Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 10-Oct-2019 | Report No: PIDISDSA25847
## BASIC INFORMATION

### A. Basic Project Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Project Name</th>
<th>Parent Project ID (if any)</th>
</tr>
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<tbody>
<tr>
<td>Papua New Guinea</td>
<td>P167184</td>
<td>Improving Access to and Value from Health Services in PNG: Financing the Frontlines</td>
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<thead>
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<th>Estimated Board Date</th>
<th>Practice Area (Lead)</th>
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<table>
<thead>
<tr>
<th>Financing Instrument</th>
<th>Borrower(s)</th>
<th>Implementing Agency</th>
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<tr>
<td>Investment Project Financing</td>
<td>Independent State of Papua New Guinea</td>
<td>National Department of Health</td>
</tr>
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### Proposed Development Objective(s)

The development objective is to contribute to increasing the utilization of quality essential health services in Project-supported provinces of the Recipient.

### Components

- Component 1: Increase service delivery readiness and community-based service delivery
- Component 2: Improve frontline service delivery performance
- Component 3: Project management
- Component 4: Contingent emergency response

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

<table>
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<th>Total Project Cost</th>
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<tr>
<td>Total Financing</td>
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<tr>
<td>of which IBRD/IDA</td>
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<tr>
<td>Financing Gap</td>
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### DETAILS

World Bank Group Financing
B. Introduction and Context

Country Context

1. The Independent State of Papua New Guinea (PNG) is a lower-middle income country (LMIC) with a population of over 8 million\(^1\). 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 infrastructure\(^2\), a large share of the population resides in remote and hard-to-reach areas.

2. 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 Gross Domestic Product (GDP) per capita (US$2,688) and more than 80 percent of the country’s exports\(^3\). 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 agriculture\(^4\).

3. 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 Capital Index and the Human Development Index 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 US$1.90 per day (2011 US$ Purchasing Power Parity) in 2009\(^5\). PNG’s ethnographic diversity represents a salient challenge for social cohesion and tribal conflict is an important driver of PNG’s social fragility\(^6\). 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 impacts\(^8\).

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\(^1\) World Bank, World Development Indicators
\(^2\) 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.
\(^4\) Ibid.
\(^5\) Ibid.
\(^6\) Ibid.
\(^7\) CPIA index
Sectoral and Institutional Context

4. **PNG has a significant unfinished agenda on building human capital.** PNG, an early adopter of the Human Capital Project, has a Human Capital Index score of 0.38. This means that a child born in PNG will be 38 percent as productive when she grows up as she could be if she enjoyed complete education and full health. PNG’s Human Capital score is below the East Asia and Pacific (EAP) region average (0.62) and is comparable to Sub-Saharan Africa (0.40).

5. **Gains in key health outcomes have been slower than expected.** PNG did not achieve any of the health-related global Millennium Development Goals. Improvements in key health outcomes in PNG have also been slower than in comparator countries. The maternal mortality ratio (MMR) declined from 258 per 100,000 live births in 2008 to 215 per 100,000 live births in 2015. It is significantly higher than the average for the EAP region (59 per 100,000 live births) and the Pacific Islands small states (75 per 100,000 live births). In fact, maternal mortality in PNG is the highest in the Western Pacific region. 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 2016. 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 this document (see paragraph 15).

6. **Stunting is a serious economic and public health problem in PNG and an obstacle to realizing the full human potential of PNG’s children.** The magnitude of the undernutrition problem is immense: nearly half of all children under five years are stunted, the fourth highest rate in world. The burden of stunting is highest amongst the poorest quintile (55 percent). However, stunting rates amongst the richest quintile are also high (36 percent) indicating that it is a problem across the wealth spectrum. Stunting imposes heavy economic costs on PNG, estimated at 2.8 percent of GDP and significantly exceeding PNG’s budgeted expenditures for both health and education sectors in 2017. Undernutrition also has a well-documented impact on child mortality and cognitive development. Estimates suggest it contributes to as much as 76 percent of under-five deaths in PNG. Research also suggests that undernutrition, specifically undernutrition in the womb, increases the likelihood of cardiovascular disease and diabetes.

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9 World Bank, World Development Indicators  
10 World Bank, World Development Indicators
7. **All causes combined, PNG’s burden of disease is much higher than in comparator countries.** PNG’s population is less healthy than would be expected for a country at its income level. The burden of disease in PNG per capita is the highest in the Pacific region and much higher than the average for LMICs. Furthermore, given the steady increase in the prevalence of non-communicable diseases (NCDs), PNG faces a double burden of disease. In 2017, NCDs represented 54.3 percent of the country’s total DALYs. Communicable, maternal, neonatal, and nutritional diseases, in turn, represented 32.6 percent and injuries accounted for the remaining 13.1 percent of the DALYs.\(^{11}\)

<table>
<thead>
<tr>
<th>Total (per 100,000 population)</th>
<th>NCDs (%)</th>
<th>Group 1 (%)</th>
<th>Injuries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNG</td>
<td>52,604</td>
<td>54</td>
<td>33</td>
</tr>
<tr>
<td>Pacific Islands</td>
<td>48,605</td>
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<td>31</td>
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<tr>
<td>EAP</td>
<td>27,220</td>
<td>78</td>
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</tr>
<tr>
<td>LMICs</td>
<td>35,552</td>
<td>54</td>
<td>37</td>
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</tbody>
</table>

Source: Institute of Health Metrics and Evaluation

8. **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 World Health Organization (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)\(^{12}\). The prevalence of HIV/AIDS in PNG is the highest in the Pacific region, with 2,800 new HIV infections in 2016. While the coverage of treatment has increased over the last decade, the

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\(^{11}\) Institute of Health Metrics and Evaluation  
country faces important challenges in retaining people on life-long treatment\textsuperscript{13}. The number of reported cases of malaria, in turn, experienced almost a nine-fold increase between 2014 and 2017: from 50,309 in 2014 to 432,000 in 2017\textsuperscript{14}. In 2018, PNG has had outbreaks of vaccine preventable diseases such as measles, and more recently, a polio outbreak\textsuperscript{15}.

