ADB

Project Administration Manual

Project Number: 41509
Loan Number: 2785
June 2014

Papua New Guinea: Rural Primary Health Services Delivery Project

CONTENTS

Project Administration Manual Purpose and Process

The project administration manual (PAM) describes the essential administrative and management requirements to implement the project on time, within budget, and in accordance with government and Asian Development Bank (ADB) policies and procedures. The PAM should include references to all available templates and instructions either through linkages to relevant URLs or directly incorporated in the PAM.

The Department of Health (DOH) and selected provinces are wholly responsible for the implementation of ADB-financed projects, as agreed upon jointly between the borrower and ADB, and in accordance with government and ADB policies and procedures. ADB staff are responsible to support implementation including compliance by DOH and selected provinces of their obligations and responsibilities for project implementation in accordance with ADB's policies and procedures.

At Loan Negotiations the borrower and ADB will agree to the PAM and ensure consistency with the Loan Agreement. Such agreement will be reflected in the minutes of the Loan Negotiations. In the event of any discrepancy or contradiction between the PAM and the Loan Agreement, the provisions of the Loan Agreement will prevail.

After ADB Board approval of the project's report and recommendation of the President, changes in implementation arrangements are subject to agreement and approval pursuant to relevant government and ADB administrative procedures (including the Project Administration Instructions), and upon such approval they will be subsequently incorporated in the PAM.

ABBREVIATIONS

ADB	-	Asian Development Bank
AusAID	-	Australian Agency for International Development
CBSC	-	Capacity Building Service Centre
CHP	-	community health post
CHW	-	community health worker
DFF	-	direct facility funding
DOH	-	department of health
EARF	-	environmental assessment and review framework
FMA	-	financial management assessment
GIS	-	geographic information system
HIV/AIDS	-	human immunodeficiency virus/acquired immune deficiency syndrome
HSIP	-	Health Sector Improvement Program
ICB	-	international competitive bidding
ICT	-	information and communication technology
IEE	-	initial environmental examination
JICA	-	Japan International Cooperation Agency
NCB	-	national competitive bidding
NGO	-	nongovernment organization
NHP	-	National Health Plan
OFID	-	OPEC Fund for International Development
O&M	-	operation and maintenance
PHA	-	provincial health authority
PHB	-	provincial health board
PHC	-	primary health care
PAM	-	project administration manual
PNG	-	Papua New Guinea
PPTA	-	project preparatory technical assistance
PSU	-	Project Support Unit
UNICEF	-	United Nations Children’s Fund
WHO	-	World Health Organization

I. PROJECT DESCRIPTION

A. Summary of Project Rationale, Location, and Beneficiaries

1. The project will strengthen the rural health system in selected areas of Papua New Guinea (PNG) by increasing the coverage and quality of primary health care (PHC) in partnership with both state and nonstate service providers through supporting the Government of PNG in implementing the National Health Plan (NHP) as it relates to rural health. It will build on the Asian Development Bank's (ADB) experience in strengthening health service delivery in rural areas of PNG.[1] The project will cover two districts in each of the following eight provinces: Eastern Highlands, East Sepik, Enga, Milne Bay, Western Highlands, West New Britain, Morobe, and the Autonomous Region of Bougainville. The approximate total number of beneficiaries in the 16 districts will be 1.2 million.

2. The provincial selection was made by the Government of PNG. ADB project preparatory technical assistance (PPTA) provided advice on health needs and service capacity in the provinces. The provincial selection procedures included extensive consultations and self-nomination by the provinces. During project preparation, since 2009 March, all provinces were informed about community health posts (CHPs) and the proposed project by the Department of Health (DOH) on a number of occasions including national health conferences in 2009 and 2010. All districts and provinces were represented in comprehensive consultations in Madang in February 2010, as well as in other forums organized by DOH in 2010. After the consultations, DOH requested all provinces to submit proposals to participate in the project. Subsequently, DOH selected those eight provinces for phase 1 for rolling out DOH's CHP program. The project is seen as the first stage of the government's Rural Health Service Transformation Project with the clear intention of rolling the project out to additional districts and provinces as government and external funds become available. Therefore, the proposed project will select only two districts in a province. Project sites within each province will be determined by the government in accordance with the agreed upon selection criteria for outputs 2, 3, 4, and 5 described in paragraphs 6 to 12.

3. The selected provinces have been preparing provincial health services plans with the support of the PPTA team. The PPTA assesses the current activities in those provinces by the government, nongovernment organizations (NGOs), and other development partners in order for the project to collaborate with existing programs and activities.

4. The government's long-term Vision 2050, its Development Strategic Plan 2010–2030, and its Medium Term Development Plan 2011-2015 aim to transform PNG's health system, to achieve the health Millennium Development Goals, and to improve PNG's ranking on the Human Development Index.[2] In support of the government's approach and in line with ADB's operational plan for health,[3] ADB's Country Partnership Strategy for PNG 2011-2015 includes health as one of the priority areas. Health Sector Assessment was conducted in 2010 as a part of the Country Partnership Strategy for PNG (accessible from the list of linked documents in Appendix 2 of the RRP).

5. The health status of the population of PNG has deteriorated over the last two decades due to severe neglect of the health system, especially in the rural areas, where 87% of the population live. An estimated 40% of rural health facilities have closed or are not fully functioning. Limited

[1] ADB provided project preparatory technical assistance. ADB. 2009. *Project Preparatory Technical Assistance to Papua New Guinea (PNG) for Strengthening Rural Primary Health Services Delivery.* Manila.
[2] The Human Development Index for PNG was 137 out of 169 in the 2010 report by UNDP.
[3] ADB. 2008. *An Operational Plan of Health for Improving Health Access and Outcomes Under Strategy 2020*. Manila.

resources, deteriorating infrastructure, poorly trained staff in the health sector, and inadequate and declining access to basic health services are among the main reasons for the decline.

6. PNG ranks 137th out of 169 countries in the United Nations Development Programme's 2010 Human Development Index. The country has high levels of poverty and weak health indicators, particularly for maternal and child health: The infant mortality rate is 57 per 1,000 live births, and the maternal mortality rate is 733 per 100,000 live births.[4] The main health problems continue to be communicable diseases, with malaria, tuberculosis, diarrheal diseases, and acute respiratory disease as the major causes of morbidity and mortality. PNG has a generalized HIV epidemic, driven predominantly by heterosexual intercourse. The epidemiological profile of PNG, with a heavy burden of communicable diseases, indicates that very significant gains in health outcomes could be achieved with simple and effective interventions focused on PHC and health promotion. While some hospital services, e.g., for maternal complications, are essential, more than 80% of health problems can be addressed adequately and at less cost through effective delivery of PHC. The current poor health status of the rural population points to a weak PHC system with a lack of outreach services such as immunization of children and providing women with the basic support required for safe delivery.

7. The provinces and districts are responsible for delivering health services through hospitals, health centers, health subcenters, and aid posts. The 1998 Organic Law on Provincial and Local-level Governments[5] significantly decentralized responsibility for delivering health services to the provinces and districts. However, the law did not adequately address how to implement the changes. In the health sector only operational responsibilities have been devolved, while capital investments remain centralized in the public investment program. Provinces are allocated a percentage of net government revenue in staffing and health sector function grants, which cover operational but not capital investment costs. As a result, resources, authority, and competency are poorly matched to decentralized responsibilities.[6]

8. To overcome this mismatch, three provinces have so far exercised the option outlined in the 2007 Provincial Health Authorities Act[7] to establish their own respective provincial health authorities (PHAs). In addition, the government, recognizing that it needs to pay greater attention to health service delivery at the district and community levels, has developed the concept of the community health post (CHP). The CHPs will provide services at the outer perimeter of the health system. Over time, the government will transform the existing facilities (aid posts/sub-health centers) into a service that has the capacity and capability to meet the requirements of the NHP.

9. ADB has provided support for the PNG health sector since the 1980s. The recently completed Health Sector Development Program[8] established the Health Sector Improvement Program (HSIP) trust account in 1998, which became a major mechanism for administering extended development assistance to the health sector. Development Coordination is further discussed in the RRP linked document 4.

10. The HIV/AIDS Prevention and Control in Rural Development Enclaves Project[9] is ongoing. It successfully built innovative partnerships with nonstate service providers to improve rural PHC

[4] Government of PNG, National Department of Health. 2010. *National Health Plan (2011-2020).* Port Moresby; Government of PNG, National Statistics Office. 2009. *Demographic Health Survey 2006*. Port Moresby.
[5] Government of PNG. 1998. *Organic Law on Provincial Governments and Local-level Governments.*
[6] See also ADB. 2003. *Country Assistance Program Evaluation.* Manila.
[7] Government of PNG. 2007. *Provincial Health Authorities Act*.
[8] ADB. 1997. *Health Sector Development Program*. Manila.
[9] ADB. 2006. *Grant 0042-PNG: HIV/AIDS Prevention and Control in Rural Development Enclaves*. Manila (Expected closing date: December 2011).

service delivery in PNG. Under that project, local health authorities in five provinces established partnerships with six large private companies in rural areas to improve more than 100 rural health facilities and provided training programs for health workers and communities for HIV/AIDS prevention. As a result, there has been a significant increase in the number of patients for PHC services in the project areas.

11. Building on the lessons and experience of the ongoing project, the proposed project will establish and develop partnerships between state and nonstate health service providers (including the private sector, churches, nongovernment organizations, and civil society) at the provincial and district levels to strengthen the rural PHC system.

12. To strengthen the existing rural PHC system in PNG, the project will, by working through the envisioned partnerships, build human resource capacity in the health sector, improve health information and monitoring systems, and revitalize rural health facilities.

13. ADB PPTA has supported DOH in its focus on rural health system strengthening and in particular the development of health services plans in the selected 8 provinces. A number of assessments (HR assessments, Social Safeguards, Poverty and Social including Gender, Economic, Financial, ICT, Partnerships) including assessment tools (costing tools, facility audit tools) and advocacy documents (radio program, CHP policy, CHP advocacy) were prepared by the PPTA team.[10] The diagnostic assessments informed the project design in section B.

14. The project will be implemented under the umbrella of the sector-wide approach (SWAp) currently in place for the health sector.[11] To avoid replicating government functions, government systems will be used whenever possible, and the government will be responsible for all project recurrent costs. The project will focus on key elements including infrastructure and training that can help the government to deliver health services more efficiently and effectively, building on the strengths of existing government and nongovernment health institutions.

B. Impact and Outcome

15. The project will contribute to improved health of the rural population in the project areas. It will make improvements in both the supply and demand sides, and strengthen the policy and legal framework for health services at all levels. The outcome will be that the selected provinces, in partnership with nonstate service providers, will more efficiently deliver quality PHC to the rural population (particularly to women and children).

C. Outputs

16. **Output 1 — National policies and standards**. The project will assist DOH in developing and implementing policies, standards, and strategies for CHPs and human resource strengthening in the rural health sector within the framework of the NHP.[12] It will play a crucial role in linking planning and coordination functions more closely to implementation. It will assist DOH in its provincial planning functions, including facility and asset management, human resource audits, and

[10] A list of documents prepared by PPTA team is in the annex 5.

[11] ADB supports the health SWAp together with other development partners, i.e., the Australian Agency for International Development, New Zealand Aid Programme, United Nations Children's Fund, United Nations Population Fund, and World Health Organization. The SWAp was initially established as a "Partnership Arrangement" to support the country's National Health Plan (2001-2010) under the HSIP 2004.

[12] PPTA supported DOH to develop Community Health Post Policy and Standards, the summary document is presented in RRP linked document 17. The full report "Community Health Post Policy, Standards and Advocacy" was prepared by DOH and Dr. Issac Ake, 2010.

staff retention, building on previous work conducted through the PNG Health Sector Support Program. This will result in the development of provincial health service plans that will guide the investment decisions being made under output 4 described in paragraphs 11-12. The project will improve health information systems by supporting the National Health Plan's Performance Assessment Framework through provision of International HIS expertise, appropriately skilled JICA volunteers at the provincial level, and the application of information and communication technology (ICT) and geographic information system (GIS) technology following its pilot application in two provinces. This activity will be aligned with the Health Metrics Network Framework (HFMN) framework. This support will (i) increase the availability of relevant information for all levels of the health sector, (ii) enable provincial and district level governments to monitor performance in the health sector, (iii) improve logistics for the supply of drugs at the local level, (iv) increase the timeliness of reporting, and (v) increase the accessibility to health and performance information. Agreement will be reached with the provincial governments to ensure sustainable financing and human resources for the improved and new facilities.

17. Two elements, the use of Geomapping to assist district level health service planning, and the use of Cell phones to improve the timeliness and accuracy of health information data gathering are being used in the district planning workshops currently being undertaken by the PPTA. The Geomapping is for the first time providing visual imagery of population density, health service capacity, facility type/ owner/status. Workshop participants surveyed in the five completed workshops overwhelmingly endorsed this approach in aiding their understanding of their health system. The use of mobile health is being trialed in two provinces, the Autonomous Region of Bougainville and Enga. This is a pilot focusing on the collection of information on health facilities. This will provide utility and cost information on the use of mobile health prior to commencement of the project.

18. **Output 2 — Sustainable partnerships between provincial governments and nonstate actors.** The project will help the provincial and district governments to develop and formalize existing or new partnerships with nonstate providers of health services. Partnership Boards will be established based on the existing partnerships with non state service providers in a province.[13] This will facilitate greater coordination and efficiency among the diverse providers as well as increased consistency and accountability of such providers. It will make available skills and experience of particular provider organizations (such as the churches) across other organizations in roles such as clinical support and supervision. In particular, it will assist provincial governments in establishing partnership boards and in negotiating and implementing agreements (including monitoring and evaluation tools and targets) with nonstate actors.

19. The project will help participating provinces to set up direct facility funding (DFF) based on the lesson learned from the pilot in the Autonomous Region of Bougainville in selected districts to enable them to better use funds provided by the government.[14] This funding arrangement decentralizes operational resources for activities such as outreach down to the facility level

20. As part of output 2, the project aims to support reinvigoration or establishment of partnership boards within 6 months of its effective date, followed by adoption of provincial health plans within 12 months of the effective date. Subsequently, partnership boards will conclude agreements among the key stakeholders, including local governments, within 24 months of the

[13] Further discussion on partnership building and agreements/contract is presented in RRP linked document 18.

