ADB

Report and Recommendation of the President to the Board of Directors

Project Number: 41509
September 2011

Proposed Loan and Administration of Grant and Loan Papua New Guinea: Rural Primary Health Services Delivery Project

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 2 September 2011)

Currency Unit	–	kina (K)
$1.00	=	K2.237136
K1.00	=	$0.44700

ABBREVIATIONS

ADB	–	Asian Development Bank
AusAID	–	Australian Agency for International Development
CHP	–	community health post
DOH	–	Department of Health
GIS	–	geographic information system
HSIP	–	Health Sector Improvement Program
ICT	–	information and communication technology
LNG	–	liquefied natural gas
NHP	–	National Health Plan
OPEC	–	Organization of Petroleum Exporting Countries
OFID	–	OPEC Fund for International Development
PAM	–	project administration manual
PHC	–	primary health care
PNG	–	Papua New Guinea
PSU	–	project support unit
UNICEF	–	United Nations Children's Fund
WHO	–	World Health Organization

NOTE

In this report, "$" refers to US dollars unless otherwise stated.

Vice-President	B.N. Lohani, Vice-President-in-Charge, Operations 2
Director General	R. Wihtol, Pacific Department (PARD)
Director	A. Iffland, Urban, Social Development, and Public Management Division, PARD
Team leader	S. Tanaka, Social Development Specialist, PARD
Team members	H. Everett, Financial Sector Specialist (Public Finance), PARD M. Davidovski, Senior Counsel, Office of the General Counsel K. Groves, Senior Policy and Aid Effectiveness Specialist, PARD S. Lee, Principal Social Development Specialist (Gender and Development), PARD H. Noro, Senior Financing Partnerships Specialist, Office of Cofinancing Operations J. Roop, Senior Environment Specialist, PARD N. Sapkota, Safeguards Specialist, PARD H. Van Rijn, Senior Governance and Capacity Development Specialist, Regional and Sustainable Development Department A. Woodruff, Infrastructure Economist, PARD P. Safran, Senior Coordination Specialist (Fragile Situations), PARD
Peer reviewer	C. Bodart, Principal Health Specialist, East Asia Department

CONTENTS

PROJECT AT A GLANCE

1. Project Name: Rural Primary Health Services Delivery Project **2. Project Number:** 41509-013

3. Country: Papua New Guinea **4. Department/Division:** Pacific Department/Urban, Social Development & Public Management Division

5. Sector Classification:

Sectors	Primary	Subsectors
Health and social protection	√	Health systems

6. Thematic Classification:

Themes	Primary	Subthemes
Social development	√	Human development
Gender equity		Gender equity in economic opportunities
Capacity development		Client relations, network, and partnership development

6a. Climate Change Impact

Adaptation	Low

6b. Gender Mainstreaming

Gender equity theme (GEN)	√
Effective gender mainstreaming (EGM)	
Some gender benefits (SGB)	
No gender elements (NGE)	

7. Targeting Classification:

General Intervention	Targeted Intervention		
	Geographic dimensions of inclusive growth	Millennium development goals	Income poverty at household level
√			

8. Location Impact:

Rural	High

9. Project Risk Categorization: Low

10. Safeguards Categorization:

Environment	B
Involuntary resettlement	C
Indigenous peoples	C

11. ADB Financing:

Sovereign/Nonsovereign	Modality	Source	Amount ($ Million)
Sovereign	Project loan	Asian Development Fund	20.0
Total			20.0

12. Cofinancing:

Financier	Category	Amount ($ Million)	Administration Type
Australian Agency for International Development	Official-Grant	40.0	Full
Japan International Cooperation Agency	Official-Grant	1.2	Not ADB Administered
OPEC Fund for International Development	Official-Loan	9.0	PARTIAL
World Health Organization	Official-Grant	1.0	Not ADB Administered
Total		51.2	

13. Counterpart Financing:

Source	Amount ($ Million)
Government	10.0
Total	10.0

14. Aid Effectiveness:

No Aid Effectiveness available.


PAPUA NEW GUINEA
RURAL PRIMARY HEALTH SERVICES DELIVERY PROJECT
114°00'E
152°00'E
4°00'S
10°00'S
Lorengau
MANUS
BISMARCK SEA
Vanimo
Aitape
Amanab
Wewak
WEST SEPIK
Sepik River
Angoram
Ambunti
Nubia
Bogia
EAST SEPIK
MADANG
Rumu River
Alexishafen
Madang
Saidor
Tabubil
Wabag
ENGA
Wapenamanda
WESTERN HIGHLANDS
Tari
Ok Tedi
Mendi
Mt. Hagen
Kundiawa
Goroka
Yonki
Markham
MOROBE
Lae
Gagidu
Kainantu
Lufa
SOUTHERN HIGHLANDS
Kagua
SIMBU
EASTERN HIGHLANDS
Samaua
Bulolo
Wau
GULF
Kikori River
Kikoro
Menyamya
Bamu River
Fly River
WESTERN
Kerema
Malalaua
Woitape
Gulf of Papua
Bereina
Kairuku
Kokoda
Popondetta
Daru
Jackson
PORT MORESBY
NATIONAL CAPITAL DISTRICT
ORO
Kwikila
Moreguina
Kupiano
CENTRAL
Raba Raba
Alotau
Esa'ala
MILNE BAY
Samarai
Misima
CORAL SEA
SOLOMON SEA
Kavieng
NEW IRELAND
Lihir
Kokopo
Keravat
Warangoi
WEST NEW BRITAIN
Talasfa
Kimbe
Kandrian
Gasmata
EAST NEW BRITAIN
Buka
AUTONOMOUS REGION OF BOUGAINVILLE
Arawa
Panguna
Buin
INDONESIA
PACIFIC REGION
North Pacific Ocean
International Dateline
Philippine Sea
MARSHALL ISLANDS
PALAU
FEDERATED STATES OF MICRONESIA
NAURU
KIRIBATI
PAPUA NEW GUINEA
SOLOMON ISLANDS
TUVALU
SAMOA
COOK ISLANDS
Coral Sea
VANUATU
TONGA
FIJI
AUSTRALIA
South Pacific Ocean
Project Province
National Capital
Provincial Capital
City/Town
National Road
Provincial Road
River
Provincial Boundary
International Boundary
Boundaries are not necessarily authoritative.
N
0 50 100 150 200
Kilometers
This map was produced by the cartography unit of the Asian Development Bank. The boundaries, colors, denominations, and any other information shown on this map do not imply, on the part of the Asian Development Bank, any judgment on the legal status of any territory, or any endorsement or acceptance of such boundaries, colors, denominations, or information.

