NATIONAL CAPITAL DISTRICT PROVINCIAL HEALTH AUTHORITY



CORPORATE PLAN

2027 - 2031

National Capital District Provincial Health Authority
Corporate Plan 2027–2031

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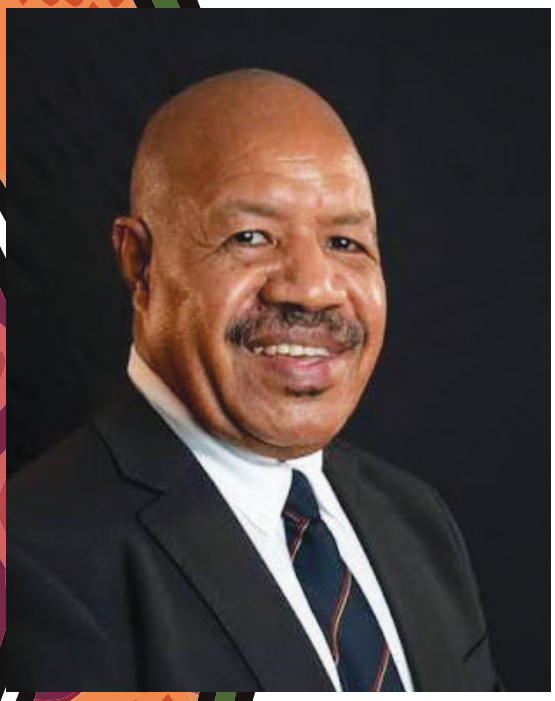
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Preface by the Governor of National Capital District



Distinguished guests, development partners, health leaders, colleagues, and friends. It is my honour to launch the National Capital District Provincial Health Authority's Corporate Plan 2027–2031. This document is a roadmap for how we, as a city and as a people, will strengthen our health system to deliver better health outcomes for every resident of the National Capital District and Motu Koitabu areas.

The past years have shown us the challenges of rapid urbanisation, population growth, and rising health demands in our capital. Our hospitals, clinics, health workers, and support systems have been stretched. Yet, amidst these challenges, we have also witnessed innovation, resilience, and a renewed spirit of collaboration. This Corporate Plan builds on those lessons and sets a clear path forward.

As your Governor, I affirm my commitment to supporting the implementation of this plan. Health is not the responsibility of the PHA alone. It requires the cooperation of all levels of government, the private sector, churches, civil society, and most importantly, our communities.

This plan recognises the value of those partnerships and calls on all of us to take ownership of health outcomes.

Our vision is simple and powerful: a healthier, safer, and more resilient National Capital District and Motu Koitabu. We want every mother to give birth safely, every child to be vaccinated, every young person to have access to health education, and every citizen and expatriate, to have confidence in the services we provide.

Let us therefore work hand in hand to translate this plan into action, and this action into real change for our people. The future of NCD depends on the health of its people, and the future of Papua New Guinea depends on a strong, healthy capital city.

I thank the NCDPHA leadership, Board Chairman Mr Daniel Waswas and CEO Dr Robin Oge, our frontline health workers, and all our partners for their dedication. Together, let us make this Corporate Plan a living document that brings hope and progress to every household in NCD.

Hon. Powes Parkop
Governor
National Capital District

Foreword by the Chairman of NCDPHA Board



It is with confidence that I present the Corporate Plan for the National Capital District Provincial Health Authority for the period 2027 - 2031. This Plan represents a vision of how health care in our nation's capital will be shaped over the next five years. It reflects our commitment to transform the delivery of health services in Port Moresby, improve the health and wellbeing of our people, and ensure that the capital city sets the standard for innovation and excellence in health care delivery in Papua New Guinea.

The development of this Plan is grounded in evidence, aligned with the National Health Plan 2021-2030 and Vision 2050, and responsive to the unique realities of our capital city. The NCD is the fastest growing and most urbanised province in the country, with a population that is young, diverse, and rapidly expanding. This brings with it new opportunities, but also significant challenges. Our health facilities, workforce, and systems are under increasing pressure to deliver quality services that can meet demand. As the custodian of health in this context, NCDPHA carries critical responsibility. We must anticipate change, act decisively, and innovate constantly to remain ahead of the challenges before us.

In the years ahead, NCDPHA will prioritise strengthening primary health care, expanding access to essential services, modernising our health facilities, and investing in digital and physical infrastructure. We will promote data-driven decision-making, enhance accountability, and foster partnerships that bring together government, development partners, private sector, churches, and civil society. No single institution can solve the health challenges of the capital on its own. Our success will depend on collaboration and collective responsibility.

This Plan would not have been possible without the commitment and collaboration of many. I sincerely acknowledge the tireless efforts of our staff, the leadership of the Chief Executive Officer and the senior executive management team, the guidance of the National Department of Health, the support of the National Capital District Commission, and the continued contributions of our development partners. Above all, I pay tribute to our frontline health workers across the three districts of the National Capital District, whose dedication, sacrifice and compassion embody the very spirit of service. The challenges ahead are significant, but our resolve is stronger.

Together, we will realise a healthier, stronger, and more equitable National Capital District—one where every citizen, regardless of their background, has the opportunity to live a healthy and productive life.

Mr Daniel Waswas
Chairman
NCDPHA Board

Message from the Chief Executive Officer



It is my pleasure to present the National Capital District Provincial Health Authority Corporate Plan for 2027 - 2031. This Plan is a statement of our shared vision and commitment to deliver accessible, equitable, and quality health services to every resident of the National Capital District and Motu Koitabu villages.

The population of Port Moresby continues to grow rapidly, placing increasing demands on our health facilities, workforce, and systems. At the same time, we are faced with a triple burden of disease—rising non-communicable diseases, persistent infectious diseases, and trauma and injuries. The COVID-19 pandemic reminded us of the vulnerabilities of our system, but it also demonstrated our resilience, our ability to innovate under pressure, and the importance of strong partnerships. This Corporate Plan builds on those lessons, while setting a course for a stronger, more sustainable, and more responsive health system.

Our vision is clear: healthy people and thriving communities in the National Capital District and the Motu Koitabu villages. To achieve this vision we will focus on nine strategic pillars that form the backbone of this Plan — unified leadership and good governance; people-centred and proactive service delivery; strengthened public health programmes and community engagement; addressing the disease burden and targeted health priorities; health facility infrastructure construction and rehabilitation; accessible medical products, vaccines and technologies; resilient and motivated human resources; sustainable and accountable health financing; and a modern, data-driven digital ecosystem. Together these pillars ensure that our efforts are comprehensive and coordinated, addressing the fundamental building blocks of a strong health system.

At the heart of this Plan are the people we serve—the mothers seeking safe childbirth, the children needing vaccines, the young people requiring health education, and the families who deserve dignified and reliable care. This is also a call to action for our dedicated staff, whose service is the backbone of our organisation. To our partners in government, development agencies, churches, civil society, and the private sector, I extend my appreciation for your ongoing collaboration, and I urge you to continue walking with us.

As Chief Executive Officer, I reaffirm my commitment to lead with integrity, transparency, and care. I pledge to foster a health system where performance is rewarded, innovation is encouraged, and the voices of patients and communities guide our decisions. The NCDPHA Corporate Plan 2027–2031 is our promise to the people of Port Moresby and Motu Koitabu—a promise that you deserve better healthcare, and that we will work to deliver it.

Together, we can and will transform health in the National Capital District—building a healthier, safer, and more resilient capital city, not only for today, but for generations to come.



Dr Robin Oge
Chief Executive Officer
National Capital District
Provincial Health Authority

ACKNOWLEDGEMENTS

The National Capital District Provincial Health Authority extends its sincere appreciation to all stakeholders and partners whose valuable contributions, technical expertise and commitment made the development of the NCDPHA Corporate Plan 2027 - 2031 possible. This Plan was developed through a comprehensive consultative process that brought together government agencies, development partners, diplomatic missions, health institutions, non-government organisations, private-sector organisations and frontline health service providers. Their active participation, constructive engagement and expert advice ensured that this Plan reflects a shared vision for strengthening health service delivery and improving health outcomes for the people of the National Capital District and Motu Koitabu.

NCDPHA gratefully acknowledges the following organisations for their invaluable support and contribution throughout the planning process:

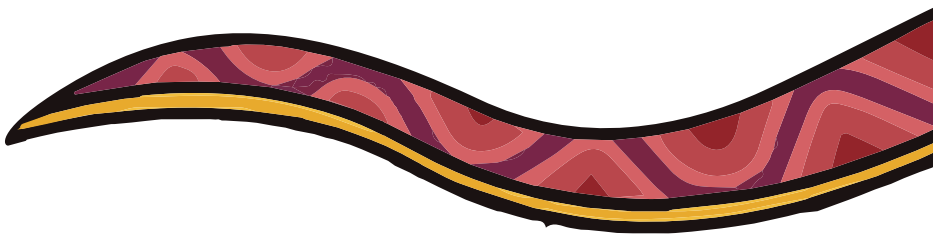
- National Capital District Provincial Health Authority.
- Office of the NCD Governor.
- District Development Authorities of Moresby South, Moresby North East, Moresby North West, and Motu Koitabu Assembly.
- National Capital District Commission.
- National Department of Health.
- Climate Change and Development Authority.
- National St John Ambulance Papua New Guinea.
- Conservation and Environment Protection Authority.
- United Nations Children's Fund.
- Embassy of Malaysia.
- Japan International Cooperation.
- The Fred Hollows Foundation Papua New Guinea.
- PNG Cancer Foundation.
- Brian Bell Group of Companies.
- Church Health Services.
- PNG Power Limited.
- Bomana Police Clinic.
- St Theresa Clinic under the Catholic Church Health Services.
- Murray Barracks Clinic.
- St. Paul's Clinic under the Catholic Church Health Services.
- PNG Educational Institute Clinic.
- Kaugere Clinic under the Living Light Foursquare Church Health Services.
- Ulamagi Clinic under the Nazarene Church.

The NCDPHA sincerely values the knowledge, experience and strategic guidance provided by these organisations, which strengthened the quality and direction of this Plan and ensured its alignment with the needs of communities within the National Capital District and Motu Koitabu. NCDPHA recognises that achieving the goals and objectives of this Plan will continue to depend on strong partnerships, collaboration and shared commitment. We therefore look forward to working alongside all stakeholders and partners during the implementation of this Plan. We would also like to thank the many others who provided assistance and advice throughout this process, even if they are not mentioned by name.

On behalf of the Board, Management and staff of NCDPHA, we extend our gratitude to all partners and stakeholders for your continued confidence and dedication to improving the health and wellbeing of the people of NCD and Motu Koitabu communities.

ACRONYMS AND ABBREVIATIONS

AIDS: Acquired Immunodeficiency Syndrome
AIPs: Annual Implementation Plans
ART: Antiretroviral Therapy
CFR: Case Fatality Rate
CHP: Community Health Post
CHVs: Community Health Volunteers
CHWs: Community Health Workers
COOP: Continuity of Operations Plan
COVID-19: Coronavirus Disease 2019
CSOs: Civil Society Organisations
DDAs: District Development Authorities
DHS: Demographic and Health Survey
DNPM: Department of National Planning and Monitoring
DoF: Department of Finance
DoT: Department of Treasury
DPM: Department of Personnel Management
DR-TB: Drug-Resistant Tuberculosis
EHR: Electronic Health Record
EIU: Economist Intelligence Unit
GESI: Gender Equality and Social Inclusion
e-NHIS: Electronic National Health Information System
EOC: Emergency Operations Centre
FBOs: Faith-Based Organisations
FSV: Family and Sexual Violence
GBV: Gender-Based Violence
GDP: Gross Domestic Product
GLOBOCAN: Global Cancer Observatory (IARC)
HEOs: Health Extension Officers
HIDP: Health Infrastructure Development Plan
HIES: Household Income and Expenditure Survey
HIS: Health Information System
HIV: Human Immunodeficiency Virus
HR: Human Resources
HRIS: Human Resource Information System
HSIP: Health Services Improvement Programme
IARC: International Agency for Research on Cancer
ICT: Information and Communication Technology
IDF: International Diabetes Federation
IFMS: Integrated Financial Management System
IMR: Infant Mortality Rate
JICA: Japan International Cooperation Agency
KPI: Key Performance Indicator
KRA: Key Result Area
LAN: Local Area Network
LMA: Local Medical Authority
M&E: Monitoring and Evaluation
MCH: Maternal and Child Health
MEL: Monitoring, Evaluation and Learning
MKA: Motu Koitabu Assembly
MMR: Maternal Mortality Ratio
MoU: Memorandum of Understanding
MTDP IV: Medium Term Development Plan IV
NACS: National AIDS Council Secretariat
NCD: National Capital District
NCDC: National Capital District Commission
NCDPHA: National Capital District Provincial Health Authority
NCDs: Non-Communicable Diseases
NDoH: National Department of Health
NGOs: Non-Governmental Organisations
NHIS: National Health Information System
NHP: National Health Plan 2021–2030
NHSS: National Health Service Standards
NSO: National Statistical Office
OHS: Occupational Health and Safety
PFMA: Public Finances (Management) Act
PGK: Papua New Guinea Kina
PHA: Provincial Health Authority
PHC: Primary Health Care
PHIS: Public Health Information System
PMGH: Port Moresby General Hospital
PNG: Papua New Guinea
PPPs: Public-Private Partnerships
SDGs: Sustainable Development Goals
SEMT: Senior Executive Management Team
SHI: Social Health Insurance
SLAs: Service Level Agreements
SPAR: Sector Performance Annual Review
STIs: Sexually Transmitted Infections
SWOT: Strengths, Weaknesses, Opportunities and Threats
TB: Tuberculosis
UHC: Universal Health Coverage
UN-Habitat: United Nations Human Settlements Programme
UNAIDS: Joint United Nations Programme on HIV/AIDS
UNFPA: United Nations Population Fund
UNICEF: United Nations Children's Fund
WAN: Wide Area Network
WASH: Water, Sanitation and Hygiene
WHO: World Health Organisation
WHO-AIMS: WHO Assessment Instrument for Mental Health Systems
mSupply: mSupply medical inventory management system



EXECUTIVE SUMMARY

The **National Capital District Provincial Health Authority (NCDPHA) Corporate Plan 2027–2031** sets the strategic roadmap for health service delivery in Papua New Guinea's capital and the Motu Koitabu areas over the next five years. Aligned with national frameworks (National Health Plan 2021–2030, MTDP IV, Vision 2050) and SDG 3, the Plan commits to a unified vision: **Healthy People and Thriving Communities in NCD and Motu Koitabu Areas**, delivered through equitable, high-quality urban healthcare.

Context & Health Landscape

- **Demographic Pressure:** NCD is the fastest-growing province in Papua New Guinea. The population is projected to expand from 756,754 (2024) to 1,115,526 by 2031 at 5.7 per cent annual growth. Just over half of residents are under 25, driving heavy demand for maternal, child and youth services.
- **Acute Inequities:** Approximately 45% of residents live across 90+ informal settlements with inadequate water, sanitation, and land security; 17.7% live below the national poverty line.
- **Triple Burden of Disease:**
    1. **Communicable Diseases:** NCD is the national epicentre for drug-resistant tuberculosis (~8,200 TB cases in 2025) and reports an adult HIV prevalence of 2.5% (more than double the national average).
    2. **Non-Communicable Diseases (NCDs):** Surging rates of hypertension, diabetes, and cervical cancer drive premature death among the working-age population (47% of NCD residents).
    3. **Trauma and Injuries:** Interpersonal violence accounts for 59 per cent of trauma presentations at Port Moresby General Hospital, two in three women experience physical or sexual violence, and road deaths reach 26 per 100,000.

System Performance & Constraints

While NCD outperforms national averages in maternal mortality (120 per 100,000) and under-five mortality (39 per 1,000), key indicators are slipping:

- **Immunisation Declines:** Measles coverage has fallen to about 59 per cent, well below the level required for herd immunity; Pentavalent 3 coverage fell to 77 per cent in 2025.
- **Access Gaps:** Outpatient utilisation is 1.0 visit per person/year (target: 2.4).
- **Infrastructure and System Deficits:** All 11 surveyed government facilities scored below the 60 per cent minimum standard for Environment and Management. In 2025 the Authority operated on revenue of PGK 55.2 million, 99 per cent of it from a single government appropriation, with some 80 per cent of recurrent expenditure absorbed by personnel emoluments, a 17 per cent vacancy rate and PGK 19.0 million in inherited legacy liabilities.

The Strategic Response: Primary Health Care Hub-and-Spoke Network

The Plan executes a decisive shift from a reactive, hospital-centric model to an **integrated, Primary Health Care (PHC)-centric network**:

- **Provincial Apex:** Construction of the new Level 5 NCD Provincial Specialist Hospital of approximately 300 beds on the greenfield site at Tete (Nigibata Road), Moresby North-West, to serve as the provincial anchor and decongest Port Moresby General Hospital.
- **District Infrastructure:** Four Level 4 District Hospitals, one for each district — Moresby South (commissioned 2027), Gerehu (redeveloped and commissioned), Nine Mile (to beconstructed) and Motu Koitabu (designed within this cycle). Two are commissioned within the plan period; two carry into the second tranche of the Strategic Plan.

- **Primary Care Network:** Establishment of approximately 15 Level 2 Community Health Posts and 6 to 7 Level 3 Health Centres by 2031 — half of the network targeted for 2036 — supported by 500 Community Health Volunteers.

Centres of Excellence: five designated hubs for specialised service delivery — Six Mile (infectious diseases), Moresby South (prevention and lifestyle medicine), Metoreai (women's and children's care), Gerehu (trauma and injury) and St Theresa (behavioural health).

The Nine Strategic Pillars

Resource allocation, operations and performance management are structured around nine pillars: unified leadership and good governance; people-centred and proactive service delivery; strengthened public health programmes and community engagement; addressing the disease burden and targeted health priorities; health facility infrastructure construction and rehabilitation; accessible medical products, vaccines and technologies; resilient and motivated human resources; sustainable and accountable health financing; and a modern, data-driven digital ecosystem.

Investment, Phasing, and Accountability

Resource Requirements

- **Five-Year Investment:** PGK 3,382.1 million over 2027–2031, the first tranche of the ten-year PGK 7,934.1 million envelope in the Strategic Health Services Development Plan 2027–2036. Of this, PGK 1,715.9 million (50.7 per cent) is capital and PGK 1,666.1 million (49.3 per cent) recurrent. The annual requirement rises from PGK 339.5 million in 2027 to PGK 909.9 million in 2031.
- **Key Allocations:** PGK 1,626.0 million for health facility infrastructure and PGK 982.6 million for the workforce — together 77.1 per cent of the five-year envelope.
- **Financing Strategy:** Reducing single-budget dependence by securing a Health Function Grant, capturing Local Medical Authority regulatory revenue, formalising municipal and district partnerships, establishing a ring-fenced Trust Account, and designing an NCD social health insurance scheme. Every source is classified as committed, probable or unfunded, and the residual funding gap is stated in Chapter 8.