[14] Facility-based funding in the health sector has been introduced in the Autonomous Region of Bougainville. This funding arrangement has been used initially for operational costs including outreach. The project will facilitate the introduction of the funding arrangement in the participating provinces. Output-based funding using project funds will be considered after the midterm review. Further discussion on DFF is presented in RRP linked document 21.

effective date. These milestones are required preconditions for selection of sites to refurbish or construct CHPs.

21. **Output 3 — Human resource development in the health sector.**[15] The project will increase the skills of health personnel in rural communities. Its focus is on training of the existing health workforce, on the understanding that the national training of health workers for rural areas is being undertaken by the PNG government with the assistance of the Australian Agency for International Development (AusAID). An approach specific to the HR needs in each province will be developed, given the large variation in the HHR needs that currently exist between provinces.[16] Initially the project will support the training of one health worker in each facility in essential obstetric care including new born care, to address maternal and child mortality. It will also support provincial training programs to maintain and upgrade skills of all workers in the rural health workforce through provision of medical training, management training including training in facilities management, and training in clinical supervision, appropriate referrals, and management supervision. The project will help the provinces to address performance and retention issues of health workers through improved staff management practices, as well as the use of incentives such as staff housing, support for regular supervision of remote facilities, management capacity development, and a rural health workers' incentive program. The project will enter into agreement with the provincial government on the supply of adequate staff numbers to serve new and upgraded facilities.

22. **Output 4 — Community health facility upgrading.** The project will build the rural health care infrastructure in the selected districts to a level such that they have the physical capacity to address the service requirements of the NHP. Based on the findings of the provinces' health service plans, the project will build up to two new CHPs and its staff housing, and upgrade and refurbish eight additional rural health facilities including staff housing in each of the 16 participating districts (total of upto 32 CHPs with 96 staff housing, 128 upgrading rural health facilities and 128 staff housing). It will provide medical equipment and small vehicles (cars, boats, or motorbikes), build new and upgrade existing staff housing, install or upgrade sanitation facilities, provide waste management facilities, and establish renewable energy supplies for the selected health facilities. Facility design will take into account climate change impacts i.e., rising sea levels for facilities on small islands.[17]

23. Before contract can be awarded for civil works on any refurbishment or construction of a health facility, the partnership agreements should be formed.

24. **Output 5 — Health promotion in local communities.** The project will support health promotion programs, increase women's involvement in all aspects of delivering health services at the community level, support village health volunteers, and engage community members in local level health planning and implementation. Based on the "Healthy Islands," the major health promotion framework for the Pacific, and PNG's existing health promotion framework, it will support existing and new initiatives by civil society organizations and communities to increase knowledge on primary health and health-seeking behavior. The focus will be on sanitation; primary health, i.e.,

[15] Output 3 activities were prepared based on the Health Human Resources Subsector Analysis conducted by PPTA team during 2010. RRP linked document 14 presents the summary. Full report "Strengthening Primary Care services in rural areas in Papua New Guinea: Addressing human Resources for Health" was prepared by Marjolein Dieleman, Royal Tropical Institute, September 2010.

[16] PNG: Health Human Resource Review Meeting Human Resource Constraints and Improving Health Outcomes Report by the World Bank Second Draft for Discussion with Government-not for quotation. June 21, 2011.

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

maternal and child health and HIV; and gender equity, prevention on gender based violence in local communities. The project will support specific programs to address domestic and sexual violence, and support the role communities play in governance planning and implementation of health services at the district, ward, and facility levels. Many provinces have existing health promotion programs, and these will be strengthened and extended. The project will work in concert with AusAID's Strongim Pipol Strongim Nesen program. PNG examples of exemplary community development such as the Domil community will be promoted. Further program contents are presented in RRP linked document 17.

25. **Output 6 — Project monitoring, evaluation, and management.** The project will establish a project support unit (PSU) to support project planning, reporting, coordination with development partners, and monitoring and evaluation. This unit will be used by the DOH as the germinal element of its "Rural Health System Transformation Project" where it intends to cluster and coordinate donor and government health system strengthening activities. Its overall approach will be focused on implementation, and the creation of an information-rich learning environment throughout the project's sphere of influence. The PSU will be part of DOH, directly reporting to a senior executive team member, and will be closely connected to relevant sections of DOH, with the intention of being fully absorbed into DOH over the life of the project. The PSU will deploy local and international consultants, JICA volunteers, as well as health mentors who will focus on system improvement in the districts and provinces. The health mentors will act as ambassadors to the project, and will assist the districts to improve work practices of front line health workers, improve interaction between health workers and community, and improve way information is collected and used to refine service delivery. The PSU will help the DOH to prepare PSU exit strategy with milestones within 12 months after project effectiveness and milestones will be monitored by the formative evaluation to ensure the absorption of PSU in DOH.

26. A formative evaluation[18] every 6 months will inform participating provinces and districts of project progress, impact, and experiences, including cross-cutting aspects such as gender and climate change. Co-financiers and WHO will be invited to provide technical inputs into this process, and the findings will be made available to all stakeholders. Further description on formative evaluation is presented in the RRP linked document 18.

27. The project intends to keep the sequence of the activities under outputs, except output 6 will start when the project starts. For example, partnership agreements under output 2 will be prepared before the activities start under output 3. Human resource training should be conducted before the upgrading of facilities under output 4. Output 5, as community interface activities, will start after health facility cites are selected.

D. Sustainability

28. The project addresses the challenge of long term financial sustainability in the following ways. The project 's financial impact has been assessed in the economic evaluation and is well within the anticipated health resource envelope as described in the National Health Plan 2011-2020, and within expected GDP growth parameters[19]. Expectations around longer term funding being a government responsibility are part of the initial agreements with the provinces. Additional operational and HR costs resulting from new or upgraded facilities are identified in the process of developing the Provincial Health Services plans and the province will agree to meeting these costs prior to construction beginning.

[18] A formative evaluation focuses on improving or enhancing a project while it is ongoing.
[19] IMF Reference – quoted in the WB HR report as real growth of 5% per annum.

29. Environmental sustainability is addressed in the design of new and upgraded facilities, with an emphasis on renewable energy sources and energy efficient designs.

30. Management sustainability is addressed by ensuring that all inputs operate within PNG government systems and processes, and that there is a transfer of technical skills over the life of the project.

I. IMPLEMENTATION PLANS

A. Project Readiness Activities

31. Table 1 summarizes the schedule of project readiness activities.

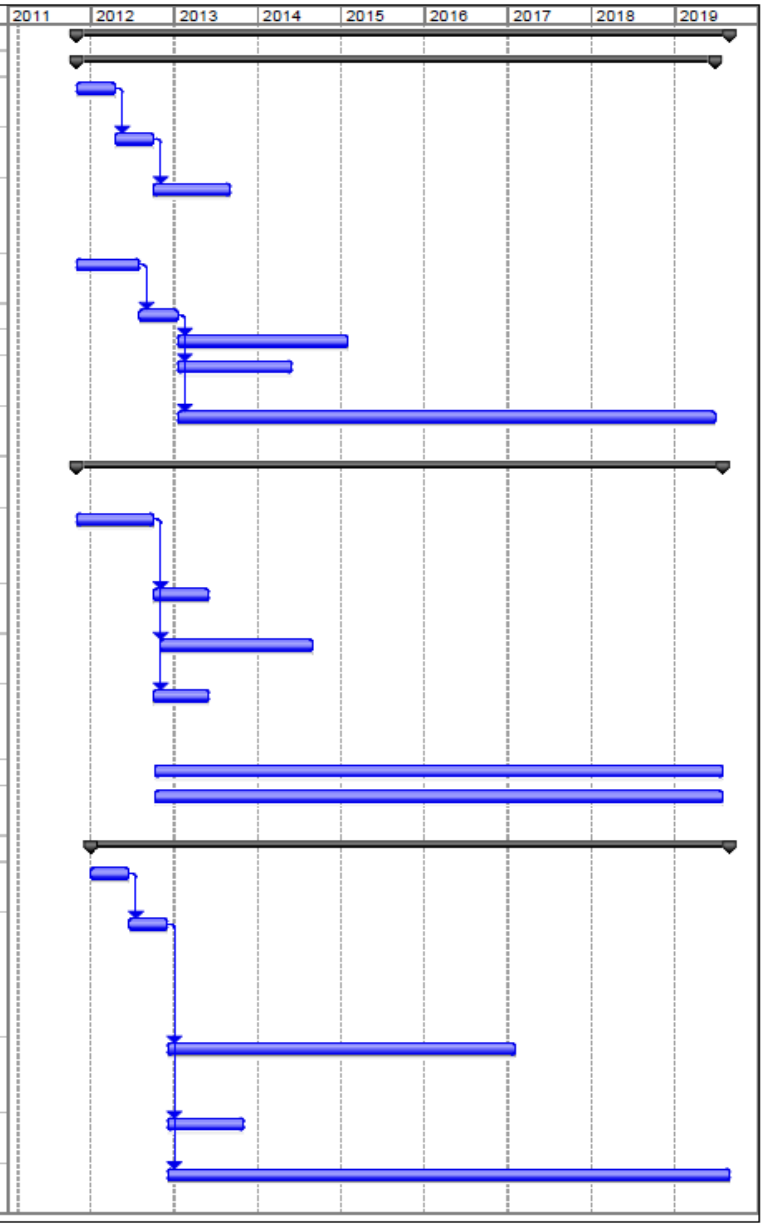
Table 1: Schedule of Project Readiness Activities

Activity	2011						Responsibility
	July	Aug	Sep	Oct	Nov	Dec	
Discuss with participating provinces including church/private partners	X	X					Project preparatory technical assistance (PPTA)
District selection	X						DOH
Clarification of development partner cofinancing[20]		X					ADB/PPTA/cofinancers
NEC approval		X					GoPNG
Designation of provincial focal point	X						DOH
Loan negotiations			X				ADB and GoPNG
ADB Board approval			X				ADB Board
Advanced contracting actions			X	X			GoPNG and ADB
Loan agreement signed					X		GoPNG and ADB
Project agreement signed					X		GoPNG/DOH/ Provinces
Recruitment of PSU				X			EA and IA supported by ADB
Formation of the project steering committee				X	X		GoPNG/DOH/PSU
Formation of the project evaluation committee				X	X		GoPNG/DOH/PSU
Government legal opinion provided					X		GoPNG
Loan effectiveness						X	ADB
Establish project implementation arrangement including designation of government shadow staff, project offices/space in each province				X	X	X	GoPNG/DOH/ Provinces/PSU

[20] Clarification of AusAID engagement/financing in national community health worker training and national maternity health capability and capacity training to ensure that there are no overlaps/gaps between aid partner activities.

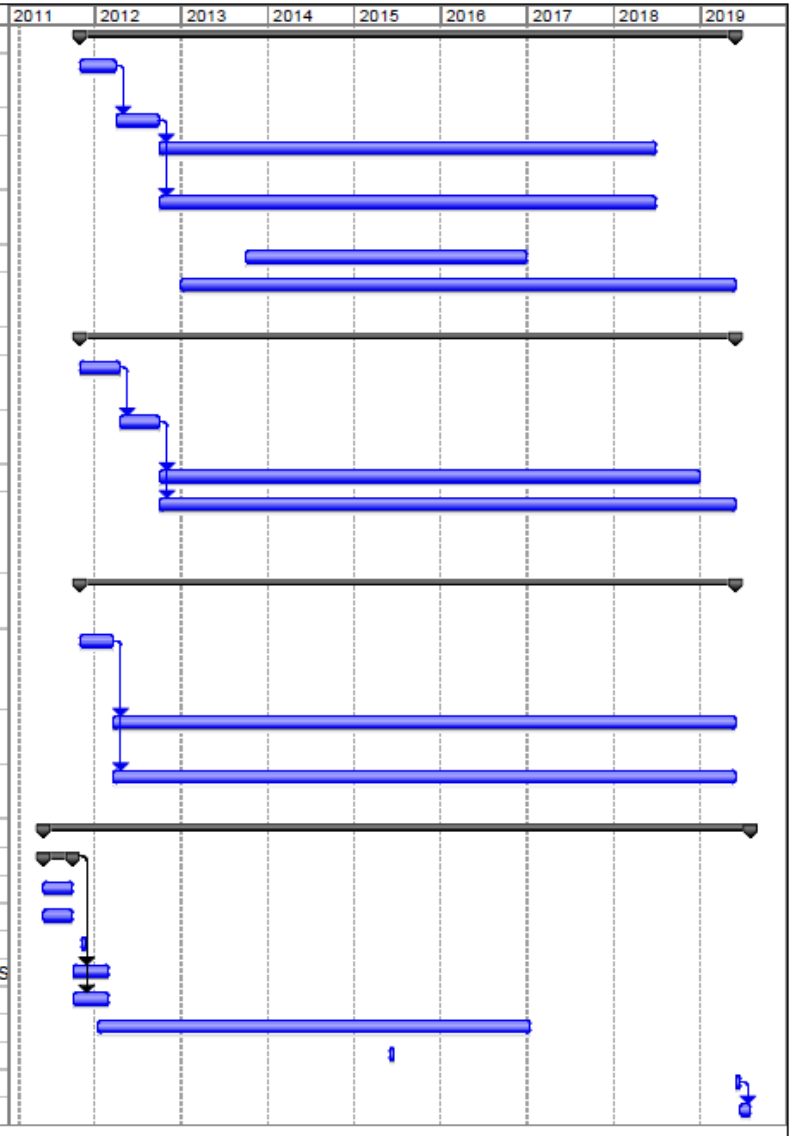
Table 2: Overall Project Implementation Plan

ID	Task Name
1	**A. DMF**
2	**Output 1: National support policies and standard**
3	1. Develop and finalize CHP policy, standard, strategy draft paper.
4	2. Develop communication tools and training materials.
5	3. Each selected provinces prepare strategies to implement policy on district health services and CHPs.
6	4. Assess on health information system and ICT situation.
7	5. Design ICT program with GIS feature
8	6. Implement ICT and GIS program
9	7. Organize workshops and trainings in selected project sites.
10	8. Routinely monitor the standard of CHP in selected sites every 6 months after completion of upgrading of each CHP facility.
11	**Output 2: Sustainable partnerships of provincial governments and non-state actors**
12	1.Prepare alliance contract/agreement in each province with local service providers including assessments on decentralization.
13	2. Finalize and agree on the alliance contract by provincial and local partners.
14	3. Provide training on contract and facility based funding.
15	4. Set up monitoring indicators, target and mechanism to manage alliance agreement/contract.
16	5. Implement the agreed contracts.
17	6. Monitor indicators, targets, set in the contract every 6 months after implementing the contracts.
18	**Output 3: Human resource development in the health sector**
19	1.Assess HR and supervising management capacity in selected provinces and districts.
20	2.Develop HR capacity development, local management strengthening strategy and training programs (utilizing existing training course materials) for CHW including costing and required resources.
21	3.Organize training for community health HR and local management/supervisors in selected provinces and districts. **1.**
22	4.Prepare annual plans for outreach programs for community health workers.
23	5.Evaluate HR and local health management capacity training every 6 months after finishing training.



