Australian Government
AusAID

Quality at Entry Report for
Asian Development Bank:
Rural Health Services Delivery Project

A: AidWorks details			
Initiative Name:	PNG Rural Primary Health Services Delivery Project (TBC)		
Initiative No:	TBA	**Total Amount:**	USD 40,000,000
Start Date:	November 2011	**End Date:**	November 2018

B: Appraisal Peer Review meeting details	
Initial ratings prepared by:	Aedan Whyatt
Meeting date:	Monday 11 July 2011
Chair:	James Gilling, FADG, Pacific Division/ Octavia Borthwick, ADG PNG & Sol Is Branch
Peer reviewers providing formal comment & ratings:	– Joanne Greenfield, Health Advisor, HHTG
Independent Appraiser:	– Jim Tulloch – Jane Thomason
Other peer review participants:	– Aedan Whyatt, Fist Secretary, AusAID PNG Health – Dr Geoff Clark, Director, AusAID PNG Health – Rob Harden, Economist, PACPNG Advisory Group – Debbie Bowman, Director, Human Development – Beth Slatyer, Health Adviser, Health and HIV – Sakiko Tanaka, Team Leader ADB – Don Matheson, ADB – Octavia Borthwick, ADG PNG& Solomon Is Branch – Sarah MaCana,Second Secretary, Democratic Governance, Port Moresby Post – Roger Wheatley, Director, PNG Policy & Program Coordination

C: Safeguards and Commitments		
1. Environment	Have the environmental marker questions been answered and adequately addressed by the design document in line with legal requirements under the *Environmental Protection and Biodiversity Conservation Act*?	Yes
2. Child Protection	Does the design meet the requirements of AusAID's Child Protection Policy?	Yes

D: Initiative/Activity description

3. Description of the Initiative/ Activity	***What is it?*** The Project, managed by the ADB, will invest $80 million (of which 25% ADB loan, 50% AusAID grant co-financing, 12.5% GoPNG) over 8 years (2011-2018) to strengthen the rural health system in selected areas of PNG and implement the National Health Plan (NHP) as it relates to rural health. It aims to increase the coverage and quality of primary health care in partnership with state and non-state providers. The project will cover two districts in each of eight provinces: *Eastern Highlands*, East Sepik, Enga, *Milne Bay, Western Highlands*, West New Britain, and Morobe and the *Autonomous Region of Bougainville.* The Project has six components: national policies and standards, sustainable partnerships between provincial governments and non-state actors, human resource development; community health facility upgrading; health promotion in local communities; and project monitoring, evaluation and management.
4. Objectives Summary	***What are we doing?*** The expected Impact and Outcome are stated as follows: The project will contribute to improved health of the rural population in the project areas. The project will address improvement of supply and demand sides, and strengthen policy and legal framework for health services at all levels. The outcome will be that the selected provinces in partnership with non-state service providers, efficiently deliver quality PHC for the rural population (particularly to women and children). By 2018 the project aims to: **Assist the NDoH:** • to develop and implement policies, standards, and strategies for CHPs and human resource strengthening in the health sector • in its provincial planning and coordination functions, including: o facility and asset management, o human resource audits, o staff retention, and o the planning of health services. **Assist the provincial and district governments:** • to develop and formalize existing or new partnerships with non-state providers of health services (aiming to facilitate coordination and efficiency and increase consistency and accountability). • to establish partnership boards and negotiate and implement agreements (including M&E tools and targets) with non-state actors. • to set up facility base funding in selected districts to enable them to better use funds provided by the government. **Assist GoPNG at all levels to:** • provide improved **health information systems**, through application of information and communication technology (ICT) and geographic information system (GIS) technology. This support will: o increase the availability of relevant information at all levels, o enable provincial and district level local governments to monitor performance, and o improve logistics for the supply of drugs at the local level. • increase **women's involvement** in all aspects of delivering health services at the community level. • support existing and new **initiatives by civil society organizations** to increase knowledge on sanitation, primary health i.e., maternal and child health and HIV, domestic and sexual violence, and gender in local communities. **Support Human Resources Development through:** • provide upskilling and capacity training for existing health workers • train district and provincial managers on facilities management and clinical supervision in all participating districts. • address performance and retention issues of the health workers. **Support improved rural service delivery through Infrastructure:** • build/upgrade two CHPs, and upgrade/refurbish 8 eight rural health facilities in each of the 16 participating districts. (160 facilities in all) • provide medical equipment and small vehicles (cars, boats or motorbikes). • upgrade staff housing; • install or upgrade sanitation facilities; • provide waste management facilities; and • establish renewable energy supplies for the selected health facilities.

