# Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 03-Oct-2018 | Report No: PIDISDSC24634

Public Disclosure Authorized

## BASIC INFORMATION

### A. Basic Project Data

| Country | Project ID | Parent Project ID (if any) | Project Name |
|---|---|---|---|
| Papua New Guinea | P167184 | | Improving Access to and Value from Health Services in PNG: Financing the Frontlines (P167184) |
| **Region** | **Estimated Appraisal Date** | **Estimated Board Date** | **Practice Area (Lead)** |
| EAST ASIA AND PACIFIC | Aug 14, 2019 | Dec 10, 2019 | Health, Nutrition & Population |
| **Financing Instrument** | **Borrower(s)** | **Implementing Agency** | |
| Investment Project Financing | Department of Treasury | National Department of Health | |

**Proposed Development Objective(s)**

To contribute to the improvement of access to and use of quality essential health services in selected provinces

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

| | |
|---|---|
| **Total Project Cost** | 30.00 |
| **Total Financing** | 30.00 |
| **of which IBRD/IDA** | 30.00 |
| **Financing Gap** | 0.00 |

### DETAILS

**World Bank Group Financing**

| | |
|---|---|
| International Development Association (IDA) | 30.00 |
| IDA Credit | 30.00 |

| Environmental Assessment Category | Concept Review Decision |
|---|---|

| | |
|---|---|
| | Track II-The review did authorize the preparation to continue |

Other Decision (as needed)

## B. Introduction and Context

Country Context

T**he Independent State of Papua New Guinea (PNG) is a lower-middle income country with a population of over 8 millioni**. PNG is a predominantly rural country - 86.9 percent of the population lives in rural areas – and given its rugged topography and very poor transport infrastructureii, a large share of the population resides in remote and hard-to-reach areas.

**PNG's economy relies heavily on natural resources and it is therefore exposed to the price volatility of international commodities**. PNG has a rich endowment of minerals and petroleum, and a high potential for agriculture, forestry and fishing. In 2016, these sectors represented almost half of PNG's GDP per capita (USD 2,688) and more than 80 percent of the country's exportsiii. In the absence of adequate stabilization measures, PNG has followed a "boom and bust" cycle of high fluctuations in revenues and expenditures driven by changes in global commodity prices. Moreover, approximately 80 percent of Papua New Guineans are directly or indirectly involved in agricultureiv.

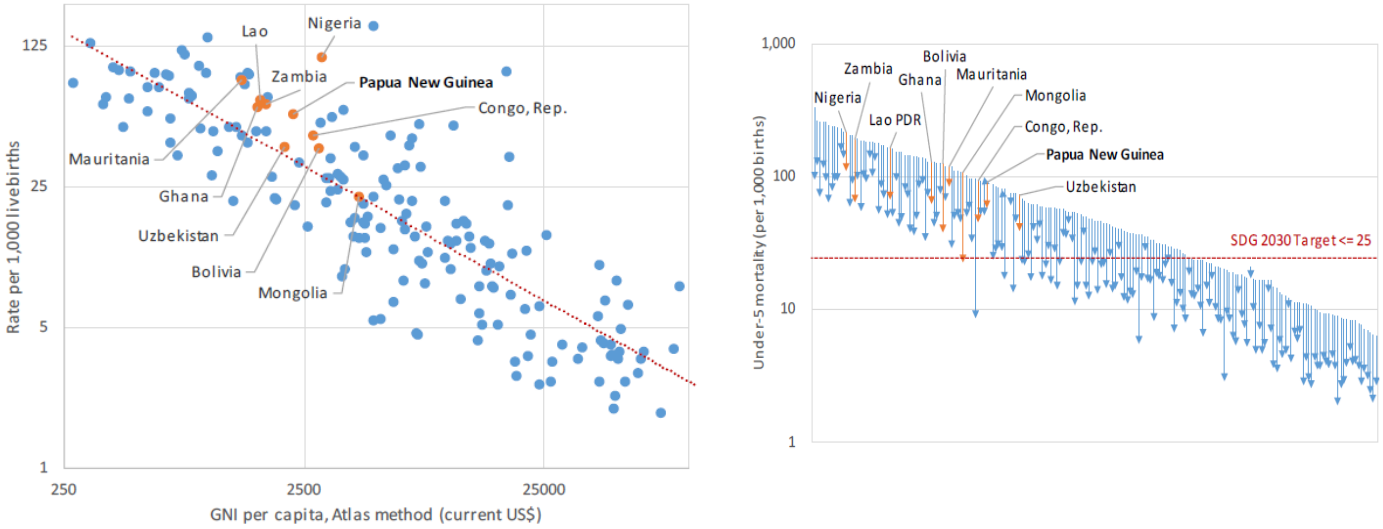
**A fragile social, political and environmental landscape have hindered improvements in socio-economic indicators**. PNG scores are low on socio-economic development indices such as the Human Development Index (HDI) and only limited improvements have been achieved on this front over the last decade. Poverty rates remain high, particularly in the rural and remote areas, with 38 percent of PNG's population living below the international poverty line of $1.90 per day (2011 USD PPP) in 2009v. PNG's ethnographic diversity represents a salient challenge for social cohesion and tribal conflict is an important driver of PNG's social fragilityvi vii. Furthermore, PNG's cultural diversity has influenced the evolution of its political system since independence in 1975. PNG has implemented a system of political decentralization that delegates large responsibilities to lower government levels. Finally, PNG faces environmental risks, such as earthquakes, floods and droughts, that can have severe social and economic impactsviii.