Overall Project Implementation Plan

ID	Task Name
24	**Output 4: Community health facility upgrading**
25	1.Prepare site selection criteria for districts and CHP sites.
26	2.Finalize site selection of districts and CHP sites.
27	3.Begin the building/upgrading/refurbishment and equipment of health facilities.
28	4.Distribute equipment including training on equipment use and maintenance.
29	5.Prepare maintenance plans.
30	6.Conduct routine maintenance and monitoring every 6 months.
31	**Output 5: Health promotion in local communities**
32	1.Assess on-going health promotion programs in selected districts and provinces.
33	2.Prepare health promotion programs and plan schedules for selected areas.
34	3.Implement health promotion programs.
35	4.Monitor and evaluate the health promotion programs every 6 months after the start of its implementation.
36	**Output 6: Project management**
37	1.Set up PSU and hire consultants for technical areas including finance/accounting and formative evaluation.
38	2.Monitor progress of activities by PSU with key indicators every 6 months.
39	3.Conduct formative evaluation every 6 months after project commencement.
40	**B. Management Activities**
41	**1. Advanced procurement for consultants**
42	Establishment of PSU
43	Rcruitement of other consultants
44	2. Inception mission
45	3. Review of environment management plan and other safeguard documents
46	4. Review and fianlized Gender action plan key activities
47	5. Review missions twice a year
48	6. Mid-term review
49	7. Project completion mission
50	8. Draft Project completion report by the government and ADB



III. PROJECT MANAGEMENT ARRANGEMENTS

A. Project Implementation Organizations – Roles and Responsibilities

Table 3: Summary of Project Implementation Organization

Project Implementation Organizations	Management Roles and Responsibilities
Department of Health	Project executing agency Provide strategic guidance, policy directions, and overall oversight to the project; Coordinate with provincial governments in the preparation and implementation of the project.
Department of Health, supported by Project Support Unit	Project implementing agencies • On behalf of the executing agency, manage the day-to-day implementation of the six project outputs at the national, provincial, and local levels. The PSU will also be responsible for the overall financial management and administration of the project. This includes the timely preparation of annual work plans and budgets; submission of withdrawal applications; the retention of supporting documents; the submission of quarterly and annual reports, and the preparation of annual audit reports and financial statements. • Key implementing agency for outputs 1 and 6.
Provincial governments / provincial health authorities	• Provide overall guidance to the implementation of the project at the provincial and local levels of government. • Establish partnership consultation process leading to agreements.[21] • Key implementing agencies for outputs 2, 3, 4, and 5. • Participate in partnership meetings and contract agreements and carry out agreed upon outputs.
State and nonstate district level health service providers (district governments, church organizations, private sector, civil society, community participants) Consultants Cofinancers	• Provide technical support to the implementation of the six project outputs, in particular output 6. • Participate in the project join-review missions including inception mission, 6 monthly reviews, mid-term reviews, project completion mission, and special administration review if necessary. • Participate in formative evaluation process and workshops with provincial and national stakeholders. • Provide technical support to the implementation through PSU.
ADB	• Lead project joint review missions including inception mission, 6 monthly reviews, mid-term reviews, project completion mission, and special administration review if necessary. • Provide support to the implementation to EA and IA supported by PSU.

32. A project steering committee will be established following the advice of the National Department of Planning and Monitoring, DOH (national and provinces), and Treasury. This committee will enable the central agencies to discuss in detail issues related to the project during its term. Terms of Reference of the committee will be discussed during the project inception mission.

33. The executing agency for the project will be DOH. DOH will provide overall strategic and policy direction for the preparation and implementation of the project. DOH will ensure that the

[21] See linked document 18 for description of partnership contracts.

project operates in full accordance with the policies and strategies laid out in the NHP 2011-2020 [22] and is coordinated with and informs other rural health system strengthening activities of both other donors and government.

34. The five selected provincial governments of Enga, East Sepik, Morobe, West New Britain, and the Autonomous Region of Bougainville and the three provincial health authorities (PHAs) of Eastern Highlands, Western Highlands, and Milne Bay will be the implementing agencies for outputs 2-5. They will make staff available in adequate numbers with the requisite skills throughout the implementation period to manage the activities and prepare reports and coordinate with the executing agency. Dedicated project staff from each provincial government/PHA will be supervised by a project manager. They will be assisted by the PSU, in particular in relation to the technical quality of design and construction.

35. DOH will ensure that no later than 30 days after the effective date, the project director will be appointed, and the implementing agencies will each have appointed for the relevant province the project manager, a safeguard officer, a social development officer, and other key staff to the relevant project offices. The PSU will play the key role in advising on districts for participation in outputs 2, 3, and 5, and on sites for refurbishment and/or construction under output 4, with the final selection to be made by the province based on the agreed upon process and selection criteria followed by agreement by DOH, subject to final approval by ADB.

36. DOH has a policy of harmonizing and integrating projects into regular services and not creating separate PSUs. The PSU will be the initial building block of the NDoH's approach to Rural Health Service Transformation, and, will also closely collaborate with other rural health system strengthening initiatives or programs supported by Government and other donor agencies. Over the course of the project, the PSU will be fully integrated into DOH.

37. To ensure project sustainability, the PSU will provide capacity development training for counterpart government staff and national consultants through technical support by international consultants over the life of the project. This will result in a transition from international to national consultant predominance over the course of the project. In addition, the PSU is to be fully integrated into DOH systems by the time the project concludes, with the government providing necessary resources to sustain, manage, and enhance project achievements in line with DOH's strategy. It is the government's intention to build on the experience and expertise of the project to strengthen the remaining 73 districts.

38. The PSU will develop operational procedures and guidelines so that transfers of responsibility for specified tasks and functions will occur according to agreed upon periodic milestones. Such procedures and guidelines will;

- require the government to maintain the availability of named partner staff associated with each consultant,
- envision weekly/periodic meetings between consultants and partner staff, and
- require maintenance of a moving/evolving list of consultant functions and timing of transfer for each function.

39. The project will require both national and international technical assistance particularly in the initial phases of the project, where the project is being asked to spearhead the DOH's broader health system strengthening activities which form the basis of the National Health Plan. The

[22] Government of Papua New Guinea. *National Health Plan 2011-2020, Back to Basics: Strengthened primary health care for all and improved service delivery for the rural majority and urban disadvantaged.* June 2010.

required technical and implementation expertise is currently not available to the DOH. The project will progressively transition its TA components into in line positions over the course of the project.

40. The following principles will be applied to the TA. The Summary Table of Consulting Services and Outline of Consultant's Terms of Reference is in Annex 2.

- The TA will be contracted to the PSU, which is an inline group in the project coordination unit (aka Rural Health System Transformation Unit) in the planning division of the DOH. The primary line of reporting for all TA positions is to the DOH.
- The project TA will focus on project implementation, not corporate processes.
- Direct government funding of TA positions will progressively replace project funding in the later years of the project.
- Levels of TA support will be monitored and reported 6 monthly, and progress towards transition into DOH structures and decline in the proportionate spend on TA are part of the monitoring framework.
- Assisting the transition to inline government positions will be a specific requirement of all TA contracts.
- Individual TA contracts will be long term (4 years) subject to satisfactory performance.
- The impact of the projects TA on long term PNG health system capacity and capability will be part of the TOR for the formative evaluation. TA inputs will be adjusted as needed based on the findings of formative evaluations.

41. The trust account established under the Health Sector Improvement Program (HSIP) will operate as a special project account, as with prior ADB projects with DOH.[23] The special project account will be managed, replenished, and liquidated in accordance with imprest account procedures as outlined in ADB's *Loan Disbursement Handbook* (January 2007), and detailed arrangements agreed on between the government and ADB.

42. The cofinanciers will participate in the project joint-review missions including inception mission, 6 monthly reviews, mid-term reviews, project completion mission, and special administration review if necessary. They will participate in the formative evaluation process and workshops with provincial and national stakeholders.

43. The World Health Organization will supply technical expertise on Maternal Health and Health Systems, including technical support in these areas to the formative evaluation process. UNICEF will support the project through its support for government child health projects.

[23] ADB. 2006. *Report and Recommendation of the President to the Board of Directors. Proposed Asian Development Fund Grant Papua New Guinea: HIV/AIDS Prevention and Control in Rural Development Enclaves Project.* Manila (Grant-0042 PNG for $22,000,000 approved on 25 April 2006, cofinanced by the Government of Australia and the Government of New Zealand).

B. Key Persons Involved in Implementation

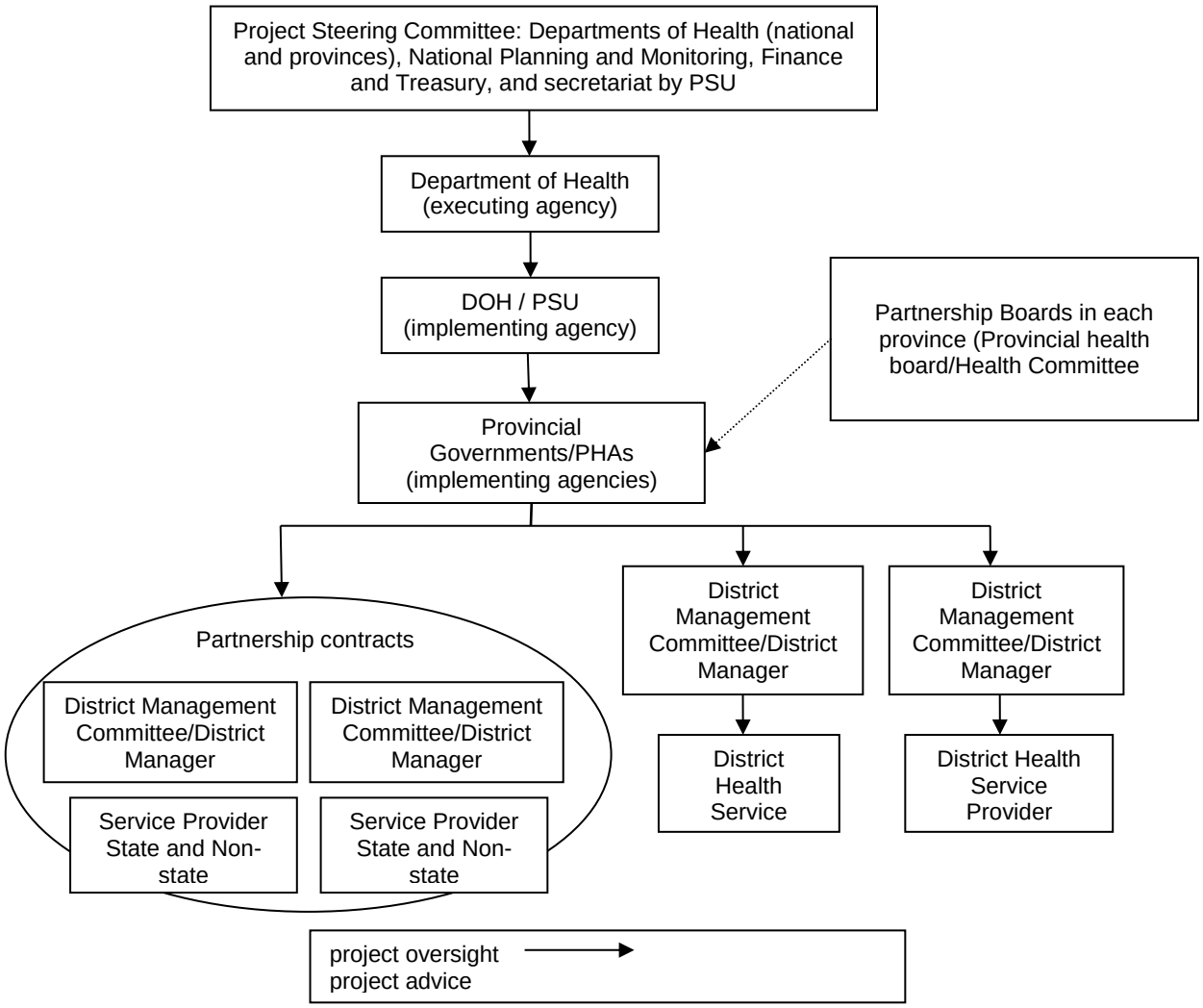
Executing Agency	
National Department of Health	Officer's Name: Pascoe Kase Position: Acting Secretary of Health Telephone: 3013602 Email address: pascoe_kase@health.gov.pg
Implementing Agencies	
Eastern Highland	Officer's Name: Mr. Ben Haili Position: Provincial Health Advisor Telephone: 532 1900, 532 1902 Fax: 532 1314 Email address: bhaili@global.net.pg Office Address: P.O. Box 392, Goroka
East Sepik	Officer's Name: Mr. Albert Bunat Position: Provincial Health Advisor Telephone: 4561306, 5321900, 5321902; Fax: 4561306 Email address: pho_esp@healthpng.gov.pg Office Address: P. O. Box 395, Wewak
Enga Province	Officer's Name: Mr. Aaron Luai Position: Provincial Health Advisor Telephone: 5471031, 5471026, 72730244 Fax: 5471384 Email address: aluai0471@datec.net.pg Office address: P. O. Box 110, Wabag
Milne Bay Province	Officer's Name: Mr. Billy Naidi Position: CEO Provincial Health Authority Telephone: 6411164, 71776772 Fax: 6410040 Email address: jack_purai@milnebay.gov.pg; pa_health.@daltron.com.pg Office address: Division of Health, Free Mail Bag, Alotau
Morobe	Officer's Name: Mr. Theo Likei Position: Provincial Health Advisor Telephone: 4731660, 4731661 Fax: 4726844/4791158/4724745 Email address: pho_morobe@healthpng.gov.pg Office address: P. O. Box 458, Lae
Western Highlands Province	Officer's Name: Dr. James Kintwa Position: CEO Provincial Health Authority Telephone: 5422071, 5421481, 71000455 Fax: 542 2071 Email address: jkintwa@daltron.com.pg Office address: P. O. Box 36, Mt Hagen
West New Britain Province	Officer's Name: Dr. Joseph Nale Position: Director Rural Health Services Telephone: 9835682, 73271598 Fax: 9834611 Email address: jnalejr@gmail.com Office address: P. O. Box 428, Kimbe
Autonomous Region of Bougainville	Officer's Name: Dr. Anthony Pumpara Position: CEP Rural Health Telephone: 973 9268, 973 9269, 73913220 Fax: 973 9268 Email address: pho_nsp@health.png.gov.pg Office address: P. O. Box 322, Buka

ADB	
Division Director	Staff Name: Andrea Iffland Position: Director, PAUS, PARD Telephone No. +6326326126 Email address: aiffland@adb.org
Mission Leader	Staff Name: Sakiko Tanaka Position: Social Development Specialist, PAUS, PARD Telephone No. +6326326722 Email address: sakikotanaka@adb.org

C. Project Organization Structure

44. The Chart 1: Organization Chart shows the reporting lines and internal structures of key functions involved in implementation of the project including the PSU. This project intends not to create new structures but to work with or improve the existing structure. There will be two new structures: the Project Steering Committee and the PSU. Both were suggested by the government, and the PSU will be integrated with DOH's Project Coordination Unit in the planning division.