E: Quality Assessment and Rating

Criteria	Assessment	Rating (1-6) *	Required Action (if needed) ‡
1. Relevance	***Why are we doing this?*** The project addresses priorities identified by the GoPNG in its National Health Plan 2011-2020, in particular by supporting the development of Community Health Posts as the primary unit of health care for rural areas, including non-state actors in service delivery, improving health worker skills and giving attention to community health promotion. The Project fits well with the Australia – PNG Health Delivery Strategy (DS) and the draft Australian Partnerships for Development health schedule: the higher-level objectives of improving the health of women and children are aligned, as are infrastructure development in rural areas, human resources and community mobilization components. There is good overlap in the selected provinces for this project and the priority provinces of AusAID's DS. Working through a multilateral partner for this project is consistent with the AusAID DS aim of using a "mixed portfolio of modalities". GoPNG has requested AusAID to channel rural health strengthening funds though this ADB Project. As a partner-lead design there is no design summary document provided that shows the relevance of Australian objectives for the partnership (why we chose to work this way) and the partners aid objectives vis a vis the development context, partner priorities and beneficiaries needs.	**4**	ADB to provide a separate design summary, which will include the relevance to Australian objectives of the partnerships

2. Effectiveness	***Will it work?*** While there is significant international evidence to support the proposed approach (i.e increasing utilisation of health services and primary health), **there is no clear and demonstrated program logic or theory of change in the project document.** This is hampered by the design structure, with annexes and cross referencing. The NDoH (and provincial authorities) - the implementing agencies - struggle to manage their existing work load and will need considerable support to take on new activities. The effectiveness of the Project will depend on the quality and management of the team that is recruited to support them, particularly the Project Manager. **Human resource development has insufficient focus on follow up mentoring and supportive supervision after initial training** to improve outcomes. PNG has an aging workforce and insufficient CHWs and nurses for rural health services as they are. The production of workforce for the new CHPs is critical and the project will need to ensure strategic alignment with NDoH HR plans Whilst the situation analysis identifies demand side financing issues, documentation does not address these challenges and focuses on supply side. This imbalance is likely to reduce the effectiveness of the approach. **Existing approach to development of partnership boards, alliance contracts and alliance boards is unnecessary complex and should be based on strengthening/fixing existing structures.** **The design underestimates significant risks, such as sustainability, over-ambition, and issues with the piloting (and recurrent funding) of new initiatives such as Community Health Posts, and direct to facility funding.** Risk levels are considered 'low' due to use of ADB procurement/accounting rules and formation of a PSU. While ADB Procurement incorporates value for money, there is a development risk that they will burden the already fragile system and undermine rather than build capacity of it. There is insufficient detail on how the ADB Project would coordinate with other relevant AusAID activities so that its service delivery objectives will be achieved.	4	As the ADB design documentation cannot be changed, AusAID to request **ADB to develop a short (e.g. 20 page) design document which needs to clearly demonstrate the analysis, linking it to what the project proposes to do, the resources it intends to use to bring about change, why particular approaches have been chosen and demonstrate value for money (e.g. use of TA) and promote sustainability, and what clear results it expects to achieve.** **Design to include follow up mentoring and supportive supervision after initial training as key strategy within HRH component.** A clear plan for the production of CHWs for the CHPs, and establishment of what will be new positions is needed. Project document should consider demand side financing or justify why this element is not included. **Design documentation to make clear that partnerships will build on existing arrangements, and state in principle how the approach will operate or identify the specific existing boards if they are known.** Risk matrix to be reviewed. **Design documents need to be more explicit that 6 monthly formative evaluations review implementation of each output and advise on whether activities should proceed; also that future investments can only proceed based on evidence of GoPNG meeting recurrent financial commitments for past/current investments.** A process for ensuring coordination between the Project and other AusAID supported activities, and that AusAID has a way of monitoring Project progress to ensure synergies are achieved is needed.