Sectoral and Institutional Context

**PNG has a significant unfinished agenda in terms of Reproductive Maternal Neonatal and Child Health and Nutrition; Gains in key health outcomes have been slower than expected.** PNG did not achieve any of the health-related global Millennium Development Goals (MDG). Improvements in key health outcomes in PNG have also been slower than in comparator countries. The Maternal Mortality Rate (MMR) declined from 258 per 100,000 live births in 2008 to 215 per 100,000 live births in 2015ix. While MMR is lower than the average for Lower Middle-Income Countries (LMICs), it is significantly higher than the average for the East Asia and Pacific (EAP) region (59 per 100,000 live births) and the Pacific Islands small states (75 per 100,000 live births). Reductions in MMR in PNG occurred at a slower pace than in comparator

countries. The Under-Five Mortality Rate (U5MR), in turn, fell from 68.8 per 1,000 live births in 2008 to 54.3 per 1,000 live births in 2016x. U5MR is more than three times higher than average U5MR in EAP and more than twice as high as the average for the Pacific Islands small states. Furthermore, U5MR in PNG is higher than the corresponding figure for LMICs and declines have been slower than in comparator countries (see Figure 1). The drivers of poor health outcomes are discussed subsequently in the concept note (see paragraph 13).

Figure 1 - Under-five mortality rates




Source: Economic Update, World Bank (2017)

**With a steady increase in the prevalence of non-communicable diseases (NCD), PNG faces a double burden of disease.** In 2016, NCDs represented 54.6 percent of the country's total Disability-Adjusted Life Years (DALYs). Communicable, maternal, neonatal, and nutritional diseases, in turn, represented 34.5 percent and injuries accounted for the remaining 10.9 percent of the DALYs. As seen in Table 1 below, the burden of disease is slightly different between men and women, with a higher prevalence of NCDs among women and a high share of DALYs driven by injuries among men. Cardiovascular diseases are the most common cause of death, followed by chronic respiratory diseases and diarrhea, lower respiratory and other common infectious diseases. Among children under five, the most common causes of death are diarrhea, lower respiratory and other common infectious diseases, followed by neonatal disordersxi.

**Table 1: Burden of Disease in PNG**

| | NCDs | Group 1 | Injuries |
|---|---|---|---|
| Total | 54.6 | 34.5 | 10.9 |
| Female | 57.9 | 35.3 | 6.8 |
| Male | 51.6 | 33.8 | 14.6 |

Source: Institute of Health Metrics and Evaluation

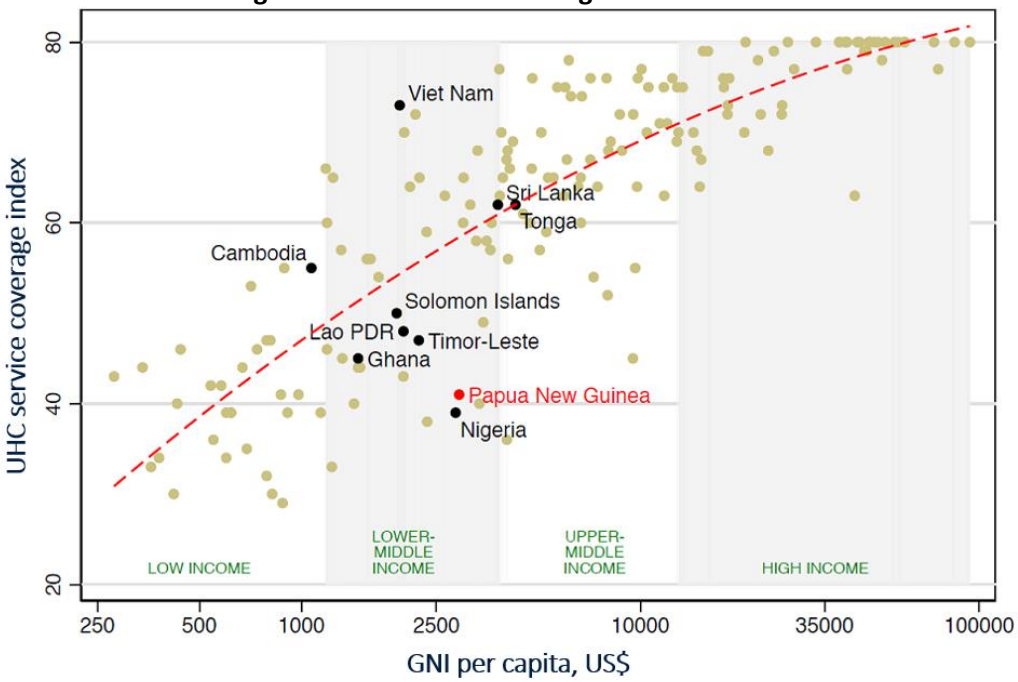
*Note : Group 1 = Communicable, maternal, neonatal, and nutritional diseases*

**The burden of communicable diseases represents a serious public health threat and also risks regional health security.** For example, the prevalence of Tuberculosis (TB) – including multidrug-resistant (MDR) TB and extensively drug-resistant

(XDR) TB, are at levels considered to be a public health emergency by the WHO. In 2015, the incidence of TB was estimated at 417 per 100,000 population (31,000 cases) and the prevalence rate was 529 per 100,000 population (39,000 cases)xii. In 2018, PNG has had outbreaks of vaccine preventable diseases such as measles, and more recently, a polio outbreakxiii.

**Coverage of essential health services is low, and coverage/ utilization of many vital services is stagnant or declining.** PNG's coverage of essential health services is low for its level of income (see Figure 2). Between 2012 and 2016, utilization of outpatient services in PNG has oscillated between 1.23 and 1.28 outpatient visits to a health facility per person per yearxiv. Less than 50 percent of women are covered by modern methods of family planning, only 55 percent of pregnant women received at least four antenatal care (ANC) check-ups, and immunization coverage rates are extremely low and declining. In 2016, only 36.4 percent of children under 1 were immunized against measles and less than 35 percent received the third dose of the pentavalent vaccine. Moreover, national averages hide important differences between provinces. While overall immunization coverage rates are low (the highest coverage rate of measles vaccines is 67 percent), there are provinces were less than one in five children are covered. As indicated, this has led to the recent outbreaks of measles and polio.