Phased Execution

- **Phase 1 (2027–2028)** — Foundations: Governance memoranda of understanding, gazettal of the Authority as Local Medical Authority, verification and settlement of legacy liabilities, Level 5 hospital design and site acquisition, drug warehouse construction and core ICT deployment.
- **Phase 2 (2029)** — Capacity Expansion: Commissioning and operations of Moresby South District Hospital, construction of the Nine Mile and Gerehu facilities, commencement of Level 5 hospital construction, network-wide Electronic Health Record rollout and full clearance of legacy liabilities.
- **Phase 3 (2030–2031)** — Consolidation and Evaluation: Commissioning of the redeveloped Gerehu District Hospital and the primary care network, peak construction on the Level 5 Provincial Hospital, operational consolidation and end-of-cycle evaluation.

Governance & Accountability

Progress will be tracked through quarterly executive reviews, quarterly Board reporting, a mid-term review in 2029 and an end-of-term evaluation in 2031. Concrete targets include:

- Deployment of 500 trained and incentivised Community Health Volunteers.
- Under-five pneumonia case fatality rate reduced from 3.4 per cent to below 2 per cent.
- Nine months in ten free of any tracer-drug stock-out lasting more than one week.
- Staff vacancy rate reduced below 10 per cent against the establishment in force.
- Full network adoption of the Electronic Health Record and measles coverage restored to 90 per cent.

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1. Introduction

1.1 Background and Context

The National Capital District is the gateway to Papua New Guinea and the hub of economic, social, and cultural life. With rapid urban growth, migration, and settlement expansion, the city faces rising demands for health services and persistent inequities in access to care. Communicable diseases such as tuberculosis and HIV remain major challenges, while non-communicable diseases like diabetes and cardiovascular conditions are on the rise. Maternal and child health indicators, though better than many provinces, still reflect unacceptable levels of preventable illness and death. NCDPHA was established to respond to these realities, integrating hospital, public health, and primary care services under one provincial health authority to improve equity, quality, and efficiency in health service delivery.

1.2 Purpose of the Corporate Plan

This Corporate Plan serves as a strategic management tool for the NCDPHA. Its purpose is to:

- Provide a clear vision and mission for health service delivery in the NCD.
- Define priorities and allocate resources effectively to achieve the greatest impact.
- Strengthen accountability and transparency through measurable outcomes and performance indicators.
- Guide collaboration with government, churches, NGOs, private sector, and development partners.
- Ensure alignment with national policies while responding to the unique needs of urban communities in Port Moresby.

1.3 Alignment with National Health Strategies

The Corporate Plan 2027–2031 defines the strategic direction of the NCDPHA over the next five years. It aligns with the National Health Plan (2021–2030), Medium Term Development Plan IV, Vision 2050, and other government priorities, while tailoring approaches to the unique urban realities of Port Moresby. It also contributes to the achievement of the Sustainable Development Goals (SDGs), particularly Goal 3 on Good Health and Wellbeing. This alignment ensures that NCDPHA's strategies complement national priorities while tailoring interventions to the unique urban realities of Port Moresby.

The Plan sets out nine strategic pillars aligned with the National Health Plan 2021–2030 that guide our programmes and investment. It provides a performance framework with clear Key Result Areas and Key Performance Indicators to track progress, ensure accountability and enable adaptive management. Where these national frameworks are succeeded during the plan period, the Authority will realign this Corporate Plan through the annual review and formally at the 2029 mid-term review.

This Corporate Plan is the first five-year implementation tranche of the NCDPHA Strategic Health Services Development Plan 2027–2036. The Strategic Plan sets the ten-year service-development direction, the target facility network and a ten-year investment envelope of PGK 7,934.1 million. This Corporate Plan converts the first five years of that direction — PGK 3,382.1 million — into corporate outcomes, Board-level performance targets, accountabilities, a financing framework and annual implementation arrangements for 2027 to 2031. A successor Corporate Plan will carry the second tranche, 2032–2036.

The planning architecture is a single cascade. National and provincial policy sets the envelope; the Strategic Health Services Development Plan 2027–2036 sets the ten-year direction; this Corporate Plan converts the first five years into corporate commitments; Annual Implementation Plans and the annual budget convert those commitments into dated activities; directorate, programme and facility workplans deliver them; and individual performance agreements make each of them the responsibility of a named officer. Every corporate outcome in this Plan is traceable through that cascade to a person accountable for it.

Figure 1.0: Cascading Logic of the whole of government plans and NCDPHA Corporate Plan



1.4 Stakeholders and Partners Involved

The successful implementation of the Corporate Plan relies on collaboration with a wide range of stakeholders and partners. These include:

- **Government:** National Department of Health, National Capital District Commission, MKA and other line agencies.
- **Health Institutions:** Port Moresby General Hospital, urban clinics and community health posts.
- **Churches and Faith-Based Organisations:** Long-standing providers of health services and community outreach.
- **Non-Governmental Organisations (NGOs):** Partners in service delivery, advocacy, and health promotion.
- **Development Partners:** Bilateral and multilateral agencies supporting health financing, technical assistance, and capacity building.
- **Private Sector:** Employers, insurers, and healthcare providers contributing to service delivery and innovation.
- **Communities:** Local leaders and settlement representatives as key partners in promoting health-seeking behaviours and accountability.

Through these partnerships, the NCDPHA aims to mobilise collective action and ensure that health outcomes in the National Capital District are improved in a sustainable and inclusive manner

1.5 Progress and Lessons from the Establishment Period

The National Capital District Provincial Health Authority was established in February 2020, bringing hospital, public health and primary care services in the capital under a single authority for the first time. Between 2021 and 2026 the resource base grew from PGK 2.8 million to an appropriation of PGK 57 million; a lawful establishment of 574 positions was approved; construction began at Gerehu and Moresby South; Metoreai Urban Clinic was commissioned; outpatient utilisation rose from 0.73 to 1.0 visits per person per year; and the 2023 accreditation survey gave the Authority its first objective measure of facility condition. This Corporate Plan is built on what that period taught us.

What was learned

- **Growth in appropriation is not the same as reliable cash flow.** Extended periods without releases, followed by large late-year disbursements, disrupted service continuity even in years when the total allocation rose. Cash-flow management and a ring-fenced Trust Account are accordingly foundational commitments of Pillar 8.
- **Buildings without establishment and recurrent provision do not deliver services.** Capital works advanced faster than the staffing and operating budgets needed to run them. Under this Plan no facility proceeds to commissioning without an approved establishment and a recurrent operating provision in place.
- **Performance cannot be managed without data.** Information systems running at 45 per cent uptime, and largely on paper, made it impossible to demonstrate what the Authority had achieved. The digital ecosystem in Pillar 9 is not a technology project; it is the precondition for accountability.

2. Organisational Overview

2.1 Mandate of NCDPHA

The National Capital District Provincial Health Authority was established under the Provincial Health Authorities Act 2007 with the mandate to integrate, coordinate, and deliver health services in the National Capital District. Its role is to ensure that all residents of Port Moresby and surrounding Motu Koitabu communities have access to safe, equitable, and quality healthcare. The NCDPHA is responsible for implementing national health policies at the provincial level, while tailoring services to address the unique urban realities of the capital city, including rapid population growth, informal settlements, and high disease burdens.

2.2 Vision, Mission, Core Values and Functions

Vision: Healthy People and Thriving Communities in the National Capital District and the Motu Koitabu villages.
Mission: Deliver high quality and equitable healthcare for all residents of the National Capital District and Motu Koitabu villages.
Goal: Improved health outcomes and reduced health disparities for all residents of the National Capital District and Motu Koitabu villages.

Figure 2.0: Guiding Principles of NCDPHA

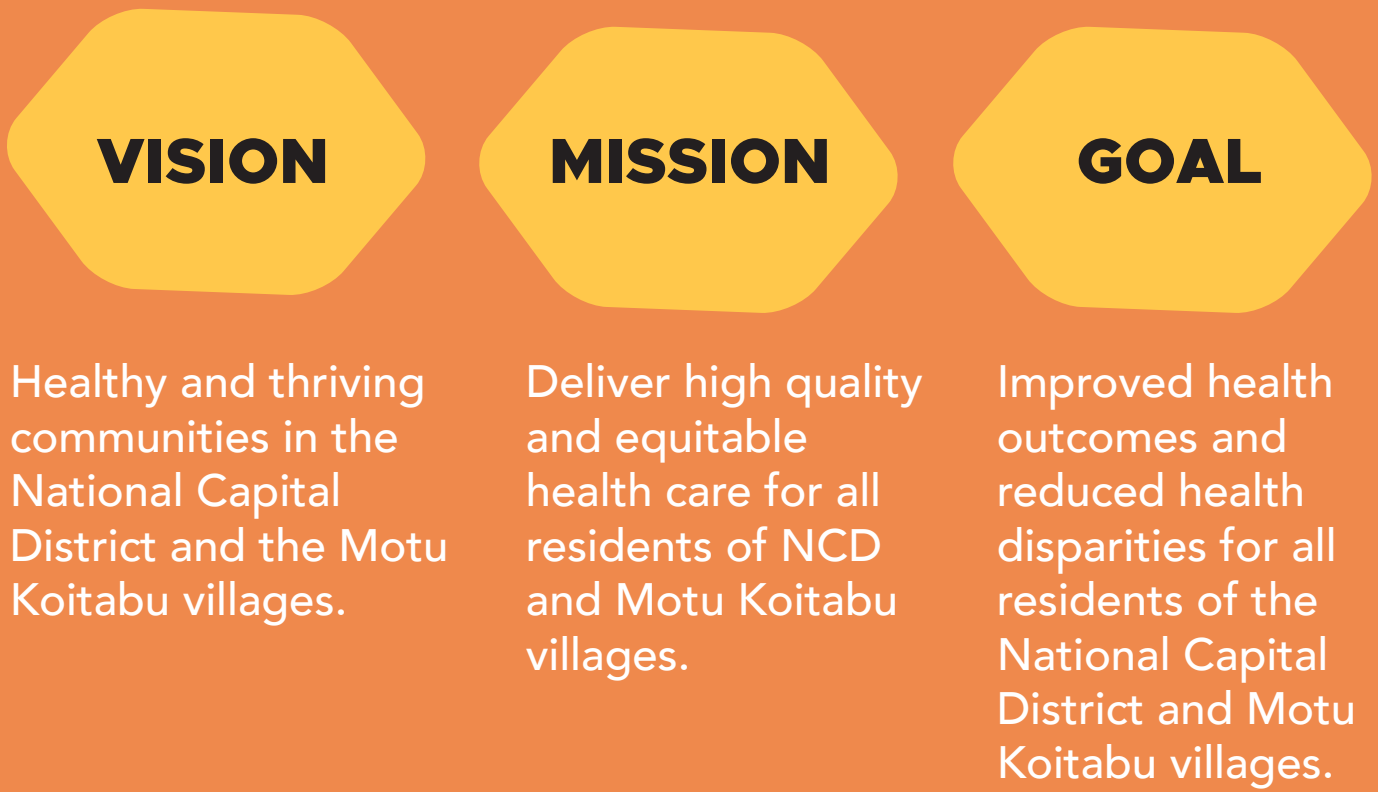


Figure 3.0 Core Values



The Authority's work is guided by seven core values: people-centredness — we put people first in all we do; equity — we promote fairness and justice for all; accountability — we take responsibility for our actions and decisions; transparency — we operate openly and honestly; innovation — we embrace change and seek better solutions; excellence — we strive for the highest standards in all we do; and teamwork — we collaborate to achieve shared goals.

Core Functions

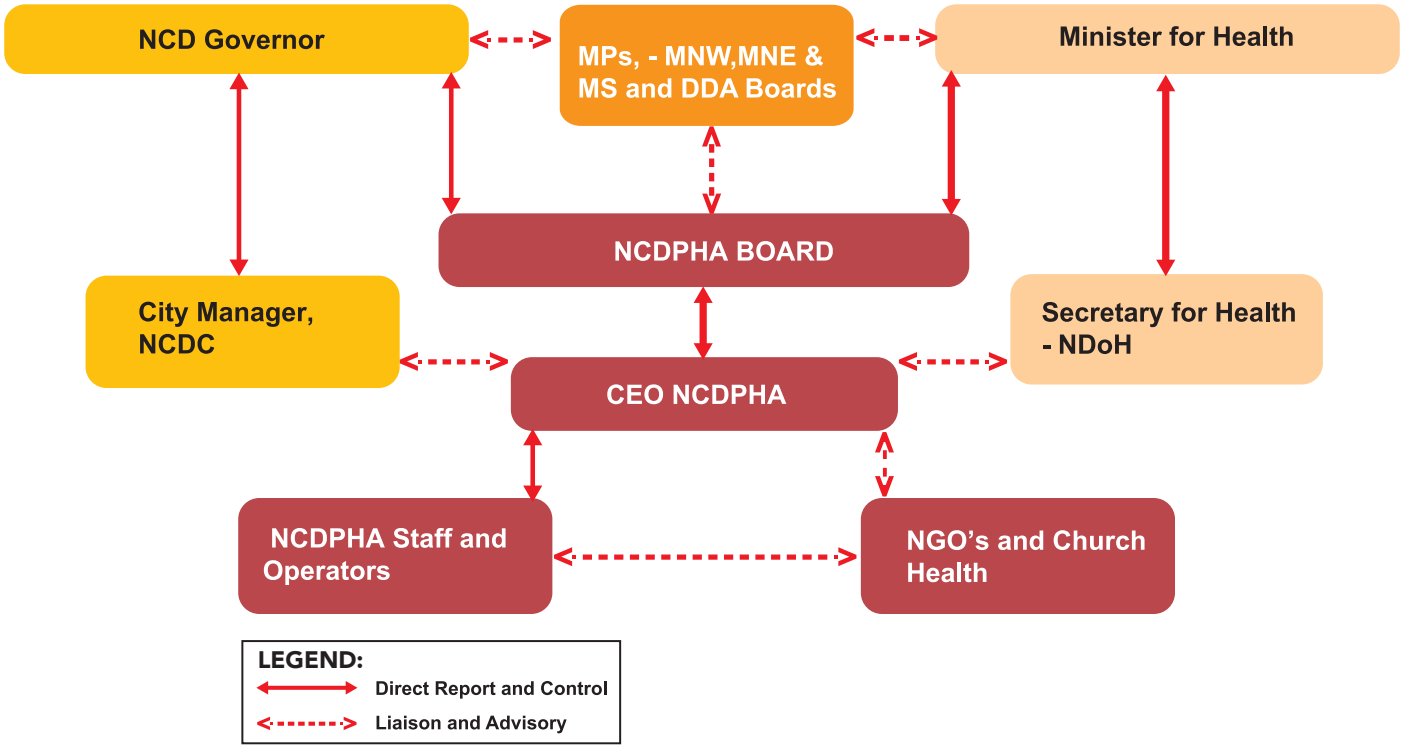
The NCDPHA delivers its mandate through the following core functions:

1. **Service Delivery:** Provision of preventive, promotive, curative, and rehabilitative health services across primary, secondary, and tertiary levels of care.
2. **Public Health Programmes:** Implementation of disease control, maternal and child health, immunisation, family health services, and health promotion programmes and initiatives.
3. **Health Systems Strengthening:** Development of institutional capacity, governance, workforce, financing, supply chain, and health information systems.
4. **Partnerships and Coordination:** Engagement with government, churches, NGOs, private sector, and development partners to maximise health outcomes.
5. **Accountability and Performance:** Monitoring, evaluation, and reporting to ensure transparency, evidence-based planning, and continuous improvement.

2.3 Governance and Leadership Structure

The NCDPHA is governed by the NCDPHA Board, chaired by an appointed representative and comprising members from government, health professionals, community leaders and key stakeholders. The Board discharges its functions through four standing subcommittees: Finance; Audit and Risk; Clinical Quality and Safety; and Regulatory Compliance. The Chief Executive Officer leads day-to-day management, supported by directorates responsible for clinical services, public health and corporate services. This governance model ensures clear accountability between national policy direction, provincial implementation and community engagement.

Figure 4.0 PHA Management and Accountability Structure



The structure places the NCDPHA Board at the centre of governance and accountability. The Board maintains liaison with, and receives advice from, key national and local stakeholders including the Minister for Health, the NCD Governor, Members of Parliament and District Development Authority Boards; statutory accountability rests with the Board itself under the Provincial Health Authorities Act 2007. The CEO reports directly to the NCDPHA Board and is responsible for managing NCDPHA staff, health facilities and service operations. The CEO also coordinates with the NCDC City Manager, Secretary for Health, non-government organisations and church health providers.



3. Situational Analysis

3.1 Introduction

The National Capital District, centred around Port Moresby, is the administrative, economic, and demographic heart of Papua New Guinea. While it is the nation's most developed region, it faces a unique and complex set of challenges driven by rapid, unplanned urbanisation and significant internal migration. This analysis outlines the key demographic, socio-economic, and health system factors that will shape the strategic direction of the NCDPHA. The district is characterized by a "dualism": a modernising core coexisting with widespread urban poverty, creating profound health inequities.

3.2 Demographic Profile: A Young and Rapidly Growing Population

The NCD's demographic profile presents both an opportunity and a significant challenge for health service delivery. The population is expanding at a rapid rate, placing continuous strain on public infrastructure and services.

Rapid Growth: The NCD population was 756,754 in 2024 and is projected to reach 1,115,526 by 2031, growing at 5.7 per cent a year. This growth is driven by a high birth rate and significant internal migration from other provinces.

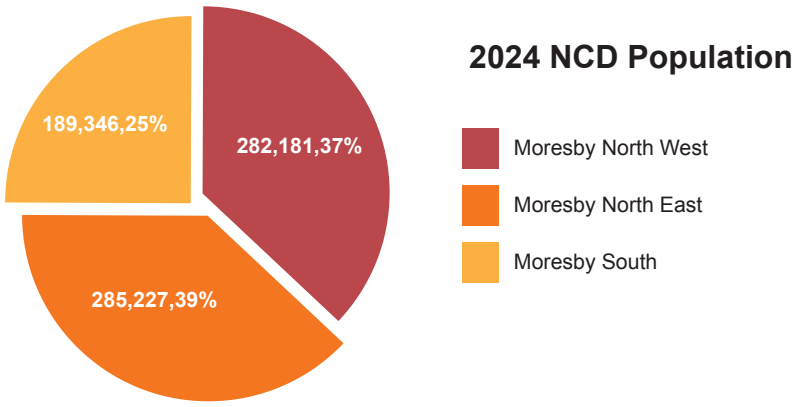
Table 1.0 Population of the National Capital District by District, 2024–2031

District	2024	2027	2031	Share of 2031 population
Moresby North-West	282,181	333,237	415,961	37.3%
Moresby North-East	285,227	336,834	420,451	37.7%
Moresby South	189,346	223,605	279,114	25.0%
National Capital District — total	756,754	893,675	1,115,526	100.0%
Motu Koitabu (sub-population)	55,000	64,951	81,075	7.3%

Source: National Statistical Office, National Population Estimate 2024.