3. Efficiency	***How will we do it?*** **Project steering committee and need to be more integrated within NDoH and sector forums.** This joint donor arrangement offers efficiency gains and reduced transaction costs for GoPNG – and AusAID IF we want to take a step back from management and engagement (20% or $16 million is to be spent on project management). We should be cautious not to hand over the policy dialogue and relationship with government with the money. Around 16% ($13 million) is allocated to consultancy services. The **proposed quantity and type of international and national consultants presented in the design is generally not linked to specific needs analysis, lack value for money (i.e. clearly linked to outcomes) and there are opportunities to reduce duplication with other development partners. Some positions, such as 'health mentors', and JICA volunteers require greater justification.** A balance of supply and demand is needed. This costly input must be well managed to be efficient use of funds. Overlap in provincial coverage with other AusAID activities is good; as with a range of inputs there is more likelihood of achieving results. This will, however, require good coordination to ensure there is no duplication. Health promotion is a notoriously difficult area in which efforts can turn out to be very inefficient. It is not completely clear what this output is trying to achieve (perhaps too much).	4	**AusAID to be a member of the project steering committee; and have opportunity to participate in needs assessments, formative evaluations and mid-term reviews and development of M&E plan; opportunity to participate in review of TORs/recruitment of consultancy services.** More justification and analysis on the TA component is required. **Design to state that ADB and AusAID will work with NDoH during diagnostic to determine appropriate mix and type of positions.** **ADB to contract only core team required for start-up, and rely on provincial diagnostics to determine other support. Key positions should be discussed with AusAID, and clearly linked to expected outcomes.** **Project documentation needs to provide clearer links for the majority of the TORs to proposed outputs, and stronger justification of why consultancy services have been chosen relative to other alternative forms of aid (value for money considerations), and in consultation with other development partner inputs.** ADB to provide a one page summary on why TA is needed. A clearer description of the health promotion Output implementation would be helpful. What are the priorities?

4. Monitoring & Evaluation	***How will we know?*** **Formative evaluations are too frequent; six monthly formative evaluations and reviews (and MoUs) are too excessive for an already weak health system. Conducting only one mid-term review for an 8 year $81.2m investment is insufficient** **There is limited development of M&E plan, and key gaps in M&E framework (such as MMR cannot be measured a district level; limited use of NHP PAF; lack of detail on outcomes; and need for integration with gender action plan). NHIS should be used for data in target districts, minimising need for additional indicators.** The M&E pal would benefit from the addition of equity indicators and disaggregated data by sex and socioeconomic quintile. TA performance management has been a recurrent issue in the past – not only in PNG. A hands-off approach by AusAID to management may be expected by the ADB; it is probably unwise for AusAID to adopt such an approach. A lot is expected to happen in 2012. Of the 24 milestones that have dates, 9 are for 2012 Q1 or Q2 and 12 are for 2012 Q3 or Q4. This seems odd for a project of 8 years. While recognizing that detail on the outer years may be difficult at this stage some milestones for those years would seem appropriate. After achievement of set-up milestones progress in most output areas is to be measured 6 monthly; but against what? The infrastructure targets are not consistent. In some places it is stated that each of the 16 districts will get two new CHPs and 8 upgraded (i.e. a total of 160), the DMF says 32 CHP + 100 health facilities (i.e. 132).	4	**Further discussion between AusAID and ADB is required to reach agreement on appropriate review approaches and timeframes, noting ADB requirements. The M&E plan to be developed during the inception phase, with greater use of NHP PAF indicators and NHS data.** **Design document to state that relevant donors and GoPNG agencies will undertake joint annual reviews across 8 provinces (not just 16 districts), as AusAID will have additional investments in 4 provinces, and NDoH plans to have its own project investments in other districts.** **AusAID accepts that baseline data and targets can be collected during inception phase. However, the design document needs to clearly state that they are indicative only, and greater work is required to align them to the NHP PAF and that a comprehensive M&E plan will also need to be completed during inception phase (M&E plan in design is insufficient).** Clarify how TA performance will be monitored and non-performance addressed. Clarify the distribution of milestones across the 8 years of the Project. (It may be reasonable to focus initially on the first 2-3 years but that should be stated.)