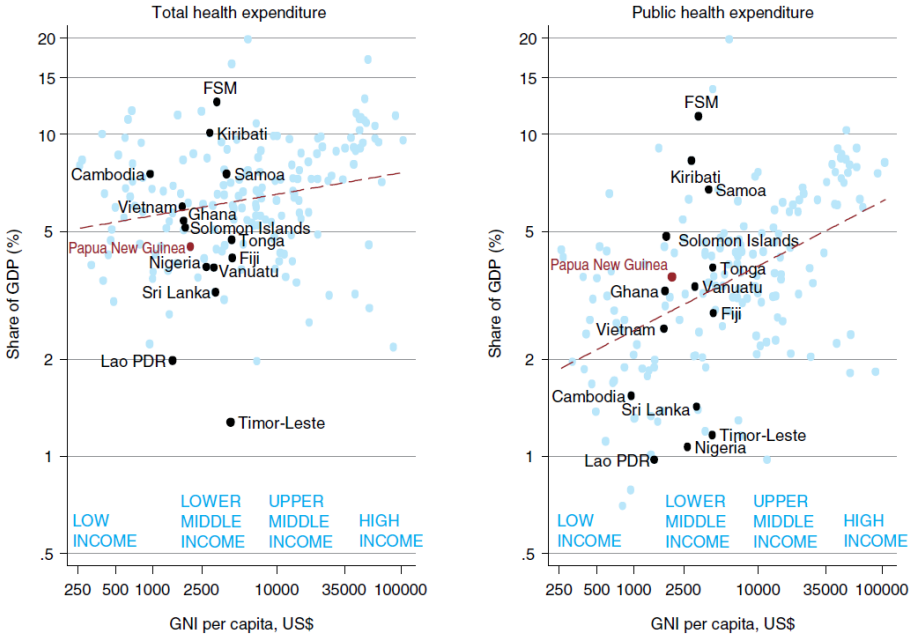
**Figure 2- UHC service coverage index**




Source: 2017 Global Monitoring Report, WHO and World Bank (2017)

**Allocations to the health sector have followed general macro-fiscal trends, partly explained by government's relatively high share of total health spending.** Total Health Expenditure (THE) as a share of GDP has remained quite stable and has varied between 4 percent and 5 percent since 2007. Similarly, public health expenditure as a share of GDP has been steady at approximately 4 percent of GDP (see figure 3 below).

**Figure 3 - THE and Public Health Expenditure (PHE) as % of GDP in East Asia Countries**




Source: Health Financing System Assessment, World Bank (2017)

**In real per capita terms, however, THE is declining, and is low relative to other LMICs.** Given high population growth rates and moderate inflation, real THE per capita has fallen and it is low compared to global standards. In 2014, real THE per capita was US$92, while the average for LMIC countries was US$265 and the average in the EAP region was US$643. Moreover, PNG's THE should be higher than comparator countries given the high cost of delivering health services in PNG. The higher costs of delivering health services is, in large part, explained by PNG's remote location, its complex topography and the high share of the population living in remote and hard to reach areas.

**External financing represents a large share of THE and graduation from this support poses risks to the financial sustainability and delivery of critical health services.** External financing amounts to approximately one fifth of THE. The share of external funding is disproportionately high for specific programs like immunization, HIV/AIDS, TB and malaria. Since PNG achieved lower middle-income status, graduation from the support of important donors like GAVI and the Global Fund has started. It should be noticed, however, that given the poor performance of PNG's health sector and the accelerated increase in the prevalence of priority diseases, development partners are exploring alternative funding mechanisms to extend their support beyond graduation deadlines. Furthermore, most external funding is channeled outside government systems and parallel service delivery mechanisms are being utilized, particularly since an audit of the Global Fund grants raised concerns about the management of these funds. Since then, non-governmental organizations (NGOs) and private sector agencies implement a large share of donor-funded projects, including those financed with grants from Gavi and the Global Fund. Donor graduation – if not adequately planned for – could lead to further increases in the health financing gap and the interruption of vital externally-financed health services such as immunization whose coverage rates are already low.

**Given the limited options to increase fiscal space for health, delivering better value from existing public spending on health will be of utter importance.** PNG's macroeconomic outlook suggests that economic growth is unlikely to drive significant increases in fiscal space in the short term. Furthermore, due to a high share of the central government budget

already going to the health sector, it is unlikely that health will be further prioritized in future budgets. Allocations from provincial internal revenue, in turn, are not systematically monitored and accounted for. While provinces have a clear mandate to fund health service delivery, there is little data on the extent to which they are doing so. Potential fiscal space might be created by adequately leveraging these resources. In terms of health sector specific resources, there is only limited scope to mobilize additional financing without having negative equity implications.

**With limited fiscal space, prioritizing maintenance and recurrent funding for operations will be essential to ensure service delivery and improve the value from public spending on health.** Funding flows that directly finance operations (e.g. Health Function Grants) need to be prioritized and expenditure on maintenance needs to increase to keep pace with the recent investments in infrastructure. This is partly explained by the limited integration of funding sources that cover capital investments (Service Improvement Programs) into the budget processxv. Furthermore, recurrent and capital investments need to be better synchronized to ensure that future infrastructure developments are accompanied by investments in the key inputs required to support the functioning of health facilities (maintenance, medical supplies, human resources, etc.).

**Drivers of poor health outcomes in Papua New Guinea**

**PNG's poor health outcomes reflect a weak health system.** These weaknesses are evident at all levels of care, including limited access to health care in a country with difficult geography, poor transportation links and a high degree of cultural diversity. Several factors within the health system contribute to poor health outcomes, among which it is worth mentioning: (i) insufficient and unpredictable funding reaching frontline service providers; (ii) weak and fragmented accountability in a decentralized environment; (iii) inadequate supervision of service delivery; (iv) low availability of critical inputs for service delivery at the facility level; and (v) limited coverage of outreach services and community-based health service delivery in a context where a large share of the population has limited access to functioning health facilities.