The Motu Koitabu population is a sub-population of the three Moresby districts and is shown separately for service-planning purposes. In 2024 the male population was 403,291 (53.3 per cent) and the female population 353,463 (46.7 per cent), a ratio of 114 males for every 100 females. Source: National Statistical Office, National Population Estimate 2024, projected at 5.7 per cent compound annual growth

Figure 5.0 NCD Population by Electorate 2024



Source: National Statistics Office 2024

A Youthful Population: The NCD has a distinctly young age profile. Nearly 30 per cent of the population is under 15 and a further 21 per cent are youth aged 15 to 24. This youth bulge creates immense and growing demand for maternal and child health services, education and employment.

Working-Age Dominance: The 25-64 age group constitutes 47% of the population, forming the core of the city's labour force. However, this group is also entering the prime age for developing non-communicable diseases.

Gender Imbalance: A sex ratio of 114 males for every 100 females points to a pattern of male-dominant migration for economic opportunity, which has distinct social and health implications.

Table 2.0 Population by Age Structure in NCD – 2024

Age Group	Total Population Group (Estimate)	Percent of Total Population (%)	Key Observations
0 – 14 years (Children)	225,513	29.8%	Indicates a massive increase in demand for primary schools and paediatric health.
15 – 24 years (Youth)	157,405	20.8%	A "youth bulge" of over 150,000 people requiring higher education and entry-level jobs.
25 – 64 years (Working Age)	356,431	47.1%	The core economic driver; makes up nearly half of the city's population.
65+ years (Older Population)	17,405	2.3%	Remains a very small fraction
Total	**756,754**	**100.0%**	**Total Male: 403,291 Total Female: 353,463 (Ratio 114:100)**

Source: National Statistical Office and UNFPA, National Population Estimate 2024



3.3 Socio-Economic Context: A Landscape of Contrasts

While the NCD boasts the highest access to modern services in PNG, these benefits are not shared equally. A significant portion of the population lives in precarious conditions, which are the primary drivers of poor health outcomes.

Informal Settlements: An estimated 45% of the NCD population resides in over 90 informal settlements, often with insecure land tenure and inadequate access to clean water, sanitation, and housing.

Uneven Access to Services: While access to piped water (67%) and electricity (86%) is far above the national average, a considerable gap remains, particularly in settlements.

Poverty and Crime: Despite having the highest rate of formal employment in PNG, 17.7% of the population lives below the national poverty line. High rates of violent crime make Port Moresby one of the world's least livable cities, contributing to a constant burden of trauma on the health system.

Table 3.0: NCD Socio-economic Indicators

Indicator	Specific Data for NCD	Source / Year
Population & Growth	756,754; annual growth rate of 5.7%.	PNG National Statistics Office, 2024.
Housing & Settlements	An estimated 45% of the NCD population lives in over 90 informal settlements.	World Bank, 2022 UN-Habitat, 2022.
Access to Piped Water	67.4% of households have access to piped water into their dwelling, yard, or plot. (National average is ~20%).	World Bank, based on HIES data, 2018.
Access to Electricity	86.1% of households use electricity as their main source of lighting. (National average is ~23%).	World Bank, based on HIES data, 2018.
Employment	55% of the population aged 15+ is in formal wage employment (highest in PNG), but youth unemployment remains a critical issue.	PNG National Statistical Office, 2024.
Education	Net primary school attendance rate is approximately 81%, one of the highest in the country.	World Bank, 2020.
Poverty Headcount	17.7% of the population lives below the national Basic Needs Poverty Line. (National average is 39.9%).	World Bank Poverty Assessment, 2020.
Crime & Safety	Port Moresby consistently ranks among the world's least liveable cities, primarily due to high rates of violent crime.	Economist Intelligence Unit (EIU) Global Livability Index, 2026.

3.4 Health Profile: A "Triple Burden" of Disease

The NCD health system is strained by a complex "triple burden" of disease, where communicable diseases, non-communicable diseases, and trauma-related injuries all present as major epidemics.

1. Communicable Diseases: NCD is the national epicenter for infectious diseases, driven by high population density and overcrowding.

- **Tuberculosis (TB):** NCD has the highest number of TB cases in PNG and is the hotspot for drug-resistant strains (DR-TB).
- **HIV/AIDS:** The prevalence rate of 2.5% is significantly higher than the national average (1%).
- **Childhood Illness:** Pneumonia and diarrheal disease remain leading causes of child mortality, directly linked to poor living conditions.

Table 4.0 Communicable Disease Indicators for NCD

Indicator	Data	Comments / Context	Source
Tuberculosis (TB)	8,200 TB cases reported in NCD in 2025.	NCD has the highest number of TB cases of any province and is the national epicentre for Drug-Resistant TB.	NCDPHA, 2025
HIV/AIDS Prevalence	2.5% prevalence rate among adults aged 15-49 in NCD.	Generalized epidemic and is significantly higher than the national average (1%). NCD has the largest number of people living with HIV in PNG.	UNAIDS / PNG NACS, 2025
Antiretroviral Therapy (ART) Coverage	Estimated 95% of people living with HIV in NCD are on treatment.	One of the highest coverage rates in PNG.	NCDPHA 2025
Malaria	Transmission is lower in urban NCD compared to rural PNG.	While not a hyperendemic zone like some provinces, cases are still common, often imported from other regions or occurring in peri-urban areas.	NDoH / WHO World Malaria Report, 2022
Pneumonia	Pneumonia ~2,500 children under 5 die from pneumonia annually in PNG.	Pneumonia is the leading infectious cause of death for children in PNG. The risk is extremely high in NCD's settlements due to malnutrition, indoor air pollution, and overcrowding. It is a top cause of paediatric hospital admissions.	UNICEF PNG, 2024
Diarrheal Disease	15% of children under 5 had diarrhoea in the two weeks preceding the survey (national data).	A leading cause of child illness and death, directly linked to contaminated water and poor sanitation. This risk is acutely high in NCD's informal settlements, which lack reliable access to safe water and hygiene facilities.	PNG Demographic and Health Survey (DHS), 2017-2018

Table 5.0 Key Health Indicators

Indicator	NCD	PNG national	Source and year
Maternal mortality ratio (per 100,000 live births)	120	171	Sector Performance Annual Review 2023; NSO Demographic and Health Survey, 2016–2018
Infant mortality rate (per 1,000 live births)	21	33	NSO Demographic and Health Survey, 2016–2018
Under-five mortality rate (per 1,000 live births)	39	49	NSO Demographic and Health Survey, 2016–2018
Measles immunisation coverage, children under one year	59%	45%	SPAR, 2025
Pentavalent 3 immunisation coverage, children under one year	77%	48%	SPAR, 2025
Under-five pneumonia case fatality rate	3.4%	-	e-NHIS, 2025
Outpatient visits per person per year	1.0	-	e-NHIS, 2025; national target 2.4
Life expectancy at birth (years)	65	65	World Health Organization, 2022

2. Non-Communicable Diseases (NCDs): Urban lifestyles are fueling a silent epidemic of NCDs, which are now a leading cause of premature death and disability.

- **Diabetes & Hypertension:** Prevalence is considered much higher than the national average, placing a heavy burden on clinical services at NCDPHA and PMGH.
- **Cancer:** Cervical cancer is the leading cause of cancer death among women, with most patients presenting at a late, untreatable stage.

Table 6.0 Non-Communicable Diseases Indicators in NCD

Indicator	Data	Comments / Context	Source & Year
Premature NCD Mortality	29% probability of dying between ages 30-70 from a major NCD.5.7%.	This national figure is heavily influenced by urban trends in NCD.	WHO NCD Country Profile, 2022
Diabetes Prevalence	8.5% of the adult population (national data).	The prevalence in NCD is considered to be much higher than the national average.	IDF, 2021
Hypertension Prevalence	28.6% of males and 26.4% of females have raised blood pressure (national data).	This is a primary risk factor for stroke and heart attacks, which are leading causes of admission and death at PMGH.	WHO NCD Country Profile, 2022
Cancer Burden	Cervical cancer is the leading cause of cancer death among women in PNG with 1675 deaths annually	PMGH is the main referral centre for cancer care, but its services are overwhelmed, and many patients present at a late, untreatable stage.	IARC/GLOBOCAN, 2020

3. Trauma, Violence, and Mental Health: The NCD faces an overwhelming load of physical and psychological trauma.

- **Interpersonal Violence:** This is the single leading cause (59%) of trauma presentations at PMGH.
- **Family & Sexual Violence (FSV):** Affecting an estimated 2 in 3 women, FSV drives immense physical trauma, mental illness, and social breakdown.
- **Mental Health Crisis:** Services are critically under-resourced, with a near-total lack of community-based care to address the widespread trauma and depression.

Table 7.0: Trauma and Injuries Indicator

Indicator	Data	Comments / Context	Source & Year
Interpersonal Violence	The #1 cause of trauma (59%) presentations at PMGH.	This includes injuries from knives, blunt objects, and firearms related to domestic violence, robbery, and community clashes.	PMGH Annual Clinical Audit, 2023
Road Traffic Accidents	26 deaths per 100,000 population. A leading cause of death and severe injury in NCD.	The GGH emergency services and PMGH manage a constant flow of multi-trauma cases from accidents involving cars, pedestrians, and Public Motor Vehicles.	WHO, 2023
Burn Injuries	Account for approximately 10% of all paediatric surgical admissions.	These injuries often result from domestic accidents in crowded informal settlements where open fires are used for cooking.	PMGH Emergency/ Surgery Annual Data, 2023

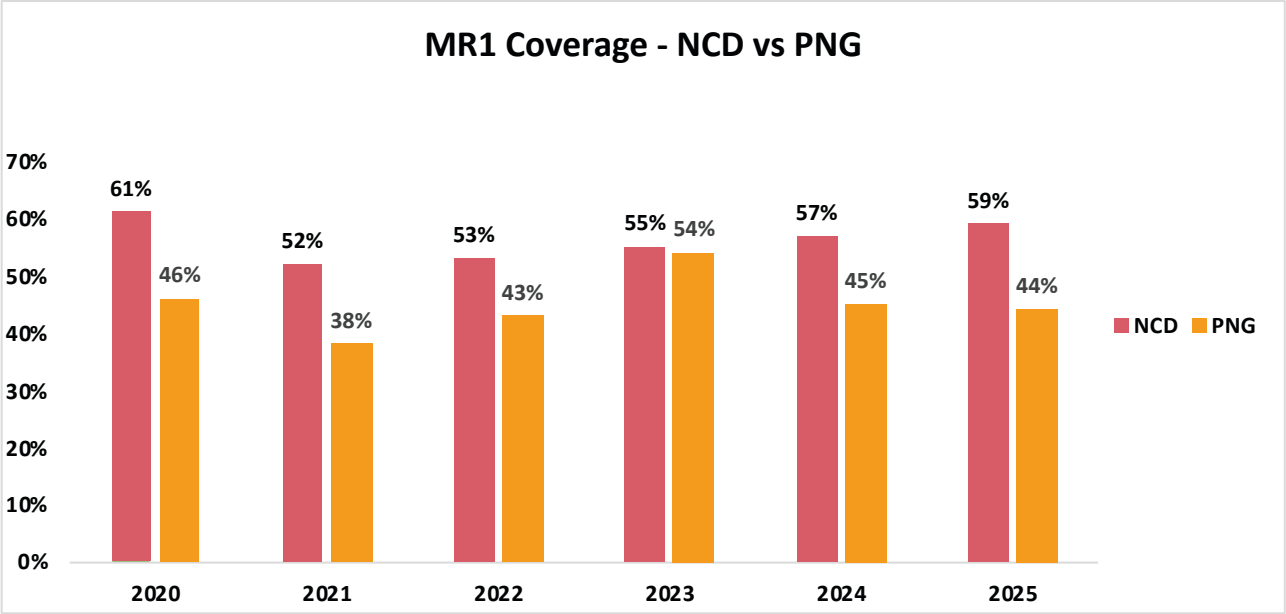
Table 8.0: Mental and Social Issues

Indicator	Data	Comments / Context	Source & Year
Family & Sexual Violence	An estimated 2 in 3 women (67%) in PNG have experienced physical or sexual violence.	NCD's Family Support Centres are inundated with survivors of violence. This is a primary driver of physical trauma, mental illness, and social breakdown.	PMGH Annual Clinical Audit, 2023
Mental Health Professionals	~0.1 psychiatrists per 100,000 people in PNG.	Services are critically under-resourced. PMGH has a small psychiatric unit, but there is only 1 community-based mental health support in NCD in St Theresa Clinic	WHO, 2023
Child Abuse	Over 75% of children report experiencing some form of violence at home.	The high-stress, high-density environment of NCD's informal settlements exacerbates risks of child abuse, neglect, and exploitation.	UNICEF PNG, 2021

4. Key Health Service Indicators and Challenges

Maternal and Child Health: While NCD performs better than the national average for facility-based births and antenatal care, progress has stalled or reversed in recent years. The most serious concern is the decline in childhood immunisation, with measles coverage falling to around 59 per cent, well below the level required for herd immunity.

Figure 6.0: Measles Immunisation Coverage for Children < 1 Year in NCD and PNG, 2020-2025



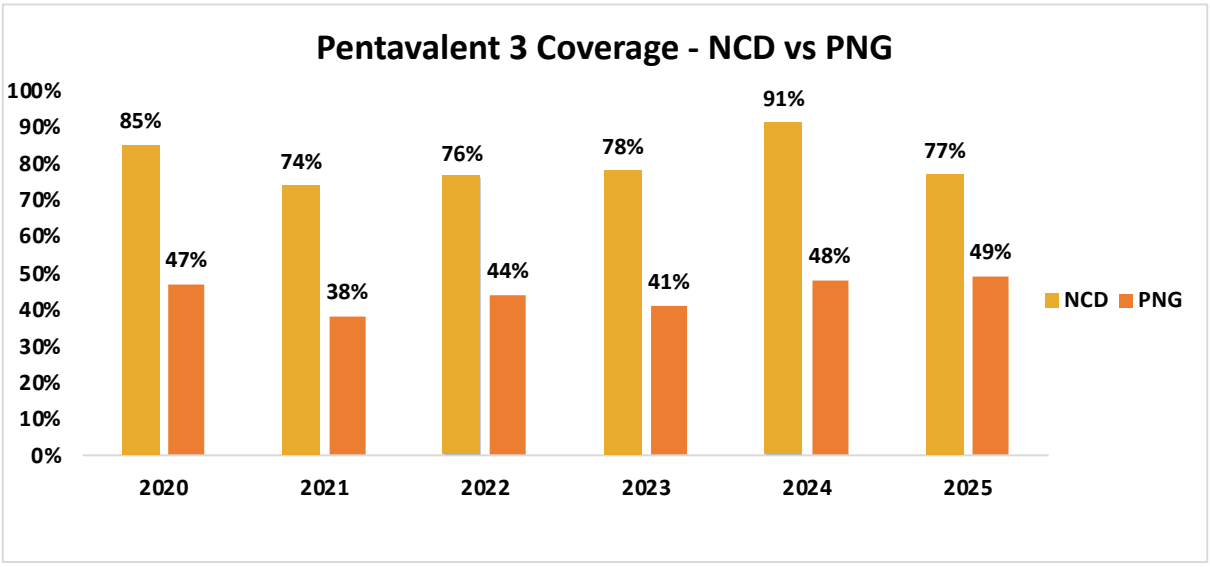
Source: National Health Information System

NCD consistently recorded substantially higher Pentavalent 3 coverage than the national average between 2020 and 2025. Coverage increased from approximately 85% in 2020 to a peak of about 91% in 2024, demonstrating strong immunisation performance. However, coverage declined to around 77% in 2025, representing a significant setback from the previous year primarily due to the Polio Supplementary Immunisation Campaigns.