9. **Measures of health care access and quality indicate that PNG lags considerably behind comparator countries.** The Healthcare Access and Quality index\textsuperscript{16} offers insights into personal health care access and quality for a range of health service areas. In 2016 PNG ranked 172\textsuperscript{nd} out of 195 countries in its performance on this index. PNG’s overall score on this index is 31.8 (out of 100), which is considerably below the average for East Asia and the Pacific (62.9), the second lowest in the Pacific, and performs comparably to the average for Sub Saharan Africa (31.9). Furthermore, the pace of improvement in the Healthcare Access and Quality index has slowed over time in PNG from 2.19 points per year between 1990 and 2000 to 0.70 per year between 2000-2016. The latter is considerably lower than the average pace of improvement in East Asia and the Pacific (2.11 per year) and Sub Saharan Africa (2.24 per year).

10. **Coverage of essential health services is low, and coverage/ utilization of many vital services is stagnant or declining.** Data on coverage reinforce this picture. PNG’s coverage of essential health services is low for its level of income (see Figure 2). Between 2013 and 2017, utilization of outpatient services in PNG has oscillated between 1.25 and 1.07 outpatient visits to a health facility per person per year\textsuperscript{17}. Under 50 percent of women are covered by modern methods of family planning, only 52 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 34 percent of children under 1 were immunized against measles and 41 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 66 percent), there are provinces where less than one in ten children are covered. This has led to the recent outbreaks of measles and polio.

\textsuperscript{13} https://www.unaids.org/en/regionscountries/countries/papuanewguinea
\textsuperscript{14} PNG Institute of Medical Research, 2018.
\textsuperscript{15} http://www.wpro.who.int/papuanewguinea/mediacentre/releases/20180725/en/
\textsuperscript{17} National Department of Health, 2016. Sector Performance Assessment Review.
11. The low coverage of quality Reproductive, Maternal, Neonatal and Child Health and Nutrition (RMNCH-N) services is a key driver of the high rate of preventable deaths for women, and rural women in particular. Low coverage of essential health services is an underlying cause of preventable deaths and the limited availability of services for pregnant women leads to a disproportionally higher share of preventable deaths among women, compared to men, and rural women compared to urban women. Poor access to pregnancy- and birth-related health services is exacerbated for rural women. According to the preliminary results of the Demographic and Health Survey (DHS) 2016-2018, only 47.2 percent of rural women who had a live birth in the 5 years preceding the survey received at least four ANC visits, while the coverage among women in urban areas was much higher (62.9 percent). Similar trends are observed for institutional delivery (51.1 percent among rural women and 85.4 among women in urban areas) and postnatal checkups during the first 2 days after birth (42.1 percent for women in rural areas and 72.2 percent among women in urban areas). The recognition of the critical importance of improving care for pregnant women and reducing maternal mortality led to the formation of a Maternal Health Task Force in 2018. The position paper developed by the Task Force highlights the need to increase the availability and quality of Primary Health Care (PHC) services for pregnant women (particularly family planning and ANC) to close the gender gap in health endowments in PNG. Further, the position paper indicates that community-based approaches – including networks of Village Health Volunteers - need to be strengthened to ensure the uptake of RMNCH-N services.

12. 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 2 percent and 4 percent since 2007. Similarly, public health expenditure as a share of GDP has been steady at approximately 2 percent of GDP (see Figure 3). Both THE and public health expenditure have been mostly driven by current spending.
13. **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, the high share of the population living in remote and hard-to-reach areas and security-related costs.

14. **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, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), TB and malaria. Since PNG achieved LMIC status, graduation from the support of important donors like GAVI and the Global Fund has started. 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.

15. **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 National 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.

16. 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 need to be prioritized and expenditure on maintenance needs to increase to keep pace with the recent investments in infrastructure financed by the Government as well as Development Partners (DPs). The limited integration of funding sources that cover capital investments [Province and District Service Improvement Programs (SIP)] into the budget process is an important contributor to the limited value for money delivered by public spending on health. 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.). Over the next 4 to 5 years, the forecast for the health sector budget is for personnel emoluments to increase by 20 percent while goods and services are expected to decrease by 15 percent. This underscores the need to prioritize maintenance and recurrent funding for operations.

Drivers of poor health and nutrition outcomes in PNG

17. 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.

18. A weak health system also translates into gaps in the delivery of direct nutrition interventions contributing to stunting. The causes of child undernutrition are multiple and span many sectors. Direct nutrition interventions address the immediate causes of undernutrition, i.e., by improving nutrient intake and reducing burden of illness, and are delivered through health and nutrition programs. Global evidence suggests that scaling up coverage of a package of ten proven cost-effective direct nutrition interventions to 90 percent could achieve a mean 20.3 percent reduction in stunting and a 61.4 percent reduction in severe wasting. This could make a substantial dent in undernutrition, particularly in countries such as PNG which are far from the 90 percent coverage rate for this proven and cost-effective package of interventions.

Insufficient and unpredictable funding reaching frontline service providers

19. Budget execution is weak, and funds do not reach their cost centers. The Health Function Grant (HFG) is an intergovernmental fiscal transfer from the central level to provincial governments to cover operational costs at rural health facilities. 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

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20 Government of PNG Budget 2019
21 Bhutta, Z. A. et al. 2013
22 The Health Function Grant covers the 3 health Minimum Priority Areas.
support (in kind or cash) and had to rely solely on out-of-pocket payments. In 2017, no funds appropriated under the HFG were disbursed. Moreover, in non-PHA provinces, there are additional bottlenecks at the provincial level, as the HFG is transferred to the PHA via provincial treasuries. Anecdotal evidence suggests that only a share of these funds reaches the health sector.