**Insufficient and unpredictable funding reaching frontline service providers**

**Budget execution is weak and funds do not reach their cost centers.** Health Function Grants (HFG) are intergovernmental fiscal transfers from the central level to the provincial government to cover operational costs at rural health facilitiesxvi. Evidence indicates shortfalls in funding at the facility level, revealing important bottlenecks at the provincial and district level. In 2012, 29 percent of health centers and 54 percent of aid posts did not receive any support (in kind or cash) and had to rely solely on out-of-pocket paymentsxvii. In 2017, no funds appropriated under the HFG were disbursed. Moreover, in non-Provincial Health Authority (PHA) provinces, there are additional bottlenecks at the provincial level, as HFG are transferred via provincial treasuries. Anecdotal evidence suggests that only a share of these funds reaches the health sector.

**Furthermore, challenges in revenue collection at the central level hinder the predictability of funding flows to the frontlines.** Warrant release and cash disbursement of the HFG is often delayed. In 2016, for example, less than 50 percent of the HFG was disbursed by September. Delays in disbursements undermine managers' capacity to deliver health services as planned and lead to interruptions in service delivery at the beginning of the year.

*Weak and fragmented accountability in a decentralized environment*

**Visibility on health spending in PNG is limited, as there is no systematic tracking of spending at the subnational level.** For operational spending, in non-PHA provinces it is difficult to ascertain what share of the HFG reaches the sector. Moreover, in both PHA and non-PHA provinces, spending is accounted for using PNG Government Accounting System (PGAS) management information system, but there is very limited monitoring and ex-post assessments of how these funds are used. Auditing systems are weak, and only a small number of provinces submit their financial statements following national audit guidelines. For capital investments, accountability is even weaker. There is limited documentation of how capital investments are planned, and there is no mandatory reporting on how these funds are spent. The Department of Implementation and Rural Development is mandated to monitor the use of Service Improvement Program (SIP) funds which should finance capital investments, but this is not done systematically and there is no official report describing the activities financed with these funds. According to an Auditor General report, there is very limited accountability of those charged with responsibility to administer SIP fundsxviii.

**Fragmentation in financing sources makes it difficult to track financing flows and get a clear picture of the resource envelope available for the sector**. Allocations to the health sector are highly fragmented and there are several institutions responsible for the allocation, use and monitoring of these funds (see Table 2). This fragmentation hinders decision-makers' capacity to coordinate investment decisions, and limits the accountability for the use of these funds.

**Fragmented accountability for health results. Until the initiation of the PHA reforms, accountability for health results has also been fragmented across entities.** The PHA reforms seek to initiate greater accountability for health results by creating a single point of business for health at the province level. PHAs have not been established in all provinces yet, however, and the reforms are being scaled up across the country.

*Table 2 - Allocation, usage and reporting of health financing*

| Spending unit | | Budget component | |
|---|---|---|---|
| | | **Operational** | **Capital investment** |
| **National** | Allocation | DOT | DNPM |
| | Usage | NDOH | NDOH |
| | Reporting to | DOT and DOF | DNPM |
| **Subnational** | Allocation | NEFC | Cabinet |
| | Usage | Provinces, PHAs, districts & facilities | Governors, MPs, DDAs |
| | Reporting to | DOT, DPLGA, DOF | DIRD |

Source: Economic Update, World Bank (2017)

*Note: DOT = Department of Treasury; DOF = Department of Finance; NEFC = National Economic and Fiscal Commission; DPLGA = Department of Provincial and Local Government Affairs; DNPM = Department of National Planning and Monitoring; MPs = Open Members; DDAs = District Development Authorities; DIRD = Department of Implementation and Rural Development.*

**Inadequate supervision of service delivery**

**Inadequate supervision led to weak oversight of health service delivery and limited support available to health facility managers.** Supportive supervision is rare and more than one third of PNG's health centers received no supervisory visits in 2016, yet another reflection of delayed and unpredictable flows of operational fundingxix. Supervision is a key management function that enables decision-makers to design strategies to improve the delivery of health services and respond to emergencies in a timely manner. The lack of supervision, combined with poor communication infrastructure1, reduce the capacity of the sector to provide the necessary support to the frontlines.

*Low availability of critical inputs for service delivery at the facility level*

**Health facilities at the frontlines lack critical inputs and infrastructure needed to deliver basic health services.** Shortage of important inputs is particularly acute in government-run lower level facilities. Church-run facilities have comparatively higher levels of readiness, but the constraints span across all types of facilities and most levels of carexx. A recent World Bank study that assessed service delivery at upper-primary care level and secondary and tertiary care2 found low infrastructure readiness to deliver health services. Most facilities needed major building repairs and lacked adequate toilets (around 60 percent), stable electrical supply (around 40 percent), and consistent water supply (around 50 percent). The report also found that the availability of basic medical equipment was low: only 11 to 12 percent of upper-level PHC facilities were qualified to safely provide Comprehensive Emergency Obstetric Care (CEmOC) and about 40 percent were

[1] While almost 90 percent of the population lives within range of a 2G mobile signal, the actual number of subscribers is still low (less than 50 percent of the population). The penetration of 3G services is much lower, covering only 16 percent of the population.
[2] Upper level primary care refers to level 3 and 4 facilities in the National Health Services Standards.

not equipped to provide Basic Emergency Obstetric Care (BEmOC) even though they provide obstetric services. Finally, drug stock-outs were widespread, even at the national referral hospitals. Stock-outs of paracetamol and other basic supplies reflect challenges in supply-chain management and affect provider's capacity to deliver essential clinical and laboratory services.

**Poorly maintained infrastructure and equipment and stock-outs also reflect delays in operational funding and poor coordination between different sources of financing.** The distribution of medical supplies remains unreliable despite improvements in distribution infrastructure. Medical supplies are procured centrally through NDoH and transported to the provinces. From there, it is the responsibility of provinces to distribute medical supplies to frontline facilities and funds are made available for this through the HFG (Health Function Grant). However, many provinces have been unable to fulfill this responsibility consistently. Unreliable distribution has led to cases of drugs expiring while in storage, awaiting distribution. Operational funding for infrastructure maintenance is provided through the HFG, an amount sufficient to prevent degradation of existing facilities. However, it is likely that provincial governments do not allocate sufficient funding to this activity. Rehabilitation or reconstruction of infrastructure should be funded through PSIP and DSIP, but this does not seem to be taking place.