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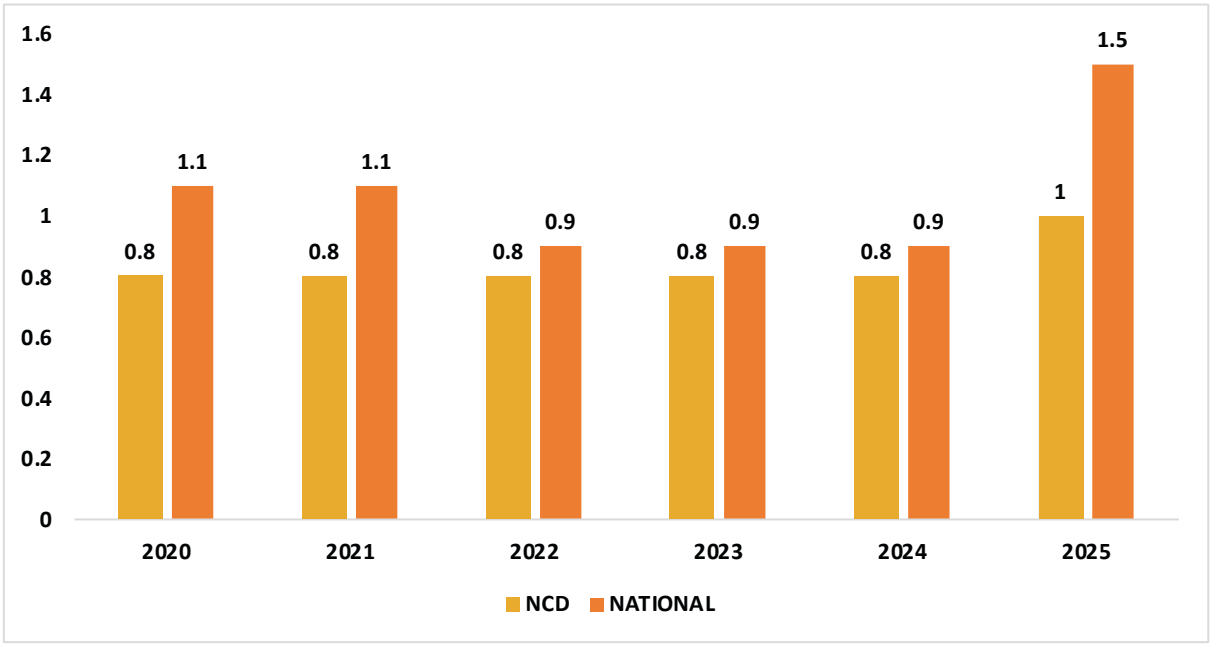
Figure 7.0: Pentavalent 3 Immunisation Coverage for Children < 1 Year in NCD and PNG, 2020-2025



Source: National Health Information System

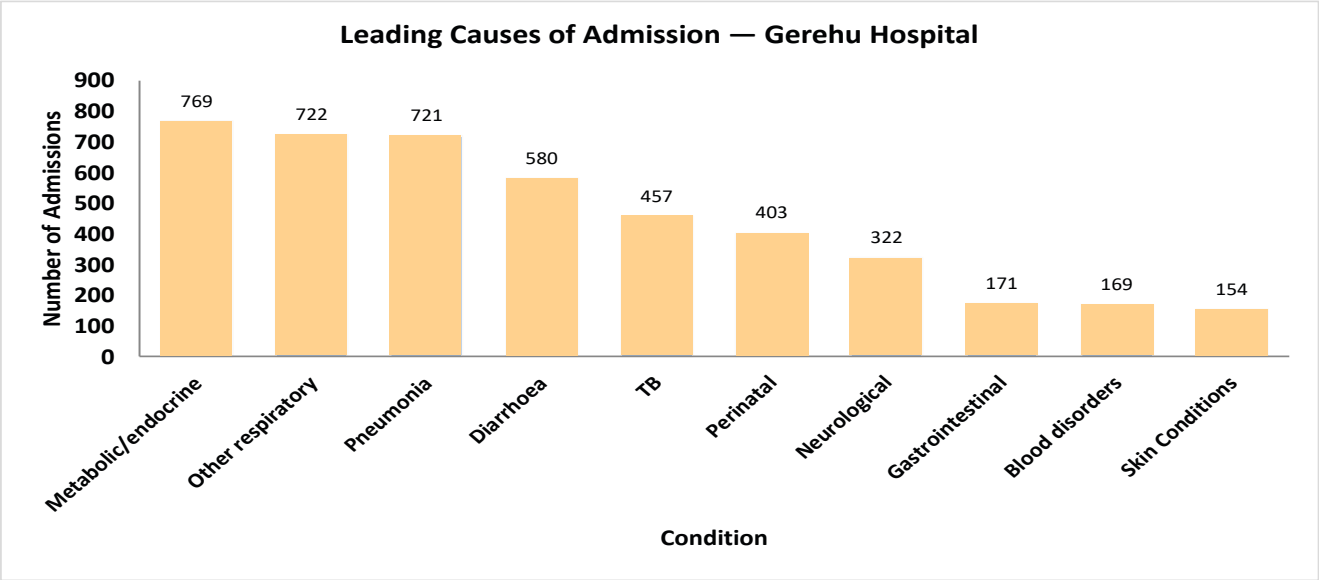
Health Service Utilisation: Outpatient service utilisation in NCD is low at 1.0 visits per person per year, far below the national target of 2.4. This may indicate poor access to primary healthcare, under-reporting of activity, or a preference for private services. Skin disease has emerged as a top reason for outpatient attendance, signaling challenges with hygiene in communities. Metabolic and endocrine conditions were the leading cause of admission at Gerehu Hospital, with 769 admissions, followed closely by other respiratory conditions (722) and pneumonia (721). Diarrhea was also a major contributor, accounting for 580 admissions, while tuberculosis recorded 457 admissions.

Figure 8.0: Outpatient Visits Per Person Per Year 2020-2025



Source: National Health Information System

Figure 9.0: Leading Causes of Admission in all age groups at Gerehu Hospital 2025



Source: National Health Information System

3.5 Corporate Systems: Finance and Human Resources

Corporate systems underpin service delivery. Strengthening governance, financial accountability, and workforce planning is essential to sustain quality care and institutional performance.

Table 9.0 Corporate System Indicators

Indicator	Position	Comment
Total operating revenue (2025)	PGK 55.2 million	NCD's Family Support Centres are inundated with survivors of violence. This is a primary driver of physical trauma, mental illness, and social breakdown.
Internally generated revenue (2025)	PGK 694,742.69	1.2 per cent of total revenue
Appropriation (2025)	PGK 54.5 million	Personnel Emolument PGK 44.1 million and Goods and Services PGK 10.4 million
Personnel emoluments	Approximately 80% of recurrent expenditure	Constrains the funds available for goods, services and maintenance
Cash flow	Historically highly irregular	Extended periods without releases followed by large late-year disbursements
Legacy liabilities (December 2024)	PGK 19.0 million	Security and escort PGK 10.1m; rental PGK 5.7m; hire cars PGK 3.2m
Approved establishment	574 positions	Approved by the Department of Personnel Management, December 2021
Staff on strength	478	98 vacancies, a vacancy rate of 17 per cent
Critical shortages	Midwives, health extension officers, environmental health officers	Chronic gaps in essential clinical and regulatory cadres
Staff on strength	56 per cent female	Gender balance achieved across leadership roles
Staff training	No training budget allocated in 2024	A budgeted in-service training plan is a Pillar 7 priority
ICT system uptime	45 per cent against a 99 per cent target	Fragmented and largely paper-based information systems

Source: NCDPHA Financial Report 2024; NCDPHA Human Resource Department 2025; Department of Treasury, National Budget.

This analysis of the Authority's corporate systems reveals that its ability to deliver quality health services is fundamentally constrained by financial and human resource limitations. In 2025 the Authority operated on revenue of PGK 55.2 million, of which 99 per cent came from a single government appropriation and some 80 per cent of recurrent expenditure was absorbed by personnel emoluments. Cash flow was highly irregular. This is compounded by a 17 per cent vacancy rate, acute shortages of midwives and environmental health officers, and the absence of any allocated training budget in 2024. Strengthening financial management and strategic workforce planning is therefore a foundational priority of this Corporate Plan.

3.6 Summary of Key Challenges and Opportunities

NCDPHA must respond to population growth, high disease burden, workforce shortages and limited facility capacity. Priorities are stronger outreach, integrated services, reliable supplies, good governance and digital health information.

Table 10.0 Key Challenges and Opportunities

Challenge	Opportunity / Strategic Focus
Rapid population growth and informal settlements	Integrate urban health planning and settlement outreach
Triple burden of disease (Communicable + NCDs+ Trauma and Injuries)	Expand integrated service delivery and preventive programmes
Weak health workforce distribution	Implement targeted recruitment and training plans
Limited facility capacity and supplies	Strengthening procurement and logistics systems
Governance and financial accountability gaps	Increase funding and institutionalise corporate governance and audit systems
Limited data-driven decision-making	Digitise health information and strengthen M&E

3.7 Current Service Delivery Model

The current de facto model of care in NCD is heavily centralised around PMGH. While designated as the national referral and teaching hospital, PMGH functions as the primary point of contact for a large volume of patients seeking services ranging from basic primary care to complex tertiary treatment. This over-reliance on PMGH strains its resources, detracts from its specialist mandate, and creates significant access barriers and overcrowding. The public primary care network, managed by the NCDPHA, consists of facilities like Gerehu Hospital and a number of urban clinics, but this network has been historically under-resourced and unable to adequately meet the demand, further funneling patients towards PMGH. Because of this, the "single most critical infrastructure project" for the NCDPHA is the construction of a new Level 5 NCD Provincial Hospital. This is the cornerstone of the strategy to "decongest" PMGH.

This core public network is supplemented by a vital ecosystem of non-state providers. Church Health Services, including facilities run by the Catholic church and other denominations, are critical pillars of community-based care, often enjoying high levels of public trust. NGOs and Faith-Based Organisations provide specialised services that fill significant gaps, such as Marie Stopes International in family planning and Anglicare in HIV/STI services. The private sector, comprising private hospitals, clinics, and pharmacies, serves a segment of the population and absorbs a portion of the healthcare demand, though its activities are not currently integrated into the national health information system, leading to an incomplete picture of the district's overall health service landscape.

A key challenge identified is a data paradox. Official service utilisation is paradoxically low at 1.0 outpatient visits per person per year against a national target of 2.4. This is not due to a lack of need, but because the high, unquantified volume of patients using Port Moresby General Hospital and the private sector is not captured in the national health information system.

Finally, the quality of care is a major issue, with poor outcomes in key areas (like child pneumonia deaths and measles immunisation rates). This is a direct result of chronic underinvestment. The 2023 National Health Service Standards (NHSS) survey confirmed this, finding that all 11 surveyed government facilities scored significantly below the 60% minimum requirement for Environment and Management Standards, providing an irrefutable mandate for urgent infrastructure renewal.

3.8 SWOT Analysis

The following SWOT analysis is structured around the core building blocks of the health system, providing a detailed assessment of the NCDPHA's capacity and challenges.

Table 11.0 SWOT Analysis

Strengths	Weaknesses
Single Mandated Authority: Established under the Provincial Health Authorities Act 2007 with a clear mandate for a unified health system ("one system, one plan, one budget").	**System Fragmentation:** A history of poor coordination between providers, especially with the separately governed Port Moresby General Hospital and private health care providers.
Formal Governance Structure: A clear leadership structure with a NCDPHA Board and CEO-led Executive Team.	**Over-Reliance on PMGH:** Chronic dependence on PMGH for primary and secondary care has led to its congestion and a weak, underutilized primary care network.
Developed Strategic Frameworks: A clear, tiered model of care and a costed Health Infrastructure Development Plan (HIDP) are in place to guide future planning.	**Severe Resource Deficits:** Critical shortages in the health workforce (17% vacancy rate), dilapidated infrastructure, and aging medical equipment fail to meet national standards.
Existing Partnerships: Foundational relationships exist with key stakeholders including NCDC, DDAs, Church Health Services, and NGOs. Central location with national referral hospital PMGH. Concentration of health workforce in NCD.	**Systemic Failures:** Pervasive administrative inefficiencies (payroll, HR), a fragile supply chain, and fragmented, paper-based information systems undermine performance.
Opportunities	**Threats**
Strong Political and Policy Alignment: High-level political support (NCD Governor, DDAs) and alignment with national health plans provide a strong basis for reform.	**Political and Economic Instability:** Changes in government priorities or national economic pressures can divert funds and disrupt strategic plans and operational budgets.
Decongesting PMGH: The development of the new Level 5 NCD Provincial Hospital and upgraded district facilities presents a clear opportunity to build a credible alternative to PMGH.	**Workforce Attrition:** Continuous loss of skilled personnel to the private sector, retirement, or resignation threatens our capacity to deliver services.
Formalising Partnerships: Opportunity to establish formal agreements (MoUs) with PMGH, NCDC, DDAs, and other providers to streamline referrals, share data, and create a truly integrated system.	**Erosion of Public Confidence:** Poor quality of care, facility closures, and medicine stockouts risk further undermining public trust in the primary care system, driving more patients to PMGH.
Modernisation and Efficiency Gains: The potential to implement a diversified funding strategy, a new manpower ceiling, and an integrated Electronic Health Record (EHR) system can transform the NCDPHA.	**External Pressures:** Rapid urbanisation, high population density, and law-and-order issues place immense strain on health services and threaten the safety of staff and facilities.

Key Strategic Priorities from the SWOT Analysis

The SWOT analysis reveals eight interconnected and overarching strategic priorities that the NCDPHA must address to achieve its vision.

1. **Establishing Unified Leadership and Governance:** The NCDPHA must transition from being just one provider to becoming the single, authoritative steward of the entire NCD health ecosystem.
2. **Reorienting the System to Primary Health Care (PHC):** NCDPHA needs to urgently address the unsustainable over-reliance on PMGH.
3. **Rebuilding the NCDPHA's Human Capital:** NCDPHA faces a severe workforce crisis. The NCDPHA must aggressively pursue a multi-faceted strategy to secure approval for an expanded workforce establishment.
4. **Executing a Foundational Renewal of Physical Assets:** The dilapidated state of our facilities and equipment is a fundamental barrier to quality care. A comprehensive and urgent programme of infrastructure renewal is non-negotiable.
5. **Achieving Financial Sustainability and Fiscal Discipline:** To ensure stability, the NCDPHA must reduce its extreme dependence on a single, unpredictable government funding stream.
6. **Driving a Complete Digital Transformation:** NCDPHA must move away from unreliable, paper-based systems. The priority is to invest in a complete digital transformation, centred on implementing an integrated Electronic Health Record (EHR) system.
7. **Partnership and Integration:** Establishing formal, functional partnerships with PMGH, NCDC, Church Health Services, NGOs, and private providers to align planning, standardise care, streamline referrals, and ensure seamless data sharing across the entire district.
8. **Medical Products, Vaccines & Technologies:** Execute a fundamental renewal of its entire physical asset base—from equipment to the supply chain that stocks them. The priority is the construction of a dedicated Medical Drug Warehouse and a systematic programme for equipping all facilities to their designated NHSS level.



4. Strategic Pillars and Goals

The strategic direction of the National Capital District Provincial Health Authority from 2027 to 2031 is built upon nine foundational pillars. Aligned with the National Health Plan 2021-2030, these pillars provide a comprehensive roadmap for our actions, resource allocation, and partnerships. Each pillar is defined by a high-level objective and supported by key strategic areas, collectively guiding us toward our vision of "Healthy People and Thriving Communities."

4.1 Strategic Pillar 1: Unified Leadership and Good Governance

Objective: To establish the NCDPHA as the single, authoritative leader and steward of an integrated, accountable, and transparent provincial health system.

Key Strategic Areas:

- **Formalise and Strengthen Inter-Governmental Coordination:** Establish structured coordination mechanisms, joint committees, and regulatory frameworks with key government entities and central agencies to streamline public health initiatives, reporting, and functional transitions.
- **Elevate Corporate and Clinical Governance:** Enhance organisational compliance, accountability, and performance monitoring by establishing targeted subcommittees, refining evaluation frameworks, and strengthening leadership capabilities across all management levels.
- **Expand Strategic Partnerships and Stakeholder Engagement**: Foster collaborative networks with public, private, faith-based, and non-governmental partners to expand healthcare service delivery, regulate quality standards, and centralise regional health data.
- **Cultivate Transparent, Evidence-Based Leadership:** Align all planning, budgeting, and operational decisions with national health priorities while building corporate governance and leadership competencies among executives and line managers.

2027–2031 Corporate Outcomes

- All key partnerships — NCDC, the four District Development Authorities, Port Moresby General Hospital, the National Department of Health and church health services — governed by executed agreements, and the transfer of environmental health and food-safety functions from NCDC completed, by 2029.
- NCDPHA gazetted as the Local Medical Authority for the National Capital District by 2028.
- Four Board subcommittees, a Project Steering Committee for capital projects and a Joint Transition Committee with NCDC established and meeting to schedule from 2027, with unqualified external audit opinions obtained from 2029.

4.2 Strategic Pillar 2: People-Centred and Proactive Service Delivery

Objective: To reorient the service delivery model from a reactive, hospital-centric system to a proactive, accessible, and high-quality Primary Health Care (PHC) network that effectively meets community needs.

Key Strategic Areas:

- **Strengthen the Primary Health Care Network and Optimise Referral Systems:** Expand and upgrade provincial, district, and urban health facilities while establishing centralised triage and referral systems to reduce the patient burden on Port Moresby General Hospital.
- **Improve Patient Care Quality and Clinical Governance:** Standardise clinical practices and quality assurance protocols across all facilities through the systematic implementation of standard operating procedures, regular clinical audits, and strict infection prevention control measures.

- **Increase Access to Quality Health Services for the Urban Disadvantaged:** Improve healthcare accessibility and equity for vulnerable populations by expanding subsidised services, addressing environmental and housing determinants of health in informal settlements, and establishing specialised clinical hubs.

2027–2031 Corporate Outcomes

- Outpatient utilisation across the NCDPHA network doubled from 1.0 to 2.0 visits per person per year by 2031.
- A centralised patient triage, referral and ambulance coordination system fully operational by 2029, and a Service Level Agreement with Port Moresby General Hospital in force from 2027.
- Three of the five designated Centres of Excellence fully operational by 2031, and free primary health care in force at all Level 2 and Level 3 facilities from 2028.

4.3 Strategic Pillar 3: Strengthened Public Health Programmes and Community Engagement

Objective: To empower communities as active partners in health and shift the system's focus from curative treatment to proactive disease prevention and health promotion, aligned with the Healthy Island Concept.

Key Strategic Areas:

- **Strengthen Community Partnerships and Participation:** Promote local ownership of public health initiatives by revitalizing Ward Health Committees, empowering community members, and formalising strategic partnerships with non-governmental, faith-based, and local government entities.
- **Establish and Sustain a Network of Community Health Volunteers:** Develop a standardised, incentive-supported operational framework to recruit, train, and integrate Community Health Volunteers into the primary healthcare network for enhanced community-level health promotion and referrals.
- **Strengthen Health Promotion and Create Supportive Environments:** Drive preventive health behaviours and climate resilience by rolling out targeted awareness campaigns, implementing the Healthy Island Concept across key urban settings, and collaborating with municipal authorities to manage environmental health risks.
- **Establish and Sustain Water, Sanitation, and Hygiene (WASH) Interventions:** Improve public health outcomes and institutional resilience by implementing a comprehensive WASH strategy, upgrading sanitation infrastructure in health facilities, expanding community access to safe water, and integrating hygiene promotion into volunteer training.
- **Operationalise the Local Medical Authority and Environmental Health Regulation:** Assume full regulatory and enforcement accountability for environmental health by integrating municipal public health personnel, conducting targeted inspections of public and residential spaces, and leading city-wide health emergency responses.
- **Expand and Strengthen Occupational Health and Safety Systems:** Protect healthcare personnel and improve facility safety by establishing a dedicated OHS committee, conducting regular risk audits, ensuring proper protective equipment distribution, and implementing compliant medical waste management systems.

2027–2031 Corporate Outcomes

- Five hundred Community Health Volunteers recruited, trained, incentivised and reporting monthly by 2031.
- An active and trained Ward Health Committee in every ward of the National Capital District and the Motu Koitabu villages by 2031.
- Eighty per cent of health facilities with continuous safe running water and compliant sanitation, and the Local Medical Authority regulatory and food-safety function fully operational, by 2031.

4.4 Strategic Pillar 4: Addressing Disease Burden and Targeted Health Priorities

Objective: To reduce the morbidity and mortality associated with the triple burden of disease in NCD (communicable diseases, non-communicable diseases, and trauma and injuries) by implementing targeted, evidence-based public health and clinical programmes.