11-2272 HR

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on (i) a proposed loan, (ii) proposed administration of a grant to be provided by the Government of Australia, and (iii) proposed administration of a loan to be provided by the Organization of Petroleum Exporting Countries (OPEC) Fund for International Development (OFID) to Papua New Guinea (PNG) for the Rural Primary Health Services Delivery Project.

2. The project will strengthen rural health systems in selected areas by expanding the coverage and improving the quality of primary health care (PHC) in partnership with state and other service providers. It will build on Asian Development Bank (ADB) experience in strengthening health service delivery in rural areas of PNG.[1] The project will cover two districts in each of the following eight provinces: Eastern Highlands, East Sepik, Enga, Milne Bay, Western Highlands, West New Britain, Morobe, and the Autonomous Region of Bougainville.[2]

II. THE PROJECT

A. Rationale

3. The government's long-term Vision 2050; Development Strategic Plan, 2010–2030; and Medium Term Development Plan, 2011–2015 aim to transform PNG's health system to achieve the Millennium Development Goals for health and improve PNG's ranking in the human development index.[3] In support of the government's approach and in line with ADB's operational plan for health,[4] ADB's country partnership strategy for PNG, 2011–2015, which recognizes issues of fragility in PNG, includes health as a priority area.[5]

4. The health status of the population of PNG has deteriorated since 1980s with severe neglect of the health system, especially in rural areas, where 87% of the population lives. An estimated 40% of rural health facilities have closed or are not fully functioning. Limited resources, deteriorating infrastructure, poorly trained staff, and inadequate and declining access to basic health services are among the main reasons for the decline.

5. The country has widespread poverty and weak health indicators, particularly for maternal and child health. The infant mortality rate is 57 per 1,000 live births and the maternal mortality rate is 733 per 100,000 live births.[6] The main health problems continue to be communicable diseases, with malaria, tuberculosis, diarrheal diseases, and acute respiratory disease being the major causes of morbidity and mortality. PNG has a generalized HIV epidemic, driven predominantly by heterosexual intercourse. The epidemiological profile of PNG, with a heavy burden of communicable disease, indicates that significant gains in health outcomes could be

---

[1] ADB provided project preparatory technical assistance: ADB. 2009. *Technical Assistance to Papua New Guinea for Strengthening Rural Primary Health Services Delivery.* Manila.

[2] The government, in consultation with ADB, selected the provinces based on the criteria on health needs and service capacity in provinces. The Department of Health (DOH) selected these eight provinces for phase 1. Further expansion of the project will be considered at midterm review. DOH has selected two participating districts per province based upon agreed selection criteria. The government will select project sites in each district in accordance with agreed selection criteria for outputs 2, 3, 4, and 5. A map is included to demonstrate the project's coverage and the distribution of its resources and benefits.

[3] PNG ranks 137th of 169 countries in the 2010 human development index. UNDP. 2010. *Human Development Report 2010.* New York.

[4] ADB. 2008. *An Operational Plan of Health for Improving Health Access and Outcomes under Strategy 2020*. Manila.

[5] ADB. 2010. *Country Partnership Strategy Papua New Guinea 2011-2015*.

[6] Government of PNG, National Department of Health. 2010. *National Health Plan (2011–2020).* Port Moresby; Government of PNG, National Statistics Office. 2009. *Demographic Health Survey 2006*. Port Moresby.

achieved with simple and effective interventions focused on PHC and health promotion. While some hospital services (e.g., for maternal complications) are essential, more than 80% of health problems can be addressed adequately and at lower cost through the effective delivery of PHC. The current poor health status of the rural population points to a weak PHC system that lacks outreach services such as for child immunization and providing women with the basic support required for safe delivery.

6. Provinces and districts are responsible for delivering health care services through hospitals, health centers, health subcenters, community health post (CHP), and aid posts. The 1998 Organic Law on provincial and local-level governments significantly decentralized responsibility for delivering health care services to the provinces and districts.[7] However, the law did not adequately address how to implement the changes. In the health sector, only operational responsibilities have been devolved, while capital investments remain centralized in the public investment program. Provinces are allocated a percentage of net government revenue through staffing and health sector functional grants, which cover operational costs but not capital investment costs. Resources, authority, and competency are thus poorly aligned with decentralized responsibility.[8]

7. To overcome this misalignment, three provinces have so far exercised the option outlined in the 2007 Provincial Health Authorities Act to establish their own provincial health authorities.[9] In addition, the government, recognizing that it needs to prioritize health service delivery in districts and communities, has recently developed the concept of the CHP in 2010. CHPs will provide services at the outer perimeter of the health system. Over time, the government will transform existing aid posts and health sub-centers into a service able to meet the requirements of the National Health Plan (NHP) 2011–2010.