**There is a severe shortage of human resources; this is compounded by gaps in basic knowledge to deliver RMNCH-N services.** In 2016, 44 percent of all positions were vacant. There are fewer than 500 registered medical officers in PNG and their distribution across the country is unequal: while almost one fifth are based in Port Moresby, there are no medical officers in the entire province of Jiwaka. The low number of health professionals is compounded by the fact that a large share of the work force is ageing. The density of nurses and community-health workers (CHW) per 1,000 population dropped from 0.49 and 0.66 in 2009 to 0.44 and 0.49 in 2016 respectivelyxxi. What is more, facility survey data point to gaps in basic knowledge to deliver RMNCH services, so existing health workers are not performing to potential. Findings from a recent health-facility based survey illustrate this point: the average doctor surveyed was able to correctly answer only 52 percent and 59 percent of questions on tests of basic child and maternal health services respectively. Knowledge scores for Health Extension Officers and nurses were similarly low.

*Limited coverage of outreach services and community-based health service delivery*

**Outreach has been identified as a Minimum Priority Activity (MPA), but there has been a stark decline in the number of outreach activities conducted since 2010xxii.** Rural outreach is key to the delivery of essential health services and has therefore been included as one of the three health-sector MPAs. The number of outreach services has declined from 42 outreach clinics per 1,000 children under-five in 2010 to 29 in 2016. Furthermore, there are significant discrepancies between provinces in the number of outreach activities conducted: while Simbu held 106 outreach clinics per 1,000 children under-five, Gulf only conducted 8xxiii. Survey data indicated that the lack of funding to purchase fuel was the main reason why outreach activities were not conducted as plannedxxiv.

**The Healthy Islands Concept (HIC) is not fully implemented in PNG.** The Healthy Island Concept (HIC) was first adopted by all Pacific Islands health ministers in 1997. The HIC has several components, including health, WASH and gender. The health component consists of a series of interventions (predominantly health promotion) that seek to empower individuals to take an active role in developing their communities. It highlights the value of social capital (how community bonds can impact individual's health status), and promotes the organization of committees at the community level to strengthen bottom-up decision-making mechanisms. The implementation of the HIC in PNG has been quite limited. While

no formal evaluation of the coverage and effectiveness of the HIC model has been conducted, health committees have not been established in every districtxxv and only a limited number of health facilities (28 percent of level 3-4 government run facilities) had community advisory committeesxxvi. In addition, health service delivery at the community level is mostly done by Community Health Workers through outreach patrols. While non-state organizations support small-scale community-based models, these programs rely on Village Health Volunteers and Village Birth Attendants as there is no functional nationwide cadre of Village Health Workers in place. As a result, the reach of health services at the community level is limited.

**Government strategies in the health sector**

**PNG's Government is committed to reversing the trajectory.** Health has been identified as a development priority and PNG is committed to advancing Universal Health Coverage (UHC). The Alotau Accord II and the Medium-Term Development Plan define PNG's development strategy and include the health sector as a priority for the Government of PNG. As an early adopter of the Human Capital Project, the Government of PNG has shown high-level support to the human development agenda, and education and health rank high in the country's development priorities. Moreover, strong alignment between the political leadership and the leadership at the relevant line ministries presents an outstanding opportunity to implement human capital enhancing programs and interventions.

**The National Health Plan (NHP) highlights the importance of investing in Primary Health Care (PHC) and establishes the vision for the health sector.** The NHP 2011-2020 sets the goal of strengthening primary health care for all ("Going back to basics") and improving service delivery for the rural majority and the urban disadvantaged. The NHP includes eight Key Result Areas (KRA) to monitor progress towards this goal. These are: (i) improving service delivery; (ii) strengthening partnerships and coordination with stakeholders; (iii) strengthening health systems; (iv) improving child survival; (v) improving maternal health; (vi) reducing the burden of communicable diseases; (vii) promoting health lifestyles; and (viii) improving PNG's preparedness for diseases outbreaks and emergency population health issues. An instrumental policy to the achievement of these KRAs is PNG's Free Primary Health Care and Subsidized Specialized Care policy. The implementation of the policy, however, has been limited and only a small sum was released to compensate facilities for the foregone revenue.

**The Provincial Health Authority (PHA) reform defines PNG's approach to the decentralization of health services and aims at consolidating hospital and PHC functions at the subnational level. PHAs were established by the PHA Act of 2007 and piloted in three provinces (Milne Bay, Eastern Highlands and Western Highlands).** An independent assessment of these provinces suggested that the reform improved their performance and strengthened the integration of hospital and PHC services. Implementation of the reforms has been voluntary, but strong leadership from the current administration has promoted the implementation of the PHA model and significantly increased the number of provinces adopting it.

**Development Partner Support**

**Development partner support to the health sector in PNG is largely delivered outside of country systems and significantly contributes to the financing of the sector, as well as service delivery (See Figure 4).** In terms of financing, Australia's Department for Foreign Affairs and Trade (DFAT) is the largest development partner. Their portfolio in the health sector amounts to circa US$64 million (AU$ 90 million) annually, and covers a wide set of priorities, including health

