRAMEWORK

The table below provides details on the key result areas (KRAs), outputs and targets that are referenced in the linkages framework in Annex 5. The linkages framework shows the connections between the new strategic priorities and the national, regional and international commitments.

<table>
<thead>
<tr>
<th>NDOH Key result areas</th>
<th>UNSDCF Outputs</th>
<th>SDG targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>KRA1: Healthier communities through effective engagement</td>
<td><strong>Output 2.1: Social Contract</strong> Renewed social contract between the Government and all sectors of Papua New Guinean society through support to the creation of conditions conducive to an ongoing, free and open dialogue, generating demand for better governance, and acceleration of nationwide implementation of the SDGs.</td>
<td><strong>Target 3.b</strong> Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.</td>
</tr>
<tr>
<td>KRA2: Working together in partnership</td>
<td><strong>Output 2.3: Service Delivery</strong> Strengthened national and subnational planning, monitoring, data and public finance management systems for improved effectiveness and efficiency in service delivery.</td>
<td>-</td>
</tr>
<tr>
<td>KRA3: Increase access to quality and affordable health services</td>
<td><strong>Output 3.2: Health</strong> Strengthened health systems to improve the well-being and access to quality, integrated, people-centred health services including TB, HIV/AIDS and sexual and reproductive health; and provide protection from health emergencies for people at national and subnational levels, particularly those in hard-to-reach areas.</td>
<td><strong>Target 3.c</strong> Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states.</td>
</tr>
<tr>
<td>KRA4: Address disease burdens and targeted health priorities</td>
<td><strong>Output 1.1: Women and the Enabling Environment</strong> Enhanced gender equality and the empowerment of women and girls at all levels in line with international norms and standards in the implementation of legislation, policies and financing</td>
<td><strong>Target 3.8</strong> Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.</td>
</tr>
<tr>
<td>KRA5: Strengthen health systems</td>
<td></td>
<td><strong>Target 2.2</strong> By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons.</td>
</tr>
<tr>
<td>NDOH&lt;sup&gt;a&lt;/sup&gt; Key result areas</td>
<td>UNSDCF&lt;sup&gt;b&lt;/sup&gt; Outputs</td>
<td>SDG&lt;sup&gt;c&lt;/sup&gt; targets</td>
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</tbody>
</table>
| **Output 1.4: Women and Violence**  
Women and girls are free from discrimination, violence, and torture through a whole-of-society approach to the promotion of gender-equitable sociocultural attitudes, norms and behaviours. |  | **Target 3.1**  
By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births. |
| **Output 3.2: Health**  
Strengthened health systems to improve the well-being and access to quality, integrated, people-centred health services including TB, HIV/AIDS and sexual and reproductive health; and provide protection from health emergencies for people at national and subnational levels, particularly those in hard-to-reach areas. |  | **Target 3.2**  
By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births. |
| **Output 3.5: Protection**  
Strengthened social protection systems and improved access to all forms of protection services by the most vulnerable and marginalized populations, which provide physical and legal protection including in violent or conflict contexts. |  | **Target 3.7**  
By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. |
|  |  | **Target 4.2**  
By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education. |
|  |  | **Target 5.2**  
Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation. |
|  |  | **Target 5.3**  
Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation. |
|  |  | **Target 5.6**  
Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. |
<table>
<thead>
<tr>
<th>NDOH(^a) Key result areas</th>
<th>UNSDCF(^b) Outputs</th>
<th>SDG(^c) targets</th>
</tr>
</thead>
</table>
| **Output 3.5: Protection**  
Strengthened social protection systems and improved access to all forms of protection services by the most vulnerable and marginalized populations, which provide physical and legal protection including in violent or conflict contexts. | | **Target 3.3**  
By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. |
| | | **Target 3.4**  
By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being. |
| | | **Target 3.5**  
Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. |
| | | **Target 3.6**  
By 2020, halve the number of global deaths and injuries from road traffic accidents. |
| | | **Target 3.a**  
Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate. |
| | | **Target 3.8**  
Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. |
| | | **Target 5.1**  
End all forms of discrimination against all women and girls everywhere. |
| | | **Target 5.2**  
Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation. |
<table>
<thead>
<tr>
<th>NDOH&lt;sup&gt;a&lt;/sup&gt; Key result areas</th>
<th>UNSDCF&lt;sup&gt;b&lt;/sup&gt; Outputs</th>
<th>SDG&lt;sup&gt;c&lt;/sup&gt; targets</th>
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</thead>
</table>