Chart 1: Project Implementation Organizations



DOH = Department of Health, PHA = provincial health authority, PSU = project support unit.
Note: District health service providers may be government, private, church, or NGO.

45. The project will be implemented at three levels of government: the national level, the provincial level, and the local level.

46. With ADB experience from the ongoing project *Grant 0042-PNG:HIV/AIDS Prevention and Control in Rural Development Enclaves* and further consultations in the field with NGOs and government and community representatives, the project will, in the first stage, bring together funding partners, health service providers, and community representatives at the provincial and district levels through partnership boards. While the NHP envisions the formation and use of

partnership health boards (PHBs), these have not been uniformly established, or if established, may in some cases be inactive.

47. The project envisions reinvigoration of existing PHBs or formation of partnership boards in each province (or, as applicable, in a district within the province). This will bring together, in a consultative and planning body, funding partners, health service providers, community representatives, and members of the local governments. The project target would be to ensure that the partnership board (whether new or based upon the existing PHB) would be formed and/or relaunched and be operational within 6 months after the effective date of the loan.

48. The partnership board will be considered to be fully functional after it has been fully constituted with all members, has adopted rules of operation and procedure including periodic meetings, has conducted two full meetings with substantive agendas, and has tabled and commenced consideration of the concept and subject matter of cooperation under the proposed partnership agreements.

49. At a subsequent stage of the project, the PHB partnership boards will formulate and sign agreements/contracts. The agreement will cover both capacity development activities (aimed at an increase in the number of skilled health personnel in rural areas) and the construction and rehabilitation of rural health facilities. The agreement will cover (i) contributions to refurbishment and construction of, and operation and maintenance (O&M) of, facilities under output 4, and access roads for the same; (ii) clinical supervision of community health workers (CHWs) working at refurbished or newly constructed facilities; (iii) guidelines for selection of CHWs to staff the facilities or CHPs, and to receive training under output 3; (iv) the resolution of issues relating to the right to use the land for the CHP; and (v) regular and periodic sharing of rural health indicators and information on services and activities within the relevant province for consolidation by the provincial government. To accommodate the necessary sequencing of activities in the project, the contracts are to be concluded within 24 months after the effective date of the proposed loan. DOH will review and be a signatory to the contracts together with the provincial governments/PHAs and representatives of the local governments.

IV. COSTS AND FINANCING

50. The estimated cost of the project is $81.2 million including taxes and duties, physical and price contingencies, interest charged during implementation.[24] The project cost includes interest charged on the ADB portion of financing $20.0 million. The balance of $61.2 million will be provided through a combination of loan, grant, and government financing as stated in Table 1.[25]

51. The ADB loan will be financed from the Asian Development Fund (ADF). It will have a 32-year term including a grace period of 8 years, an interest rate of 1% per annum during the grace period and 1.5% per annum thereafter, and such other terms and conditions as set forth in the draft loan and project agreements.

Table 4: Financing Plan

Source	Type	Amount US$ (million)	Share of Total (%)
Asian Development Bank	ADF Loan	20.00	24.63%
Australian Agency for International Development[a]	Grant	40.00	49.26%
OPEC Fund for International Development (OFID)[b]	Loan	9.00	11.09%
JICA Volunteers[c]	Grant	1.20	1.48%
World Health Organization[d]	Grant	1.00	1.23%
Government of Papua New Guinea	GF	10.00	12.31%
	Total	**81.20**	**100.00%**

ADF = Asian Development Fund, GF = Government Finance, JICA = Japan international Cooperation Agency.
[a] The grant will be administered by ADB.
[b] The OFID board is expected to approve the cofinancing in December 2011. The loan will be partially administrated by ADB.
[c] JICA and WHO contribution is in-kind.
Source: Asian Development Bank.

52. ADB is financing 24.63% of the total project cost. These funds will be utilized for (i) consultancy services; (ii) institutional strengthening at the national, provincial, and district levels; (iii) ICT developments and geo-mapping for rural health services; (iv) construction and refurbishment of rural health facilities; and (v) O&M costs, including the purchase of vehicles. Interest during implementation of the ADB loan will be capitalized into the loan amount.

53. Cofinancing of $40 million, which equates to 49.26% of the total project cost, will be provided by AusAID, to be administered by ADB. It will finance (i) consultancy services; (ii) institutional strengthening at the national, provincial, and district levels; (iii) medical equipment; (iv) capacity development of health service staff; (v) construction and refurbishment of rural health facilities; and (vi) health promotion; and it also includes ADB s administration fee, audit cost and provision for foreign exchange fluctuations, provided that these items are not covered by the interest and investment income earned on this grant, or any additional grant contribution by the Government of Australia.[26]

54. The government has also requested a loan of $9 million from the OPEC Fund for International Development (OFID) to jointly finance the project. This equates to 11.09% of the total

[24] Transportation and insurance are eligible expenses for ADB administrated financing.
[25] As background analyses, Economic Analysis and Country Economic Indicators are presented in RRP linked document 9 and 10, respectively.
[26] All project disbursements will be made on a pro rata basis in accordance with applicable percentage of cost allocation tables.

project cost. The OFID loan will be used to support the construction and refurbishment of rural health facilities. The OFID loan will be administered by ADB on a partial basis, with ADB reviewing the withdrawal applications and then advising OFID to make disbursements.

55. The government will fund 12.31% of the total project cost, $10 million in cash including in-kind of $0.5 million to fully cover recurrent costs and also to provide funding for the (i) construction and refurbishment of rural health facilities, (ii) health promotion, (iii) capacity development, and (iv) contingencies. Taxes and duties will be financed by the government and ADB. The government has also requested the Japan International Cooperation Agency (JICA) to provide 12 senior volunteers (in-kind) to work in the selected provinces as provincial partnership coordinators.[27] The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) will support the project with technical assistance in their areas of expertise.[28]

56. Tax calculations are based on customs tariffs, import levies, and excise on fuel. Taxation rates applied include the government service tax of 10%, and taxes and duties of 21% on office furniture and equipment. Given the nature of the project and the high level of grant funding, and based on agreement with the government, it is anticipated that a tax exemption will be given for all project activities in particular, civil works, vehicles and medical equipment. Physical contingencies have been provided at 10% on civil works and 6% on equipment and training. Price contingencies were provided for civil works materials, equipment, and vehicles and based on domestic cost escalation factors for PNG for local currency costs. A devaluation offset is included in the price contingency based on the United States dollar inflation rate of 1%.

57. The proceeds of the loans and grant will be used to finance eligible project expenditures. All goods, works, and services to be financed out of the loans and grant proceeds will be procured in accordance with the Loans, Grant, and Project Agreements and will be used exclusively in carrying out the project. ADB may refuse to finance a contract where goods or services have not been procured under procedures in accordance with those agreed upon between the government and ADB, or where the terms and conditions of the contract are not satisfactory to ADB.

58. An exchange rate of K2.63 to $1.00 has been used as the current rate at the time of writing. Detailed costs are shown in the following tables.

59. The cost financing ratio per financier was revised to allow a full financing of a single expenditure item by a financier where possible. The changes were approved by ADB on 24 June 2013. Financing table (Table 5) and detailed costs were revised as shown in the following tables. An exchange rate of K2.15 to $1.00 has been used.

60. Civil works contracts will be financed by four packages. Civil works package 1 amounting $5,015 will be financed by the Government of PNG; civil work package 2 amounting $8,777 will be financed by the Government of Australia represented by AusAID; civil work package 3 amounting $7,899 will be financed by OFID; and civil work package 4 amounting $3,385 will be financed by ADB.

[27] Volunteers will be retained by JICA under standard JICA procedures but will work under the project.

[28] A WHO health system expert and maternal health expert will contribute 20% of their time to the project through output 6 on formative evaluation. UNICEF will provide parallel in-kind financing. Activities under output 5 will utilize information, education, and communication materials on health promotion developed by UNICEF. See further information in linked documents 17 and 18.

Table 5: Revised Financing Table

Source	Type	Amount US $ (million)	Share of Total (%)
Source Development Bank	ADF Loan	18.60	23.31%
Australian Agency for International Development[a]	Grant	40.00	50.13%
OPEC Fund for International Development (OFID)[b]	Loan	9.00	11.28%
JICA Volunteers[c]	Grant	1.20	1.50%
World Health Organization[d]	Grant	1.00	1.25%
Government of Papua New Guinea	GF	10.00	12.53%
	Total	**79.80**	**100.00%**

ADF = Asian Development Fund, GF = Government Finance, JICA = Japan international Cooperation Agency.
[a] The grant will be administered by ADB.
[b] The OFID board is expected to approve the cofinancing in December 2011. The loan will be partially administrated by ADB.
[c] JICA and WHO contribution is in-kind.
Source: Asian Development Bank.

Table 6: Detailed Cost Estimates by Expenditure Category

	Kina 000's			US$ '000s		
I. Investment Costs	**Local**	**Foreign**	**Total**	**Local**	**Foreign**	**Total**
A. Civil Works						
1. Civil Works Package 1	10,782	0	10,782	5,015	0	5,015
2. Civil Works Package 2	0	18,871	18,871	0	8,777	8,777
3. Civil Works Package 3	0	16,983	16,983	0	7,899	7,899
4. Civil Works Package 4	0	6,769	6,769	0	3,148	3,148
Subtotal	**10,782**	**42,623**	**53,405**	**5,015**	**19,825**	**24,840**
B. Medical Equipment	0	3,139	3,139	0	1,460	1,460
C. Vehicles	0	3,073	3,073	0	1,429	1,429
D. ICT and GMIS Provision	0	5,019	5,019	0	2,334	2,334
1. Volunteers (In-Kind from GoJ)[a]	0	2,580	2,580	0	1,200	1,200
E. Training	32	13,069	13,102	15	6,079	6,094
F Sustainable Partnerships	0	912	912	0	424	424
G. Health Promotion	49	16,076	16,125	23	7,477	7,500
H. Consulting services						
1. International Consultants	0	22,814	22,814	0	10,611	10,611
2. National Consultants	0	7,838	7,838	0	3,646	3,646
3. International Travel	0	1,467	1,467	0	682	682
4. Domestic Travel	0	3,714	3,714	0	1,727	1,727
I. IT Setup Costs	0	380	380	0	177	177
J. Formative Evaluation Contract	0	4,577	4,577	0	2,129	2,129
1. WHO (In-Kind contribution)	0	2,150	2,150	0	1,000	1,000
K. Operation and Maintenance for PSU	3,589	209	3,798	1,669	97	1,766
Total Investment Costs	**14,453**	**129,640**	**144,094**	**6,722**	**60,298**	**67,020**
II. Recurrent Costs						
A. Project Management Costs[b]	1,079	0	1,079	502	0	502
B. Administration	778	0	778	362	0	362
C. Communications	1,798	0	1,798	837	0	837
D. Security	327	0	327	152	0	152
Total recurrent costs	**3,983**	**0**	**3,983**	**1,852**	**0**	**1,852**
Total Project Base Costs	**18,436**	**129,640**	**148,076**	**8,575**	**60,298**	**68,873**
III. Contingencies						
A. Physical Contingencies	1,129	9,159	10,287	525	4,260	4,785
B. Price Contingencies	1,935	9,579	11,514	900	4,455	5,355
Sub - total contingencies	**3,064**	**18,738**	**21,802**	**1,425**	**8,715**	**10,140**
IV. Loan Financing Charges						
A. Interest during implementation	0	1,692	1,692	0	787	787
Total project costs (I+II+III+IV+V)	**21,500**	**150,070**	**171,569**	**10,000**	**69,800**	**79,800**

GMIS = Geo Mapping Information System, GOJ = Government of Japan, ICT = Information Communication Technology, IT = Information Technology, WHO = World Health Organization.
[a] This amount is an in-kind contribution from the Government of Japan for JOVC volunteers.
[b] This amount includes in-kind contributions of the government for office space, utility costs and management supervision equivalent to $500,000.
Source: Asian Development Bank estimates.

A. Allocation and Withdrawal of Loan and Grant Proceeds

61. Except as ADB may otherwise agree, each item of expenditure will be financed from the proceeds of the loan on the basis of the percentages set forth in Tables 7 and 8.

Table 7: Allocation and Withdrawal of ADB Financing Loan

Category			ADB Financing	
Number	Item	ADB Financing ($'000s)[a]	Percentage and Basis for Withdrawal from the Loan Account	
1	Civil Works[b]	3,148	100	percent of total expenditure claimed[c]
2	Medical Equipment	0	-	percent of total expenditure claimed[c]
3	Vehicles	1,210		percent of total expenditure claimed[c]
3a	Vehicles-Old Financing	204	50	percent of total expenditure claimed
3b	Vehicles- New Financing	1,007	100	percent of total expenditure claimed
4	ICT and GMIS Provision -New Financing	2,334	100	percent of total expenditure claimed
5	Training - Old Financing	2.8	5	percent of total expenditure claimed
6	Sustainable Partnerships New Financing	424	100	percent of total expenditure claimed
7	Consulting services	8,031	50	percent of total expenditure claimed
8	IT Setup Costs-New Financing	177	100	percent of total expenditure claimed
9	Formative Evaluation Contract	0	-	percent of total expenditure claimed
10	Operation and Maintenance - Old Financing	47	50	percent of total expenditure claimed
11	Unallocated	2,438		
12	Financing (Loan Interest)	787	100	of amounts due
	Total	**18,600**		

ADB = Asian Development Bank, GMIS = geo-mapping information system, ICT = information and communication technology, IT = information technology.
Note: Old financing includes actual expenditure as of March 2013 plus projected expenses until end April 2013.
[a] Total amount allocated for ADB financing.
[b] No contracts shall be awarded from Civil Works (Package 3) until the OFID Loan Agreement has been duly executed and delivered.
[c] Exclusive of taxes and duties imposed within the territory of the Borrower.