8. ADB has provided support for the PNG health sector since the 1980s. The completed Health Sector Development Program[10] established the Health Sector Improvement Program (HSIP) trust account in 1998, which became a major mechanism for administering extended development assistance to the health sector.[11]

9. The HIV/AIDS Prevention and Control in Rural Development Enclaves Project[12] has successfully built innovative partnerships with non-state service providers to improve rural PHC service delivery. Under that project, local health authorities in eight provinces established partnerships with six large private companies to improve more than 100 rural health facilities and trained health workers and communities in preventing HIV/AIDS transmission, significantly increasing the number of PHC beneficiaries in project areas.

10. Building on the lessons and experience of the existing project, the proposed project will support the government in implementing NHP, as it relates to rural health. The project will establish and develop partnerships between state and other health care service providers, including the private sector, churches, nongovernment organizations, and civil society, working at the provincial and district level to strengthen the rural PHC system.

---

[7] Government of PNG. 1998. *Organic Law on Provincial Governments and Local-level Governments.* Port Moresby.
[8] ADB. 2003. *Country Assistance Program Evaluation: Papua New Guinea.* Manila.
[9] Government of PNG. 2007. *Provincial Health Authorities Act*. Port Moresby.
[10] ADB. 1997. *Report and Recommendation of the President to the Board of Directors: Proposed Loans and Technical Assistance Grant to Papua New Guinea for the Health Sector Development Program*. Manila.
[11] Development Coordination (accessible from the list of linked documents in Appendix 2).
[12] ADB. 2006. *Report and Recommendation of the President to the Board of Directors: Proposed Asian Development Fund Grant to Papua New Guinea for HIV/AIDS Prevention and Control in Rural Development Enclaves Project.* Manila (Grant 0042-PNG).

11. By working through the envisioned partnerships, the project will build human resource capacity in the health sector, improve health information and monitoring systems, and revitalize rural health facilities to strengthen the existing rural PHC system in PNG. The project will expand the coverage and improve the quality of PHC services for the rural population by strengthening the rural health system at the provincial and district level.

12. The project will be implemented under the sector-wide approach currently in place for the health sector.[13] To avoid replicating government functions, the project will use government systems whenever possible, and the government will be responsible for all facility recurrent costs. The project will focus on infrastructure and training that can help the government deliver health services more efficiently and effectively,[14] building on the strengths of existing health institutions run by the government and others.

B. Impact and Outcome

13. The project will contribute to improved health for the rural population in project areas. The outcome will be that the selected provinces, in partnership with non-state service providers, will efficiently deliver high-quality PHC to the rural population, in particular to women and children. The design and monitoring framework is in Appendix 1.

C. Outputs

14. **Output 1: National policies and standards.** The project will assist the Department of Health (DOH) to develop and implement policies, standards, and strategies for CHPs[15] and strengthen human resources in the health sector within the framework of the NHP. It will assist DOH in its provincial planning and coordination functions, including facility and asset management, human resource audits, staff retention, and planning health services. The project will provide improved health information systems by applying information and communication technology (ICT) and geographic information systems (GIS). This support will (i) increase the availability of information at all levels of the health sector, (ii) enable provincial and district governments to monitor the performance in the sector, and (iii) improve logistics for supplying drugs locally.

15. **Output 2: Sustainable partnerships between provincial governments and non-state actors.** The project will help provincial and district governments to develop and formalize existing or new partnerships with non-state providers of health services by forming a partnership board.[16] This will facilitate greater coordination and efficiency among diverse health service providers and improve their consistency and accountability. In particular, it will assist provincial governments in formalizing partnerships and negotiating and implementing agreements with non-state actors, including the development of monitoring and evaluation tools and targets. The project will help

[13] ADB supports the health sector-wide approach with other development partners: the Australian Agency for International Development, New Zealand Aid Programme, United Nations Children's Fund, United Nations Population Fund, and World Health Organization. The sector-wide approach was initially established as a "partnership arrangement" to support the country's National Health Plan, 2001–2010 under the HSIP in 2004.

[14] Long-term commitment and capacity development are in line with the ADB's approach to fragile countries. ADB. 2007. *Achieving Development Effectiveness in Weakly Performing Countries (The Asian Development Bank's Approach to Engaging with Weakly Performing Countries)*. Manila. http://www.adb.org/Documents/Policies/Achieving-Development-Effectiveness/SecM30-07.pdf.

[15] Community Health Post Policy and Standard (accessible from the list of linked documents in Appendix 2).

[16] Partnership Building and Agreements and Contracts (accessible from the list of linked documents in Appendix 2). Forming the partnership board will be a condition to commencing civil works.

participating provinces to set up facility-based funding in selected districts to enable better use of government funds.[17]

16. **Output 3: Human resource development in the health sector.** The project will strengthen the skills of health personnel in rural communities. It will provide skills and capacity training for health workers and training in facility management and clinical supervision for district and provincial managers in participating districts. The project will also support the government to address issues of performance and retention of health workers.