Key Strategic Areas:

- **Improve Maternal, Neonatal, and Child Health Outcomes:** Enhance maternal and child health indicators by expanding immunisation coverage, scaling up family planning, increasing capacity for supervised deliveries, and improving emergency obstetric and neonatal care across all health facilities.
- **Reduce the Burden of Communicable Diseases:** Control the spread of infectious diseases by scaling up prevention, treatment, and care for tuberculosis, HIV, and malaria, while strengthening surveillance systems to detect and respond to climate-sensitive and water-borne disease outbreaks.
- **Reduce Morbidity and Mortality from Non-Communicable Diseases, Injuries and Trauma, and Lifestyle Factors:** Mitigate the impact of lifestyle diseases, cancers, and physical trauma by expanding screening programmes, enforcing public health regulations on tobacco, alcohol and betelnut chewing, promoting active lifestyles, and increasing support services for gender-based violence.
- **Enhance Emergency Preparedness and Outbreak Response Capabilities:** Strengthen institutional readiness for public health crises by establishing a permanent Public Health Emergency Operations Centre, improving capacity to monitor emerging health and climate threats, and expanding diagnostic and treatment capabilities at key facilities.

2027–2031 Corporate Outcomes

- Measles immunisation coverage restored to 90 per cent and Pentavalent 3 coverage to 90 per cent by 2031.
- Under-five pneumonia case fatality reduced from 3.4 per cent to below 2 per cent by 2031.
- A permanent Public Health Emergency Operations Centre established by 2029, and gender-based violence support services available at every district hospital by 2031.

4.5 Strategic Pillar 5: Health Facility Infrastructure Construction and Rehabilitation

Objective: To transform the NCDPHA's physical infrastructure from a state of systemic failure into a modern, resilient, and fit-for-purpose network of health facilities that meet national standards and community needs.

Key Strategic Areas:

- **Executing the Health Infrastructure Development Plan (HIDP):** Constructing new multi-storey facilities at key sites and undertaking a comprehensive rehabilitation programme for all remaining facilities.
- **Equipping Facilities for Effective Service Delivery:** Ensuring all clinics and hospitals are equipped with the necessary modern equipment, skilled workforce, and reliable utility systems (power, water, waste).

2027–2031 Corporate Outcomes

- Level 5 Provincial Hospital designed and sited by 2028, construction commenced in 2029, and at least 60 per cent of works certified complete by 2031.
- Moresby South District Hospital commissioned and operationalized by 2027 and Gerehu District Hospital redeveloped and commissioned in 2031, with Nine Mile and Motu Koitabu District Hospitals advanced to construction and design respectively.
- Ten to twelve new or redeveloped facilities commissioned to National Health Service Standards by 2031, together with the Bio-Medical Centre and its Public Health and Food Safety Laboratory annex.

4.6 Strategic Pillar 6: Accessible Medical Products, Vaccines and Technologies

Objective: To ensure a reliable, efficient, and uninterrupted supply of safe and effective medical products, vaccines, and technologies to all NCDPHA health facilities.

Key Strategic Areas:

- **Optimise Medical Supplies Procurement, Technology Integration, and Distribution Services:** Modernize the pharmaceutical and diagnostic supply chain by upgrading storage, transport, and inventory management systems, establishing dedicated advisory and quality assurance units, and deploying specialised technologies to support both clinical operations and environmental health monitoring.

2027–2031 Corporate Outcomes

- Central Medical Drug Warehouse constructed and operational by 2029, with mSupply installed in every facility.
- Nine months in ten free of any tracer-drug stock-out lasting more than one week, by 2031.
- A Drug and Therapeutic Advisory Committee and a Pharmaceutical Inspection and Quality Assurance Unit established and functioning by 2030.

4.7 Strategic Pillar 7: Resilient and Motivated Human Resources

Objective: To build, retain, and motivate a competent, adequately sized, and equitably distributed health workforce capable of meeting the demands of an expanding health system.

Key Strategic Areas:

- **Optimise Workforce Recruitment, Deployment, and Retention:** Address critical staffing gaps and improve retention by conducting comprehensive human resource audits, resolving systemic payroll and housing issues, and restructuring the organisation to expand the workforce and integrate regulatory and environmental health personnel.
- **Develop a High-Performing and Future-Ready Health Workforce:** Build long-term organisational capacity by establishing continuous professional training programmes, deploying a robust Human Resource Information System, strengthening academic partnerships, and securing formal approvals for expanded structural and facility staffing.

2027–2031 Corporate Outcomes

- Approval of the expanded 2,046-position establishment obtained by 2028, with a separate submission for the Level 5 Provincial Hospital as it approaches commissioning.
- Vacancy rate against the establishment in force reduced from 17 per cent to below 10 per cent by 2031.
- Payroll and entitlement backlog cleared by 2028, a Human Resource Information System operational by 2029, and a budgeted in-service training plan delivered in every year of the cycle.

4.8 Strategic Pillar 8: Sustainable and Accountable Health Financing

Objective: To establish a stable, transparent, and sustainable financial foundation for the NCD health system, with resources strategically aligned to primary health care priorities.

Key Strategic Areas:

- **Financial Governance, Systems, and Internal Controls:** Institutionalise operational accounts by deploying the Integrated Financial Management System (IFMS) and establishing a dedicated Finance Committee to oversee strict compliance with the Public Finances (Management) Act. This system will be supported by a transparent, facility-based budgeting model, rigorous cash flow monitoring, and systematic clearance of legacy debts. The authority will actively collaborate with the Auditor General's Office to conduct regular financial audits.
- **LMA Revenue Capture and Dedicated Funding Streams:** Under the Local Medical Authority mandate, NCDPHA will establish a structured revenue-capture system to manage and collect public health licensing fees, food premise inspection charges, and regulatory fines.
- **Alternative Healthcare Financing and Trust Management:** To protect health service delivery from funding volatility, a dedicated Trust Account will be established to manage emergency and donor contributions transparently. NCDPHA will develop and assess alternative healthcare financing frameworks, including a health insurance programme.

2027–2031 Corporate Outcomes

- Integrated Financial Management System fully operational and external audit opinions obtained from 2029.
- Verified legacy liabilities of PGK 19.0 million cleared by 2031.
- Local Medical Authority regulatory revenue captured, a ring-fenced Trust Account operating, and the design of an NCD social health insurance scheme completed by 2031.

4.9 Strategic Pillar 9: A Modern, Data-Driven Digital Ecosystem

Objective: To build a robust and resilient digital health ecosystem that enables evidence-based decision-making, improves clinical quality, and enhances operational efficiency at all levels of the health system.

Key Strategic Areas:

- **Establishing Core ICT Infrastructure:** Building a new on-premises data centre and a reliable network (LAN/WAN) to connect all health facilities.
- **Integrating Health Information Systems:** Implementing an integrated Electronic Health Record (EHR) system to create a single source of patient information and strengthening compliance with the National Health Information System. This will also include information systems for human resource, workflow processes, public health information system and others as needed.
- **Strengthening Data Governance and Use:** Building capacity for data analysis to support clinical management and strategic planning and exploring innovative digital solutions like telemedicine.
- **Promoting Health Research:** Collaborating with research and tertiary institutions to conduct and manage medical and health system research.

2027–2031 Corporate Outcomes

- Data centre and wide area network operational by 2028, with system uptime of at least 95 per cent by 2031.
- Electronic Health Record in use at all district hospitals by 2029 and across the whole facility network by 2031, integrated with e-NHIS, the Human Resource Information System, the Integrated Financial Management System and mSupply.
- A data governance framework, disaster recovery capability and telemedicine services established by 2031.

5. Implementation Framework

The successful execution of the NCDPHA Corporate Plan depends on a robust and adaptive implementation framework. This framework defines how the strategic priorities will be translated into action, ensures accountability across levels, and provides mechanisms for monitoring progress and making mid-course corrections.

5.1 Governance and Leadership

- **NCDPHA Board:** Provides overall oversight, policy direction, and accountability for implementation.
- **Chief Executive Officer (CEO):** Leads implementation, supported by senior management.
- **Senior Executive Management Team (SEMT):** Translates strategic priorities into annual operational plans and budgets.
- **Clinical Governance Committee:** Ensures service quality, safety, and adherence to standards.

Figure 10.0: NCDPHA Stucture.





5.2 Accountability and Escalation

Every corporate outcome in this Plan has a named accountable office. The matrix below sets out who decides, who delivers, who reports and to whom, and where a matter is escalated when it goes off track. It is the basis on which the Board holds management to account and on which management holds directorates and facilities to account.

Table 12.0 Accountability Matrix

Office	Decides and endorses/approves	Lead accountability	Reports to, and how often	Escalation
NCDPHA	The Corporate Plan and its amendments; the Annual Implementation Plan and annual budget; the corporate risk register; capital business cases above the delegated threshold; agreements with PMGH, NCDC and the District Development Authorities	Stewardship of the Plan; appointment and performance of the Chief Executive Officer	Governor & PEC, Minister for Health and NDoH annually; the public through the annual report	Final authority within the Authority
Board subcommittees — Finance; Audit and Risk; Clinical Quality and Safety; Regulatory Compliance	Recommendations to the Board within their terms of reference	Scrutiny of quarterly performance, financial, clinical governance and risk reports before they reach the Board	NCDPHA Board, quarterly	Refer to the full Board
Chief Executive Officer	Finance and human resource management; daily operations	NCDPHA Board, quarterly	Board Chairman	Refer to the full Board
Senior Executive Management Team	In-year reallocation within the Annual Implementation Plan; corrective action plans	Conversion of this Plan into Annual Implementation Plans and directorate workplans; quarterly performance review	CEO monthly; Board subcommittees quarterly	Chief Executive Officer
Corporate Services Directorate	Financial delegations within the CEO's limits; procurement within threshold	Pillars 1, 7, 8 and 9 — financial governance, the workforce, information systems and revenue	CEO monthly; Finance and Audit and Risk subcommittees quarterly	Chief Executive Officer
Curative Health Services Directorate	Clinical protocols and standard operating procedures	Pillar 2 — the primary health care network, referral and triage, clinical governance, Centres of Excellence and the PMGH interface	CEO monthly; Clinical Quality and Safety subcommittee and other committees quarterly	Chief Executive Officer
Public Health Services Directorate	Public Health Services Directorate Environmental health and food-safety enforcement under the Local Medical Authority mandate	Pillars 3 and 4 — community engagement, volunteers, water and sanitation, regulation, immunisation and disease programmes	CEO monthly; Public Health, Regulatory Compliance, and other subcommittees quarterly	Chief Executive Officer
Corporate Services Directorate - Facilities and Infrastructure Branch	Technical acceptance of works within delegation	Pillars 5 and 6 — the capital programme, commissioning, equipment and the medical supply chain	CEO monthly; Project Steering Committee and other committees monthly	Project Steering Committee, then the SEM and the Board
Planning, Monitoring and Evaluation	Data quality standards and the indicator protocol	The Results Framework; quarterly and annual performance reports; the 2029 mid-term review and the 2031 evaluation	CEO quarterly; Board through the subcommittees	Chief Executive Officer
Facility and programme managers	Expenditure within the facility-based budget delegation; programme-level operational decisions	Facility and programme service delivery, standards compliance, monthly data returns and workplan delivery	Directorate head, monthly	Directorate head
NCDC and the four District Development Authorities	Their own allocations to health; the transfer of environmental health and food-safety functions	Co-funding and local prioritisation; counterparty to the Joint Transition Committee	Joint Transition Committee monthly until transfer is complete; Health Partnership Committee quarterly	Chief Executive Officer, then the Board
PMGH, church health services, non-government organisations and development partners	Their own clinical, service and funding decisions	Delivery of agreed services and support under service level agreements and memoranda of understanding, with reporting into e-NHIS	Joint review quarterly under each agreement; Health Partners Forum annually	Health Partnership Committee, then the Board

Escalation
A Board-level indicator that is off track for two consecutive quarters requires a corrective action plan from the lead accountable office to the Senior Executive Management Team within 30 days, and a report by the Chief Executive Officer to the relevant Board subcommittee at its next meeting. An appropriation not released within 30 days of the scheduled date triggers a revised cash-flow plan and a letter from the Chief Executive Officer to the Departments of Treasury and Finance, copied to the Board Chairman. A capital project that slips by more than one quarter against its stage-gate schedule is reviewed by the Project Steering Committee, and any change to scope, cost or completion date requires Board approval. Non-performance by a partner is reviewed under the dispute provisions of the relevant agreement, then by the Health Partnership Committee and, if unresolved, by the Board.

5.3 Proposed Service Delivery Model: An Integrated, People-Centred, Primary Health Care Centric Approach

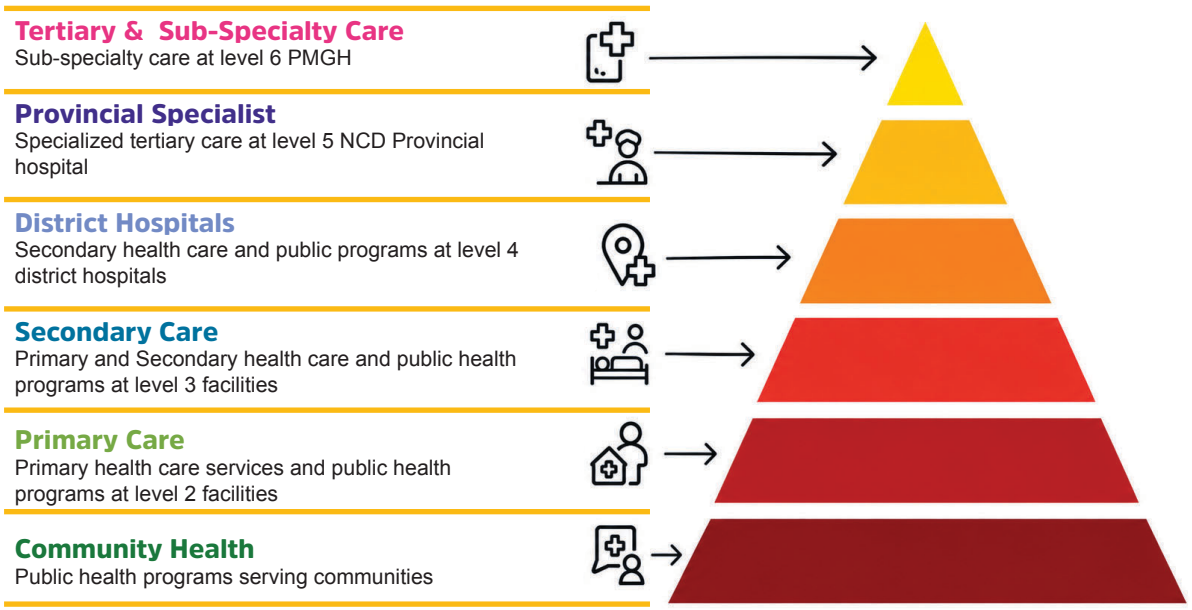
A Fundamental Strategic Shift
The National Capital District Provincial Health Authority is implementing a fundamental shift in its approach to healthcare delivery. We are moving away from a traditional, hospital-centric system towards an integrated, people-centred, and Primary Health Care (PHC) focused model. The primary goal of this new framework is to achieve Universal Health Coverage (UHC) by providing accessible, equitable, and efficient care closer to where people live.

This model decentralises service delivery, establishing a clear, hierarchical network of facilities designed to manage health needs at the most appropriate level.

The Hierarchical Model of Care
The integrated people centred primary health care centric service delivery model is structured as a pyramid, emphasizing that the vast majority of health needs should be managed at the community and primary care levels.

1. **The Foundation (Level 1 & 2 - Community & Primary Health):** This is the cornerstone of our system, focusing on preventative health, health promotion, and the management of common illnesses. Strong and accessible Level 2 clinics will serve as the main entry point to the health system, reducing the burden on hospitals.
2. **The Support System (Levels 3 and 4 — Secondary and District Care):** Upgraded Level 3 Urban Clinics and four designated Level 4 District Hospitals, one for each district, form the core referral network. These facilities provide a broader range of services, including diagnostics, minor procedures and inpatient care, and actively support the primary care clinics within their network.
3. **The Apex (Levels 5 & 6 - Specialist & Sub-Specialty Care):** At the peak is the new Level 5 NCD Provincial Specialist Hospital, serving as the primary referral centre for complex cases within the NCDPHA network. The Level 6 Port Moresby General Hospital will function as our strategic partner for national-level, highly specialised care, allowing it to focus on its mandate as a national referral and teaching hospital.

Figure 11.0 Service Delivery Model for NCDPHA: Integrated, People-Centred, Primary Health Care Centric Approach



Operational Structure: The Hub-and-Spoke Network

To ensure logical and efficient patient flow, our model is operationalised through a classic hub-and-spoke architecture. All NCDPHA and partner facilities are organised into geographical clusters that feed into their designated Level 4 District Hospital hub. These hubs, in turn, are supported by the central Level 5 Provincial Hospital. This structure clarifies referral pathways, strengthens the role of primary care, and ensures that specialist resources are used effectively for the most complex cases.

Strategic Specialisation: Centres of Excellence

To strategically address the NCD's most significant disease burdens, we will implement a Health Facility Disease Focus-Based Model. This innovative approach designates key facilities to serve as specialised "Centres of Excellence," which will act as hubs for clinical expertise, advanced diagnostics, targeted prevention programmes, and training for the entire health network.