Table 8: Allocation and Withdrawal of ADB Financing Loan

Category			ADB Financing	
Number	Item	ADB Financing (SDR)	Percentage and Basis for Withdrawal from the Loan Account	
1	Civil Works	2,105	100%	percent of total expenditure claimed
2	Medical Equipment	0	0%	percent of total expenditure claimed
3	Vehicles	809		percent of total expenditure claimed
3a	Vehicles-Old Financing	136	50%	percent of total expenditure claimed
3b	Vehicles- New Financing	673	100%	percent of total expenditure claimed
4	ICT and GMIS Provision -New Financing	1,561	100%	percent of total expenditure claimed
5	Training - Old Financing	2	5%	percent of total expenditure claimed
6	Sustainable Partnerships New Financing	284	100%	percent of total expenditure claimed
7	Consulting services	5,369	50%	percent of total expenditure claimed
8	IT Setup Costs-New Financing	118	100%	percent of total expenditure claimed
9	Formative Evaluation Contract	0	0%	percent of total expenditure claimed
10	Operation and Maintenance - Old Financing	31	50%	percent of total expenditure claimed
11	Unallocated	1,630		
12	Financing (Loan Interest)	526	100%	percent of amounts due
	Total	**12,435**		

ADB = Asian Development Bank, GMIS = geo-mapping Information System, ICT = information and communication technology, IT = information and technology, SDR = special drawing rights.

62. Except as a cofinancer may otherwise agree, each item of expenditure will be financed from the proceeds of the grant on the basis of the percentages set forth in Table 9.

Table 9: Allocation and Withdrawal of AusAID Grant Proceeds

Category			AusAID Financing		
Number		Item	AusAID Financing ($'000s)[a]	Percentage and Basis for Withdrawal from the Grant Account	
1		Civil Works	8,777	100	percent of total expenditure claimed[b]
2		Medical Equipment - New Financing	1,460	100	percent of total expenditure claimed[b]
3		Vehicles - Old Financing	219	50	percent of total expenditure claimed[b]
4		ICT and GMIS Provision	0	0	percent of total expenditure claimed
5		Training	6,076		
	5a	Training - Old Financing	45	85	percent of total expenditure claimed
	5b	Training - New Financing	6,031	100	percent of total expenditure claimed
6		Sustainable Partnerships	0	0	percent of total expenditure claimed
7		Consulting Services	8,636	50	percent of total expenditure claimed
8		Health Promotion	7,477		percent of total expenditure claimed
	8a	Health Promotion - Old Financing	45	85	percent of total expenditure claimed
	8b	Health Promotion - New Financing	7,432	100	percent of total expenditure claimed
9		IT Setup Costs	0	0	percent of total expenditure claimed
10		Formative Evaluation - New Financing	2,129	100	percent of total expenditure claimed
11		Operation and Maintenance - Old Financing	50	50	percent of total expenditure claimed
12		Unallocated[c]	5,176		percent of total expenditure claimed
		Total	**40,000**		

AusAID = Australian Agency for International Development, GMIS = geo-mapping information system, ICT = information and communication technology, IT = information technology.
[a] Total amount allocated for AusAID financing.
[b] Exclusive of taxes and duties imposed within the territory of the Recipient. For Categories 4-11, the taxes and duties will be financed by the government and/or ADB.
[c] May be used towards ADB's administration fee, audit costs, bank charges, a provision for foreign exchange fluctuations, etc.

63. Except as OFID may otherwise agree, each item of expenditure will be financed from the proceeds of the loan on the basis of the percentages set forth in Table 10.

Table 10: Allocation and Withdrawal of OFID Financing Loan

Category		OFID Financing		
Number	Item	OFID Financing ($'000s)[a]	Percentage and Basis for Withdrawal from the Loan Account	
1	Civil Works[b]	7,899	100	percent of total expenditure claimed[c]
2	Unallocated	1,100		
	Total	**9,000**		

OFID = OPEC Overseas Fund for International Development.
[a] Total amount allocated for OFID financing.
[b] No contracts shall be awarded from Civil Works (Package 3) until the OFID Loan Agreement has been duly executed and delivered.
[c] Exclusive of taxes and duties within the territory of the Borrower.

64. **Financing charges.** A breakdown of the amount allocated for financing charges on the ADB loan during the implementation period of the project is attached in the schedule (to be supplied).

65. **Reallocation.** Notwithstanding the allocation of loan/grant proceeds and the withdrawal percentages set forth in the tables:

(i) if the amount allocated to the loans/grant in any category appears to be insufficient to finance all agreed upon expenditures in that category, ADB may, in consultation with the government and cofinancers, (a) reallocate to such category, to the extent to meet the estimated shortfall, amounts of the loans/grant that have been allocated to another category, but in the opinion of ADB are not required to meet other expenditures; and (b) if such allocation cannot meet the estimated shortfall, ADB may reduce the withdrawal percentage applicable to such expenditures in order that further withdrawals under such category may continue until all expenditures thereunder have been made; and

(ii) if the amount of the loans/grant allocated to any category appears to exceed all agreed upon expenditures in that category, ADB may, in consultation with the government and cofinancers, reallocate such excess amount to any other category.

Table 11: Detailed Cost Estimates by Financier[a]

Amounts in $000's		Government		ADB Loan		Current	SDR	AusAID Grant[b]		Volunteers		OFID Loan[c]		WHO		Total	% of	Total	Total
	Total	Amount	%	Amount	%	US$	Equivalent	Amount	%	Amount	%	Amount	%	Amount	%	Amount	Total Exp	Amount	Exp
	As per Orig US$					*As of 9 June 2013*										*As per Orig US$*		*As of 9 June 2013*	
I. Investment Costs																			
A. Civil Works																			
A1. Civil Works Package 1	5,015	5,015	100%	0	0%		-	0	0%	0	0%	0	0%	0	0%	5,015	6.18%	5,015	6.28%
A2. Civil Works Package 2	8,777	0	0%	0	0%		-	8,777	100%	0	0%	0	0%	0	0%	8,777	10.81%	8,777	11.00%
A3. Civil Works Package 3	7,899	0	0%	0	0%		-	0	0%	0	0%	7,899	100%	0	0%	7,899	9.73%	7,899	9.90%
A4. Civil Works Package 4	3,385	0	0%	3,385	100%	3,148	2,105	0	0%	0	0%	0	0%	0	0%	3,385	4.17%	3,148.42	3.95%
Subtotal	**25,077**	**5,015**	**20%**	**3,385**	**1%**	**3,148**	**2,104.87**	**8,777**	**35%**	**0**	**0%**	**7,899**	**32%**	**0**	**0%**	**25,077**	30.88%	**24,840**	**31.13%**
B. Medical Equipment																			
B.1 Old Financing Percentage	313	0	0%	0	30%		-	0	70%	0	0%	0	0%	0	0%	0	0.00%	-	0.00%
B.2 New Financing Percentage	1,147	0	0%	0	0%		-	1,460	100%	0	0%	0	0%	0	0%	1,460	1.80%	1,460	1.83%
Subtotal	**1,460**	**0**	**0%**	**0**	**0%**		**-**	**1,460**	**100%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**1,460**	**1.80%**	**1,460**	**1.83%**
C. Vehicles																			
C.1 Old Financing Percentage	438	0	0%	219	50%	204	136	219	50%	0	0%	0	0%	0	0%	438	0.54%	422.67	0.53%
C.2 New Financing Percentage	1,083	0	0%	1,083	100%	1,007	673	0	0%	0	0%	0	0%	0	0%	1,083	1.33%	1,006.73	1.26%
Subtotal	**1,521**	**0**	**0%**	**1,302**	**86%**	**1,210**	**809**	**219**	**14%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**1,521**	**1.87%**	**1,429.40**	**1.79%**
D. ICT and GMIS Provision																			
D.1 New Financing Percentage	2,510	0	0%	2,510	100%	2,334	1,561	0	0%	0	0%	0	0%	0	0%	2,510	3.09%	2,334.30	2.93%
1. Volunteers (In Kind from GoJ)	1,200	0	0%	0	0%	-	-	0	0%	1,200	100%	0	0%	0	0%	1,200	1.48%	1,200	1.50%
Subtotal	**3,710**	**0**	**0%**	**2,510**	**68%**	**2,334**	**1,561**	**0**	**0%**	**1,200**	**32%**	**0**	**0%**	**0**	**0%**	**3,710**	**4.57%**	**3,534.30**	**4.43%**
E. Training																			
E.1 Old Financing Percentage	63	15	10%	3	5%	2.8	1.9	45	85%	0	0%	0	0%	0	0%	63	0.08%	62.79	0.08%
E.2 New Financing Percentage	6,031	0	0%	0	0%	-	-	6,031	100%	0	0%	0	0%	0	0%	6,031	7.43%	6,031	7.56%
Subtotal	**6,094**	**15**	**0.25%**	**3**	**0.05%**	**2.8**	**1.9**	**6,076**	**100%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**6,094**	**7.50%**	**6,093.79**	**7.64%**
F. Sustainable Partnerships																			
F.1 New Financing Percentage	456	0	0%	456	100%	424	284	0	0%	0	0%	0	0%	0	0%	456	0.56%	424.33	0.53%
Subtotal	**456**	**0**	**0%**	**456**	**100%**	**424**	**284**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**456**	**0.56%**	**424**	**0.53%**
G. Health Promotion																			
G.1 Old Financing Percentage	68	23	15%	0	0%	-	-	45	85%	0	0%	0	0%	0	0%	68	0.08%	68	0.09%
G.2 New Financing Percentage	7,432	0	0%	0	0%	-	-	7,432	100%	0	0%	0	0%	0	0%	7,432	9.15%	7,432	9.31%
Subtotal	**7,500**	**23**	**0.3%**	**0**	**0%**	**-**	**-**	**7,477**	**99.7%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**7,500**	**9.24%**	**7,500**	**9.40%**
H. Consulting services																			
1. International Consultants	10,996	0	0%	5,498	50%	5,113	3,418.4	5,498	50%	0	0%	0	0%	0	0%	10,996	13.54%	10,611.33	13.30%
2. National Consultants	3,778	0	0%	1,889	50%	1,757	1,174.5	1,889	50%	0	0%	0	0%	0	0%	3,778	4.65%	3,645.72	4.57%
3. International Travel	707	0	0%	353	50%	329	219.7	353	50%	0	0%	0	0%	0	0%	707	0.87%	682.10	0.85%
4. Domestic Travel	1,790	0	0%	895	50%	832	556.5	895	50%	0	0%	0	0%	0	0%	1,790	2.20%	1,727.46	2.16%
Subtotal	**17,271**	**0**	**0%**	**8,636**	**50%**	**8,031**	**5,369**	**8,636**	**50%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**17,271**	**21.27%**	**16,667**	**20.89%**
I. IT Setup Costs																			
New Financing Percentage	190	0	0%	190	100%	177	118	0	0%	0	0%	0	0%	0	0%	190	0.23%	177	0.22%
Subtotal	**190**	**0**	**0%**	**190**	**100%**	**177**	**118**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**190**	**0.23%**	**177**	**0.22%**

Amounts in $000's	Total	Government Amount	%	ADB Loan Amount	%	Current US$	SDR Equivalent	AusAID Grant[b] Amount	%	Volunteers Amount	%	OFID Loan[c] Amount	%	WHO Amount	%	Total Amount	% of Total Exp	Total Amount	Total Exp
				As per Orig US$		*As of 9 June 2013*										*As per Orig US$*		*As of 9 June 2013*	
J. Formative Evaluation Contract																			
J.1 New Financing Percentage	2,129	0	0%	0	0%	-	-	2,129	100%	0	0%	0	0%	0	0%	2,129	2.62%	2,129	2.67%
1. WHO (In-Kind contribution)	1,000	0	0%	0	0%	-	-	0	0%	0	0%	0	0%	1,000	100%	1,000	1.23%	1,000	1.25%
Subtotal	**3,129**	**0**	**0%**	**0**		**-**	**-**	**2,129**	**68%**	**0**		**0**		**1,000**		**3,129**	**3.85%**	**3,129**	**3.92%**
K. Operation and Maintenance																			
K.1 Old Financing Percentage	101	0	0%	50	50%	47	31.3	50	50%	0	0%	0	0%	0	0%	101	0.12%	97.08	0.12%
K.2 New Financing Percentage	1,669	1,669	100%	0	0%	-	-	0	0%	0	0%	0	0%	0	0%	1,669	2.06%	1,669.40	2.09%
Subtotal	**1,770**	**1,669**	**94%**	**50**	**3%**	**47**	**31**	**50**	**3%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**1,770**	**2.18%**	**1,766.48**	**2.21%**
New Total Investment Cost (Revised)	**68,178**	**6,722**	**10%**	**16,532**	**24%**	**15,375**	**10,279**	**34,824**	**51%**	**1,200**	**2%**	**7,899**	**12%**	**1,000**	**1%**	**68,177**	**83.96%**	**67,020.23**	**83.99%**
II. Recurrent Costs																			
A. Project Management Costs[d]	502	502	100%	0	0%	-	-	0	0%	0	0%	0	0%	0	0%	502	0.62%	501.90	0.63%
B. Administration	362	362	100%	0	0%	-	-	0	0%	0	0%	0	0%	0	0%	362	0.45%	361.98	0.45%
C. Communications	837	837	100%	0	0%	-	-	0	0%	0	0%	0	0%	0	0%	837	1.03%	836.50	1.05%
D. Security	152	152	100%	0	0%	-	-	0	0%	0	0%	0	0%	0	0%	152	0.19%	152.09	0.19%
Total recurrent costs	**1,852**	**1,852**	**100%**	**0**	**0%**	-	-	**0**	**0%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**1,852**	**2.28%**	**1,852.47**	**2.32%**
New Total Project Base Cost	**70,030**	**8,575**	**12%**	**16,532**	**24%**	**15,375**	**10,279**	**34,824**	**50%**	**1,200**	**2%**	**7,899**	**11%**	**1,000**	**1%**	**70,030**	**86.24%**	**68,872.71**	**86.31%**
III. Contingencies																			
A. Physical Contingencies	4,959	525	11%	1,146	23%	1,066	712.5	2,657	54%	0	0%	537	11%	0	0%	4,865	5.99%	4,784.78	5.89%
B. Price Contingencies	5,365	900	17%	1,476	28%	1,373	917.7	2,519	47%	0	0%	563	11%	0	0%	5,459	6.72%	5,355.48	6.60%
Sub - total contingencies	**10,324**	**1,425**		**2,622**		**2,438**	**1,630**	**5,176**	**50%**	**0**	**0%**	**1,100**	**11%**	**0**	**0%**	**10,324**	**12.71%**	**10,140.26**	**12.49%**
IV. Loan Financing Charges																			
A. Interest during implementation	846	0	0	846	100%	787	526.0	0	0	0	0	0	0	0	0	846	1.04%	786.78	0.99%
Total project costs (I+II+III+IV)	**81,200**	**10,000**	**12%**	**20,000**	**25%**	**18,600**	**12,435**	**40,000**	**49%**	**1,200**	**1%**	**9,000**	**11%**	**1,000**	**1%**	**81,200**	**100.00%**	**79,800**	**100%**

ADB = Asian Development Bank, AusAID = Australian Agency for International Development, GoJ = Government of Japan, JICA = Japan International Cooperation Agency, OFID = OPEC Fund for International Development, SDR = special drawing rights, WHO = World Health Organization.