17. **Output 4: Community health facility upgrading.** The project will build or upgrade two CHPs and upgrade and refurbish eight rural health facilities in each of 16 participating districts. It will provide medical equipment and small vehicles including cars, boats, or motorbikes. It will upgrade staff housing, install or upgrade sanitation and waste-management facilities, and supply selected health facilities with renewable energy. Design of facilities will take into account climate change impacts, e.g., rising sea levels for facilities on small islands.[18]

18. **Output 5: Health promotion in local communities.** The project will increase women's involvement in all aspects of delivering community health services. Through health programs, it will support existing and new initiatives by civil society organizations to increase knowledge on sanitation, primary health (i.e., maternal and child health and HIV/AIDS), and gender (including domestic and sexual violence) in local communities.[19]

19. **Output 6: Project monitoring, evaluation and management.** The project will support planning, reporting, coordination with development partners, and monitoring and evaluation. It will establish a project support unit (PSU) in DOH. A formative evaluation every 6 months will inform stakeholders of project progress, impact, and experiences, including crosscutting aspects such as gender and climate change.[20]

D. Investment and Financing Plans

20. The project is estimated to cost $81.2 million, including taxes and duties. The project cost includes physical and price contingencies and interest charged during implementation. Table 1 summarizes the investment plan. Detailed cost estimates by expenditure category and by financier are in the project administration manual.[21]

21. The government has requested a loan in various currencies equivalent to SDR 12,435,000 from ADB's Special Funds resources to help finance the project. The loan will have a 32-year term, including a grace period of 8 years; an interest rate of 1.0% per annum

[17] Direct Facility Funding (accessible from the list of linked documents in Appendix 2). Facility−based funding in the health sector has been introduced in the Autonomous Region of Bougainville, used initially for operational costs including outreach. The project will facilitate the introduction of the funding arrangement in participating provinces. Output-based funding using project funds will be considered after the midterm review of the project.

[18] Adaptation and mitigation measures should be guided by the opportunities and challenges for climate change and health in PNG. Commonwealth Secretariat. 2009. *Commonwealth Health Ministers' Update 2009.* London (Country Survey on Health and Climate Change: Papua New Guinea. http://www.thecommonwealth.org/files/191129/FileName/PapuaNewGuinea_2009.pdf)

[19] Proposed Program for Output 5: Health Promotion in Local Communities (accessible from the list of linked documents in Appendix 2).

[20] Formative Evaluation (accessible from the list of linked documents in Appendix 2). Formative evaluation focuses on improving or enhancing a project while it is being implemented. Annual reviews will be conducted with stakeholders, with ADB leading joint review missions.

[21] Project Administration Manual (accessible from the list of linked documents in Appendix 2).

during the grace period and 1.5% per annum thereafter; and such other terms and conditions as set forth in the loan and project agreements.

Table 1: Project Investment Plan

Item		Amount[a] ($ million)
A.	**Base Cost**[b]	
	Output 1: National policies and standards	2.90
	Output 2: Sustainable partnerships	5.32
	Output 3: Human resource development	7.34
	Output 4: Community health facility upgrading	28.82
	Output 5: Health promotion in local communities	8.71
	Output 6: Project monitoring, evaluation and management	16.93
	Subtotal (A)	**70.02**
B.	**Contingencies**[c]	**10.33**
C.	**Financing Charges during Implementation**[d]	**0.85**
	Total (A+B+C)	**81.20**

[a] Includes taxes and duties of $3.12 million to be financed by the Asian Development Bank and the government. The Asian Development Bank will finance all taxes on expenditures 100% financed by it and the Australian Agency for International Development.
[b] In mid-2010 prices.
[c] Physical contingencies are computed at 10% for civil works and 6% for equipment and training. Price contingencies are computed at 1% on foreign exchange costs and domestic cost escalations for Papua New Guinea for local currency costs.
[d] Based on standard Asian Development Fund terms.
Source: Asian Development Bank estimates.

22. The Government of Australia, represented by the Australian Agency for International Development (AusAID), is currently refocusing its aid program in PNG, with health and education as key delivery areas. To improve aid effectiveness, the Government of PNG has recommended that all aid agencies, including AusAID, channel their support for improving rural health service delivery through the project. The Government of Australia will, through its PNG Health Delivery Strategy Program, provide grant cofinancing equivalent to $40 million, to be administered by ADB.

23. The Government of PNG has requested cofinancing of $9 million from OFID, to be administered by ADB.[22] OFID has provided its firm commitment, with OFID board approval expected in December 2011. In the unlikely event that cofinancing from OFID is not provided within 6 months following the effectiveness of the loan, the government shall take all necessary and appropriate steps to make available all counterpart funds required for timely and effective completion of the project whether through either budget allocations or other arrangements acceptable to ADB, in the absence of which the government and ADB shall agree to scale down the scope of the project and if applicable to adjust the relevant financing arrangements.

24. The government has requested the Japan International Cooperation Agency to provide 12 senior volunteers to work in selected provinces as provincial partnership coordinators.[23] The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) will support the project with technical assistance in their areas of expertise.[24]

[22] The OFID loan will have a 20-year term, including a grace period of 5 years; an interest rate of 1.75% per annum; and a service charge of 1%.
[23] Volunteers will be retained by the agency under its standard procedures but will work under the project.
[24] Proposed Program for Output 5: Health Promotion in Local Communities; Formative Evaluation (accessible from the list of linked documents in Appendix 2). One WHO health system expert and one maternal health expert will contribute 20% of their time to the project through output 6 (formative evaluation). UNICEF will provide parallel in-kind financing. Activities under output 5 will use information, education, and communication materials on health promotion developed by UNICEF.