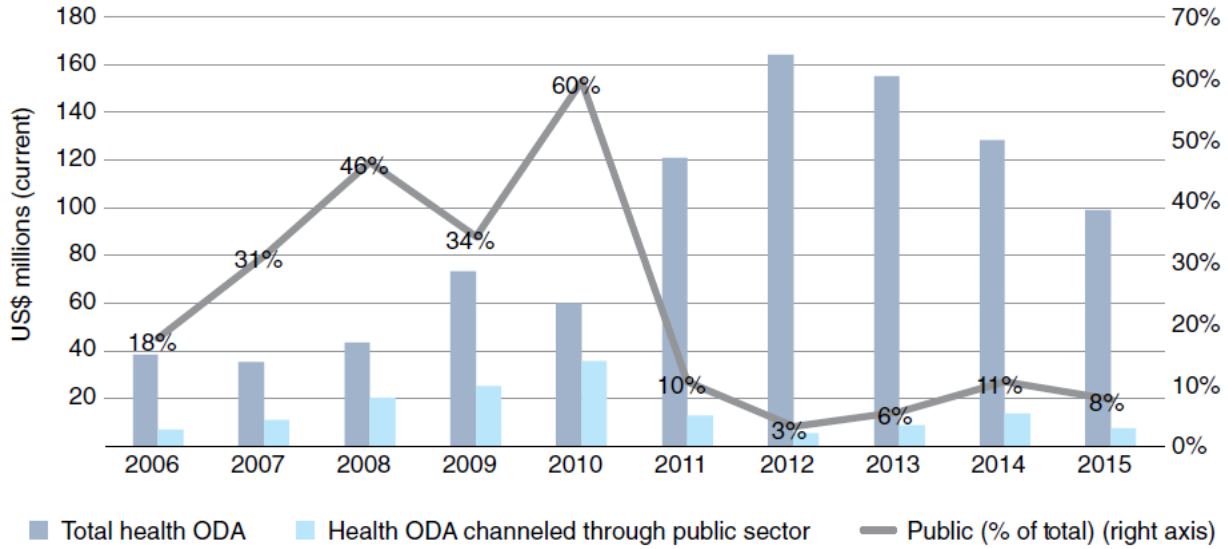
system strengthening, health security, maternal and child health and subnational service delivery. In 2018, the Asian Development Bank (ADB) approved a policy-based loan and renewed their investment project for a second phase. ADB's investments focuses primarily on the development of rural health infrastructure and the roll-out of the electronic health management information system (eNHIS) in selected provinces. In facilities supported by the project, the ADB will provide in-service training on RMNCH and support facility managers. In addition, the project will provide management training for health sector staff country-wide and strengthen the procurement and distribution of drugs. The policy-based loan includes triggers related to reforms in the procurement of medical supplies, to the institutionalization of a tender management module in msupply, to the implementation of financial management tools, and to the strengthening of the budgeting process. Since 2006, Gavi has invested over US$33 million in immunization, including technical assistance, cold-chain equipment and service deliveryxxvii. Since 2004, Global Fund has invested US$272 million and disbursed US$ 232 million in Papua New Guinea. For the 2018-2020 funding cycle, the Fund provides support to malaria activities through Rotarians Against Malaria and to HIV/AIDS and TB through World Vision. International and national NGOs play an important role in the delivery of health services. They include, among others, Save the Children, World Vision, Marie Stopes International and Susu Mamas. Finally, Church Health Services (CHS), an umbrella organization that includes several faith-based organization, is critical in the delivery of health services. They provide approximately 50 percent of all health services and cover a high share of the services delivered to communities in remote and hard to reach areas.

*Transition of key donors and need for long-term engagement in Health in PNG*

**PNG faces the prospect of declining assistance from critical partners such as Global Fund and Gavi.** As mentioned previously, as PNG has achieved middle income country status, important donors like Gavi and the Global Fund have begun to decrease their support. Global Fund grants to PNG have decreased by nearly 50 percent in the current funding cycle. Gavi is expected to complete its transition from PNG by 2021. This is expected to have a disproportionate adverse impact on the vital services supported by Global Fund and Gavi funding unless the transition is well-managed. In this context, both Global Fund and Gavi have signaled interest in co-financing IMPACT Health with a view to strengthen country systems to maintain and improve service delivery and health outcomes.

**Recognizing the challenges ahead, including those posed by the donor transition, Government of PNG requested a longer term programmatic engagement from the World Bank Group in Health Nutrition and Population.** The letter of request for an IDA-18 Health Nutrition and Population operation specifically requested a multi-year programmatic engagement in the health sector. While the concept note is prepared as a single operation, it should be viewed as part of a longer-term sectoral engagement. Subsequent operations would seek to incorporate learnings from the proposed six-year Project, and adapt and scale up this engagement to additional provinces.

*Figure 4 - Official Development Assistance (ODA) for Health by Channel (US$ millions)*




Source: Creditor Reporting System (CRS), Organization for Economic Co-operation and Development (OECD) 2017

*Note: OECD-CRS include Gavi resources in multilateral arrangements, not to the public sector. Gavi procures supplies via UNICEF Supply Division. ODA channeled through public sector includes both donor and recipient governments.*

Relationship to CPF

**The operation will contribute to the second pillar of the CPS for 2013-2016xxviii focused on improvements in the quality of life and the livelihoods of women and girls as well as men and boys.** The operation will contribute to improvements in the delivery of frontline health services, notably Reproductive Maternal Neonatal and Child Health and Nutrition and TB-related services. In doing so, the operation will directly contribute to improvements in the quality of life for women and girls as well as men and boys. Improving early childhood nutrition has implications not only for survival but also for cognitive development and, ultimately, for individual life changes.

**The new Country Partnership Framework is under preparation**. As it is currently proposed, the operation contributes to the following: (i) Governance cross-cutting area through interventions focused on improving use of public funding for health and to improve accountability for health results; (ii) Gender cross-cutting area- by improving access to quality reproductive, maternal and child health services; and (iii) Improvements in frontline health service delivery (focus area 2).