Note: Amounts and financing percentages may not sum precisely due to rounding; Actual expenditure as of end March 2013 plus projected expenses until end April 2013; Contingencies under AusAID and ADB may be used for civil works.

[a] The project costs are inclusive of taxes and duties to be financed by the government and ADB. ADB will finance all taxes on those expenditures 100% financed by ADB and AusAID.

[b] This amount includes ADB administration fee, audit costs, bank charges, and a provision for foreign currency fluctuations (if any) to the extent that these items are not covered by the investment income earned on this grant, or any additional grant contribution by the Government of Australia.

[c] The loan will be partly administered by ADB.

[d] This amount represents in-kind contribution by the government.

Source: Asian Development Bank estimates.

Table 12: Detailed Costs Estimates by Outputs/Components

Amounts in $000's	Output 1	Output 2	Output 3	Output 4	Output 5	Output 6	Total
I. Investment Costs							
A. Civil Works							
1. Civil Works Package 1	0	0	0	5,015	0	0	5,015
2. Civil Works Package 2	0	0	0	8,777	0	0	8,777
3. Civil Works Package 3	0	0	0	7,899	0	0	7,899
4. Civil Works Package 4	0	0	0	3,148	0	0	3,148
Subtotal	**0**	**0**	**0**	**24,840**	**0**	**0**	**24,840**
B. Medical Equipment	0	0	0	1,460	0	0	1,460
C. Vehicles	0	0	0	0	0	1,429	1,429
D. ICT and GMIS Provision	2,334	0	0	0	0	0	2,334
1. Volunteers (In Kind from GoJ)	0	1,200	0	0	0	0	1,200
E. Training	0	0	6,094	0	0	0	6,094
F Sustainable Partnerships	0	424	0	0	0	0	424
G. Health Promotion	0	0	0	0	7,500	0	7,500
H. Consulting services							
1. International Consultants	212	1,804	637	531	531	6,897	10,611
2. National Consultants		1,276	437	1,094	328	510	3,646
3. International Travel	61	68	55	41	27	430	682
4. Domestic Travel	69	380	69	466	294	449	1,727
I. IT Setup Costs	0	0	0	0	0	177	177
J. Formative Evaluation Contract	0	0	0	0	0	2,129	2,129
1. WHO (In-Kind contribution)	0	0	0	0	0	1,000	1,000
K. Operation and Maintenance	0	0	0	0	0	1,766	1,766
Total Investment Costs	**2,677**	**5,153**	**7,292**	**28,431**	**8,680**	**14,788**	**67,020**
II. Recurrent Costs							
A. Project Management Costs*	0	0	0	0	0	502	502
B. Administration	36	54	0	54	0	217	362
C. Communications	0	0	0	0	0	837	837
D. Security	0	0	0	0	0	152	152
Total recurrent costs	**36**	**54**	**0**	**54**	**0**	**1,708**	**1,852**
Total Project Base Costs	**2,713**	**5,207**	**7,292**	**28,486**	**8,680**	**16,496**	**68,873**
III. Contingencies	4%	7%	10%	42%	13%	24%	100%
A. Physical Contingencies	191	335	478	2,010	622	1,148	4,785
B. Price Contingencies	214	375	536	2,249	696	1,285	5,355
Sub - total contingencies	**406**	**710**	**1,014**	**4,259**	**1,318**	**2,434**	**10,140**
IV. Loan Financing Charges	4%	7%	10%	42%	13%	24%	100%
A. Interest during implementation	31	55	79	330	102	189	787
Total project costs (I+II+III+IV+V)	**3,150**	**5,972**	**8,384**	**33,075**	**10,100**	**19,118**	**79,800**

GMIS = geo mapping information system, GoJ = Government of Japan, ICT = information and communication technology, IT = information technology, WHO = World Health Organization.
*This amount represents in-kind contribution by the Government.
Source: Asian Development Bank estimates.

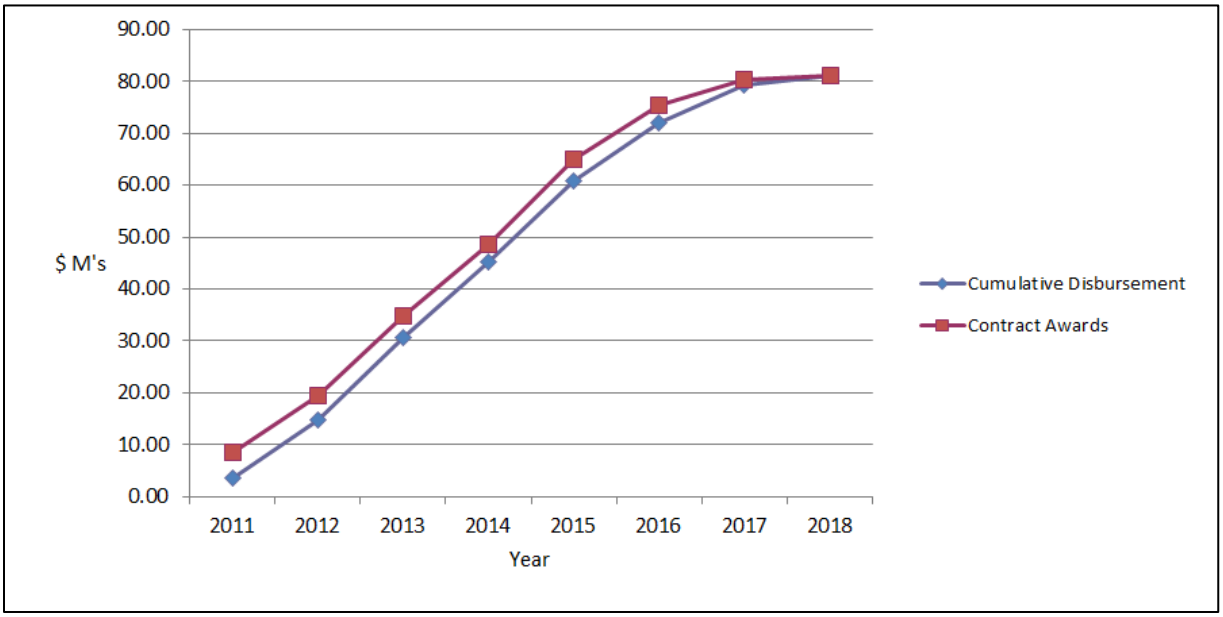
Table 13: Detailed Cost Estimates by Year

Amounts in $000's	Total	2012	2013	2014	2015	2016	2017	2018	2019	Total
I. Investment Costs										
A. Civil Works										
1. Civil Works Package 1	5,015	0	251	502	752	1,003	1,003	1,003	502	5,015
2. Civil Works Package 2	8,777	0	439	878	1,317	1,755	1,755	1,755	878	8,777
3. Civil Works Package 3	7,899		395	790	1,185	1,580	1,580	1,580	790	7,899
4. Civil Works Package 4	3,148		157	315	472	630	630	630	315	3,148
Subtotal	**24,840**	**0**	**1,242**	**2,484**	**3,726**	**4,968**	**4,968**	**4,968**	**2,484**	**24,840**
B. Medical Equipment	1,460	0	73	292	292	292	292	219	0	1,460
C. Vehicles	1,429	143	214	214	286	286	143	143	0	1,429
D. ICT and GMIS Provision	2,334	350	934	584	350	117	0	0	0	2,334
1. Volunteers (In-Kind from GoJ)	1,200	180	480	300	180	60	0	0	0	1,200
E. Training	6,094	305	914	914	914	1,219	914	914	0	6,094
F Sustainable Partnerships	424	21	64	64	64	64	64	64	21	424
G. Health Promotion	7,500	0	750	1,125	1,125	1,125	1,500	1,125	750	7,500
H. Consulting services										
1. International Consultants	10,611	531	2,653	2,653	2,122	1,592	531	531	0	10,611
2. National Consultants	3,646	182	729	729	729	547	365	182	182	3,646
3. International Travel	682	34	205	205	68	68	34	34	34	682
4. Domestic Travel	1,727	86	475	475	259	173	130	86	43	1,727
I. IT Setup Costs	177	44	44	44	44	0	0	0	0	177
J. Formative Evaluation Contract	2,129	106	213	319	319	319	319	266	266	2,129
1. WHO (In-Kind contribution)	1,000	15	200	200	200	200	100	85	0	1,000
K. Operation and Maintenance	1,766	177	265	265	221	221	221	221	177	1,766
Total Investment Costs	**67,020**	**2,175**	**9,454**	**10,867**	**10,900**	**11,250**	**9,580**	**8,838**	**3,958**	**67,020**
II. Recurrent Costs										
A. Project Management Costs*	502	50	75	63	63	63	63	63	63	502
B. Administration	362	36	54	45	45	45	45	45	45	362
C. Communications	837	84	125	105	105	105	105	105	105	837
D. Security	152	15	23	19	19	19	19	19	19	152
Total recurrent costs	1,852	185	278	232	232	232	232	232	232	1,852
Total Project Base Costs	**68,873**	**2,360**	**9,732**	**11,098**	**11,131**	**11,481**	**9,811**	**9,069**	**4,189**	**68,872**
III. Contingencies										
A. Physical Contingencies	4,785	164	676	771	773	798	682	630	291	4,785
B. Price Contingencies	5,355	0	107	375	696	1,018	1,178	1,285	696	5,355
Sub - total contingencies	**10,140**	**164**	**783**	**1,146**	**1,470**	**1,815**	**1,860**	**1,915**	**987**	**10,140**

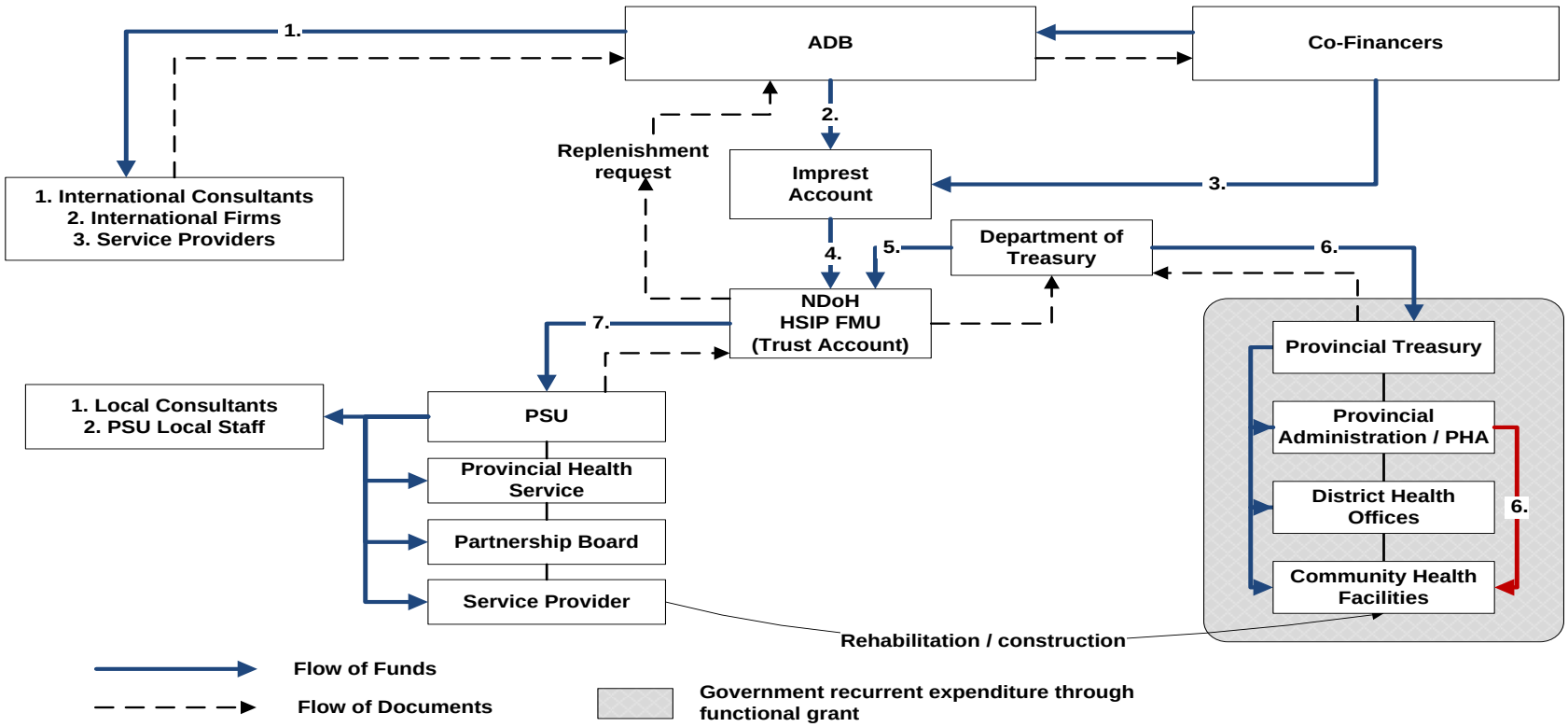
Amounts in $000's	Total	2012	2013	2014	2015	2016	2017	2018	2019	Total
IV. Loan Financing Charges			4%	8%	11%	15%	18%	21%	23%	100%
A. Interest during implementation	787	0	31	63	87	118	142	165	181	787
Total project costs (I+II+III+IV+V)	**79,800**	**2,524**	**10,547**	**12,307**	**12,687**	**13,414**	**11,813**	**11,150**	**5,357**	**79,800**
Expenditure per year (%)		**3%**	**13%**	**15%**	**16%**	**17%**	**15%**	**14%**	**7%**	**100%**

GMIS = geo-mapping information system, GoJ = Government of Japan, ICT = information and communication technology, IT = information technology.
[a] This amount represents in-kind contribution by the government.
Source: Asian Development Bank estimates.