**Indicator 5.2.2**  
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence  

**Target 16.1**  
Significantly reduce all forms of violence and related death rates everywhere.

**Output 3.3: Water, Sanitation and Hygiene (WASH)**  
WASH systems strengthened to ensure people have equitable access to affordable, gender-sensitive, environmentally and climate friendly safe drinking water and sanitation services and have awareness of safe hygiene behaviour.

**Output 3.4: Food Security and Nutrition**  
Increased food security as a result of the establishment of food systems and nutrition sensitive agriculture, especially for those most marginalized and isolated.

**Output 5.2: Climate Action**  
Enhanced climate adaptation and mitigation measures are delivered to strengthen the capacity of Papua New Guinea to mitigate the impacts of climate change on ecosystems, communities, livelihoods and the economy.

**Output 5.3: Disaster Risk Management**  
Strengthened resilience and preparedness of the most vulnerable and displaced communities through implementation of disaster management strategies and systems.

**Target 3.9**  
By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

**Target 3.d**  
Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

**Target 6.1**  
By 2030, achieve universal and equitable access to safe and affordable drinking water for all.

**Target 6.2**  
By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.

**Target 13.1**  
Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries.

NDOH, National Department of Health; SDG, Sustainable Development Goal; TB, tuberculosis; UHC, universal health coverage; UNSDCF, United Nations Sustainable Development Cooperation Framework.

<sup>a</sup> National Health Plan 2021–2030 volume 1: policies and strategies (https://www.health.gov.pg/pdf/NHP_1A15.pdf)


<sup>c</sup> Sustainable Development Goals (https://sdgs.un.org/goals)
## ANNEX 4. RESULTS FRAMEWORK