**20. Furthermore, challenges in revenue collection at the central level hinder the predictability of funding flows to the frontlines.** Warrant releases and cash disbursements of the HFG are often delayed. In 2016, for example, less than 50 percent of the HFG was disbursed by September, i.e., three months before the end of the fiscal year in PNG. 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**

**21. Complex institutional arrangements in the health sector challenge the implementation of policies and programs to accelerate improvements in health outcomes.** Since PNG’s independence in 1975, the health sector has been progressively decentralized. The creation of new bodies at the subnational level, such the PHAs and the District Development Authorities, was not accompanied by a comprehensive harmonization of the legal framework to transfer responsibilities from the previous institutions holding these responsibilities. This has created a complicated institutional setting. According to the several laws and regulations governing the health sector, provincial, district and Local Level Government authorities have a role in the delivery of health services. As a consequence of that, these stakeholders receive funding from the national and provincial government to perform these functions. In addition to coordination between the national and subnational levels, managing health services at the subnational level therefore requires coordination between several stakeholders, including the Provincial Administration, the PHA, District Development Authorities and Members of Parliament.

**22. 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 the old PNG Government Accounting System (PGAS) management information system, but there is very limited monitoring and ex-post assessments of how these funds are used. Whereas the National Department of Health (NDOH) has moved onto the Integrated Finance Management System (IFMS). 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 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 limited accountability of those charged with responsibility to administer the SIP funds.

**23. 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.

**24. Fragmented accountability for health results.** Until the initiation of the PHA reforms, accountability for health

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24 A legislative review and harmonization is now underway.

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

<table>
<thead>
<tr>
<th>Spending unit</th>
<th>Budget component</th>
<th>Operational</th>
<th>Capital investment</th>
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<tr>
<td></td>
<td>Usage</td>
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<td></td>
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<td>Allocation</td>
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<td>Usage</td>
<td>Provinces, PHAs, districts &amp; facilities</td>
<td>Governors, MPs, DDAs</td>
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<tr>
<td></td>
<td>Reporting to</td>
<td>DOT, DPLGA, DOF</td>
<td>DIRD</td>
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*Note: DOT = Department of Treasury; DOF = Department of Finance; NDOH = National Department of Health; 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**

25. **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 funding. Supervision is a key management function that enables decision-makers to design strategies to improve the delivery of health services and to respond to emergencies in a timely manner. The lack of supervision, combined with poor communication infrastructure, reduce the capacity of the sector to provide the necessary support to the frontlines. Further, this issue was identified by the Maternal Health Task Force as a key driver of high maternal mortality rates.

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

26. **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 care. A recent World Bank study that assessed service delivery at upper-primary care level and secondary and tertiary care.

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27 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.

28 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.

29 Upper level primary care refers to level 3 and 4 facilities in the National Health Services Standards for Papua New Guinea 2011-2020, issued by GoPNG on June 2011.
found low infrastructure readiness to deliver health services. Most facilities needed major building repairs and lacked adequate toilets (around 60 percent), stable electricity 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 and about 40 percent were not equipped to provide Basic Emergency Obstetric Care even though they provided 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.

27. 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. 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 that should be sufficient to prevent degradation of existing facilities assuming provincial governments contribute their required co-financing. However, it is likely that provincial governments do not allocate enough co-financing to this activity. Rehabilitation or reconstruction of infrastructure should be funded through Province and District SIP funds, but this does not seem to be taking place.

28. 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 uneven: 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 workforce is ageing. The density of nurses and community-health workers per 1,000 population dropped from 0.49 and 0.66 in 2009 to 0.44 and 0.49 in 2016 respectively. Moreover, facility survey data points to gaps in basic knowledge to deliver RMNCH-N 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**

29. Outreach has been identified as a Minimum Priority Area, but there has been a stark decline in the number of outreach activities conducted since 2010. Rural outreach is key to the delivery of essential health services, such as ANC, and has therefore been included as one of the three health-sector Minimum Priority Areas. The number of outreach services has declined from 42 outreach clinics per 1,000 children under five in 2010 to 29 in 2017. Furthermore, there are large differences between provinces in the number of outreach activities conducted: while Simbu held 109 outreach clinics per 1,000 children under-five, East Sepik only conducted 6. Survey data indicated that the lack of funding to purchase fuel was the main reason why outreach activities were not conducted as planned.

30. The Healthy Islands Concept (HIC) is not fully implemented in PNG and the reach of health services at the community level is limited. The Healthy Island Concept was first adopted by all Pacific Islands health ministers in 1997.

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33 World Bank, 2017. Service Delivery by Health Facilities in PNG.
The HIC has several components, including health, Water, Sanitation and Hygiene (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 individuals’ health status) and promotes the organization of committees at the community level to strengthen bottom-up decision-making and accountability 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 district34 and only a limited number of health facilities (28 percent of level 3-4 government run facilities) had community advisory committees35. In addition, health service delivery at the community level is mostly done by Community Health Workers, a health worker cadre, through outreach patrols. NGOs support small-scale community-based models. 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.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The PDO is to contribute to increasing the utilization of quality essential health services in Project-supported provinces of the recipient.