25. The government will provide $10 million[25] to fund part of taxes, duties, and recurrent costs. It will also fund part of (i) civil works, (ii) health promotion, (iii) training, and (iv) contingencies. The loan from ADB will finance (i) civil works; (ii) equipment; (iii) vehicles; (iv) ICT and GIS; (v) training and workshops; (vi) consulting services; (vii) operation and maintenance, including for the PSU; and (viii) financing charges on the Asian Development Fund loan during implementation. The financing plan is in Table 2.

Table 2: Financing Plan

Source	**Type**	**Amount** ($ million)	**Share of Total** (%)
Asian Development Bank	ADF Loan	20.0	24.63
Government of Australia[a]	Grant	40.0	49.26
OPEC Fund for International Development[b]	Loan	9.0	11.09
Japan International Cooperation Agency[c]	Grant	1.2	1.48
World Health Organization[c]	Grant	1.0	1.23
Government of Papua New Guinea	Budget	10.0	12.31
Total		**81.2**	**100.00**

ADF = Asian Development Fund, OPEC = Organization of Petroleum Exporting Countries.
[a] Through the Australian Agency for International Development administered by ADB.
[b] The OPEC Fund for International Development board is expected to approve the cofinancing in December 2011; partly administered by ADB.
[c] Through in-kind contributions.
Source: Asian Development Bank.

E. Implementation Arrangements

26. DOH will be the executing agency, with oversight by the Department of National Planning and Monitoring, Department of Treasury, and Department of Finance. DOH will be the implementing agency for outputs 1 and 6, and the provincial governments (including provincial health authorities, if established) of the selected provinces will be the implementing agencies for the other outputs.

27. Implementation arrangements are summarized in Table 3 and described in detail in the project administration manual (PAM). The project will collaborate with other development partners in the health sector.[26]

Table 3: Implementation Arrangements

Aspects	**Arrangements**		
Implementation period	1 November 2011–31 October 2019		
Estimated completion date	31 October 2019		
Loan closing date	30 April 2020		
Project management			
(i) Project steering committee	DOH, Department of National Planning and Monitoring, Department of Finance, and Department of Treasury		
(ii) Executing agency	DOH		
(iii) Key implementing agencies	DOH, provincial government authorities in Eastern Highlands Province, East Sepik Province, Enga Province, Milne Bay Province, Western Highlands Province, West New Britain Province, Morobe Province, and the Autonomous Region of Bougainville		
(iv) Project support unit	Embedded at DOH and based in Port Moresby		
Procurement	International competitive bidding; national competitive bidding; shopping	64 contracts for civil works, two contracts for medical equipment, two contracts for vehicles, and eight contracts for workshops	$28.51 million
Consulting services	Quality- and cost-based	ICT and GIS provision (firm); formative	$27.9

[25] Of which $500,000 will be in-kind contributions for office space, utility costs, and management supervision.
[26] Development Coordination (accessible from the list of linked documents in Appendix 2).

Aspects	Arrangements		
	selection (80:20) for firms and NGOs; individual selection; single-source selection	evaluation (firm); health promotion and training (NGO and firm); 8–15 contracts for 536 person-months of international firms and consultants, 15–20 contracts for 1,566 person-months of national consultants, NGOs, and firms	million
Retroactive financing and advance contracting[a]	Advance contracting will be applied for selecting consultants. Retroactive financing will be up to 20% of the ADB loan and AusAID grant for procuring consulting services for project support unit. It will not apply earlier than 12 months prior to the signing of the loan agreement.		
Disbursement	The ADB loan and funding from cofinanciers will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2007, as amended from time to time). Loan and grant disbursement will generally be through a combination of direct payments and the use of an imprest account and special project accounts. Special project accounts will be established within the HSIP trust account and will be managed, replenished, and liquidated in accordance with imprest account procedures as outlined in the *Loan Disbursement Handbook* and detailed arrangements agreed in the PAM between the government and ADB.		

ADB = Asian Development Bank, AusAID = Australian Agency for International Development, DOH = Department of Health, GIS = geographic information system, HSIP = Health Sector Improvement Program, ICT = information and communication technology, NGO = nongovernment organization, PAM = project administration manual.
[a] Management approved the availability of retroactive financing in July 2011.
Source: Asian Development Bank.

III. DUE DILIGENCE

A. Economic and Financial

28. The strengthened delivery of improved rural PHC will mean (i) improvements in productivity resulting from reduced morbidity and mortality and time spent caring for sick relatives, (ii) increased household savings through improved accessibility to health facilities, and (iii) consumption benefits derived by individuals from feeling healthier. The economic internal rate of return of the project is estimated at 21%, exceeding the 12% threshold for viability.[27] Underestimation is likely, since psychological and consumption benefits associated with improved health cannot be captured in numerical values. The financial analysis concluded that the project is sustainable based on the government's commitment to cover the costs of personnel, medical supplies, and the operation and maintenance of all rural health facilities developed and refurbished under the project.

B. Governance

29. DOH has implemented numerous aid projects using the HSIP trust account. The financial analysis found that financial management arrangements for implementing the HSIP are adequate, with documented financial procedures, computerized accounting software, and a functioning internal control system. Because the financial management unit depends heavily on external consultants, the financial management assessment recommends providing adequate accounting expertise.[28] The procurement capacity assessment concluded that DOH and the national procurement agency face significant challenges in terms of resources and capacity, causing in the past noncompliance with applicable procedures, which could affect the management of project procurement through government systems. To mitigate these concerns, project-specific measures to enhance governance and prevent corruption include (i) engaging a senior accounting expert and an international procurement expert to ensure the accuracy of

[27] Economic Analysis (accessible from the list of linked documents in Appendix 2).
[28] Project Administration Manual (Section V: Financial Management Assessment); Financial Analysis (accessible from the list of linked documents in Appendix 2).

project accounts and compliance with procurement procedures; (ii) direct payment procedures for all international and PSU consultants and other high-value goods and services, with regular internal audits of financial management and procurement in addition to the planned external audit; (iii) an evaluation committee to review criteria for tenders of small civil works; and (iv) a dedicated section of the DOH website to serve as the project website, publishing procurement and performance data to maximize transparency.[29] Risk mitigation is discussed in detail in the PAM and set out in the risk assessment and risk management plan.[30]

30. ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with the government and DOH. Specific policy requirements and supplementary measures are described in the PAM.