<table>
<thead>
<tr>
<th>Strategic priority</th>
<th>Strategic deliverable</th>
<th>National indicator</th>
<th>SDG Indicator</th>
<th>GPW indicator</th>
<th>UNSDCF indicator</th>
<th>National baseline value</th>
<th>Source &amp; baseline year</th>
<th>Target (2028)</th>
<th>Responsible team lead</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Priority 1 – Resilient Systems for Health</strong></td>
<td>SD1: Strengthened human resources for health</td>
<td>Density of physicians (per 10 000 population)</td>
<td>3.c.1 Health worker density and distribution</td>
<td>8.1 Health worker density and distribution</td>
<td>0.7</td>
<td>NHRHSP 2021-2030</td>
<td>2.7</td>
<td>Human Resources for Health</td>
<td>eNHIS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Density of nurses and midwives (per 10 000 population)</td>
<td></td>
<td></td>
<td>3.2.7 Health worker density</td>
<td>4.3</td>
<td>NHRHSP 2021-2030</td>
<td>18.1</td>
<td>Human Resources for Health</td>
<td>eNHIS</td>
</tr>
<tr>
<td></td>
<td>SD2: Improved access to quality essential medicines, vaccines, diagnostics and devices</td>
<td>Number of health facilities that have a core set of relevant essential medicines, vaccines, diagnostics and devices available and affordable on a sustainable basis</td>
<td>3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis</td>
<td>4.a.1 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis</td>
<td>3.2.8 Outpatient service utilization per capita</td>
<td>NA</td>
<td>NDOH Service Statistics</td>
<td>80</td>
<td>Health Systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.a.2 Availability of essential medicines for primary health care, including the ones free of charge</td>
<td></td>
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<tr>
<td></td>
<td>SD3: Accelerated fight against antimicrobial resistance (AMR)</td>
<td>Percentage of bloodstream infections due to selected antimicrobial-resistant organisms</td>
<td>3.d.1 International health regulation capacity and health emergency preparedness</td>
<td>42.1 Percentage of bloodstream infections due to antimicrobial-resistant organisms</td>
<td>NA</td>
<td>NDOH Service Statistics</td>
<td>Reduction in numbers</td>
<td>Health Systems</td>
<td>eNHIS</td>
<td></td>
</tr>
<tr>
<td>Strategic priority</td>
<td>Strategic deliverable</td>
<td>National indicator</td>
<td>SDG Indicator</td>
<td>GPW Indicator</td>
<td>UNSDCF indicator</td>
<td>National baseline value</td>
<td>Source &amp; baseline year</td>
<td>Target (2028)</td>
<td>Responsible team lead</td>
<td>Means of verification</td>
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<tr>
<td>SD4: Strongest use of multi-source strategic information including research for evidence-based decision-making</td>
<td>that meet the data verification factor within 10% range</td>
<td>NA</td>
<td>NDOH Service Statistics</td>
<td>75% for all indicators assessed</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Death registration coverage</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>SDS: Improved availability of and access to quality essential health services</td>
<td>Population with household expenditures on health greater than 25% of total household expenditure or income</td>
<td>3.8.2 Catastrophic health spending</td>
<td>NA</td>
<td>WHO Country Profile 2018</td>
<td>30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Total health expenditure as a percentage of GDP</td>
<td>3.8.2 Catastrophic health spending</td>
<td>2.50%</td>
<td>UNDP Report 2020</td>
<td>6%</td>
<td>Health Systems</td>
<td>National health accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Availability of national health insurance policy or strategy</td>
<td></td>
<td>NA</td>
<td>NDOH Service Statistics</td>
<td>Completed</td>
<td>Health Systems</td>
<td>National health accounts</td>
<td></td>
<td></td>
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<tr>
<td>Strategic priority</td>
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<tr>
<td>SD6: Enhanced action and innovation for health through effective governance, partnerships and intersectoral coordination</td>
<td>Partner coordination meetings held monthly</td>
<td>NA</td>
<td>WHO country office meeting minutes</td>
<td>Established number of coordination meetings</td>
<td>Meeting minutes</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Improved coordination at national and subnational levels</td>
<td>NA</td>
<td>Coordination Improved</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Strategic Priority 2 – Healthier populations and NCDs</td>
<td>Total fertility rate</td>
<td>4.2</td>
<td>DHS 2016–2018</td>
<td>3.6</td>
<td>NHIS</td>
<td></td>
<td></td>
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</tbody>
</table>

**UHC service coverage index**

3.8.1 Coverage of essential health services (defined as the average coverage of essential health services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)

1.1 Access barriers to primary care due to distance

Number of provinces implementing the package of essential non-communicable (PEN) disease interventions for primary health care.