Key Results

31. The achievement of the PDO will be measured through the following PDO-level results indicators:

   i. Percentage of Eligible Level 2-4 Health Care Facilities36 in Selected Provinces37 that have achieved a Minimum Service Quality Score

   ii. Percentage increase in the number of Outreach Visits in Selected Provinces

   iii. Percentage increase in the number of pregnant women who have received four (4) or more antenatal care check-ups*

   iv. Percentage increase in the number of children aged one (1) year who have received Diphtheria Pertussis Tetanus 3 (DPT3)

   v. Increase in the number of registered Drug Susceptible TB (DSTB) patients on treatment who have been cured*

* Given that Integrated Facility Supervision Checklists will prioritize key indicators that contribute to the quality and coverage of essential RMNCH-N services, this PDO level indicator, along with number of pregnant women who have received four or more ANC check-ups and gender disaggregated increase in the number of registered DSTB patients on treatment who have been cured will allow the Project to monitor progress in closing the gender gap in health endowments between women and men, and rural women and urban women.

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35 World Bank, 2017. Service Delivery by Health Facilities in PNG.
36 For the purposes of the Project, Eligible Level 2-4 Health Care Facilities include health care facilities managed by GoPNG and/or churches within the Selected Provinces, which are classified as Levels 2 to 4 in accordance with the National Health Service Standards and set forth in the DLI Operational Manual.
37 Selected Provinces include provinces in PNG that have met the selection criteria for participating in Component 1 of the Project as set forth in the Project Operational Manual and agreed with the Bank.
In PNG, PHC services, or Frontline Health Services, refer to services delivered through level 1, 2, 3 and 4 facilities.38

D. Project Description

32. IMPACT Health, a proposed US$30 million equivalent operation, will support GoPNG, and specifically the NDOH and selected PHAs, with strengthening the delivery of frontline health services in selected provinces.

33. The Project is comprised of four components which are briefly described in the following paragraphs as follows:

Component 1: Increase service delivery readiness and community-based service delivery (US$12.4 million)

34. Component 1 seeks to increase readiness to deliver frontline health services as well as to trial and scale up community-based innovations to generate demand for and improve access to facility and outreach-based health services. Frontline health services are defined as those delivered at PHC facilities, i.e., levels 1-4, and services provided through outreach. Component 1 will finance the purchase of equipment and supplies, training, technical assistance (TA) and limited infrastructure upgrades.

35. This component includes four sub-components. Sub-components 1.1, 1.2 and 1.3 will be focused on four Selected Provinces, two Early Adopter Provinces to be identified prior to Project effectiveness and two Expansion Provinces to be selected prior to expansion (for a detailed description of the process to be followed for the selection of the four Selected Provinces please refer to the respective section in paragraph 7).

36. Implementation of province-specific activities under Sub-components 1.1, 1.2 and 1.3 will begin in the Early Adopter Provinces and potentially expanded to up to two Expansion Provinces assuming adequate implementation progress. Expansion will be considered after a review of implementation progress and is proposed in Year 3. However, expansion may be considered sooner if the Project implementation is deemed strong enough to merit it. Project disbursement levels will be one of the criteria used to ascertain implementation readiness for geographic expansion.

37. Sub-component 1.1: Strengthening readiness to deliver services at frontline facilities and through outreach (US$5.0 million).

38. This sub-component seeks to increase service delivery readiness at frontline health facilities (i.e., facilities at levels 1-4) in Selected Provinces. It is proposed that this sub-component will finance inputs to strengthen service delivery readiness. This may include: (i) carrying out training to build health workers’ skills and improve the quality of essential health services (like family planning and ANC); (ii) improving communications information technology; (iii) providing equipment to ensure the availability of services at frontlines facilities (e.g. fetal stethoscopes and delivery kits), supplies and ambulances to ensure availability of health services; (iv) upgrading health facilities to meet to national standards (i.e., water and electricity, provision of health care waste management equipment/supplies - no new facilities will be constructed); and (v) increasing capacity to screen for and deliver counseling and other support services to address gender-based violence, including by taking advantage of ANC and other points of contact that women have with the health system. Activities financed under this sub-component will prioritize those that will contribute to closing the gender gap in health endowments between women and men, and between rural women and urban women. These include training to improve the quality of essential health services like family planning and ANC, the procurement of basic equipment to ensure the availability of services at frontlines facilities (e.g. fetal stethoscopes and delivery kits), and the purchase of ambulances to refer complicated cases to higher-level facilities. Finally, Sub-component 1.1 activities will also seek to increase capacity to screen for and deliver counseling and other support

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38 The National Health Service Standards in PNG classify facilities according to levels 1 to 4. These include, respectively, Aid Posts, Community Health Posts, Rural Health Centers (or Urban Clinics) and District Hospitals.
services to address gender-based violence by taking advantage of ANC and other points of contact that women have with the health system. The investments proposed will be complementary and oriented to filling the gaps that exist. Furthermore, any investments in health facility infrastructure and equipment will aim to close the gaps identified in Provincial Health Service Development Plan and prioritize facilities based on ease of physical access and transport links, and the presence of a minimal complement of skilled staff.

39. **Sub-component 1.2: Innovations in community-based service delivery (US$2 million).** The objective of this sub-component is to trial and subsequently scale-up digital innovations to improve access to and use of frontline health services. This sub-component will finance: (i) contracts with non-state providers to implement strategies to improve access to services at the community level, particularly digital innovations to supervise and support Community Health Workers and volunteers in remote rural communities, as well as to support citizen engagement and accountability for service delivery; and (ii) evaluation of a proof-of-concept for implementation. Investments in community-based service delivery (particularly those in Community Health Workers and volunteers) are expected to contribute to increases in the uptake of health services. These efforts will particularly target pregnant women in order to reduce the number of preventable deaths among women driven by the low coverage and utilization of RMNCH-N services. Each of the two Early Adopter Provinces will implement one innovation. At the end of three years of implementation, these innovations will be evaluated to inform decisions on scaling up implementation to at least one district in each of the four Selected Provinces for this component.