## C. Proposed Development Objective(s)

To contribute to the improvement of access to and use of quality essential health services in selected provinces

Key Results (From PCN)

**The performance of the project will be measured by a set of indicators contained in the Results Framework.** Key Project Development Objective (PDO) results will be disaggregated by gender where relevant. Indicators tracking achievement of the PDO are likely to include:

i. Number of primary health care facilities in Project-supported provinces that meet quality standards for ANC, institutional deliveries, Family Planning, Immunizations, TB detection and treatment and Vitamin A supplementation [Criteria for quality to be specified in terms of basic infrastructure, working equipment, supplies, trained staff]
ii. Number of outreach patrols carried out each year in Project-supported provinces
iii. Number of ANC visits in Project-supported provinces **
iv. Number of children immunized in Project-supported provinces **
v. Innovations for community-based service delivery piloted and scaled up in Project-supported provinces

In PNG, primary health care services refer to level 1, 2, 3 and 4 facilities. Box 1 below presents the National Health Service Standards organization of health facilities by levels.

**Proposed proxies for service availability. The alternative would be to use facility-based survey measures.

Box 1: National Health Service Standards: Health facilities in PNG

| | NHSS level | Type of facility | Approximate catchment population | Staffing estimates (minimum) | Description of services |
|---|---|---|---|---|---|
| Tertiary or specialist care | Level 7 | National Referral Hospital (PMGH) | National (7-8 million) | Multiple medical, surgical, nursing and allied health specialties. | National tertiary referral role<br>• Inpatient and outpatient care, including medical, maternal and child health, and major surgical services, public health<br>• Sub-speciality services<br>• Clinical support services |
| | Level 6 | Regional Referral Hospitals | 1 per region (2-3 million) | Multiple medical, surgical, nursing and allied health specialties. | Regional tertiary referral role<br>• Inpatient and outpatient care, including medical, maternal and child health, and intermediate/major surgical services, public health<br>• Some sub-speciality services<br>• Clinical support services |
| | Level 5 | Provincial Hospitals | 1 per province (60,000-700,000) (2.7 beds/1,000 population) | Dependent on size of province. Some specialist health workers. | Provincial secondary referral role<br>• Inpatient and outpatient care, including medical, maternal and child health, and intermediate surgical services, public health<br>• Some sub-speciality services<br>• Clinical support services |
| | Level 4 | District Hospitals | 1 per district (30,000-100,000) | 1 Rural Medical Specialist<br>1+ doctors<br>1-2 nurses<br>2 CHWs | District primary/secondary referral role<br>• Inpatient and outpatient care, including medical, maternal and child health, and minor/intermediate surgical services, public health<br>• Public health, primary health care and clinical support services<br>• Outreach & supervisory programs to Level 3, 2 and 1 |
| Primary health care | Level 3 | Health Centres (Rural)<br>Urban Clinics | Local Level Government (LLG) jurisdiction (5,000-40,000) | 1-2 HEOs<br>1-2 nurses<br>2 CHWs<br>(same approximate staffing for both) | LLG primary referral role<br>• Outpatient and inpatient care, including core clinical services - medical, maternal and child health, and minor surgical services<br>• Public health, primary health care and clinical support services<br>• Outreach & supervisory programs to Level 2 and 1<br>(for Urban Clinics, as above minus inpatient care services) |
| | Level 2 | Community Health Posts | Multiple wards or small urban centre<br>Grade 1: >10,000<br>Grade 2: 5-10,000<br>Grade 3: <5,000 | 1 Nurse<br>2 CHWs | Community primary referral role<br>• Inpatient short stay care up to 24 hours<br>• Outreach & mobile services<br>• Outpatient care, including reproductive and child health, TB DOTS, HIV and malaria prevention, nutrition, school and dental health |
| | Level 1 | Aid Posts | Ward or multiple small villages (1,000-2,000) | 1-2 CHWs | Basic health care and referral (outpatient services)<br>• Public health education<br>• Basic primary health care<br>• Community-based programs and community support |

## D. Concept Description

**IMPACT Health will be financed as an Investment Project Financing (IPF) credit in the equivalent amount of USD 30 million and implemented over six years from 2020 to 2026.** It seeks to improve the utilization and quality of essential health services delivered by primary care facilities by addressing the following key bottlenecks: (i) Improving readiness to deliver services at primary care facilities and through outreach; (ii) Strengthening the PFM and service delivery management capacity of PHAs and the NDOH to strengthen primary care service delivery; (iii) Piloting and scaling up innovations for community-based service delivery; and (iv) Strengthening a focus on results at the PHA and NDOH levels. A package of input-based support (Technical Assistance, training and procurement) and performance-linked incentives using Disbursement Linked Indicators (DLIs) is envisaged. The proposed geographic coverage of IMPACT Health is two provinces. Subject to the achievement of performance triggers (to be specified) at the Mid Term Review, and the availability of additional grant co-financing, the geographic scope could be expanded to two more provinces, bringing the total number of provinces up to four.

**The Project will seek to improve access to and utilization of quality essential health services.** This includes reproductive maternal neonatal and child health services targeted at women and young children, who are among the most vulnerable members of a community. In order to improve the reach of health services at the community level, reduce cultural barriers to use/ generate demand for health services and support health promotion activities, innovative community-based service delivery approaches will be piloted and scaled up. This may include intensified stakeholder engagement.

## SAFEGUARDS

### A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

Project Location is Papua New Guinea (some selected provinces to be confirmed). There is limited physical access to health care in Papua New Guinea (PNG), with difficult geography and poor transportation links. Several factors within the health system contribute to poor health outcomes, among which it is worth mentioning: (i) insufficient and unpredictable funding reaching frontline service providers; (ii) weak and fragmented accountability in a decentralized environment; (iii) inadequate supervision; (iv) low availability of critical inputs for service delivery at the facility level; and (v) limited coverage of outreach services in a context where a large share of the population has limited access to functioning health facilities.

Health facilities at the frontlines lack critical inputs and infrastructure needed to deliver basic health services. Shortage of important inputs is particularly acute in government-run lower level facilities.

### B. Borrower's Institutional Capacity for Safeguard Policies

There is a severe shortage of human resources; this is compounded by gaps in basic knowledge to deliver RMNCH-N services. In 2016, 44 percent of all positions were vacant.
There is a severe shortage of resource capacity to apply safeguards policies.