Figure 1: Contract and Disbursement S-Curve



B. Funds Flow Diagram



1. Direct payment procedures – in accordance with the loan disbursement handbook.
2. Imprest Account – funds released to US$ Imprest account by funding source.
3. OFID Imprest Account – account replenished directly
4. Imprest account – funds released from dedicated imprest accounts to HSIP trust account.
5. GoPNG project funds – funds released by the Department of Treasury to HSIP trust account.
6. GoPNG regular funding – functional grants which provide operational and maintenance support for rural health facilities.
7. Project support unit – staffed with accounting and procurement expertise and knowledge of ADB policies and procedures.
8. Direct facility funding – proposed for new Community Health Posts.

ADB = Asian Development Bank, FMU = Financial Management Unit, GoPNG = Government of Papua New Guinea, HSIP = Health Services Improvement Project, NDoH = National Department of Health, PHA = Provincial Health Authority, PSU = Project Support Unit.

V. FINANCIAL MANAGEMENT

66. The financial management assessment (FMA) was prepared in accordance with ADB's Guidelines for the *Financial Management and Analysis of Projects*[29] (the Guidelines) and the publication *Financial Due Diligence A Methodology Note*.[30] The assessment was completed incorporating ADB's experience in the implementation of Grant 0042-PNG: *Prevention and Control of HIV/AIDS Rural Development Enclaves Project* in DOH[31] (the enclaves project). Financial due diligence for the project was undertaken and presented in the RRP linked document 8.

67. The project aims to build on the lessons learned and the financing modality implemented under the enclaves project while incorporating some flexibility should the strategic financing of the health sector within the Government of PNG change during project implementation. The assessment concluded that, while country-level financial management issues remain a challenge as assessed in the Risk Assessment and Management Plan (linked document 15), DOH has been building its credibility as an executing and implementing agency in the performance of its financial management duties under the enclaves project. However, challenges remain within DOH, as discussed in detail in the following sections.

A. Financial Management Assessment

68. The FMA was completed for DOH as the executing and implementing agency; it also took into consideration sector financing, which is currently performed through the HSIP trust account, and the implications of potential changes to current sector funding arrangements. The FMA also examined the project funding arrangements in the short and medium term. An assessment of government systems for transferring government grant funding for recurrent expenditures to the provincial and district levels to ensure sustained adequate resourcing of CHPs and associated rural health facilities was also completed.

1. Health Services Improvement Program

69. A trust account has been established under HSIP to aggregate direct funding allocated by the development partners towards the strategic health policies and objectives as outlined by DOH in the NHP. In the past there have been issues with release of funds to the district level from this trust fund account; however, this has improved in recent years with the recruitment of a full-time finance advisor in DOH provided through the Capacity Building Service Centre (CBSC). The advisor supports the HSIP financial management unit as well as providing strategic financial management advice to DOH. The CBSC also provides a finance manager for the HSIP financial management unit.[32] There have not been any significant expenditure control issues identified under the enclaves project for which funding to the trust account is earmarked for specific project activities. This is largely a result of the supportive role played by the project management unit in ensuring that adequate control procedures are in place and operating. There is an issue, however, with the unavailability of the HSIP trust account for the first 2-3

[29] ADB. 2005 *Financial Management and Analysis of Projects*. Manila.
[30] ADB. 2009. *Financial Due Diligence A Methodology Note*. Manila.
[31] ADB. 2006. *Grant Assistance to Papua New Guinea for HIV/AIDS Prevention and Control in Rural Development Enclaves*. Manila.
[32] CBSC is a partnership approach between the Government of PNG, the Department of Health, the Department of National Planning and Rural Development, and the Government of Australia. The goal of the program is to develop capacity in agreed upon priority areas in the health sector in PNG. Financial management is considered a priority area.

months of the financial year, which has hindered previous project implementation and will continue to hinder future project implementation if not addressed. The issue has been raised previously; however, DOH must ensure that the account is available and operating throughout the entire financial year. There is some risk that the finance advisor and finance manager provided by CBSC could be withdrawn from their roles. There is provision within the project to provide support to the HSIP financial management unit should this support be removed.

2. Provincial Authorities / Provincial Health Authorities

70. Provincial health services do not receive their operational funding from DOH; rather, they are funded directly from the government treasury through functional health grants, which are intended to cover operations, outreach, and distribution of medical supplies. These grants are disbursed through the provincial treasury offices. Concerns have been raised about the value and timely release of funds to rural health facilities through this mechanism; the monitoring of this expenditures; and the ability of the system to generate accurate, meaningful expenditure information over time. This system is essential to the overall sustainability of rural health service delivery. The project will provide support to help strengthen provincial health systems, including the introduction of the DFF to ensure that newly created facilities receive the O&M funds required to perform their operational activities.

3. Direct Facility Funding[33]

71. The project is designed to strengthen rural health facilities and the services they provide. One key aspect to ensure the successful delivery of rural health care will be the timely flow of funds[34] from provincial to district health facilities to cover operational costs. A pilot case study is currently being undertaken by DOH in the Autonomous Region of Bougainville, where direct funding of health facilities is employed. This allows funds to be released directly to the health facilities, bypassing administrative bottlenecks at the provincial and district levels. It is anticipated in government planning that the DFF will be employed in all rural health facilities with time. Under this project, the government undertakes to introduce this method of funding for recurrent costs in at least 50% of the project facilities during the implementation period.

72. The PSU, supporting the provincial governments, will work with the staffs of the facilities chosen under the project to pilot DFF and assist in developing procedures to support preparation of the quarterly micro budgets and submission of supporting documentation for past quarterly expenditures. The project will train facility staff in DFF.

4. Project Financial Management

73. The PSU will operate with a similar arrangement to the enclaves project, wherein the PSU is responsible for ensuring compliance with all ADB financial management issues and the HSIP financial management unit is responsible for the timely processing of transactions through the government's financial management system. While the arrangements under the enclaves project were satisfactory, some improvements are included for the new project due to the increased scale. A senior project manager will be engaged to manage the project activities. This manager will be recruited through quality- and cost-based selection and agreed upon by ADB and the government. The project accounting function will engage one international finance and procurement specialist with supporting accountants in the PSU. Accounting assistants will be

[33] See RRP linked document 19 for further information on DFF.
[34] Refers to government funds for rural health facilities.

engaged to support the selected provincial governments with project financial management and disbursement requirements. All PSU staff will receive training in ADB policies and procedures to help ensure compliance with ADB financial management and disbursement requirements. The PSU will be further supported through the recruitment of one senior procurement specialist and an appropriate administration quota as agreed upon by the project manager, ADB, and the government.

74. The DOH internal audit function will complete regular audits of the project receipts, expenditures, and procurement practices in all project locations. Where the DOH internal audit function lacks the capacity to perform these activities, the internal audit activity will be outsourced to private sector suppliers.

B. Disbursement

75. The ADB loan and cofinancing loan/grant proceeds paid to ADB will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2007, as amended from time to time),[35] and detailed arrangements agreed upon between the government and ADB.

76. Pursuant to ADB's Safeguard Policy Statement (2009),[36] ADB funds and cofinancing loan/grant proceeds may not be applied to the activities described on the ADB Prohibited Investment Activities List set forth at Appendix 5 of the Safeguard Policy Statement. All executing and implementing agencies will ensure that their investments in construction and refurbishment of facilities under output 4 are in compliance with applicable national laws and regulations and will apply the prohibited investment activities list (Appendix 5) to subprojects financed by ADB.

77. Three imprest accounts, one for each funding source,[37] will be established and administered by the executing agency. The currency of the imprest accounts will be US dollars. The imprest accounts will be used for receipt of initial loan and grant withdrawals and also for account replenishment. Each imprest account may be used only for transfers to its respective special project account, to be established within the HSIP trust account (per below), or for refunds to ADB, AusAID, or OFID.

78. The HSIP trust account, which operates under the oversight of the HSIP management branch under DOH, will be used for part of the loans and grant disbursement. The HSIP trust account is maintained in PNG kina. Under the HSIP trust account, three special project accounts, one for each financier, will be established and administered, with all transactions to be recorded, accounted for by funding source, and audited. The special project accounts will be established immediately after loan effectiveness to ensure project implementation and timely disbursement. The currency of the special project accounts will be PNG kina. Each special project account will be funded by its respective imprest account and will be managed, replenished, and liquidated in accordance with imprest account procedures as outlined in ADB's *Loan Disbursement Handbook* (January 2007 as amended from time to time).

79. The maximum ceiling of each imprest account and its respective special project account (established within the HSIP trust account), in aggregate, will not exceed the estimated

[35] Available at: http://www.adb.org/Documents/Handbooks/Loan_Disbursement/loan-disbursement-final.pdf
[36] Available at: http://www.adb.org/Documents/Policies/Safeguards/Safeguard-Policy-Statement-June2009.pdf
[37] One account for ADB funds, one account for AusAID funds, and one account for OFID funds.

expenditures to be financed through the respective special project account for 6 months of project implementation, or $1 million, whichever is lower.

80. Before the submission of the first withdrawal application, the Government of PNG should submit to ADB sufficient evidence of the authority of the person(s) who will sign the withdrawal applications on behalf of the borrower, together with the authenticated specimen signatures of each authorized person. The request for initial advance to the imprest accounts should be accompanied by an Estimate of Expenditure Sheet[38] clearly identifying the level of funding for each account and setting out the estimated expenditures to be financed through the imprest accounts for the first 6 months of project implementation, and submission of evidence satisfactory to ADB that imprest accounts have been duly opened, and that the special project accounts have been established. For the OFID loan, ADB will review the withdrawal applications and advise OFID to make the disbursement. Therefore, when preparing a withdrawal application for the OFID loan, there should be two copies, the original sent to ADB for review and a copy to OFID for its records. The withdrawal applications should be submitted to ADB and OFID simultaneously.

81. For every liquidation and replenishment request for the imprest and special project accounts, full supporting documentation is required. The claim procedure under the imprest account method with full supporting documentation is given in the Loan Disbursement Handbook.

82. In addition, for every liquidation and replenishment request, the government will furnish to ADB (i) a statement of account (bank statement) where the imprest account is maintained, (ii) the imprest account reconciliation statement reconciling the above-mentioned bank statement against the executing agency's records, (iii) a special project account cashbook (similar to what is provided under PNG Grant 0042), (iv) a special project account reconciliation statement reconciling the cashbook to the outstanding advance, and (v) a copy of the HSIP trust account bank statement. The minimum value per withdrawal application is $100,000. The government, through the executing agency, is to consolidate claims to meet this limit for reimbursement and imprest/special account claims. Withdrawal applications and supporting documents will demonstrate, among other things, that the goods and/or services were produced in or from ADB members, and are eligible for ADB financing.

83. Direct payment procedures should generally be used whenever possible. Direct payments will be made for international consultants and international PSU staff, which require submission of approved invoices and documentation to ADB in accordance with ADB's *Loan Disbursement Handbook*. Direct payment may also be made for ICT and GIS contracts and formative evaluation as well as other high-value goods and services contracts awarded to service providers as agreed upon between ADB and the government. Commitment letter procedures will not be used for civil works.

84. DOH should submit to ADB annual contract awards and disbursement projections at least a month before the start of each calendar year. DOH is responsible for (i) requesting budgetary allocations for counterpart funds, (ii) collecting supporting documents, and (iii) preparing and sending withdrawal applications to ADB.

[38] Available in Appendix 29 of the *Loan Disbursement Handbook*.

85. The government contribution to project costs will be budgeted for in each project year, with necessary funds placed in the HSIP trust account at the beginning of the financial year to cover such expenditure.

86. The funding mechanism to utilize HSIP will be reviewed to consider other funding mechanism when other mechanisms are recommended by IMRG or other independent reviews.

C. Accounting

87. The executing and implementing agencies will maintain separate project accounts and records by funding source for all expenditures incurred under the project. The project accounts will follow international accounting principles and practices. The PSU will be staffed with one senior accountant and one accountant with supporting accounting staff at each implementing agency. The project accounts will follow international accounting principles and practices. The PSU staff will complete regular reconciliation with the accounting information maintained by the HSIP financial management unit; the PSU will maintain all project transaction data in computerized format.

D. Auditing

88. The executing agency will cause the detailed consolidated project accounts to be audited in accordance with International Standards on Auditing and/or in accordance with the government's audit regulations as set forth in the HSIP financial management manual by an auditor acceptable to the ADB. The imprest and special project accounts will be audited as part of the annual audit of the HSIP trust account, which will be managed through the Office of the Auditor General. The annual audit will be outsourced to a private firm. International competitive bidding should be considered during the outsourcing process. The audited accounts will be submitted in the English language to ADB within 6 months of the end of the fiscal year by the executing agency. The annual audit report will include a separate audit opinion on the use of the imprest and special project accounts. The government and DOH have been made aware of ADB’s policy on delayed submission, and the requirements for satisfactory and acceptable quality of the audited accounts. ADB reserves the right to verify the project's financial accounts to confirm the share of ADB’s and cofinancer financing used in accordance with ADB’s policies and procedures.

VI. PROCUREMENT AND CONSULTING SERVICES

89. A procurement capacity assessment was completed for DOH, focusing on the procurement sections of the HSIP management branch and the medical supplies branch. The overall conclusion of the assessment was that the low level of procurement resources and limited numbers of technically qualified staff remain a challenge for DOH. The PSU will support the procurement of goods, works, and services under the project through the engagement of an international procurement expert. The expert will assist in developing procuring capacity in the procurement section of the HSIP management branch which will be responsible for procurement processing on behalf of the executing agency. AusAID is supporting the procurement of medical supplies through a separate initiative.

A. Advance Contracting Action and Retroactive Financing

90. All advance contracting will be undertaken in conformity with ADB's Procurement Guidelines (2010, as amended from time to time)[39] and ADB's Guidelines on the Use of Consultants (2010, as amended from time to time).[40] The issuance of invitations to bid under advance contracting will be subject to ADB approval.