40. **Sub-component 1.3: Strengthening readiness at Provincial Health Authorities (PHAs) (US$3.25 million).** The objective of this sub-component is to build the capacity of PHAs in Selected Provinces on PFM, service planning, supportive supervision, performance management, monitoring and oversight and other relevant areas to ensure good quality health service delivery. These may include training, TA, purchase of equipment to support performance monitoring and oversight, including tablets to support data collection and skills building during supervision, communications and information technology equipment and vehicles, as well as operating costs for supportive supervision and maintenance for vehicles procured. Supervision tools will be designed to cover key areas that affect the quality of RMNCH-N services such as the availability of critical inputs and the level of competency of health workers to deliver such services. The specific capacities targeted by this sub-component include: PFM, service planning and supervision. Support provided through this component will complement that provided under the PNG Program of Advisory Services and Analytics (PASA), assuming there is geographic overlap in support. Support provided will also complement the Asian Development Bank (ADB) financed training to PHA Board leadership and PHA managers by delivering continuous assistance and mentoring.

41. **Sub-component 1.4: National oversight (US$2.15 million).** The objective of this sub-component is to support national, primarily NDOH, oversight of: (a) PHA reforms and (b) service delivery results of Frontline Health Facilities in Selected Provinces. This sub-component will finance inputs including: (i) appointing an independent verification agent for Component 2; (ii) providing technical support to PHAs to improve the delivery of Frontline Health Services; (iii) finalizing a policy and regulatory framework for the PHAs reforms; and (iv) communicating and information sharing Project information with PHAs and other key stakeholders. Inputs may also include purchase of equipment to support performance monitoring and oversight, including independent verification costs, operating costs, training and TA. Financing for independent verification is included in sub-component 1.4 as it is also a mechanism to strengthen routine data collection systems essential for NDOH’s oversight of the health sector.

43. **Additional support for improved quality and monitoring of services will be available under the Primary Health Care Performance Initiative (PHCPI) to be financed outside the Project.** PHCPI is a partnership between the World Bank Group, the WHO and Bill and Melinda Gates Foundation in collaboration with Results for Development and
Ariadne Labs, to promote quality PHC for all, with a focus on low and middle-income countries.

44. **Component 2: Improve frontline service delivery performance (US$14.6 million).** Component 2 aims to support program activities designed to strengthen health systems at the national and provincial levels in order to improve the delivery of Frontlines Health Services in Project supported Provinces. Financing for this component will be provided based on results tracked by Disbursement Linked Indicators (DLIs). Financing under this component will be disbursed against evidence of achievement of DLI targets and documentation that the expenditures, identified in Eligible Expenditure Programs (EEP), to achieve DLI results have been incurred as further detailed in the DLI Operational Manual annexed to the Project Operational Manual (POM). The DLIs for IMPACT Health include a set of tracer indicators of health systems strengthening actions as well as their end results, i.e., services delivered and quality of care. The DLIs selected reflect the priorities identified in the NHP (2011-2020, as well as emerging priorities in the next Plan), National Health Service Standards and MTDP III. The results-linked financing provided through this component will seek to leverage investments to increase capacity to achieve improvements in frontline service delivery made under Component 1 as well as by GoPNG and by other DPs therefore improving value-for-money delivered from public spending on health more broadly.

45. **The DLIs target strategic bottlenecks to strengthening frontline service delivery.** These include: (i) Delayed flow of operational funding to PHAs by promoting the transfer of performance-linked funds to PHAs that achieve the relevant targets early in the fiscal year; (ii) Weak sector governance due to fragmented and limited accountability for results; (iii) Inadequate supervision of service delivery. Supervision is not adequately used as a mechanism to support improvements in service delivery, including as a training and upward accountability tool; (iv) Declining outreach from health facilities. Outreach is an important means of expanding access to services in a country with difficult terrain and dispersed populations. In so doing, it is expected that the DLIs can promote improvements in service utilization and quality of care.

46. **DLIs provide flexible financing to achieve results.** DLI financing can be utilized in a flexible manner to address contextual bottlenecks for service delivery, whether these constitute infrastructure, equipment, operating costs, training or other. Guidelines on use and reporting on DLI funds will be included in the DLI operational manual, which will be a part of the POM. DLI financing will be used in accordance with MTDP III priorities.

**Disbursement Linked Indicators.**

47. Three types of health systems strengthening DLIs are proposed: (i) National DLIs (N-DLIs) which reward the achievement of results measured at the national level; (ii) Provincial DLIs (P-DLIs) which reward the achievement of results measured at the provincial level but are restricted to the four Selected Provinces selected to receive support under components 1.1, 1.2 and 1.3; and (iii) Competitive Provincial DLIs (C-DLIs) which reward the achievement of results measured at the provincial level and are open to all Provinces with an established PHA and which indicate interest in being considered for this component. Funding under competitive DLIs will be awarded to the two highest ranked improvers for each year. If more than two Eligible Provinces are ranked in the top two, the associated DLI funds will be split equally amongst these Provinces as further detailed in the DLI Operational Manual. Since these DLIs relate to improvements over the Province’s baseline, it is anticipated that it may be easier for PHA Provinces with poorer indicators to achieve them, hence improving equity. Following the disbursement of DLI funds to NDOH upon the achievement of P-DLI and/or C-DLI targets, NDOH will accordingly allocate and transfer funds out of its own budget (PHA Performance Funds) to the relevant Provinces for the achievement of P-DLIs and/or C-DLIs, in accordance with the details set out in the DLI Operational Manual. Unused DLI funds remaining at the end of Year 5 will be reallocated to Component 1.