1.2 Hospital admission that can be avoided with appropriate primary care

**Partner coordination meetings held monthly**

Improved coordination at national and subnational levels

**Total fertility rate**

4.2

DHS 2016–2018

3.6

NHIS
<table>
<thead>
<tr>
<th>Strategic priority</th>
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<th>National indicator</th>
<th>SDG Indicator</th>
<th>GPW indicator</th>
<th>UNSDCF indicator</th>
<th>National baseline value</th>
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<th>Target (2028)</th>
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<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio (per 100 000 live births)</td>
<td>3.1.1 Maternal mortality ratio</td>
<td>12.1 Maternal mortality ratio</td>
<td>3.2.3 National maternal mortality ratio</td>
<td>171</td>
<td>DHS 2016–2018</td>
<td>150 per 100 000 live births</td>
<td>Heathier Populations</td>
<td>NHIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive (modern) prevalence rate (%)</td>
<td>3.1.2 Proportion of births of women having at least 4 ANC visits (%)</td>
<td>12.2 Proportion of pregnant women who had at least 4 ANC visits</td>
<td>76%</td>
<td>DHS 2016–2018</td>
<td>&gt; 79%</td>
<td>Heathier Populations</td>
<td>eNHIS</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Delivered in health facility (%)</td>
<td>3.1.3 Proportion of births attended by skilled health personnel</td>
<td>12.2 Proportion of births attended by skilled health personnel</td>
<td>55%</td>
<td>DHS 2016–2018</td>
<td>&gt; 80%</td>
<td>Heathier Populations</td>
<td>eNHIS</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Adolescent birth rate per 1000 women aged 15–49 years</td>
<td>3.7.2 Adolescent birth rate (10–14 years; 15–19 years) per 1000 women in that age group</td>
<td>NA</td>
<td>14.7</td>
<td>CCA 2022</td>
<td>5.0</td>
<td>Heathier Populations</td>
<td>eNHIS</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Newborn mortality ratio (per 1000 live births)</td>
<td>3.2.2 Newborn mortality rate</td>
<td>13.2 Newborn mortality rate</td>
<td>20</td>
<td>DHS 2016–2018</td>
<td>&lt; 12 per 1000 live births</td>
<td>Heathier Populations</td>
<td>eNHIS</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Infant mortality ratio (per 1000 live births)</td>
<td>22</td>
<td>DHS 2016–2018</td>
<td>12</td>
<td>Heathier Populations</td>
<td>eNHIS</td>
<td></td>
<td></td>
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<tr>
<td>Under-5 mortality rate (per 1000 live birth)</td>
<td>3.2.1 Under-5 mortality rate</td>
<td>13.1 Under-5 mortality rate</td>
<td>49</td>
<td>DHS 2016–2018</td>
<td>&lt; 20 per 1000 live births</td>
<td>Heathier Populations</td>
<td>eNHIS</td>
<td></td>
<td></td>
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<tr>
<td>Strategic priority</td>
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<td>SDG Indicator</td>
<td>GPW indicator</td>
<td>UNSDCF indicator</td>
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<tr>
<td>Births attended by skilled health personnel</td>
<td>3.1.2 Proportion of births attended by skilled health personnel</td>
<td>12.2 Proportion of births attended by skilled health personnel</td>
<td>12.2</td>
<td>UNSDCF indicator</td>
<td>National baseline value</td>
<td>CCA 2022</td>
<td>&gt; 95%</td>
<td>Heathier Populations</td>
<td>eNHIS</td>
<td></td>
</tr>
<tr>
<td>Number of cases of congenital syphilis per 100 000 live births</td>
<td>NA</td>
<td>NDOH 2021</td>
<td>&lt; 20%</td>
<td>Heathier Populations</td>
<td>eNHIS</td>
<td></td>
<td></td>
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<tr>
<td>Proportion of HIV-positive pregnant women given ART</td>
<td>81%</td>
<td>NDOH 2021</td>
<td>&gt; 95%</td>
<td>Heathier Populations</td>
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<tr>
<td>Proportion of ANC women tested for syphilis</td>
<td>90%</td>
<td>NDOH 2021</td>
<td>&gt; 95%</td>
<td>Heathier Populations</td>
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<td>Mother-to-child transmission rate</td>
<td>27.5% (vertical)</td>
<td>Triple elimination operational plan 2020</td>
<td>&lt; 5%</td>
<td>Heathier Populations</td>
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<tr>
<td>Proportion of syphilis there are positive pregnant women treated for syphilis</td>
<td>&gt; 81%</td>
<td>NDOH 2021</td>
<td>&gt; 95%</td>
<td>Heathier Populations</td>
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<td>Exclusive breastfeeding under age 6 months (%)</td>
<td>62%</td>
<td>WUENIC 2022</td>
<td>76%</td>
<td>Heathier Populations</td>
<td>eNHIS</td>
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<td>SD2: Improved immunization coverage</td>
<td>DPT3/Pentavalent Vaccine 3 coverage (%)</td>
<td>3.2.2 Proportion of children who received DPT3/Penta3 vaccination</td>
<td>36%</td>
<td>WUENIC 2022</td>
<td>80%</td>
<td>VDI</td>
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<td>Measles Containing Vaccine (MCV1) coverage (%)</td>
<td>44%</td>
<td>DHS 2016–2018</td>
<td>80%</td>
<td>VDI</td>
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<td>All basic vaccination coverage (%)</td>