### C. Environmental and Social Safeguards Specialists on the Team

Nicholas John Valentine, Environmental Specialist
Joyce Onguglo, Social Specialist

### D. Policies that might apply

| Safeguard Policies | Triggered? | Explanation (Optional) |
|---|---|---|
| Environmental Assessment OP/BP 4.01 | Yes | The project design as currently conceived poses a low environmental and social risk, in this instance it is considered a category B project.<br>It is understood that civil works at health facilities will be minor and thus will have limited potential to cause environmental harm. The civil works planned are repairs and refurbishment. The number of facilities and types of repairs/ refurbishment will depend on the provinces selected and health facilities identified to be refurbished. No new construction is expected to be undertaken as the civil works will look at existing buildings.<br><br>Matters for consideration include inventory control of chemicals and medicines, medical and general waste |

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|---|---|---|
| | | management and health and safety awareness/training for frontline staff. As the location and details of sub-project investments will not be known until implementation, as the provinces are yet to be identified, an Environmental and Social Management Framework (ESMF) will be prepared for disclosure prior to appraisal.<br>At this early stage, it can be determined that there will be no new construction and no new land acquisition. The health centers to be refurbished/repaired are yet to be determined under the project and in this regards, typical health centers, will focus on level 1-4 facilities, i.e., primary care facilities only. The services provided by level 1-4 facilities are quite basic. Therefore, while managing medical waste will be assessed during preparation, the amount of medical waste generated by a typical facility is expected to be relatively small for safeguards. |
| Performance Standards for Private Sector Activities OP/BP 4.03 | No | The project does not finance private sector-led economic development activities. |
| Natural Habitats OP/BP 4.04 | No | Not relevant to the project |
| Forests OP/BP 4.36 | No | Not relevant to the project |
| Pest Management OP 4.09 | No | The project does not involve the use of pesticides |
| Physical Cultural Resources OP/BP 4.11 | No | The project will undertake minor civil works at the existing health facilities and will not require construction on land with known physical cultural resources (PCR). This is therefore, not relevant to the project. |
| Indigenous Peoples OP/BP 4.10 | Yes | In Papua New Guinea, the people are largely considered indigenous. Since the vast majority of potentially affected population is indigenous, no separate instrument will be required, but relevant elements of the policy are integrated into project design, including the facilitation of community engagement, ongoing community consultation and awareness program.<br>A social assessment and free, prior and informed consultation process will be undertaken during project preparation to inform project design and the ESMF. |
| Involuntary Resettlement OP/BP 4.12 | No | PNG is known to have complex land issues. Under the project design, however, it is understood that minor civil works will be undertaken on existing health facilities, which will not require land, therefore no involuntary resettlement will take place in this project. |

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| | | However, through regular community engagement and consultation, clear communication related to project design will be provided to affected communities (in the selected provinces). The project will ensure that appropriate community consultations takes place. |
| Safety of Dams OP/BP 4.37 | No | The project does not include dam construction |
| Projects on International Waterways OP/BP 7.50 | No | The project is not situated on international waterways |
| Projects in Disputed Areas OP/BP 7.60 | TBD | Depending on the selection of the provinces, this will be triggered in accordance. |

### E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Mar 25, 2019

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

Safeguard-related studies to be launched by February 2019 and completed by July/ August 2019.

## CONTACT POINT

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## APPROVAL

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| Task Team Leader(s): | Aneesa Arur |

**Approved By**

| | | |
|---|---|---|
| Practice Manager/Manager: | Enis Baris | 04-Oct-2018 |
| Country Director: | Mona Sur | 07-Oct-2018 |

[i] World Bank, World Development Indicators
[ii] In 2016, PNG ranked 105 out of 160 in the World Bank's Logistics Performance Index for infrastructure. With less than 0.5 km of roads per square kilometer of land, PNG has one of the lowest levels of road density in the region.
[iii] World Bank, 2017. Papua New Guinea Systematic Country Diagnosis.
[iv] Ibid.
[v] Ibid.
[vi] Ibid
[vii] CPIA index
[viii] World Bank, 2017. Papua New Guinea Systematic Country Diagnosis (DRAFT).
[ix] World Bank, World Development Indicators
[x] World Bank, World Development Indicators
[xi] Institute of Health Metrics and Evaluation
[xii] World Health Organization (WHO), 2015. Global TB Report 2015
[xiii] http://www.wpro.who.int/papuanewguinea/mediacentre/releases/20180725/en/
[xiv] National Department of Health, 2016. Sector Performance Assessment Review.
[xv] World Bank, 2017. Economic Update: Reinforcing Resilience.
[xvi] The Health Function Grant covers the 3 health Minimum Priority Areas.

[xvii] Howes, Mako, Swan, Walton, Webster and Wiltshire, 2014. "A Lost Decade? Service delivery and reforms in Papua New Guinea 2002-2012". The National Research Institute and the Development Policy Center, Canberra.
[xviii] Government of PNG, 2014. Auditor General.
[xix] National Department of Health, 2016. Sector Performance Assessment Review.
[xx] According to the Service Delivery by Health Facilities in PNG report (World Bank, 2018), the readiness index for level 3 and 4 public sector facilities was 40.3, 48.6 for level 3 and 4 church-run facilities, 84.6 for level 5 and 6 facilities, and 100 percent for the level 7 facility. The index aggregates several readiness dimensions and shows the percentage of readiness indicators that were met on average within each level of care and type of facility.
[xxi] National Department of Health, 2016. Annual Management Report.
[xxii] National Department of Health, 2016. Sector Performance Assessment Review.
[xxiii] National Department of Health, 2016. Sector Performance Assessment Review.
[xxiv] World Bank, 2017. Service Delivery by Health Facilities in PNG.
[xxv] Rural Primary Health Services Delivery Project, 2014. Formative evaluation. Baseline Evaluation Report.
[xxvi] World Bank, 2017. Service Delivery by Health Facilities in PNG.
[xxvii] World Bank, 2017. Health Financing System Assessment.
[xxviii] CPS 2013-2016, extended to 2018. Report 71440-PG.