48. Table 3 below describes the DLIs and Project financing allocated to each over the duration of the Project.
### Table 3: Disbursement Linked Indicators (DLIs) contribution to PDO

<table>
<thead>
<tr>
<th>DLI #</th>
<th>DLI</th>
<th>Province eligibility</th>
<th>Contributes to the PDO by improving</th>
<th>DLI Financing Value (US$ equivalent)</th>
<th>Time-bound*/Scalable**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National DLIs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DLI 1</td>
<td>National DLI 1: Memoranda of Understanding (MoU) signed with up to four (4) Selected PHAs</td>
<td>National result-Not applicable</td>
<td>Sector governance and performance oversight</td>
<td>600,000</td>
<td>Time-bound: Yes (Year 1 Target is to be achieved within Year 1; Year 3 Target is to be achieved within Year 2-Year 5); Scalable: Yes</td>
</tr>
<tr>
<td>DLI 2</td>
<td>National DLI 2: Integrated Facility Supervision Checklist adopted and updated</td>
<td>National result-Not applicable</td>
<td>Quality</td>
<td>600,000</td>
<td>Time-bound: No; Scalable: No</td>
</tr>
<tr>
<td>DLI 3</td>
<td>National DLI 3: Timely transfer of PHA Performance Funds</td>
<td>National result-Not applicable</td>
<td>Flow of funds to the frontlines</td>
<td>1,500,000</td>
<td>Time-bound: No; Scalable: Yes</td>
</tr>
<tr>
<td>DLI 4</td>
<td>National DLI 4: Number of Selected Provinces that have achieved all Provincial DLIs</td>
<td>National result-Not applicable</td>
<td>Sector governance and oversight</td>
<td>1,000,000</td>
<td>Time-bound: Yes; Scalable: Yes</td>
</tr>
<tr>
<td><strong>Provincial DLIs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>DLI 5</td>
<td>Provincial DLI 1: Number of Selected PHAs with a complete Annual Implementation Plan submitted in a timely manner and in accordance with NDOH specifications</td>
<td>Provincial result-4 Selected Provinces are eligible</td>
<td>Sector governance and Public Financial Management</td>
<td>1,600,000</td>
<td>Time-bound: Yes; Scalable: Yes</td>
</tr>
<tr>
<td>DLI 6</td>
<td>Provincial DLI 2: Percentage of Eligible Level 2-4 Health Care</td>
<td>Provincial result-4 Selected</td>
<td>Quality and performance oversight</td>
<td>2,100,000</td>
<td>Time-bound: Yes; Scalable: Yes</td>
</tr>
<tr>
<td>DLI #</td>
<td>DLI</td>
<td>Province eligibility</td>
<td>Contributes to the PDO by improving</td>
<td>DLI Financing Value (US$ equivalent)</td>
<td>Time-bound*/Scalable**</td>
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<tr>
<td>DLI 7</td>
<td>Provincial DLI 3: Number of PHA Boards that have used routine data for decision making</td>
<td>Provinces are eligible</td>
<td>PDO Indicator</td>
<td>1,200,000</td>
<td>Time-bound: Yes; Scalable: Yes</td>
</tr>
<tr>
<td>DLI 8</td>
<td>Provincial DLI 4: Percentage increase in the number of Outreach Visits in Selected Provinces</td>
<td>Provincial result- 4 Selected Provinces are eligible</td>
<td>Use PDO indicator</td>
<td>2,100,000</td>
<td>Time-bound: Yes; Scalable: Yes</td>
</tr>
</tbody>
</table>

**Competitive DLIs**

| DLI 9 | Competitive DLI 1: Percentage increase in the number of pregnant women who have received four (4) or more ANC check-ups | Provincial result- all PHA Provinces are eligible | Use PDO indicator | 1,200,000 | Time-bound: Yes; Scalable: No |
| DLI 10 | Competitive DLI 2: Percentage increase in the number of children under one | Provincial result- all PHA Provinces are eligible | Use PDO indicator | 1,200,000 | Time-bound: Yes; Scalable: No |
Component 3: Project management (US$3 million)

49. Financing under Component 3 will support technical and operational assistance to the Project Coordination Unit (PCU) on Project management and implementation. This may include TA for the PCU, equipment and furniture, operating costs to support supervision, including supervision-related costs incurred by the NDOH, as well as a vehicle, if needed. While the PCU will include existing staff from NDOH, full or part-time TA is expected to be required for a number of posts, such as Project Coordinator, Procurement Specialist, Financial Management Specialist, Monitoring & Evaluation Specialist, Communications specialist and Administrative Assistant. Where feasible, technical assistance will be shared with the PCU for the Emergency TB Project.

Component 4: Contingent emergency response (US$0 million)

The objective of this component is to improve GoPNG's response capacity in the event of an emergency, following the procedures governed by OP/BP 8.00 (Rapid Response to Crisis and Emergencies). The Component would support a rapid response to a request for urgent assistance in respect of an event that has caused, or is likely to imminently cause, a major adverse economic and/or social impact to PNG associated with a natural or man-made crisis or disaster. In the event of an emergency, financial support could be mobilized by reallocation of funds from other Components to support expenditures on a positive list of goods and/or specific works and services required for emergency recovery. A Contingent Emergency Response Component Project Operational Manual (CERC POM), governing implementation arrangements for this component, will be prepared with support under the Project Preparation Grant (PPG).
E. Implementation

Institutional and Implementation Arrangements

50. The NDOH will be the implementing agency for IMPACT Health, as it plays a critical role in the oversight of PNG’s health system. The NDOH is responsible for the design and implementation of national policies and programs, as well as the consolidation of the national budget for all health agencies including PHAs. PHAs are legally accountable to the Minister of Health and HIV/AIDS, and the establishment and operationalization of PHAs is a national reform championed by the NDOH.