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<td>35%</td>
<td>DHS 2016–2018</td>
<td>&gt; 86%</td>
<td>VDI</td>
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<td>Last birth protected against tetanus (%)</td>
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<td></td>
<td>38%</td>
<td>DHS 2016–2018</td>
<td>&gt; 95%</td>
<td>VDI</td>
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<td>Prevalence of hepatitis B surface antigen (HBsAg) among children 4–6 years old</td>
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<td>2.3</td>
<td>PubMed datab</td>
<td>1.2</td>
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| SD3: Improved actions for gender equality, prevention of gender-based violence and addressing other social determinants of health | Prevalence of intimate partner violence |                    |               |               | 3.2.10 Number of districts that have rolled out psychosocial support services for survivors of GBV
3.2.12 Number of women, adolescents and youth, including women and young people with disabilities, who benefited from GBV services (including services related to mental health and psychosocial support). | 63 | DHS 2016–2018 | 47 | SDH | Reports |
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<td>SD4: Stronger community engagement and strategic communication for healthier communities</td>
<td>PHAs that have developed annual implementation plans with community engagement Village health assistants per 1000 population</td>
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<td>80</td>
<td>NDOH Policy Documents</td>
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<td>SD5: Prevention of non-communicable diseases and mental health</td>
<td>33.1 Proportion of women between the ages of 30 to 49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies</td>
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<td>Age-standardized mean population salt intake per gram per day in persons 18+ years</td>
<td>24.1 Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years</td>
<td></td>
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<td>6.7</td>
<td>WHO NCD Country Profile 2018</td>
<td>3.5</td>
<td>Healthier Populations</td>
<td>STEPS survey</td>
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<td>Age-standardized prevalence of tobacco use among persons age 15+ years</td>
<td>3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older</td>
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<td>29.8</td>
<td>WHO NCD Country Profile 2018</td>
<td>22.0</td>
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<td>Age-standardized prevalence of insufficient physical activity among persons aged 18+ years</td>
<td>Age-standardized prevalence of insufficiently physically inactive persons age 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent)</td>
<td>27.1 Age-standardized prevalence of insufficiently physically inactive persons age 18+ years</td>
<td>12.8</td>
<td>WHO NCD Country Profile 2018</td>
<td>11.0</td>
<td>Healthier Populations</td>
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<td>Age-standardized prevalence of raised blood pressure among persons aged 18+ years</td>
<td>Age-standardized prevalence of raised blood pressure among persons age 18+ (defined as systolic blood pressure of &gt; 140 mmHg and/or diastolic blood pressure &gt; 90 mmHg) and mean systolic blood pressure</td>
<td>31.1 Age-standardized prevalence of raised blood pressure among persons age 18+ years</td>
<td>17.0</td>
<td>WHO NCD Country Profile 2018</td>
<td>9.0</td>
<td>Healthier Populations</td>
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<td>Suicide rate per 100 000 population</td>
<td>Suicide mortality rate</td>
<td>3.4.2 Suicide mortality rate</td>
<td>28.1 Suicide mortality rate</td>
<td>5.4</td>
<td>WHO NCD Country Profile 2018</td>
<td>4.4</td>
<td>Healthier Populations</td>
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<td><strong>Strategic Priority 3 – Integrated health services</strong></td>
<td>SD1: Reduced burden of high-priority diseases including HIV, tuberculosis, malaria, sexually transmitted infections and hepatitis to accelerate progress towards their elimination at national and subnational levels</td>
<td>HIV incidence rate (per 1000 uninfected population)</td>
<td>3.3.1 Number of new HIV infections per 1000 uninfected population, by sex, age and key populations</td>
<td>39.1 Number of new HIV infections per 1000 uninfected population, by sex, age and key populations</td>
<td>39.2 Number of HIV related deaths</td>
<td>0.38</td>
<td>UNAIDS Report&lt;sup&gt;2&lt;/sup&gt;</td>
<td>0.15</td>
<td>HIV</td>
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<tr>
<td>TB incidence per 100 000 population</td>
<td>3.2 TB incidence per 100 000 population</td>
<td>36.1 TB incidence per 100000 population per year</td>
<td>3.2.5 Number of new and relapse TB cases detected and put on treatment</td>
<td>424e</td>
<td>NDOH Service Statistics</td>
<td>290</td>
<td>TB</td>
<td>Programme data</td>