5. Sustainability	***Have we planned for benefits to last?*** **There is no exit strategy for financing, and statements such as 'government systems will be used wherever possible' are too vague.** The Community Health Post is a new concept, and requires a higher level of staffing and infrastructure than the current rural health system has in place. The construction of new facilities, appointment of new staffing and associated recurrent costs, and contracts for non-state actors will add recurrent expenditure to the participating provinces, which they may be unable to maintain. Lasting benefits of infrastructure improvements will depend largely on whether the GoPNG allocates resources and management effort to maintenance. The Project seems to assume this will happen. Past experience would suggest otherwise and the Project should work actively to influence this. There does not seem to be much analysis on the impact of this approach on the sustainable financing of the health sector. The health worker capacity building will be sustainable if training is competency based and well done and supportive supervision instituted. In the absence of these gains may be short term. An institutional base for management training developed as part of the Project would help ensure sustainability for this type of capacity building. **The PSU needs to be more integrated within NDoH.** Sustainability of Project benefits will be proportionate to the degree of effective institutionalization of the processes that achieve them. The PSU seems to stand quite separate from the NDoH although there is a commitment for it to be fully integrated by the end of the project. There also needs to be an exit strategy for TA. An environmental assessment has been undertaken to inform the design. The Project adequately addresses environmental concerns.	4	**Design to state that financing approaches will attempt to progressively use GoPNG systems over the 8 year timeline with a clear objective of integration by 2019, and supported by joint development partner assessments of fiduciary risk to support this shift.** **Design needs to be much more explicit in design documents on how its own financing approach will move progressively toward greater use of PNG systems steps (both direct and use of HSIP).** **Design documentation should go further in identifying opportunities to integrate the PSU into NDOH sectoral policy and planning division and set appropriate milestones for full integration.** The ADB needs to think more about the exit strategy and prepare together with the government
6. Gender Equality	Project documentation includes a Gender Action Plan (GAP) with reasonable activities and targets under each of the Project's outputs. It would be useful to see how men are going to be mobilised and involved to support reproductive health care and their wives access to such services. The head of PSU will be responsible for the overall implementation of the GAP, and will develop specific performance and monitoring indicators for GAP activities. Social/gender/community development specialists will be responsible for: monitoring and reporting on the progress of GAP implementation; ensuring collection of sex-disaggregated data for all project activities; and establish baseline data to monitor the progress of all project outputs and GAP activities. The executing agency, supported by PSU, will report on the progress of GAP activities in regular progress reports on overall project activities to ADB and GoPNG.	5	N/A

7. Analysis and Learning	***Have well have we thought this through?*** The situation analysis provides a good description of the health problems in PNG and annexes provide useful analysis of economic indicators, risks, environmental assessment etc. However the document is light on details on health care financing, TA recruitment and management, governance, and other health system issues and constraints. **Lessons from are mentioned briefly but not discussed.** As the project is much broader in scope and complexity, **lessons from relevant programs such as they are more relevant and have not been incorporated.** There is insufficient information provided to get a good picture if ADB has the track record or capacity to produce results in the sector or if the right problems/issues are being addressed by the project. **The project is based on country-wide analysis, and in selective provinces which are regionally representative, but little analysis of specific needs exists for districts chosen. AusAID recognises the approach the NDoH has taken to deciding on provinces to participate in project, and that this is beyond ADB control. As a result, detail on each component is generic and not tailored to the specific needs of each province/district. AusAID's proposed diagnostic work in 2011 can fully cover off on NDoH proposed support and the majority of proposed support in four provinces.** There are a number of assumptions in the Design, which include certain assurances from government which would be unlikely to hold true, based on previous experience. These include: that the PSU will be absorbed into the NDOH during the life of the Project; availability of medical supplies, staffing and recurrent costs of new Community Health Posts (CHPs) and refurbished centres.	4	**Design to include section on lessons learned from: ADB Rural Development Enclaves Project; Health Sector Support Program; and Capacity Building Service Centre within project description in PAM, with a particular focus on performance management of TA; issues with recurrent financing of capital investments; and success of GIS/ICT systems and their applicability.** **All lessons need to be reflected in the design intent – i.e. how does the design take account of past lessons – not simply as separate paragraphs. Lessons learned need to go into more detail and specifically apply to all six components.** **Provincial, district and NDoH diagnostic work is required before activity preparation and implementation can commence. AusAID and ADB to undertake joint/delegated diagnostic assessments in the 8 provinces during 2011-12. Opportunities to collaborate include: developing shared TORs/methodology for missions; delegated responsibility or participation in missions; commissioning same team to complete all diagnostics.** **ADB should focus on scheduling the outstanding diagnostic work in remaining four provinces and areas which have not been covered in sufficient detail (e.g. infrastructure and health promotion).**

* **Definitions of the Rating Scale:**			
Satisfactory *(4, 5 and 6)*		***Less than satisfactory*** *(1, 2 and 3)*	
6	Very high quality; needs ongoing management & monitoring only	**3**	Less than adequate quality; needs to be improved in core areas
5	Good quality; needs minor work to improve in some areas	**2**	Poor quality; needs major work to improve
4	Adequate quality; needs some work to improve	**1**	Very poor quality; needs major overhaul

‡ **Required actions (if needed):** These boxes should be used wherever the rating is less than 5, to identify actions needed to raise the rating to the next level, and to fully satisfactory (5). The text can note recommended or ongoing actions.