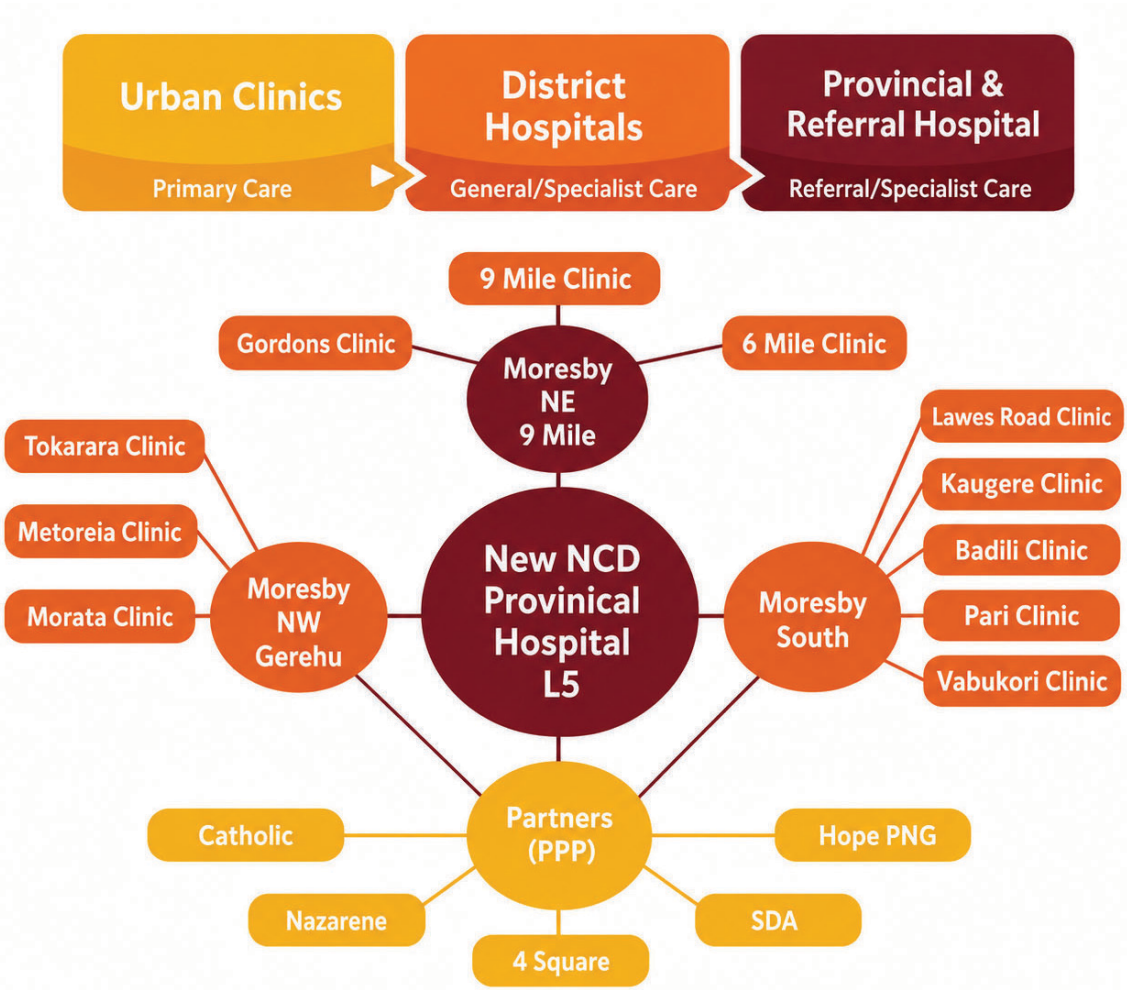
1. **Six Mile Clinic** - Centre for Infectious Disease Control and Prevention
2. **Moresby South District Hospital** - Centre for Prevention and Lifestyle Medicine
3. **Metoreai Health Centre** - Centre for Women and Children's Care
4. **Gerehu District Hospital** - Trauma and Injury Care Centre
5. **St Theresa Clinic** - Centre for Behavioural Health Care

While these centres will provide advanced care for their specific focus areas, they will remain integrated within the PHC network, supporting all other clinics through clear referral pathways, outreach, and capacity building, thereby ensuring every resident has access to both comprehensive primary care and the specialised care.

Clear Roles and Patient Pathways

Each level of care has a clearly defined role and function, adhering to the National Health Service Standards. This role delineation ensures that every facility operates reliably at its designated level, backed by the necessary resources and infrastructure. The planned patient journey begins at the primary care level (Levels 1-2). Patients are only referred to higher levels of care (Levels 3-6) when their clinical needs exceed the capacity of their current facility. This sequential pathway is designed to eliminate facility bypassing, reduce congestion at our hospitals, and ensure patients receive the right care at the right place and time.

Figure 12.0: Hub and Spoke Network: Hierarchy of the Level of health service delivery at the NCDPHA health facilities.



Critical Enablers for Success

The successful implementation of this integrated model is dependent on several critical enablers:

- **A Centralised Ambulance, Triage, and Referral System:** To ensure timely and appropriate patient transport between facilities.
- **An Integrated Digital System:** A planned Electronic Health Record (EHR) system will allow patient information to flow seamlessly across all levels of care.
- **Formalised Partnerships:** Service Level Agreements (SLAs) with PMGH, Church Health Services, and other key partners will standardise protocols and ensure a cohesive referral chain.

5.4 District Health Services Implementation Plan

The core principle of this implementation plan is the establishment of a robust, tiered, and integrated health system. Each electorate will be anchored by a designated Level 4 District Referral Facility (Hospital), which will serve as the hub for clinical referrals, public health coordination, and supply chain management for a network of upgraded Level 3 Urban Clinics and Level 2 Health Sub-Centres. The planned facility upgrade and service expansion targets detailed below are directly mandated by the findings of the 2023 NHSS Accreditation Assessment Survey, which found systemic deficiencies in facility infrastructure and service capacity across the districts.

This five-year plan front-loads the anchor referral infrastructure — the four District Hospitals (Level 4) and the design and commencement of the NCD Provincial Hospital (Level 5) — so that the backbone of the tiered system is established early, while delivering approximately half of the community-level facility network (Level 2 Community Health Posts and Level 3 Health Centres) targeted for completion by 2036 under the Strategic Health Services Development Plan.

NHSS Standards Applied
The NHSS guide facility planning based on population size and service coverage.

Level 2 – Community Health Post (CHP): 1 per 5,000–10,000 people
Level 3 – Health Centre: 1 per 20,000 people
Level 4 – District Hospital: 1 per district

Realistic Health Facility Plan
Applying the raw NHSS ratios to NCD gives an inflated number of facilities that would be unrealistic for a small, urban, middle income province like NCD. We will recalibrate using urban realities: dense population, good road connectivity and ease of access.

Instead of strict ratios, we are using scaled benchmarks:

- **Level 2 (CHPs):** about 1 per 50,000 people in urban settings (instead of 1 per 5,000–10,000).
- **Level 3 (Health Centres):** about 1 per 150,000 people (instead of 1 per 20,000).
- **Level 4 (District Hospitals):** four, one per district.
- **Level 5 (Provincial Hospital):** 1 for NCD.

Table 13.0 Health Facility Network Plan for 2031

District	Population 2031	Level 2 Community Health Posts	Level 3 Health Centres	Level 4 District Hospitals	Level 5 Provincial Hospital
Moresby North-West	415,961	5–6	2	1	1
Moresby North-East	420,451	5–6	2	1	-
Moresby South	279,114	3–4	2	1	-
Motu Koitabu	81,075	1	1	1	-
NCD — 2031 target	1,115,526	15	6–7	4	1
NCD — 2036 network	1,471,859	30	12–14	4	1

The 2031 targets represent approximately half of the facility network targeted for 2036 in the Strategic Health Services Development Plan 2027–2036, and reflect scaled urban benchmarks rather than the raw National Health Service Standards ratios. The Motu Koitabu population is a sub-population of the three Moresby districts and is not additional to the NCD total. The Level 5 Provincial Hospital is sited at Tete (Nigibata Road), Moresby North-West.

By 2031 the population of the National Capital District is projected to reach 1,115,526, with Moresby North-West and Moresby North-East each above 415,000, Moresby South approaching 280,000 and the Motu Koitabu sub-population above 80,000. This first phase of the network establishes approximately 15 Community Health Posts (Level 2) and 6 to 7 Health Centres (Level 3), anchored by four District Hospitals (Level 4), one in each district, together with the new NCD Provincial Hospital (Level 5). Given the district's dense urban setting, strong road connectivity and the presence of Port Moresby General Hospital as a national referral hub, this phased benchmark establishes the backbone of the tiered system early, with the remaining community-level facilities added in the second phase toward the 2036 targets.

Climate Change and Building Climate-Sensitive and Resilient Systems

The NCD, as a coastal urban centre, is particularly vulnerable to the impacts of climate change, including rising sea levels, increased frequency and intensity of extreme weather events, and associated health risks. To ensure the long-term sustainability and effectiveness of the NCDPHA's health infrastructure and services, it is imperative to integrate climate change adaptation and resilience strategies into all aspects of planning and implementation. This includes designing and constructing new facilities, as well as upgrading existing ones, to be climate-sensitive.

Figure 13.0: NCDPHA Health Facility Plan for 2031



5.5 Planning and Phasing

The implementation of this Corporate Plan will be executed over three distinct but interconnected phases, ensuring a logical and sustainable transformation of the NCD health system across the five-year period from 2027 to 2031.

Table 14.0 Implementation Phases and Annual Milestones, 2027–2031

Year	Phase	Principal deliverables
2027	Phase 1 — Foundations	Board subcommittees and delegations in force. Agreements executed with NCDC, the four District Development Authorities and the National Department of Health, and a Service Level Agreement signed with Port Moresby General Hospital. Joint Transition Committee and Project Steering Committee established. Level 5 hospital design commenced and site acquisition advanced. Medical Drug Warehouse construction commenced. Data centre and network build commenced and the Integrated Financial Management System, Finance and HR business workflow systems deployed. Legacy liabilities verified. Moresby South District Hospital construction completed.
2028	Phase 1 — Foundations	Gazettal as Local Medical Authority published. Approval of the 2,046-position establishment obtained. Moresby South District Hospital commissioned and operationalized. Level 5 hospital design approved and site fully secured. Data centre operational and Electronic Health Record procured. Gerehu District Hospital redevelopment commenced. Environmental health officers transferred from NCDC. Free primary health care in force at all Level 2 and Level 3 facilities.
2029	2029 Phase 2 — Expansion and systems	Level 5 Provincial Hospital construction commenced. Nine Mile District Hospital construction commenced. Medical Drug Warehouse operational and mSupply installed in all facilities. Electronic Health Record live at all district hospitals. Legacy liabilities cleared. Six Mile, Morata and Badili redevelopments in construction. Mid-term review completed and priorities recalibrated.
2030	Phase 3 — Consolidation	Level 5 Provincial Hospital construction in progress. Bio-Medical Centre and Public Health and Food Safety Laboratory commissioned. Electronic Health Record extended across urban clinics. Ten to twelve new or redeveloped facilities commissioned. Five hundred Community Health Volunteers deployed and reporting. Centres of Excellence operational at Six Mile, Gerehu and Moresby South.
2031	2031 Phase 3 — Consolidation and evaluation	Gerehu District Hospital redevelopment commissioned. Level 5 Provincial Hospital works at least 60 per cent certified complete, with commissioning carried into the second tranche. Primary care network of approximately 15 Community Health Posts and 6 to 7 Health Centres established. Vacancy rate below 10 per cent. End-of-term evaluation completed and the Corporate Plan 2032–2036 prepared.

5.6 Annual Implementation Plans

- Annual plans will break the nine Strategic Pillars down into **specific activities, budgets, and responsibilities.**
- Each division (Clinical Services, Public Health, Human Resources, Finance, Facilities and Infrastructure, and ICT) will prepare annual workplans aligned to corporate priorities and to the costed pillar budgets.
- Facility-based budgeting will empower facility managers and improve local accountability, with district-level budgets reflecting the actual cost of delivering services under the NHSS.
- Quarterly and annual reviews will ensure progress tracking and allow workplans to be adjusted in response to performance data.

Table 15.0 Annual Implementation Planning Calendar

Period	Activity	Responsible
July–August	Performance and expenditure position for the current year reviewed; corporate outcomes for the coming year confirmed against this Plan and Budget submitted to Treasury with funding submissions to partners.	Planning, Monitoring and Evaluation, Finance and HR
July - September	Directorate, programme and facility workplans and facility-based budgets prepared and costed	Directorate heads; facility and programme managers
October	Draft Annual Implementation Plan and budget consolidated and tested against the financing framework	Senior Executive Management Team
November	Annual Implementation Plan and budget approved	NCDPHA Board
December	Plan aligned to the appropriation; individual performance agreements signed for the coming year	Chief Executive Officer; directorate heads
Quarterly	Performance and expenditure review; corrective action plans; in-year reallocation within the approved envelope	Senior Executive Management Team; Board subcommittees
Annually (Q1)	Annual performance review workshop with the Board, management, facility managers and external partners; annual health sector report submitted	Chief Executive Officer

5.7 From the Corporate Plan to Individual Performance Agreements

The Plan is delivered through an unbroken line of accountability. The Board sets the Chief Executive Officer's annual performance agreement directly from the corporate outcomes and Board-level indicators in this Plan. The Chief Executive Officer sets directors' agreements from the Annual Implementation Plan. Directors set the agreements of programme managers and facility managers from directorate and facility workplans. Every corporate outcome is therefore traceable to at least one named officer whose performance is assessed against it, and every officer can see how their work contributes to the Plan.

5.8 Institutional Arrangements

- **NCDPHA Headquarters**: As the authority mandated under the Provincial Health Authorities Act 2007, leads governance, finance, human resources, planning, and system-wide coordination and oversight.
- **Health Facilities (District hospitals, urban clinics, PMGH and community linkages):** Implement service-delivery initiatives within the tiered, hub-and-spoke model of care.
- **Stakeholders and Partners:** Government agencies, NCDC, DDAs, NGOs, FBOs, private sector, and development partners engaged through the Health Partnership Committee, an advisory body to the NCDPHA Board, with all major partnerships governed by formal MOUs or Service Level Agreements.
- **Communities:** Engaged as active partners in health via settlement health committees, village boards, community health volunteer networks, and youth groups.

5.9 Resource Mobilisation and Financing

- **Diversifying Funding Sources:** The core funding is from the Government of PNG (NDoH, Treasury, NCDC grants). NCDPHA will reduce its over-reliance on a single funding stream by advocating for more predictable government funding and by formalising partnerships to leverage supplementary support from the National Capital District Commission (NCDC), District Development Authorities (DDAs), and development partners. To bridge the funding gap — NCDPHA will also explore innovative financing models, including a phased NCD Social Health Insurance (SHI) pilot, public-private partnerships, corporate clinics, and internally generated revenue.
- **Strengthening Financial Governance and Controls:** NCDPHA will institutionalise fiscal discipline by fully implementing the Integrated Financial Management System (IFMS) for enhanced transparency, enforcing strict compliance with the Public Finances (Management) Act, establishing a ring-fenced Trust Account for donor and emergency financing, and maintaining robust internal controls and regular audit mechanisms.
- **Strategic Resource Allocation:** A key priority is to verify and clear in full the legacy liabilities of approximately PGK 19.0 million inherited by the Authority, freeing the operational budget for core clinical services. A provision of PGK 34.0 million is carried within Pillar 1 for verification, settlement and associated costs. All future expenditure will be explicitly aligned with the strategic priorities of this Plan, directing resources away from non-clinical overheads and into patient care and health outcomes.

5.10 Workforce and Capacity Development

The priority is to build a larger, more skilled, and motivated workforce capable of delivering high-quality care across the expanded health network. Key actions include:

- **Strategic Workforce Expansion:** Securing Department of Personnel Management approval by 2027 for an expanded establishment of more than 2,046 positions — from the current approved ceiling of 574 — to staff all new and upgraded facilities, with a particular focus on public health. A separate establishment submission will be made for the Level 5 Provincial Hospital as it approaches commissioning.
- **Develop a Human Resource Strategy** to address chronic shortages, reduce the vacancy rate from 17 per cent to below 10 per cent against the establishment in force, and correct the maldistribution of skilled cadres (doctors, health extension officers and midwives), recruiting approximately 300 staff a year across the plan period.
- **Upskill staff** in primary health care, emergency response, ICT systems, and management, through a budgeted in-service training plan.
- **Introduce performance appraisal systems and a Human Resource Information System (HRIS)** to drive accountability and support workforce planning.
- **Build community health volunteer networks** for settlement outreach, and improve retention throughsafe institutional housing and resolution of payroll and entitlement issues.

5.11 Medical Supply Management Strategy

The strategy is to transform the fragile medical supply chain into a modern, reliable, and efficient system that eliminates stockouts. Key actions include:

- Constructing a dedicated central Medical Drug Warehouse (Transit Store) to serve as the hub for inventory management, quality control, cold-chain, and distribution.
- Implementing a modern inventory management system (mSupply) across all facilities to enable data-driven quantification, storekeeping standards, and "last-mile" logistics.
- Transitioning from an inefficient "push" system to a proactive "pull" system driven by actual patient consumption data, so facilities receive what they need, when they need it, supported by a Drug and Therapeutic Advisory Committee and pharmacovigilance mechanisms.

5.12 Information and Communications Technology Strategy

Execute a complete digital transformation, moving away from unreliable, paper-based processes to a modern, integrated digital ecosystem. Key actions include:

- Building foundational ICT infrastructure, including a new central Data Centre and a reliable Wide Area Network (WAN) and Local Area Network connecting NCDPHA HQ, Gerehu Hospital, and all major urban clinics, with a Disaster Recovery centre for business continuity.
- Implementing a new, integrated Electronic Health Record (EHR) system to create a "single source of truth" for all patient information, integrated with e-NHIS, HRIS, IFMS and mSupply.
- Strengthening data governance through a formal framework, a data warehouse for analytics, and staff capacity building to enable evidence-based decision-making. Telemedicine and disease-surveillance capacity will be introduced to extend specialist access and improve operational efficiency at every level.

5.13 Infrastructure Strategy

Execute a foundational renewal of the entire physical health estate, guided by the Health Infrastructure Development Plan (HIDP), to ensure all facilities are safe, modern, climate-resilient, and fit-for-purpose. Key actions include:

- Constructing the new Level 5 NCD Provincial Specialist Hospital of approximately 300 beds on the greenfield site at Tete (Nigibata Road), Moresby North-West, to serve as the modern apex of the NCD health system and decongest Port Moresby General Hospital. Design and site acquisition complete in 2028; construction commences in 2029 and continues into the second tranche of the Strategic Plan.
- Replacing dilapidated clinics with new multi-storey facilities at Gerehu, Six Mile, Gordons and Badili, executing a comprehensive rehabilitation programme for all remaining Level 2 and Level 3 sites, and delivering the four Level 4 District Hospitals — Moresby South (2028), Gerehu (2031), Nine Mile (from 2029) and Motu Koitabu (design phase) — to National Health Service Standards.
- Implementing a systematic programme to modernise all medical equipment against National Health Service Standards, constructing the Bio-Medical Centre for equipment repair and maintenance with its Public Health and Food Safety Laboratory annex, and establishing a preventive maintenance and asset-management system to protect these investments.

5.14 Capital Investment Governance

The capital programme of PGK 1,715.9 million is governed by a Project Steering Committee chaired by the Chief Executive Officer, reporting monthly to the Senior Executive Management Team and quarterly to the Board. Every project passes four stage gates and may not proceed without approval at each: Gate 1, business case — need, options, capital and recurrent cost, staffing establishment, land tenure and statutory approvals confirmed; Gate 2, design approval — design meets national standards, climate-resilience and disability-access requirements, the cost plan is confirmed and the site is legally secured; Gate 3, contract award — procurement under the Public Finances (Management) Act and National Procurement Act with prequalification, performance security and an independent certifier appointed; Gate 4, commissioning — works certified complete, equipment installed, the establishment filled and a recurrent operating budget in place. No facility is commissioned without an approved establishment and a recurrent operating provision, and any change to the scope, cost or completion date of a major project requires Board approval.