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<td>Strategic priority</td>
<td>Strategic deliverable</td>
<td>National indicator</td>
<td>SDG Indicator</td>
<td>GPW indicator</td>
<td>UNSDCF indicator</td>
<td>National baseline value</td>
<td>Source &amp; baseline year</td>
<td>Target (2028)</td>
<td>Responsible team lead</td>
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<td>Management and control of non-communicable diseases including mental health</td>
<td>Mortality between 30 and 70 years (premature mortality) from NCDs</td>
<td>3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease</td>
<td>21.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory diseases measured by probability of dying between the exact ages of 30 and 70 years</td>
<td>27</td>
<td>WHO NCD Country Profile 2018</td>
<td></td>
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<td>18</td>
<td>Healthier Populations</td>
<td>Civil Registration Systems</td>
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<tr>
<td>Strategic Priority 4 – Health Security</td>
<td>SD1: Enhanced capacity for preparedness and response to health emergencies</td>
<td>Public health emergency (outbreak or disaster) after-action review conducted</td>
<td></td>
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<td>100%</td>
<td>DHS 2016–2018</td>
<td>100%</td>
<td>Health Emergency and Environment</td>
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<td>SD2: Strengthened food safety measures</td>
<td>Population using improved sanitation facilities (%)</td>
<td>3.3.1 Number of people reached with at least basic sanitation services through UN programmes</td>
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<td>29%</td>
<td>DHS 2016–2018</td>
<td>60%</td>
<td>Health Emergency and Environment</td>
<td>Surveillance reports</td>
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<td>Strategic priority</td>
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<td>National indicator</td>
<td>SDG Indicator</td>
<td>GPW indicator</td>
<td>UNSDCF indicator</td>
<td>National baseline value</td>
<td>Source &amp; baseline year</td>
<td>Target (2028)</td>
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<td>SD3: Strengthened mitigation, response and adaptation measures to address the health impacts of climate change and environmental hazards</td>
<td>Policy, strategy and operational plans for adaptation measures in place nationally and subnationally</td>
<td>NA</td>
<td>NDOH Service Reports</td>
<td>Yes</td>
<td>Health Emergency and Environment</td>
<td>Programme Data</td>
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<td>SD4: Prevent, detect and respond to disease outbreaks to minimize morbidity, mortality, and socioeconomic impact</td>
<td>Outbreaks/urgent events identified and reported are assessed by NDOH/PHA within 48 hours of receiving the report</td>
<td>70</td>
<td>NDOH Service Reports</td>
<td>90</td>
<td>Health Emergency and Environment</td>
<td>Programme Data</td>
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<td>SD5: Improved water, sanitation, and hygiene (WASH) including health-care waste management and infection prevention and control</td>
<td>Population using safely managed sanitation services (%)</td>
<td>3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe WASH services)</td>
<td>43.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe WASH services)</td>
<td>3.3.1 Number of people reached with at least basic sanitation services through UN programmes</td>
<td>3.3.2 Number of people reached with at least basic water that is safe and available when needed, through UN programmes</td>
<td>3.3.3 Number of people reached with at least basic hygiene services through UN programmes</td>
<td>DHS 2016–2018 World Bank data repository</td>
<td>63</td>
<td>10.8</td>
<td>Health Emergency and Environment</td>
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AMR, antimicrobial resistance; ANC, antenatal care; ART, antiretroviral therapy; CCA, Common Country Analysis; DHS, Demographic and Health Survey; GBV, gender-based violence; eNHIS, electronic National Health Information System; GDP, gross domestic product; GPW, General Programme of Work; HBV, hepatitis B virus; HCV, hepatitis C virus; NCD, noncommunicable disease; NDOH, National Department of Health; NHIS, National Health Information System; NHRHSP, National Human Resources for Health Strategic Plan; NHWA, National Health Workforce Accounts; NTD, neglected tropical disease; OOP, out-of-pocket; Penta3, pentavalent vaccine (third dose); PHA, provincial health authority; SD, strategic deliverable; SDG, Sustainable Development Goal; SDH, Social Determinants of Health; TB, tuberculosis; UHC, universal health coverage; UN, United Nations; UNAIDS, United Nations Joint Programme on HIV/AIDS; UNDP, United Nations Development Programme; UNSDCF, United Nations Sustainable Development Cooperation Framework; VDI, Vaccine-Preventable Diseases Integrated Surveillance; WASH, water, sanitation and hygiene; WHO, World Health Organization; WUENIC, WHO and UNICEF Estimates of National Immunization Coverage.