51. The NDOH is in the process of a reorganization. The description below is based on the existing configuration. The NDOH Secretary for Health will be the Project Director for IMPACT Health, with day-to-day running of the Project delegated to the NDOH Deputy Secretary, National Health Policy and Corporate Services (NHPCS). The Deputy Secretary will be assisted by the PCU, which will be mapped to a health sector coordination secretariat once it is set up. The PCU will be responsible for carrying out day-to-day management and implementation of the Project. It will comprise staff within NDOH, as well as a Project Coordinator who will be contracted over the Project period, and other consultants providing support to fiduciary aspects (procurement and financial management) and safeguards, coordination, monitoring and evaluation, and communication of Project activities. PCU requirements will be reviewed during implementation and the need for any additional capacity will be explored during the ongoing preparation. Given the existence of an active World Bank-financed Project in the health sector, the Emergency TB Project, consultants will share their time between the Emergency TB Project and IMPACT Health PCUs in cases where full-time support may not be needed (e.g., in the case of the procurement specialist).

52. Individual consultants in the PCU will be required to support Project implementation and to build the capacity of existing NDOH staff in key Project implementation areas such as (a) Project management; (b) procurement; (c) financial management; (d) safeguards; and (e) information dissemination. By not later than six months after effective date of the Financing Agreement, the following positions within the PCU will be recruited or appointed: (a) a Project coordinator; (b) a procurement specialist; (c) a financial management specialist; (d) a monitoring and evaluation specialist; and (e) an administrative assistant, each with terms of reference, qualifications and experience satisfactory to the Bank. All contracted individuals will be assigned to support one or more existing NDOH staff who will be nominated by the NDOH Deputy Secretary on NHPCS. Regardless of any structural changes within the NDOH, the Project will require the support from the various technical areas, such as PHC, finance, management, policy, planning, performance monitoring and research, disease control and surveillance, public health, and health promotion.

53. The PCU will be responsible to support the NDOH for the following tasks:

(a) preparation, approval and adoption of the POM and the CERC POM;
(b) overall administration of the Project, including the preparation of annual work plans and budgets;
(c) overall implementation of Project activities, with the support of the NDOH technical departments, and those PHAs participating in the Project;
(d) overall administration of financial management, procurement, environmental and social safeguards management, and communication on all Project activities;
(e) overall monitoring, evaluation and reporting of Project activities and DLIs, including submission of findings by the IVA on which funds will be disbursed against DLIs;
(f) organization of quarterly reviews, ensuring that the World Bank implementation support reviews are timed to match at least two of these quarterly reviews per year; and

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39 The PHA Act (2007) and the PHA Amendment Act (2013).
54. With reference to DLIs, the NDOH will be responsible for implementing Component 2 with the support of participating PHAs. The POM, which will be adopted by not later than 3 months after the effective date of the Financing Agreement, will include a DLI Operational Manual annex which will set out detailed operational guidelines on implementation, including guidelines on the verification of DLI targets and utilization of and reporting on Component 2 funds. This will include guidelines on utilization of Component 2 funds for infrastructure upgrades and equipment in line with MTDP III. To support implementation of this Component, the NDOH will, prior to carrying out any activities under Component 2, enter into an MoU with each PHA in the four Selected Provinces for Provincial DLIs (P-DLIs). An MoU between the NDOH and PHA will also be required for a province to be eligible for the Competitive DLIs (C-DLIs). These MoUs will (a) set out the roles and responsibilities of the NDOH and PHAs in implementing Component 2, including further detail on the DLIs, such as the relevant baseline or method for calculating the baseline, require compliance with the POM, and specify details for the transfer of PHA Performance Funds to PHAs that meet P-DLI or C-DLI targets, as further detailed in the DLI Operational Manual. PHA Performance Funds are intended to improve the flow of GoPNG funding to the frontlines.

55. Technical support for the implementation of DLIs will be provided by different levels and entities within the PNG Health System. Technical departments within the NDOH, notably Strategic Policy and Planning Division, Public Health Division and Corporate Services Division, will support the achievement of DLI results, including through: (i) Support to establishing, operationalizing and building the capacity of PHAs and facilitating PHA functioning; (ii) Direct support to service delivery through vertical programs; and (iii) Oversight and management of the health system. PHAs, in turn, will manage delivery of frontline health services.

56. **Province selection.** The selection process for the four Selected Provinces (two Early Adopter and two Expansion Provinces) to implement Sub-components 1.1, 1.2 and 1.3 consists of 3 main steps as further detailed in the POM. The first step is the application of pre-qualification criteria to determine eligible Provinces. These criteria are: (a) The presence of PHA established prior to March 2019; (b) Health outcomes, as measured by the Sector Performance Annual Report (SPAR) reporting; (c) Level of PFM capacity; (d) Regional representation; (e) DPs’ support to the health sector; and (f) Convergence with the World Bank-financed Agriculture Project. With reference to the selection criteria ‘b’ and ‘c’ the objective is to include mid-level performers. With reference to criterion ‘e’, Provinces that receive high levels of DP support will not be considered. During the second stage of the selection process, the NDOH will invite PHAs in the Provinces that meet all pre-qualification criteria to provide an Expression of Interest. In the third and final step, NDOH will review the Expressions of Interest and select Selected Provinces based on the quality of these submissions. This process will be conducted twice during the life of the Project: the first time will be for the selection of two Early Adopter Provinces and this will be completed prior to effectiveness (anticipated in January 2020). The second time will be for the selection of Expansion Provinces and this will be completed prior to Project expansion (planned for June 2022). Based on the experience with Early Adopter Provinces, the selection criteria for Expansion Provinces may be modified.