5.15 Monitoring, Evaluation and Learning

The Results Framework at Table 17.0 aligns the strategic pillars, Key Result Areas and the National Health Plan 2021–2030, and employs a dual set of outcome and output indicators. Key mechanisms are:

- **Quarterly performance reviews** by the Senior Executive Management Team (SEMT) and Directorate Heads, reporting to the Board's subcommittees.
- **Annual health sector performance reports** prepared through an annual review workshop and shared with stakeholders.
- **Mid-term review in 2029** to validate the strategic direction and recalibrate strategies through adaptive management.
- **End-of-term evaluation in 2031** to assess overall impact and inform the next corporate planning cycle.
- Indicators will track inputs, outputs, outcomes, and impact (e.g., immunisation rates, TB treatment success, NCD screening coverage, and the maternal mortality ratio).

5.16 Communication and Accountability

Annual Corporate Plan progress will be shared with:

- NCDPHA Board
- Government (NDoH, DoT, DPM, DNPM, Chief Secretary Office, NCDC, DDAs, Development Partners)
- Partners and community stakeholders
- Regular communication through public forums, radio, digital platforms, and health committees.
- Accountability reinforced via transparent reporting, audits, and community scorecards.

This framework makes the Corporate Plan action-oriented, accountable, and adaptive — ensuring that strategic goals translate into measurable health improvements for NCD communities across the 2027–2031 cycle.

5.17 Equity, Inclusion, Patient Experience and Resilience

Five commitments run across every pillar of this Plan and are reported to the Board with the Results Framework.

- **Equity of access:** Services are planned around where need is greatest. Primary health care at Level 2 and Level 3 facilities is free of charge, outreach is directed to informal settlements, and all performance data is disaggregated by age, sex, district and settlement type so that inequity is visible and can be acted upon.
- **Gender equality and social inclusion:** A Gender Equality and Social Inclusion function is established in the Office of the Chief Executive Officer. Gender balance in leadership is maintained, services for survivors of family and sexual violence are available at every district hospital by 2031, and inclusion requirements are written into every partner agreement.

- **Disability access:** Every new and upgraded facility is designed and certified to disability-access standards, and existing facilities are progressively improved through the rehabilitation programme.
- **Patient experience and safeguarding:** Every facility conducts and publishes an annual patient feedback survey by 2031, and operates a complaints and feedback process. The Authority maintains a safeguarding policy for children and vulnerable adults, with mandatory staff training and a protected reporting procedure.
- **Climate resilience:** All new construction and major rehabilitation are climate-resilient by design, every facility holds a minimum of 72 hours of backup power and water, and disease surveillance is extended to climate-sensitive conditions.



6. Risk Management

6.1 Introduction

The implementation of the NCDPHA Corporate Plan 2027–2031 will take place in a dynamic and challenging environment. Risks may arise from financial, operational, institutional, socio-economic, and environmental factors. A proactive risk management framework will enable the Authority to anticipate, mitigate, and respond to threats while ensuring continuity of essential health services.

6.2 Corporate Risk Register

The register below records each corporate risk, its cause and consequence, its rating before and after controls, the officer who owns it, the additional mitigation required and the trigger that signals the risk is materialising. It is reviewed by the Audit and Risk subcommittee each quarter and by the Board twice yearly, and is updated with each Annual Implementation Plan.

Table 16.0 NCDPHA Corporate Risk Register 2027–2031

NO.	Risk and cause	Consequence	Inherent rating	Controls, additional mitigation and risk owner	Residual rating and review
R1	Funding shortfall — the Plan requires resources above the current appropriation, and cash releases are irregular.	Deferral of capital works, arrears to suppliers, interruption to services.	High	Multi-year budget submissions aligned to the Public Investment Programme; ring-fenced Trust Account; Health Function Grant sought; diversified income under the Local Medical Authority mandate; scenario-based implementation (Section 8.4). Trigger: appropriation not released within 30 days of schedule. Owner: Director Corporate Services (Finance).	Medium Quarterly.
R2	Political, policy and partnership change — shifting priorities, or failure of the PMGH, church or partner agreements.	Diversion of funds, loss of continuity, breakdown of referral pathways.	High	Formal agreements with all levels of government and every service partner, each with defined standards, reporting and dispute provisions; NDoH–NCDC–NCDPHA joint committee; quarterly Health Partnership Committee review; annual realignment through the Annual Implementation Plan. Owner: Chief Executive Officer.	Medium Quarterly.
R3	Land tenure and statutory approvals — title, planning and environmental approvals for the Tete site not completed to programme.	Delay to the Level 5 Provincial Hospital, the Plan's largest capital commitment.	High	Site acquisition completed as a 2027–2028 milestone before construction commitment; Project Steering Committee oversight; legal and survey due diligence before design approval. Trigger: title not secured by mid-2028. Owner: Director Corporate Services, with the Board Secretary.	Medium Quarterly.
R4	Procurement failure, contractor underperformance or cost escalation above the 7 per cent construction assumption.	Cost overrun, delay, sub-standard construction, reduction in deliverable scope.	High	Stage-gated approval; prequalification and performance security on all major contracts; independent certification of progress claims; contingency carried within phased capital envelopes; annual revaluation of the capital programme. Owner: Director Corporate Services (Procurement) with the Facilities and Infrastructure Branch.	Medium Quarterly.
R5	Establishment approval not obtained — the 2,046-position establishment is delayed or granted in part.	New and upgraded facilities cannot be staffed; the workforce budget cannot be executed.	High	Early submission in 2027 with a costed business case; staged submission strategy; a separate submission for the Level 5 hospital. Trigger: approval not obtained by end-2028. Owner: Director Corporate Services (Human Resources).	Medium Quarterly.

N0.	Risk and cause	Consequence	Inherent rating	Controls, additional mitigation and risk owner	Residual rating and review
R6	Workforce shortage and attrition, driven by payroll and entitlement failures, housing and market competition.	Service closure, loss of skilled staff, low morale.	High	Dedicated payroll and entitlements task force; institutional housing programme; budgeted in-service training; performance management and career pathways; Human Resource Information System from 2029. Owner: Director Corporate Services (Human Resources).	Medium Quarterly.
R7	Recurrent cost of commissioned facilities is not funded as new assets come into service	Newly built facilities open without staff, supplies or maintenance.	High	Every capital business case carries a recurrent operating estimate and a staffing establishment before commissioning approval; recurrent provision built into the Annual Implementation Plan two years ahead of each commissioning date. Owner: Director Corporate Services (Finance).	Medium Quarterly.
R8	Medical supply interruption — supply chain failure, stock-outs and cold-chain breaks.	Treatment interruption, loss of public confidence, avoidable mortality.	High	Central Medical Drug Warehouse operational from 2029; mSupply across all facilities; consumption-driven distribution; Drug and Therapeutic Advisory Committee; buffer stock of tracer items. Trigger: any tracer-drug stock-out beyond two weeks. Owner: Director Corporate and Curative Health Services (Medical Supplies).	Medium Quarterly.
R9	Information systems failure, cyber attack, loss of patient data, or incomplete and late reporting into e-NHIS.	Loss of clinical records, breach of confidentiality, and performance that cannot be measured.	High	Disaster recovery centre and tested continuity plans; role-based access control, encryption and audit logging; annual penetration testing; data governance framework; monthly facility data validation and twice-yearly data-quality audits; reporting clauses in every partner agreement. Owner: Director Corporate Services (ICT) with the Planning, Monitoring and Evaluation Team.	Medium Quarterly.
R10	Law and order — crime affecting staff safety, facility security and outreach.	Service suspension, staff attrition, restricted access to settlements.	High	Investment in facility security; escort arrangements for outreach; community partnership through Ward Health Committees; incident reporting and review. Owner: Director Corporate Services.	Medium Quarterly.
R11	Climate and disaster events — flooding, extreme weather, sea-level rise and outbreak risk in a coastal urban setting.	Facility damage, service interruption, disease outbreak.	Medium	Climate-resilient design for all new and upgraded facilities; 72-hour backup power and water; Emergency Operations Centre and facility Continuity of Operations Plans; climate-sensitive disease surveillance. Owner: Director Public Health.	Medium. Semi-annually.
R12	Fraud, corruption and misappropriation across procurement, revenue collection and liability settlement.	Financial loss, audit qualification, loss of public and partner confidence.	High	Integrated Financial Management System with full audit trail; segregation of duties; internal audit reporting to the Audit and Risk subcommittee; Auditor-General engagement; independent verification of all legacy liabilities before settlement; protected disclosure procedure. Owner: Internal Auditor.	Medium Quarterly.

6.3 Contingency Planning

To ensure resilience in the face of unexpected shocks, NCDPHA will maintain contingency measures, including:

- **Emergency Operations Centre (EOC):** Strengthened to coordinate rapid response during outbreaks and disasters.
- **Emergency Health Fund:** Establish a contingency budget line for outbreak response, essential medical supplies, and rapid deployments.
- **Continuity of Operations Plans (COOP):** Facility-level preparedness for disasters, pandemics, or system breakdowns.
- **Partnership Activation Protocols:** Rapid mobilisation of NGOs, churches, and development partners during emergencies.
- **Community-Based Preparedness:** Settlement health committees trained in first response, community surveillance, and basic disaster preparedness.

This Risk Management chapter ensures that the Corporate Plan is resilient, proactive, and responsive to both internal and external challenges.



7. Monitoring, Evaluation and Reporting

Effective implementation of the NCDPHA Corporate Plan requires a robust Monitoring, Evaluation, and Reporting (M&E) framework. This ensures that strategic priorities are tracked, outcomes measured, and lessons applied to inform adaptive management.

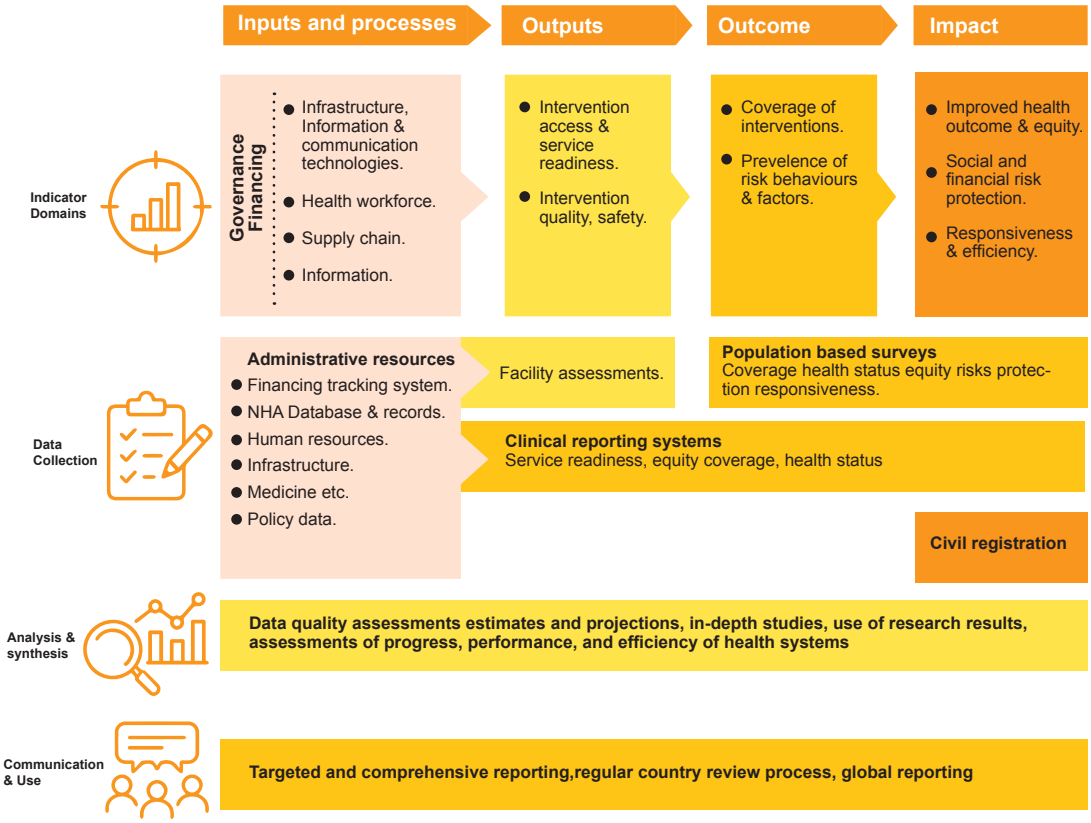
7.1 Monitoring and Evaluation Framework and Tools

The NCDPHA M&E framework is designed to monitor inputs, processes, outputs, outcomes, and impact across all strategic pillars. It provides structured guidance for planning, data collection, analysis, and reporting.

Key components include:

1. **Results Framework:** Links strategic pillars, strategic objectives, initiatives, expected outcomes, and performance indicators.
2. **Data Collection Tools:**
   - Facility-level reporting forms for service delivery data.
   - Health Information System (HIS) dashboards for real-time monitoring.
   - Community surveys and outreach reports to assess population-level impact.
   - Patient feedback and satisfaction surveys.
3. **Evaluation Tools:**
   - Mid-term review tools to assess progress against targets.
   - End-of-term evaluation instruments to measure impact and inform future planning.
4. **Capacity Building:** Training of staff in M&E methods, data analysis, and reporting to ensure high-quality, timely information.

Figure 14.0 Monitoring and Evaluation Framework



Source: National Department of Health 2023

7.2 Key Performance Indicators (KPIs)

KPIs provide measurable benchmarks for tracking progress against the Corporate Plan objectives. KPIs are aligned with the National Health Plan 2021–2030 and focus on **service coverage, quality, equity, and system performance.**

KPIs by Strategic Pillars:

Table 17.0 Results Framework: Board-Level Performance Indicators, 2027–2031

Pillar	Board-level indicator	Baseline (2026)	2029 mile-stone	2031 target	Source and frequency	Lead accountable office
1	Percentage of key partnerships (NCDC, the four District Development Authorities, PMGH, NDoH and church health services) governed by an executed memorandum of understanding or service level agreement	20%	100%	100%	Partnership register; semi-annual	CEO; Director Corporate Services
2	Outpatient visits per person per year across the NCDPHA network	1.0	1.5	2.0	e-NHIS; quarterly	Director Curative Health Services
2	Number of designated Centres of Excellence fully operational	0	2	3	Facility accreditation records; annual	Director Curative Health Services
3	Community Health Volunteers trained, deployed and reporting monthly	0	300	500	CHV register; quarterly	Director Public Health
3	Percentage of health facilities with continuous safe running water and NHSS-compliant sanitation	100%	100%	100%	NHSS facility audit; annual	Director Public Health
4	Measles immunisation coverage, children under one year sanitation	59%	85%	90%	e-NHIS; quarterly	Director Public Health
4	Under-five pneumonia case fatality rate	3.4%	2.5%	Below 2%	e-NHIS; quarterly	Director Curative Health Services
5	Level 5 Provincial Hospital — progress against the approved construction programme	0% (pre-con-struction)	Construction commenced	At least 60% of works certi-fied complete	Certified progress reports; quarterly	Facilities and Infra-structure Branch
5	New or redeveloped facilities constructed to NHSS and commissioned	0	4	10–12	Commissioning certificates; semi-	Facilities and Infrastructure Branch
6	Percentage of months in which no facility records a tracer-drug stock-out lasting more than one week	30%	70%	90%	mSupply; monthly	Director Corporate Services (Medical Supplies)
7	Approval of the 2,046-position establishment by the Depart-ment of Personnel Management	Not approved	Approved and in execution	Fully executed	Departmental instrument; annual	Director Corporate Services (Human Resources)
7	Vacancy rate against the establishment in force	17%	10%	Below 10%	Human Resource returns; quarterly	Director Corporate Services (Human Resources)
8	Percentage of verified legacy liabilities cleared	0%	50%	100% cleared and Maintained	Financial reports; quarterly	Director Corporate Services (Finance)
8	External audit opinion on the NCDPHA financial statements	Outstanding 2022-2025	Unqualified	Unqualified	Auditor-General; annual	Director Corporate Services (Finance)
9	Percentage of NCDPHA facilities using the Electronic Health Record for patient records	0%	All district hospitals	All facilities	EHR system reports; quarterly	Director Corporate Services (ICT)
9	ICT system uptime across the NCDPHA network	45%	85%	At least 95%	ICT monitoring reports; quarterly	Director Corporate Services (ICT)
All	Percentage of new and upgraded facilities meeting disability access and climate-resilience design standards	0%	100% of new works	100% of new works	Commissioning certificates; annual	Facilities and Infrastructure Branch
All	Patient experience: percentage of facilities conducting and publishing an annual patient feedback survey	0%	75%	100%	Patient feedback reports; annual	Director Curative Health Services

7.3 Reporting Mechanisms

Internal Reporting:

- **Quarterly Progress Reports:** Submitted by facility managers and programme leads to the Senior Executive Management Team (SEMT) and to the NDOH.
- **SEMT Review Meetings:** Assess progress, identify bottlenecks, and approve corrective actions.
- **Board Reports:** Quarterly reporting to the NCDPHA Board and its subcommittees for governance oversight, with a comprehensive annual report.

External Reporting:

- **Quarterly Progress Reports:** Submitted by the Senior Executive Management Team (SEMT) and to the NDOH.
- **Annual Health Sector Report:** Submitted to the National Department of Health (NDoH) and NCDC.
- **Health Partners Forum:** Annual report shared with development partners, NGOs, and private sector stakeholders.
- **Community Feedback Mechanisms:** Public forums, settlement committees, and digital platforms to provide transparency and accountability.

7.4 Frequency of Reviews

- **Monthly:** Facility-level reporting and data validation.
- **Quarterly:** Senior Executive Management Team progress reviews and corrective action plans.
- **Quarterly:** Board and subcommittee performance and expenditure reports; annual stakeholder report.
- **Annual:** Comprehensive Corporate Plan progress report with KPI analysis.
- **Mid-Term (2029):** Strategic review to assess progress, adjust priorities, and reallocate resources if needed.
- **End-of-Term (2031):** Final evaluation to measure impact, inform lessons learned, and guide the next Corporate Plan cycle.

7.5 Learning and Adaptive Management

M&E findings will inform continuous improvement through evidence-based decision-making.

- Lessons learned from programme implementation will be documented and disseminated to all stakeholders.
- Feedback loops between community, facilities, and management will enhance responsiveness, accountability, and service quality.

This M&E framework ensures that NCDPHA can track progress, demonstrate accountability, and achieve the outcomes set out in the Corporate Plan.

8. Budget and Financial Projections

A sound financial strategy is critical to ensure the effective implementation of the NCDPHA Corporate Plan 2027–2031. This chapter outlines the funding sources, budget allocation, costing of major initiatives, and sustainability measures to support service delivery, system strengthening, and population health outcomes.