C. Poverty and Social

31. The project is gender category I (gender equity as a theme).[31] Project improvements will contribute to poverty reduction and provide social benefits by expanding coverage and improving the quality of PHC for rural women and children.[32] Many health problems in PNG, such as high maternal and infant mortality, poor reproductive health, poor nutrition, and communicable diseases, can be prevented with affordable access to PHC, including skilled professionals supervising deliveries and adequate medical equipment, and the project will contribute significantly to improving the health and economic circumstances of rural residents. To increase awareness of maternal health, the project will support health promotion conducted by health workers and village health volunteers. It will employ a social, gender, and community development specialist to monitor the implementation of gender action plans and report on progress, together with the PSU. The formative evaluation team will collect and analyze sex-disaggregated data for all project activities under the gender action plan.

D. Safeguards

32. **Environment.** The project is environment category B in accordance with ADB's Safeguard Policy Statement (2009). An environmental assessment and review framework was prepared to guide the assessment and review of project investments. An initial environmental examination was prepared to provide DOH with technical guidance on expected environmental issues and how to address them in a manner consistent with the Safeguard Policy Statement.

33. **Social safeguards.** The project is involuntary resettlement category C and indigenous peoples category C in accordance with the Safeguard Policy Statement. The project is not expected to require land acquisition or involuntary resettlement. All civil works will be on land currently used by health facilities. A land assessment framework provides detailed guidelines for assessing and confirming that the land proposed for each health facility is owned by the state or a health services partner organization (e.g., a church) with control over the operations of the existing facility. Melanesians comprise the vast majority of the PNG population, and the project is not expected to have any negative impact on indigenous peoples. While a separate indigenous peoples plan is not needed, all project outputs will be delivered in a culturally appropriate and participatory manner to meet the needs of various beneficiaries.

---

[29] These measures are in line with the recommendations of the ADB's approach to fragile countries (footnote 14).
[30] Risk Assessment and Risk Management Plan (accessible from the list of linked documents in Appendix 2).
[31] ADB. Guidelines for Gender Mainstreaming Categories of ADB Projects. http://www.adb.org/gender/gender-categories.asp
[32] Summary Poverty Reduction and Social Strategy; Gender Action Plan (accessible from the list of linked documents in Appendix 2).

34. DOH has endorsed the environmental and land assessment frameworks and initial environmental examination for the project, which are posted on the ADB website.[33] The project will support DOH, the implementing agencies, and other stakeholders by strengthening their capacity to effectively manage safeguard activities.

E. Risks and Mitigating Measures

35. Major risks and mitigating measures are summarized in Table 4. The benefits of the project are expected to outweigh the associated risks.

Table 4: Summary of Risks and Mitigating Measures

Risks	Mitigating Measures
Financing delays and lack of counterpart funds for asset operation and maintenance at provincial and local levels	The government gives an assurance in the loan agreement to provide appropriate counterpart recurrent funding. Site selection criteria require evidence of appropriate recurrent funding through the Health Function Grant.
Risk of reduction in availability of decision-making authority in government needed for project implementation for 6–8 months surrounding national elections scheduled for July 2012; risk of civil unrest	The risk is spread over eight participating provinces, permitting the project to place adaptive emphasis on less-affected areas during the election period. The project aims to identify key decision points to be accelerated prior to the election period. Site selection criteria require preparatory milestones to have been met. The project will accelerate in progressive provinces where the site selection criteria can be satisfied notwithstanding pending elections. The project emphasizes partnership in health service delivery with non-state providers such as churches and private firms, whose capacity to make decisions is not directly affected by election-related disruption.
Insufficient numbers or quality of government staff and community health workers for project implementation and operation of community health posts and other health facilities, especially in remote rural areas	The PSU, in line with recommendations of the ADB's approach to fragile countries, supports capacity development of the executing agency and implementing agencies. The government covenants in the loan agreement require that appropriate numbers of community health post staff are made available; this is also a site selection criterion. Output 1 supports the government in developing a staff incentive program; output 3 provides training in supervision and management. Output 4 includes staff housing as part of the civil works component, providing an incentive for staff to stay. The project supports the preparation and delivery of a comprehensive rural health services training plan including the training of trainers. Provinces explicitly agree to provide sufficient human resource and recurrent costs for the new and upgraded facilities.
Insufficient acceptance of the local partnership modality	Partnership boards under output 2 will be established or re-launched prior to the agreements for effective cooperation. Consultations will be held among stakeholders including provincial and local government authorities, private service providers, churches, civil society, and communities.
Lack of civil works contractors, cost escalation and delays in civil works because of the high demand by the PNG LNG project,[a] security concerns, including about election-related	The selection of facility sites and civil work contractors is transparent and includes consultations with local communities. Community buy-in, and enhanced security, will be developed through community participation in the partnership boards, which are a precondition for civil works. Civil works are scheduled to be implemented from the fourth quarter of 2012 to

[33] Environmental Assessment and Review Framework; Initial Environmental Examination; Land Assessment Framework (accessible from the list of linked documents in Appendix 2).