F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

Project Location is Papua New Guinea (PNG) (with Selected Provinces to be confirmed). There is limited physical access to health care in 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.

G. Environmental and Social Safeguards Specialists on the Team

Rosemary Alexandra Davey, Environmental Specialist
Joyce Onguglo, Social Specialist

### SAFEGUARD POLICIES THAT MIGHT APPLY

<table>
<thead>
<tr>
<th>Safeguard Policies</th>
<th>Triggered?</th>
<th>Explanation (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td>Yes</td>
<td>The Project design as currently conceived poses a low environmental and social risk, in this instance it is considered a category B project. It is understood that civil works at the health facilities will be minor relating to repairs and refurbishment of existing buildings only, therefore have limited potential to cause environmental harm. The number of facilities and types of repairs/refurbishment will depend on the Selected Provinces. Matters for consideration include inventory control of chemicals and medicines, medical and general waste management and health and safety awareness/training for frontline staff. Since the Provinces to be selected are yet to be identified, the location and details of sub-project investments will not be known until implementation. For this reason, an Environmental and Social Management Framework (ESMF) has been prepared and distributed for disclosure prior to appraisal. At this early stage, it is indicated that there will be no new construction or land acquisition. As the health centers to be refurbished/repaired are yet to...</td>
</tr>
</tbody>
</table>
be determined under the Project, in this regard, 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.

<table>
<thead>
<tr>
<th>Performance Standards for Private Sector Activities OP/BP 4.03</th>
<th>No</th>
<th>The Project does not finance private sector-led economic development activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural Habitats OP/BP 4.04</td>
<td>No</td>
<td>Not relevant to the Project</td>
</tr>
<tr>
<td>Forests OP/BP 4.36</td>
<td>No</td>
<td>Not relevant to the Project</td>
</tr>
<tr>
<td>Pest Management OP 4.09</td>
<td>No</td>
<td>The Project does not involve the use of pesticides</td>
</tr>
<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
<td>No</td>
<td>The Project will not require construction on land with known physical cultural resources (PCR). This is therefore, not relevant to the Project.</td>
</tr>
<tr>
<td>Indigenous Peoples OP/BP 4.10</td>
<td>Yes</td>
<td>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. A social assessment framework is prepared to include free prior and informed consultation process to inform the design of the project during preparation and ESMF. A stakeholder engagement framework is prepared and is included into the ESMF to identify key stakeholders, and describe mechanisms for consultation and disclosure of safeguard policies. A high level social assessment is prepared for Project implementation and is included into the ESMF.</td>
</tr>
<tr>
<td>Involuntary Resettlement OP/BP 4.12</td>
<td>No</td>
<td>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 it is anticipated that no involuntary resettlement will take place in this Project. However, through regular community engagement and consultation, clear communication related to Project</td>
</tr>
</tbody>
</table>
design will be provided to affected communities (in the Selected Provinces). The Project will ensure that appropriate community consultations takes place.

<table>
<thead>
<tr>
<th>Safety of Dams OP/BP 4.37</th>
<th>No</th>
<th>The Project does not include dam construction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projects on International Waterways OP/BP 7.50</td>
<td>No</td>
<td>The Project is not situated on international waterways</td>
</tr>
<tr>
<td>Projects in Disputed Areas OP/BP 7.60</td>
<td>No</td>
<td>Depending on the Selected Provinces, this will be triggered in accordance.</td>
</tr>
</tbody>
</table>

**KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT**

**A. Summary of Key Safeguard Issues**

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
   The project is considered to be a category B project. There is limited environmental risk associated with the planned minor civil works at health facilities. Since the Provinces have not been selected, the number of facilities and types of repairs/refurbishment will depend on the Selected Provinces and health facilities identified to be refurbished.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
   At this early stage, it can be determined that there will be no new construction and no new land acquisition.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
   An Environmental and Social Management Framework (ESMF) is prepared for appraisal and Environmental and Social Management Plans will be prepared for each province, once they are selected and known.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
   The borrower will engage in key consultation with the communities, details of the consultation are described in the stakeholder engagement framework. Minor civil works will be completed in accordance with the Environmental and Social Framework (ESMF) and environmental and social management plans (ESMP) which will include occupational health and safety considerations. Waste management will be completed in accordance with the health care waste management plans including the disposal of any medical waste that may be generated.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
   Key stakeholders will be the National Department of Health, the local level government of the provinces identified (LLG), the provincial government stakeholders.
### B. Disclosure Requirements

#### Environmental Assessment/Audit/Management Plan/Other

<table>
<thead>
<tr>
<th>Date of receipt by the Bank</th>
<th>Date of submission for disclosure</th>
<th>For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors</th>
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</thead>
<tbody>
<tr>
<td>30-Sep-2019</td>
<td>02-Oct-2019</td>
<td></td>
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</table>

"In country" Disclosure  
Papua New Guinea  
30-Sep-2019

Comments

#### Indigenous Peoples Development Plan/Framework

<table>
<thead>
<tr>
<th>Date of receipt by the Bank</th>
<th>Date of submission for disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Sep-2019</td>
<td>02-Oct-2019</td>
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</tbody>
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"In country" Disclosure  
Papua New Guinea  
30-Sep-2019

Comments

### C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

**OP/BP/GP 4.01 - Environment Assessment**

Does the project require a stand-alone EA (including EMP) report?  
No

**OP/BP 4.10 - Indigenous Peoples**

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?  
No
The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes

Have costs related to safeguard policy measures been included in the project cost?
Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

CONTACT POINT

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APPROVAL

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Approved By

Safeguards Advisor:

Practice Manager/Manager: Enis Baris 03-Oct-2019

Country Director: Mona Sur 10-Oct-2019