8.1 Summary of Funding Sources

NCDPHA's operational and capital funding will be derived from multiple sources:

1. Government Funding:

- Core financing from the Department of Finance (DoF) for recurrent and capital expenditures.
- Funding from the National Department of Health (NDoH) for Health Infrastructure Development Grants.
- Allocations from the National Capital District Commission (NCDC) and DDAs for local health initiatives, infrastructure, and urban health programmes.

2. Donor and Development Partner Support:

- Grants and technical assistance from bilateral and multilateral agencies.
- Support for specific programmes, such as TB, HIV, malaria, maternal and child health, and health system strengthening.

3. Public-Private Partnerships (PPPs):

- Engagement with private healthcare providers, corporate entities, and NGOs to co-fund infrastructure, diagnostics, and service delivery initiatives.

4. Internal Revenue and Cost Recovery Mechanisms:

- Primary health care at Level 2 and Level 3 facilities is provided free of charge. Cost recovery is limited to elective and specialist services for non-vulnerable groups, occupational health services to employers, and training and laboratory services provided to third parties.
- Regulatory revenue captured under the Local Medical Authority mandate, including public health licensing fees, food premise inspection charges and regulatory fines.

5. Community and Philanthropic Contributions:

- Targeted support from faith-based organisations, NGOs, and community initiatives to extend services to settlements and vulnerable groups.

8.2 Budget Breakdown by Priority Area

The five-year budget is structured around the nine strategic pillars and is drawn directly from the ten-year financial model set out in the NCDPHA Strategic Health Services Development Plan 2027–2036. Table 18.0 presents the annual requirement by pillar; Table 19.0 sets out the financing framework, the status of each funding source and the resource mobilisation task.

Table 18.0 Five-Year Budget by Strategic Pillar, 2027–2031 (PGK million)

Strategic pillar	2027	2028	2029	2030	2031	2027 - 2031
1. Unified Leadership and Good Governance	13.1	14.2	12.3	11.6	10.9	62.1
2. People-Centred and Proactive Service Delivery	19.5	22.8	27.7	34.1	42.1	146.2
3. Strengthened Public Health Programmes and Community Engagement	11.4	14.6	17.6	20.9	24.2	88.7
4. Addressing Disease Burden and Targeted Health Priorities	16.3	19.4	22.7	26.4	30.5	115.3
5. Health Facility Infrastructure Construction and Rehabilitation	91.0	235.0	399.0	454.0	447.0	1,626.0
6. Accessible Medical Products, Vaccines and Technologies	30.8	38.6	48.1	57.9	70.0	245.4
7. Resilient and Motivated Human Resources	137.5	163.6	192.2	225.8	263.5	982.6
8. Sustainable and Accountable Health Financing	2.4	2.5	3.7	4.3	4.9	17.8
9. A Modern, Data-Driven Digital Ecosystem	17.5	25.0	21.5	17.2	16.8	98.0
Total annual requirement	**339.5**	**535.6**	**744.8**	**852.2**	**909.9**	**3,382.1**
of which capital	109.0	260.5	418.0	468.0	460.4	1,715.9
of which recurrent	230.5	275.1	326.8	384.2	449.5	1,666.1

All figures are in PGK million, nominal (year of spend), rounded to one decimal place; totals may not sum exactly owing to rounding. Economic assumptions: general inflation 5.0 per cent a year; salary escalation 6.0 per cent; construction escalation 7.0 per cent; medical and pharmaceutical inflation 8.0 per cent.

Over the five-year corporate cycle the Plan requires PGK 3,382.1 million — the first tranche of the ten-year PGK 7,934.1 million investment envelope. Of this, PGK 1,715.9 million (50.7 per cent) is capital and PGK 1,666.1 million (49.3 per cent) recurrent. Annual requirement rises from PGK 339.5 million in 2027 to PGK 909.9 million in 2031 as construction accelerates. Pillars 5 and 7 together account for PGK 2,608.6 million, or 77.1 per cent of the envelope. The analysis is anchored on the economic assumptions above and on two benchmarks: the World Health Organization minimum operational baseline of US$40 per capita for an essential health care system, and the Authority's Universal Health Coverage target of US$80 per capita for total recurrent expenditure by 2031.

8.3 Financing Framework and Resource Mobilisation

Delivering this Plan requires resources well above the Authority's current appropriation. That is stated openly here, because a five-year plan that does not confront its own financing is not a plan. The table below sets out each source, the instrument through which it will be secured, its status and the office accountable for securing it. The indicative government appropriation assumes the 2026 base of PGK 83.8 million growing at 5 per cent a year.

Table 19.0 Five-Year Financing Framework, 2027–2031

Funding source	Instrument	2027–2031 (PGK m)	Status	Lead office
Government recurrent appropriation	Annual appropriation	486.2	Committed (indicative at current levels)	Director Corporate Services (Finance)
Health Function Grant	National Department of Health grant	To be secured	Probable — submission from 2027	Chief Executive Officer
Health Infrastructure Development Grant	Public Investment Programme	To be secured	Probable — annual submission	Facilities and Infrastructure Branch
National Capital District Commission allocations	Memorandum of understanding	To be secured	Probable — agreement in 2027	Chief Executive Officer
District Development Authority service improvement funds (four districts)	Memorandum of understanding	To be secured	Probable — agreement in 2027	Director Corporate Services
Development partner grants and technical assistance	Project agreements	To be secured	Probable — confirmed annually	Director Corporate Services
Local Medical Authority regulatory revenue	Licences, inspection fees and fines	To be secured	Conditional on gazettal in 2028	Director Public Health
Public-private partnerships	Partnership agreements	To be secured	Conditional on the Partnership Policy, 2028	Chief Executive Officer
Internally generated revenue	Elective, occupational health, training and laboratory services	To be secured	Baseline PGK 0.17m (2024)	Director Corporate Services (Finance)
NCD social health insurance	Contribution scheme	Nil in this cycle	Design completed by 2031; revenue from 2032	Chief Executive Officer
Total five-year requirement		3,382.1		
Identified at current appropriation levels		486.2		
Additional resources to be mobilised		2,895.9		

Amounts shown as "to be secured" will be quantified in each Annual Implementation Plan as agreements are concluded. The Chief Executive Officer will report the movement of each source between committed, probable and unfunded to the Board quarterly.

8.4 Implementation Scenarios

Resource mobilisation on this scale carries risk. The Plan is therefore built to be delivered at three levels, and the Board will determine each year, through the Annual Implementation Plan, which level the confirmed resources support. Under the minimum scenario, recurrent services are sustained, statutory obligations met, and only committed capital works proceed — Moresby South District Hospital, the Medical Drug Warehouse, core information and communications technology, and the clearance of legacy liabilities — with the Level 5 Provincial Hospital advancing to design only. Under the base scenario, the full primary health care network and the district hospital tier are delivered and construction of the Level 5 hospital proceeds at a rate matched to confirmed funding. Under the accelerated scenario the Plan is delivered as costed at PGK 3,382.1 million. Under every scenario the Authority protects, in order of priority, essential clinical services and the medical supply chain, the safety and entitlements of its workforce, its statutory obligations, and the maintenance of existing facilities; capital expansion is the variable that adjusts.

8.5 Sustainability Strategy

To ensure long-term financial sustainability, NCDPHA will implement the following measures:

1. **Government Commitment:** Advocate for multi-year budget allocations and ensure timely disbursement of recurrent and capital funds.
2. **Diversified Funding:** Leverage donor support, PPPs, and community contributions to complement government funding and reduce dependency. Develop and implement a health insurance scheme.
3. **Cost-Efficiency Measures:** Optimise resource allocation, reduce duplication, and implement energy-efficient and scalable facility upgrades.
4. **Revenue Generation:** Maintain free primary health care at Level 2 and Level 3 facilities while developing Local Medical Authority regulatory revenue, occupational health services and third-party training and laboratory services as sustainable internal income streams.
5. **Financial Accountability:** Strengthen internal audit, expenditure monitoring, and performance-based budgeting to enhance transparency and build donor confidence.
6. **Partnership Sustainability:** Formalise agreements with NGOs, faith-based organisations, and the private sector to maintain ongoing programme support.

This chapter ensures that the NCDPHA Corporate Plan is financially grounded, demonstrating both feasibility and a path to sustainable, long-term health system strengthening.



APPENDICES

Appendix 1.0 List of Stakeholders Consulted

The following organisations participated in the consultative process and provided technical advice, policy guidance, operational perspectives, and stakeholder input to the development of this Corporate Plan:

Government Ministries, National Agencies and Public Institutions

- National Capital District Provincial Health Authority
- Office of the NCD Governor
- District Development Authorities of Moresby South, Moresby North-East, Moresby North-West, and the Motu Koitabu Assembly
- National Capital District Commission
- National Department of Health
- Climate Change & Development Authority
- Conservation & Environment Protection Authority
- National St John Ambulance Papua New Guinea
- PNG Power Limited

Development Partners and International Organisations

- UNICEF
- Embassy of Malaysia
- Japan International Cooperation Agency (JICA)
- The Fred Hollows Foundation Papua New Guinea

Health Partners and Non-Government Organisations

- Church Health Services
- PNG Cancer Foundation

Private Sector Partners

- Brian Bell Group of Companies

Health Facilities and Service Delivery Partners

- Bomana Police Clinic
- St Theresa Clinic under Catholic Church Health Services
- Murray Barracks Clinic under the Ministry of Defence
- St Paul's Clinic under Catholic Church Health Services
- PNG Educational Institute Clinic
- Kaugere Clinic under the Living Light Foursquare Church Health Services
- Ulamagi Clinic under the Nazarene Church


NGPRA

Appendix 2.0 Health Facility Catchment Populations 2026

HF Code	Health Facility	Total Pop 2026	Under 1 Yr	1–5 Yrs	15–44 Yrs	Est. Births
40104	6 Mile UC	28,322	836	2,645	7,164	821
40105	9 Mile UC	23,242	686	2,170	5,879	674
40301	Badili UC	41,328	1,220	3,859	10,453	1,199
40110	Bomana CIS UC	36,701	1,084	3,428	9,282	1,065
40109	Bomana Police College UC	36,701	1,084	3,428	9,282	1,065
40201	Gerehu UC	45,301	1,337	4,230	11,457	1,314
40102	Gordons UC	28,322	836	2,645	7,164	821
40106	Jacksons Airbase UC	23,241	686	2,170	5,879	674
40307	Kaugere 4 Square UC	23,981	709	2,239	6,066	696
40302	Kila Kila UC (closed)	13,732	407	1,283	3,472	398
40303	Lawes Road UC	41,328	1,220	3,859	10,453	1,199
40202	Morata UC	19,515	577	1,822	4,936	565
40203	Murray Barracks UC	37,761	1,115	3,526	9,550	1,095
40304	Pari UC	23,981	709	2,239	6,066	696
40306	PNGDF Taurama UC	23,981	709	2,239	6,066	696
40103	Port Moresby General HO	48,655	1,436	4,543	12,308	1,411
40205	St Theresa UC	37,761	1,115	3,526	9,550	1,095
40308	Ulamagi Nazarene UC	28,322	836	2,645	7,164	821
40206	Tokarara UC	37,761	1,115	3,526	9,550	1,095
40207	University of PNG UC	19,515	577	1,822	4,936	565
40305	Vabukori UC	23,981	709	2,239	6,066	696
40108	PNG Education Institute UC	28,322	836	2,645	7,164	821
40208	PNG IPA UC	19,515	577	1,822	4,936	565
40309	Salvation Army Koki UC	13,732	407	1,283	3,472	398
40107	Susu Mamas UC (closed)	48,655	1,436	4,543	12,308	1,411
40209	St Pauls UC	45,301	1,337	4,230	11,457	1,314
40211	Anglicare Begabari UC	19,515	577	1,822	4,936	565
40210	Marie Stopes UC	27,012	798	2,523	6,832	784
	TOTAL	**845,484**	**24,971**	**78,951**	**213,848**	**24,519**

Kila Kila Urban Clinic and Susu Mamas Urban Clinic are currently closed. Their combined catchment of 62,387 people is served on an interim basis by neighbouring facilities.. Source: NCDPHA catchment allocation, projected from the National Statistical Office National Population Estimate 2024 at 5.7 per cent annual growth.



Appendix 3.0 Key Health and Development Statistics at a Glance

Basic Indicators		Year
Under 5 Mortality Rank	44	2020
Under 5 Mortality Rate	89	1990
Under 5 Mortality Rate	40	2023
U5MR by sex male	47	2020
U5MR by sex female	40	2020
Infant Mortality Rate (<1)	65	1990
Infant Mortality Rate (<1)	37	2023
Neonatal Mortality Rate	21	2023
Total Population (thousands)	10,763	2023
Annual no. of Births (thousands)	265	2023
GNI per capita (US$)	2,900	2023
Life Expectancy at Birth	66.1	2023
Total Adult Literacy Rate (%)	62.4	2008–12

Women		Year
Females as a % of males	96	2008–12
Adult Literacy Rate (Female as % of Male)	90.9	2008–12
Primary Enrolment (Female as % of Male)	89.2	2008–12
Contraceptive Prevalence (%)	32.4	2007–12
Antenatal Care – at least one visit	76.1	2016–18
Antenatal Care – at least four visits	49.0	2016–18
Delivery Care – Skilled attendant at birth	56.4	2016–18
Delivery Care – Institutional Delivery	54.7	2016–18
Maternal Mortality Ratio	192	2020
Lifetime Risk of Maternal Death (1 in :)	110	2020

Nutrition		Year
Low Birth weight (%)	11	2008–12
Exclusive Breastfeeding (%)	56	2016–18
Breastfeeding at Age 2 (%)	71.6	2016–18
Underweight (%)		
o Moderate & Severe	26	2016–18
o Severe	5.3	2008–12
Stunting (%) -Moderate & Severe	49.5	2016–18
Wasting (%) -Moderate & Severe	14.1	2016–18
Overweight (%) -Moderate & Severe	13.7	2016–18
Vitamin A Supplementation (%)	15	2012
Iodised Salt Consumption (%)	91.9	2008–12

Education		Year
Youth Literacy Rate, Male	67	2008–12
Youth Literacy Rate, Female	74.8	2008–12
Primary School Participation, Male	101	2008–12
Primary School Participation, Female	98.5	2008–12

The Rate of Progress		Year
Under 5 Mortality Rate	143	1970
Under 5 Mortality Rate	89	1990
Under 5 Mortality Rate	79	2000
Under 5 Mortality Rate	40	2023
Total Fertility Rate	6.2	1970
Total Fertility Rate	3.1	2023

Health		Year
Immunisation Coverage (%), BCG	48	2022
Immunisation Coverage (%), DPT1	45	2022
Immunisation Coverage (%), DPT3	36	2022
Immunisation Coverage (%), Polio 3	36	2022
Immunisation Coverage (%), MCV	44	2022
Immunisation Coverage (%), HepB3	36	2022
Immunisation Coverage (%), HiB3	36	2022
Immunisation Coverage (%), Neonatal Tetanus	67	2020

Demographics		Year
Crude Death Rate	17.4	1970
Crude Death Rate	7.3	2023
Crude Birth Rate	44.2	1970
Crude Birth Rate	35.1	1990
Crude Birth Rate	24.6	2023
Life Expectancy	46.0	1970
Life Expectancy	55.6	1990
Life Expectancy	66.1	2023
Urbanised Population (%)	13.5	2023

HIV/AIDS		Year
Adult HIV Prevalence (%)	0.9	2023
People living with HIV (thousands)	72	2023
Women living with HIV (thousands)	41	2023

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3. WHO & UNICEF Estimates of National Immunisation Coverage (WUENIC), 2023 revision - Papua New Guinea (2022 data). data.unicef.org/.../immunisation/png.pdf.
4. UN Maternal Mortality Estimation Inter-agency Group - WHO, UNICEF, UNFPA, World Bank Group, UN DESA (2023), Trends in Maternal Mortality 2000-2020. data.worldbank.org/indicator/SH.STA.MMRT?locations=PG.
5. UNAIDS - Papua New Guinea country snapshot / 2023 HIV Estimates. unaids.org/en/regionscountries/countries/papuanewguinea.
6. Papua New Guinea Demographic & Health Survey 2016-18 (National Statistical Office), as compiled in the UNICEF-WHO-World Bank Joint Malnutrition Estimates and the Global Nutrition Report country profile. globalnutritionreport.org/.../papua-new-guinea.
7. World Bank Open Data - Papua New Guinea (life expectancy, crude birth & death rates, total fertility rate, GNI per capita, urban population). data.worldbank.org/country/papua-new-guinea.

A DEDICATION TO THE PEOPLE OF THE NATIONAL CAPITAL DISTRICT



This plan is not, in the end, a document about buildings.

It is true that what follows in these pages is measured in concrete and kina: a new Level 5 Provincial Specialist Hospital of some three hundred beds rising on the greenfield site at Tete; four Level 4 district hospitals anchoring Moresby Northeast, Moresby Northwest, Moresby South and Motu Koitabu; urban clinics rehabilitated or rebuilt to national standard; laboratories, birthing suites, generators, water storage, staff housing. Intensive capital investment, phased across five years. These are the commitments this Authority has made, and they are set out here so that they may be counted.

But a hospital is not a building. It is the place where a woman in labour at two in the morning is met by a midwife who is rested, paid, and equipped. A clinic is not a roof and four walls. It is the certainty that when a father carries his child through the gate at Lawes Road or Morata or Metoreai, someone is there, the lights are on, the laboratory is working, and the medicine is on the shelf. The purpose of every figure in this plan is to make that certainty ordinary.

To the health workers of the National Capital District, this plan is owed first. For too long you have delivered care in buildings that were failing around you, without reliable power, without running water, without the equipment your training entitled you to use. You held the system together with your own competence and your own patience, and the record of your service is written nowhere in these appendices. It should have been. Everything set out here is an attempt to give you, at last, the conditions you have always deserved.

To the people of the National Capital District, this plan is a promise, and it is offered as one. The years and the phases in the pages are dates. They belong to you now, and you are entitled to hold this Authority to every one of them, to ask in 2029 what was finished in 2028, and to expect an honest answer.

We will not deliver all of it perfectly. We will be delayed, and we will be corrected. But the direction is set, the money is costed, the sequence is published, and the accounting has begun.

This Corporate Plan 2027-2031 is dedicated to the residents of the National Capital District and Motu Koitabu communities — to those it will serve, and to those who, for want of the services described in these pages, it comes too late to serve.



NCD PROVINCIAL HEALTH AUTHORITY
PORT MORESBY, PAPUA NEW GUINEA


"ALL W
LAUNCHING OF GOV
CHARTER AND TE
THEME: BUILDIN
DATE: 4th
HEALTHY SERVICES, HEA
Port Mores

NATIONAL CAPITAL DISTRICT
PROVINCIAL HEALTH AUTHORITY



CORPORATE PLAN

2027 - 2031