F: Next Steps *completed by Activity Manager after agreement at the Appraisal Peer Review meeting*		
Provide information on all steps required to finalise the design based on *Required Actions* in "C" above, and additional actions identified in the peer review meeting	Who is responsible	Date to be done
1. A short design document to be developed, which needs to clearly demonstrate the analysis, linking it to what the project proposes to do, the resources it intends to use to bring about change, why particular approaches have been chosen and demonstrate value for money (e.g. use of TA) and promote sustainability, and what clear results it expects to achieve. This will become a 6th annex to the PAM.	ADB with input from AW & NM	5 August
2. Design to include follow up mentoring and supportive supervision after initial training as key strategy within HRH component.	ADB	5 August
3. Design documentation to make clear that partnerships will build on existing arrangements, and state in principle how the approach will operate or identify the specific existing boards if they are known.	ADB	5 August
4. Design document to be more explicit that 6 monthly formative evaluations review implementation of each output and advise on whether activities should proceed; also that future investments can only proceed based on evidence of GoPNG meeting recurrent financial commitments for past/current investments.	ADB	5 August
5. Design document to state that AusAID to be a member of the project steering committee; and have opportunity to participate in needs assessments, formative evaluations and mid-term reviews and development of M&E plan; opportunity to participate in review of TORs/recruitment of consultancy services.	ADB	5 August
6. Design document to state that ADB and AusAID will work with NDoH during diagnostic to determine appropriate mix and type of positions. ADB to contract only core team required for start-up, and rely on provincial diagnostics to determine other support. Key positions should be discussed with AusAID, and clearly linked to expected outcomes.	ADB	5 August
7. Design documentation needs to provide clearer links for the majority of the TORs to proposed outputs, and stronger justification of why consultancy services have been chosen relative to other alternative forms of aid (value for money considerations), and in consultation with other development partner inputs.	ADB	5 August
8. Further discussion between AusAID and ADB is required to reach agreement on appropriate review approaches and timeframes, noting ADB requirements. The M&E plan to be developed during the inception phase, with greater use of NHP PAF indicators and NHS data.	ADB and Post	November 2011 to early 2012
9. Design document to state that relevant donors and GoPNG agencies undertake joint annual reviews across 8 provinces (not just 16 districts)	ADB	5 August
10. The design document needs to clearly state that targets are indicative only, and greater work is required to align them to the NHP PAF and that a comprehensive M&E plan will also need to be completed during inception phase	ADB	5 August
11. Design to state that financing approaches will attempt to progressively use GoPNG systems over the 8 year timeline with a clear objective of integration by 2019, and supported by joint development partner assessments of fiduciary risk to support this shift.	ADB	5 August
12. Design needs to be more explicit on how its own financing approach will move progressively toward greater use of PNG systems steps (both direct and use of HSIP).	ADB	5 August
13. Design documentation should go further in identifying opportunities to integrate the PSU into NDOH sectoral policy and planning division and set appropriate milestones for full integration.	ADB	5 August
14. Design to include section on lessons learned from: ADB Rural Development Enclaves Project; Health Sector Support Program; and Capacity Building Service Centre within project description in PAM, with a particular focus on performance management of TA; issues with recurrent financing of capital investments; and success of GIS/ICT systems and their applicability. All lessons need to be reflected in the design intent – i.e. how does the design take account of past lessons – not simply as separate paragraphs. Lessons learned need to go into more detail and specifically apply to all six components.	ADB	5 August

F: Next Steps *completed by Activity Manager after agreement at the Appraisal Peer Review meeting*		
15. AusAID and ADB to undertake joint/delegated diagnostic assessments in the 8 provinces during 2011-12. Opportunities to collaborate include: developing shared TORs/methodology for missions; delegated responsibility or participation in missions; commissioning same team to complete all diagnostics. ADB should focus on scheduling the outstanding diagnostic work in remaining four provinces and areas which have not been covered in sufficient detail (e.g. infrastructure and health promotion).	ADB and Post	October 2011-2012
16. Final checking of both the ADB project documentation and AusAID design document (APM Annex 6) to ensure there is consistency on all key issues.	ADB	5 August

G: Other comments or issues *completed by Activity Manager after agreement at the APR meeting*

H: Approval *completed by **ADG or Minister-Counsellor** who chaired the peer review meeting*

On the basis of the final agreed Quality Rating assessment (C) and Next Steps (D) above:

☑ **QAE REPORT IS APPROVED**, and authorization given to proceed to:

- ◉ **FINALISE** the design incorporating actions above, and proceed to implementation
- *or:* ○ **REDESIGN** and resubmit for appraisal peer review

☐ **NOT APPROVED** for the following reason(s):

James Gilling	signed:	12/8/11.

When complete:

- Copy and paste the approved ratings, narrative assessment and required actions into AidWorks and attach the report.
- The original signed report must be placed on a registered file