Risks	Mitigating Measures
disruption	avoid disruptions surrounding elections in 2012.
Lack of capacity in fiduciary functions	Most project support will be through direct payment. Procurement and accountancy expertise is provided through the PSU. An international consultant in the PSU will provide training and capacity development in financial management and ADB disbursement procedures for the executing agency.

[a] The ongoing private sector and PNG government project, in an approximate amount of $18 billion, for the development of LNG exports from Southern Highlands province.

Source: Asian Development Bank.

IV. ASSURANCES AND CONDITIONS

36. The government has assured ADB that implementation of the project shall conform to all applicable ADB policies including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, and disbursement as described in detail in the project administration manual and loan documents.

37. The government has agreed with ADB on certain covenants for the project, which are set forth in the loan agreement and project agreement.[34]

38. As a condition for loan effectiveness, the commitment of grant cofinancing from the Government of Australia will have become final in form and substance satisfactory to ADB and the grant agreement concerning the provision by ADB of such cofinancing to the government will have been signed and delivered in form and substance satisfactory to ADB.

V. RECOMMENDATION

39. I am satisfied that the proposed loan would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve

(i) the loan in various currencies equivalent to SDR12,435,000 to Papua New Guinea for the Rural Primary Health Services Delivery Project from ADB's Special Funds resources with an interest charge at the rate of 1.0% per annum during the grace period and 1.5% per annum thereafter; for a term of 32 years, including a grace period of 8 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan and project agreements presented to the Board;

(ii) the administration by ADB of the grant not exceeding the equivalent of $40,000,000 to Papua New Guinea for the Rural Primary Health Services Delivery Project, to be provided by the Government of Australia; and

(iii) the administration by ADB of the loan not exceeding the equivalent of $9,000,000 to Papua New Guinea for the Rural Primary Health Services Delivery Project, to be provided by the OPEC Fund for International Development.

Haruhiko Kuroda
President

9 September 2011

[34] Such assurances include that effectiveness of the OFID loan agreement shall be a condition to the award of selected civil works contracts by the government.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
Impact Improved health of rural population in the project areas	By 2022, improvements in the project area from a 2006 baseline: Maternal mortality rates decreased from 733 per 100,000 to 360 Infant mortality rates decreased from 57 per 1,000 live births to 35, with sex and socioeconomic quintiles disaggregated Neonatal mortality rates decreased from 29 per 1,000 live births to 18, with sex and socioeconomic quintiles disaggregated Child under 5 mortality rates decreased from 75 per 1,000 live births to 44, with sex and socioeconomic quintiles disaggregated	Demographic health survey Census National health information system	**Assumptions** Local governments are committed to and set priorities on improving rural health services and referral networks. Political stability is maintained. **Risk** Poor governance, issue of fragility, and institutional factors affect returns on health investments and the performance of health services.
Outcome Selected provinces, in partnership with non-state service providers, deliver high-quality PHC to rural residents, in particular to women and children	By 2019: Health service utilization rates increased annually for antenatal care, family planning, deliveries at facilities, and immunization for rural women and children in selected districts, compared with the baseline in 2011[a] At least 32 CHPs providing child, maternity, and other public health services with qualified community health workers PHC funding per capita increasing by 5% in real terms in selected provinces compared with the baseline in 2011	National health information system National Economic Fiscal Commission's survey and research (www.nefc.gov.pg) Provincial coordinating and monitoring committee District and facility level activity reports Provincial annual reports	**Assumptions** Improved health system performance will reduce maternal, infant, and child deaths. Improving 32 CHPs will have a significant impact on health outcomes at the district level. **Risks** System improvements do not affect maternal death rates. Issues of fragility and factors outside the health sector deteriorate, worsening health outcomes. Improvements are not generalized across other health facilities in the district.
Outputs 1. National and selected provincial and district governments implement policies and standards for community health posts	By 2019 (except where otherwise indicated): National, 8 provincial and 16 district governments adopted CHP policy by Q4 of 2014	Regular facility audits Annual human resource audit in selected districts Review of health information	**Assumptions** The government continues to support CHP policy for implementation. Strengthening PHC service delivery through CHPs remains a priority for both the national and

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
	CHPs in 16 districts with access to real-time health information through information technology by the fourth quarter of 2014.	available at CHPs, health centers, and at the district level District contracts	subnational governments, as well as of other stakeholders. **Risks** Some provinces and districts fail to commit to CHPs or provide human resource or budgetary support for them. The project becomes downsized because funding from cofinanciers is not provided on time. The fragile security situation in the country impedes mobility and timely and effective implementation.
2. Sustainable partnership established between selected provincial governments and non-state actors for delivering PHC services	16 selected districts delivering health services based on partnership agreements by 2015		
3. Community health workers in project areas have the capacity to provide quality PHC services.	50% of facilities use direct facility funding by Q4 of 2018. The number of community health workers skilled in maternal medicine increased by at least 10% in selected districts compared with 2011 baseline, and at least half are women [a] Maternal and child health by trained health workers increased by 10% in selected districts compared with 2011 baseline [a]		
4. Selected provincial and district governments upgraded selected rural health facilities	At least 32 CHPs and 160 health facilities in the selected provinces built or upgraded with water and electricity available 24 hours a day, seven days a week At least 32 CHPs and 160 health facilities equipped with furniture, fittings, and medical and nonmedical equipment, including a maternal health set by CHP policy document and policy on biomedical equipment		
5. Local communities in project areas are aware of maternal and child health, HIV, sanitation, and gender issues	At least 50% of women actively engaged in two health promotion and gender programs at selected project sites Antenatal care coverage (both 1st and 4th antenatal care visits) improved in selected project districts measured by gap between baseline and national goal narrowing by 50% by 2018		
6. Effective project monitoring, evaluation and management, services rendered	Project activities completed on schedule by 31 October 2019 and the government's completion report submitted by 31 January 2020.		