c Noncommunicable diseases country profiles 2018 (https://www.who.int/publications/i/item/9789241514620)
ANNEX 5. LINKAGES FRAMEWORK

The table below shows the linkages between the new strategic priorities and the national, regional and international commitments. It shows clearly how the strategic objectives are linked to the major national plans, i.e. the National Health Plan 2021–2030 and Vision 2050, For the Future: Towards the Healthiest and Safest Region, the Healthy Islands initiative of the Pacific subregion, the United Nations Sustainable Development Cooperation Framework (UNSDCF), the Sustainable Development Goals (SDGs) and the Thirteenth General Programme of Work (GPW 13) goals. See Annex 3 for further details on the key result areas (KRAs), UNSDCF outputs and SDG targets.

<table>
<thead>
<tr>
<th>Strategic priority</th>
<th>NDOH* KRAs</th>
<th>Vision 2050</th>
<th>For the Future</th>
<th>Healthy Islands</th>
<th>UNSDCFb (Outputs)</th>
<th>SDGc</th>
<th>GPW 13 Goals</th>
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<tbody>
<tr>
<td>1. Resilient systems for health</td>
<td>KRA 2: Working together in partnership</td>
<td>Strategic planning, integration and control</td>
<td>Reaching the unreached</td>
<td>Advocacy, healthy policy; strategic information; SWAP</td>
<td>2.1, 2.3, 3.2</td>
<td>3.8, 3.6, 3.8</td>
<td>Universal health coverage (UHC) Systems strengthening</td>
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<td>KRA 3: Increase access to quality and affordable health services</td>
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<td>KRA 5: Strengthen health systems</td>
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<td>2. Healthier populations and NCDs</td>
<td>KRA 4: Address disease burdens and targeted health priorities</td>
<td>Human capital development, gender, youth and people empowerment</td>
<td>Reaching the unreached</td>
<td>Strengthened health system based on primary health care</td>
<td>1.1, 1.4, 3.2, 3.4, 3.5</td>
<td>2.2, 3.1, 3.2, 3.7, 4.2, 5.2, 5.3, 5.6</td>
<td>UHC Better health and well-being</td>
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<td>3. Integrated health services delivery targeted to high-priority diseases</td>
<td>KRA 1: Healthier communities through effective engagement</td>
<td>Institutional development and service delivery</td>
<td>Reaching the unreached</td>
<td>Enhance multisectoral planning, partnerships and networking</td>
<td>3.2, 3.3, 3.5</td>
<td>3.3, 3.4, 3.5, 3.6, 3.8, 5.1, 5.2, 5.2, 16.1</td>
<td>UHC Better health and well-being</td>
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<td>KRA 4: Address disease burdens and targeted health priorities</td>
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<td>4. Health security</td>
<td>KRA 4: Address disease burdens and targeted health priorities</td>
<td>Environmental sustainability and climate change</td>
<td>Reaching the unreached</td>
<td>Climate change &amp; environment, health emergencies</td>
<td>3.3, 3.4, 5.2, 5.3</td>
<td>3.9, 6.1, 6.2, 13.1, 3.6</td>
<td>Protection from health emergencies</td>
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GPW 13, Thirteenth General Programme of Work; KRA, key result area; NDOH, National Department of Health; SDG, Sustainable Development Goal; SWAP, sector-wide approach; UHC, universal health coverage; UNSDCF, United Nations Sustainable Development Cooperation Framework.


c Sustainable Development Goals (https://sdgs.un.org/goals)