Activities with Milestones	Inputs
1. National and selected provincial and district governments implementing policies and standards for community health posts 1.1 Develop and finalize CHP policy, standards, strategy draft paper by Q2 2012. 1.2 Develop communication tools and training materials by Q4 2012. 1.3 Each province prepares strategies to implement the policy on health services and CHP by Q2	ADB: $20 million Asian Development Fund loan

Activities with Milestones	Inputs
2013. 1.4 Assess health information system and ICT situation by Q3 2012. 1.5 Design an ICT program with GIS feature by Q1 2013. 1.6 Implement the ICT and GIS program from Q4 2012 to 2019 1.7 Organize workshops and training at selected project sites from 2013 to 2018. 1.8 Routinely monitor the CHP standards at selected sites every 6 months after the completion of upgrading CHP facility. **2. Sustainable partnership established between selected provincial governments and non-state actors for delivering PHC services** 2.1 Prepare contracts and/or agreement in each province with local service providers including assessments on decentralization in 2012–2013. 2.2 Set up monitoring indicators, targets, and mechanism to manage agreements and contracts by Q1 2013. 2.3 Finalize and agree on contracts for provinces and local partners in 2012–2013. 2.4 Provide training on contracts and direct facility funding management from Q1 2013 to 2014. 2.5 Implement the agreed contracts starting from Q4 2012. 2.6 Monitor indicators and targets set in the contract every 6 months in 2012–2019. **3. Community health workers in project areas with the capacity to provide quality PHC services.** 3.1 Assess human resources and supervising management capacity in selected provinces and districts by Q3 2012. 3.2 Develop human resource capacity and local management strengthening strategy and training programs (using existing training course materials) for community health workers, including costing and required resources, starting in Q4 2012 to Q2 2013. 3.3 Organize training for community health human resources and local management and supervisors in Q1 2013–2018. 3.4 Prepare annual plans for outreach programs for community health workers starting in Q4 2012. 3.5 Evaluate human resource and local health management capacity training every 6 months after finishing training. **4. Selected provincial and district governments upgraded selected rural health facilities** 4.1 Prepare site selection criteria for districts and CHP sites in 2012. 4.2 Finalize site selection of districts and CHP sites by Q4 2012. 4.3 Build, upgrade, refurbish, and equip health facilities from Q4 2012 to 2019. 4.4 Distribute equipment and training on equipment use and maintenance starting from Q1 2013 to 2019. 4.5 Prepare maintenance plans starting in Q1 2013. 4.6 Conduct routine maintenance and monitoring every 6 months. **5. Local communities in project areas aware of maternal and child health, HIV, sanitation, and gender issues** 5.1 Assess ongoing health promotion programs in selected districts and provinces by Q4 2012. 5.2 Prepare health promotion programs and plan schedules for selected areas in 2013. 5.3 Implement health promotion programs in 2013–2019. 5.4 Monitor and evaluate health promotion programs every 6 months after the implementation of the health promotion programs. **6. Effective project monitoring, evaluation and management, services rendered** 6.1 Set up a PSU and hire consultants for technical areas including finance, accounting, and formative evaluation by Q2 2012. 6.2 Prepare annual work plans by Q3 2012. 6.3 Prepare annual projections of contract awards and disbursements every 6 months. 6.4 Monitor progress of PSU activities with key indicators every 6 months starting from Q4 2012. 6.5 Maintain and update project accounts and ensure that annual audits are completed on time. 6.6 Prepare quarterly progress reports. 6.7 Monitor and report on the implementation of the gender action plan. 6.8 Conduct formative evaluation every 6 months after project commencement, 2012–2019.	Government: $10 million AusAID: $40 million OFID: $9 million JICA: $1.2 million in-kind WHO: $1 million in-kind

ADB = Asian Development Bank, AusAID = Australian Agency for International Development, CHP = community health post, GIS = geographic information system, ICT = information and communication technology, JICA = Japan International Cooperation Agency, OFID = OPEC Fund for International Development, PHC = primary health care, PSU = project support unit, Q = quarter, WHO = World Health Organization.

[a] District baseline data and the targets will be established during year 1 of project implementation.

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=41509-01-3

1. Loan Agreement
2. Project Agreement
3. Grant Agreement
4. Sector Assessment (Summary): Health
5. Project Administration Manual
6. Contribution to the ADB Results Framework
7. Development Coordination
8. Financial Analysis
9. Economic Analysis
10. Country Economic Indicators
11. Summary Poverty Reduction and Social Strategy
12. Gender Action Plan
13. Initial Environmental Examination
14. Environmental Assessment and Review Framework
15. Risk Assessment and Risk Management Plan

Supplementary Documents

16. Health Human Resources Subsector Analysis (Summary)
17. Proposed Community Health Post Policy and Standard (Summary)
18. Partnership Building Between Provincial Governments and Nonstate Actors for Rural Health System Strengthening in Papua New Guinea (Summary of Output 2)
19. Proposed Program for Output 5: Health Promotion in Local Communities (Summary)
20. Formative Evaluation (Summary)
21. Direct Facility Funding (Summary)
22. Consultation and Participation Plan
23. Land Assessment Framework