91. The borrower, DOH, and the implementing agencies have been advised that approval of advance contracting does not commit ADB to finance the project.

92. **Advance contracting.** The government has requested ADB approval of advance contract action to process consultant selection.

93. **Retroactive financing.** The government has requested ADB approval of retroactive financing for the recruitment of PSU consultants (project manager, team leader-information/evaluation specialist, procurement and finance specialist, senior accountant, accountant, communication and reporting, two administration officers). Retroactive financing will be up to 20% of respective ADB loan and AusAID grant for procurement of consulting services for PSU but not earlier than 12 months prior to the signing of the loan agreement.

B. Procurement of Goods, Works, and Consulting Services

94. All procurement to be financed under the project will be carried out in accordance with ADB's *Procurement Guidelines* (2010, as amended from time to time). Before the start of any procurement, ADB and the government will review the public procurement laws of the central and provincial governments to ensure consistency with ADB's *Procurement Guidelines.* If national competitive bidding (NCB) procedures are adopted in some circumstances, a review will be completed on the capacity of provincial tender boards to ensure that the ability exists to execute the public tendering process in a transparent and timely manner prior to use of that facility.

C. Procurement Plan

95. The planned procurement will comprise (i) a turnkey contract for supply and installation of health information system hardware and software based on geo-mapping and communications technology, (ii) small-scale civil works for the construction of CHPs and

[39] Available at: http://www.adb.org/Documents/Guidelines/Procurement/Guidelines-Procurement.pdf
[40] Available at: http://www.adb.org/Documents/Guidelines/Consulting/Guidelines-Consultants.pdf

refurbishment of existing rural health facilities, (iii) supply of medical equipment and vehicles, (iv) training for upgrading skills of CHWs, and (v) consultancy services for project management and institutional capacity and systems strengthening. The project will support the use of local contractors to support domestic industries and increase local ownership for CHPs and health facilities.

96. **Procurement of small civil works** will follow a combination of shopping procedures and NCB. Shopping will be used for contracts up to $100,000, and NCB for procurement packages between $100,000 and $1 million. International competitive bidding (ICB) will be used for civil works contracts exceeding $1 million. The procurement method will be determined by the international procurement specialist after site selection and detailed facility designs and estimates are prepared.

97. No contracts shall be awarded for Civil Works (Package 3) until the OFID Loan Agreement shall have been duly executed and delivered.

98. **Procurement of goods** (medical equipment, vehicles, boats, motorbikes, furniture) will be grouped into two packages for medical equipment, two for vehicles, two for boats, two for motorbikes, and two for furniture. ICB procedures will be used for goods contracts estimated above $500,000, NCB procedures for those between $100,000 and $500,000, and shopping procedures for those under $100,000.

99. **Procurement of consulting services** will be completed using NGOs, firms, and individual consultants according to ADB's *Guidelines on the Use of Consultants*.[41] The quality- and cost-based selection method will be used for all consultants recruited through NGOs and firms with a standard quality: cost ratio of 80:20. An estimated 2,102 person-months (536 international and 1,566 national) are anticipated to (i) facilitate project management and implementation, and (ii) strengthen the institutional and operational capacity of DOH and provincial health services authorities.

100. Consulting services, contractors, and NGOs will also be required to support the project through (i) health promotion, (ii) capacity development and training activities, and (iii) formative evaluations. The formative evaluation needs to have independence from the project team, but needs to be firmly grounded in PNG to maximize the opportunities to develop local capacity and contribute to sustained local system learning. Given the variety of services and the geographical disparity of PNG, a flexible approach will be undertaken for the engagement of individual consultants based on specific circumstances, skill levels, and geographic location. Contractors (NGO and firms) will be engaged through Quality Cost Based Selection (QCBS), Consultant's Qualification Selection, or Single-Source Selection. For individual consultants will be engaged by a combination of single-source selection and individual consultant selection. Given the project's value and the importance to its success, ADB, in agreement with the government, will assist with the procurement of the international project manager and the international finance and procurement specialist.

101. Performance of consulting services will be monitored and evaluated by 6 monthly joint review meeting based on the assessments done by the formative evaluation. Necessary adjustments for the consulting services will be discussed at the inception, join review meetings, midterm review with the government.

[41] Checklists for actions required to contract consultants by method are available in the e-Handbook on Project Implementation at: http://www.adb.org/documents/handbooks/project-implementation/

102. An 18-month procurement plan indicating threshold and review procedures, goods, works, and consulting services contract packages and NCB guidelines is included in Annex 1. All consultants will be recruited according to ADB's *Guidelines on the Use of Consultants*.[a] The list of consultants and the outline terms of reference for consulting services are detailed in Annex 2.

[a] Checklists for actions required to contract consultants by method are available in the e-Handbook on Project Implementation at: http://www.adb.org/documents/handbooks/project-implementation/

VII. SAFEGUARDS

103. **Safeguards categorization.** This project is envisaged to have few if any environmental impacts (Category B) and no requirement for involuntary resettlement (Category C) or related indigenous peoples impacts (Category C). All sites will be at existing health facilities. There are, however, a variety of issues relating to wastewater treatment that require consideration. Construction activities will occur only in small areas – probably no more that 0.25 hectare per location. While the actual location of the facilities will be determined within the early stages of the project, it is certain that they will be located within populated areas, in proximity to existing roads and infrastructure. For this reason, their construction will not require the clearance of any forest, or ecologically important vegetation. No significant vegetation, primary forest, or conservation areas will be affected by the development. There will be no impacts on any flora or fauna. The project will retain safeguards specialists on a part-time (international) and a full-time (national) basis. While the focus of those consultants will be on the identification, resolution, and monitoring of environmental and climate change issues, he/she will also be responsible for social impact monitoring and the maintenance of ADB standards.

104. **Environment.** An environmental assessment and review framework (EARF) has been prepared to guide the assessment and review process for project investments. These investments, which will be dispersed in 16 rural districts, are expected to be small-scale and repetitive in nature. Once sites are selected, specific details on how to mitigate and monitor effects are provided in the project's initial environmental examination (IEE). DOH and the Department of Environment and Conservation will clear the framework and examination in accordance with their rules and procedures. The EARF and IEE are presented in the RRP linked documents 13 and 14 respectively.

105. Table 12 provides an outline on the major actions associated with preparation, submission, and approval of environment documents within the government and to ADB.

Table 12: Environmental Actions and Conditions

Environmental Management Actions	Action Flow	Conditions Required to Complete Actions
Preconstruction Stage	Project becomes effective	
Establish environmental management system	Safeguards Specialist (SS) and Environmental Civil Engineer (EE) recruited to PSU, Safeguards Officer (SO) appointed to each IA.	Budget, facilities, and staff for environmental management have been provided according to Loan Agreement and EARF.
Conduct environmental studies	IAs prepare IEEs and EMPs	Consultants/qualified experts recruited, IEEs and EMPs approved by ADB and government as per EARF.
EE, SS, and Project Architect will support IA to ensure that EMP requirements are integrated into project design. EE, SS, and/or	EMP mitigations integrated into design documents	IA has necessary technical capacity and experience to integrate EMP requirements into design.

Environmental Management Actions	Action Flow	Conditions Required to Complete Actions
Project Architect confirm that design meets EMP requirements. EE, SS, and/or Project Architect extract construction requirements from EMP and submit to IA for inclusion in tender documents. EE, SS, and/or Project Architect review tender documents and confirm that environmental management provisions are sufficient. EE, SS, and/or Project Architect support SO in reviewing environmental conditions of bids and rank contractors on this ability. SS, EE, and SO review construction EMP (CEMP) prepared by consultants or contractors. IA approves CEMP after receiving comments from EE and SS. PSU with SO verifies compliance of contractor with CEMP at site meeting ***Preconstruction completed***	Tender documents prepared Tenders evaluated and contractor appointed Contractor prepares CEMP Contractor inducted to site by SS, EE, and/or SO Contractor approved to start work	Environmental conditions have been prepared that are integrated into tender documents. SO to be a member of the Bid Evaluation Panel Contractor appoints environmental manager and staff. After award of contract, contractor prepares CEMP. Contractor cannot take possession of construction site until (i) CEMP has been approved, and (ii) induction is completed satisfactorily.
Construction Stage SO monitors contractor's CEMP compliance activities, coordinates consultation events, and liaises with EE and SS as required. SS and EE audit construction activities. SS and EE evaluate monitoring program. SS, EE, and SO assist ADB on supervision missions according to the Loan Agreement. If noncompliance is identified, PSU (EE and SS) support IA (SO) to instruct contractors to prepare and implement corrective action plan (CAP). ***Construction completed***	Contractor begins work. Environmental monitoring undertaken and reports prepared. (i) by contractor: periodical environmental report sent to IA; (ii) by NDOH: semiannual environmental report to ADB according to the Loan Agreement NDOH submits CAP (if any), to ADB for review Construction completed and project commissioned	Contractor complies with CEMP requirements for implementing and monitoring work on-site. SS and EE verify monitoring reports for project with potentially significant adverse impacts. IAs review and sign off on completed work. DOH (with PSU assistance) submits monitoring report (including CAP, if any) to ADB for review according to the Loan Agreement, and to environmental authorities according to host country regulations. Project works completed in accordance with the CEMP, and all sites satisfactorily

Environmental Management Actions	Action Flow	Conditions Required to Complete Actions
		rehabilitated and restored. Payments may be withheld if sites are not cleared and closed to meet CEMP specifications.
Operation commences	Submission of monitoring reports to ADB according to Loan Agreement	DOH submits monitoring reports to ADB according to Loan Agreement.

IA = Implementation Agency, CAP = Corrective Action Plan, DOH = Department of Health, EMP = Environmental Management Plan.

106. **Involuntary resettlement.** The project is not expected to involve involuntary land acquisition or resettlement. All civil works will be undertaken at existing locations of concerned health facilities. A land assessment framework has been prepared that provides detailed guidelines to assess and confirm that the land proposed for each health facility is indeed state land or is owned by the partner organization (e.g., a church) that runs such a facility. The land assessment framework is presented in the RRP linked document 23.

107. **Indigenous peoples.** Melanesians comprise the vast majority of the PNG population. The project is not expected to have any negative impact on indigenous peoples. While a separate indigenous peoples plan is not needed, all project components will be implemented in a culturally appropriate and participatory manner to meet the needs of various people of the country.

108. DOH will endorse the draft safeguard documents for the project and provide relevant information from these documents to local stakeholders. The draft documents will be posted in the ADB website. The project will support the executing agency, implementing agency, and other stakeholders in strengthening their capacity to effectively manage safeguard activities.

VIII. GENDER AND SOCIAL DIMENSIONS

109. **Gender categorization.** The project is classified as "gender equity."

110. **Gender action plan.** Social and Poverty analysis was conducted by the PPTA team (see the summary poverty reduction and social strategy presented in RRP linked document 12. Based on the analysis, the gender action plan for the project was developed (see Annex 3). The executing agency and implementing agency are responsible and the resources needed to implement the gender action plan. Gender-sensitive indicators are specified in the gender action plan and in the design and monitoring framework. An international or national gender specialist will be recruited.

111. **Consultation and participation.** During project preparation, an international medical anthropologist and a national research assistant visited five provinces in PNG covering all four regions. Extensive consultations were conducted in rural communities, including male and female community representatives, community leaders, health facility staff, health staff at the district and provincial levels, other provincial officials, and church health secretaries.

112. Consultation was conducted to ascertain health-related behaviors, issues that affect use of health services by rural communities, and ideas about CHPs. Issues during consultations included (i) health delivery systems and utilization including barriers to accessing health services, (ii) community organization and decision making, (iii) diet and infant feeding, (iv) reproductive health, (v) sexually transmitted illnesses, (vi) family planning, (vii) maternal health, and (viii) community participation in health. To promote community ownership of CHPs and greater participation in health, the project will continue consultations with communities through CHP management committees. A consultation and participation plan in the linked document 22 was prepared for the project.

IX. GENERAL SELECTION CRITERIA FOR DISTRICTS AND HEALTH FACILITIES

113. The selection of districts and health facility sites will be finalized after Board approval for outputs 2-5 and will satisfy the following criteria:

(i) the facility or site is located in a participating province and participating district and is in a predominantly rural area;
(ii) the proposed works have been identified and designed by the relevant implementing agency in a participatory manner with input from the community;
(iii) community consultation for selection of the site has been conducted;
(iv) the proposed works are integrated into a comprehensive provincial health plan;
(v) the proposed facility/site has available/earmarked budget for recurrent cost in the health functional grant;
(vi) the proposed facility/site has sufficient human resources/staff and supervision capacity;
(vii) institutional and financial arrangements for construction and O&M of the facility and access to the facility have been agreed upon by the partnership board/provincial health board;
(viii) the proposed works comply with all requirements of relevant national laws and regulations and ADB's *Safeguard Policy Statement (2009)* and the Environment Management Plan, Environment Assessment and Review Framework, and Land Assessment Framework;
(ix) the relevant district or local level government or participating health service provider has clear and unencumbered title to or clear and undisputed lease rights to the associated land plot on which the selected health facilities are located or the CHP is to be located, without claims of third parties, and the province has supplied adequate written confirmation of the same from the relevant authorities and community participants, as applicable, including relevant permits, deeds, and other title and lease documentation; and
(x) access to and from the site and proposed facility for vehicles or other means of transport to the site will already be in place or will be constructed in parallel with the project and at the expense of nonproject funds.

114. Within each participating province, the districts to participate in the project will satisfy the following criteria:

(i) The district is selected with a view to maximizing the delivery of health services for rural populations that are most underserved at the outset of the project such as the percentage of the population accessible to health facilities within 2 hours traveling time.
(ii) The district is selected with a view to prioritizing refurbishment of the most inadequate health infrastructure facilities
(iii) The district is selected with due consideration for the ability to absorb and utilize the proposed investment of resources, taking into account levels of security, law and order, governance, and administrative capacity.

X. PERFORMANCE MONITORING, EVALUATION, REPORTING, AND COMMUNICATION

A. Project Design and Monitoring Framework

115. The design and monitoring framework is attached in Annex 4.

B. Monitoring

1. Project Performance Monitoring

116. Project performance monitoring will be carried out using the targets, indicators, assumptions, and risks in the design and monitoring framework including how beneficiaries will be involved in project monitoring and/or evaluation. Disaggregated baseline data for output and outcome indicators gathered during project processing will be updated and reported twice a year and after each ADB review mission. These reports will provide information necessary to update ADB's project performance reporting system.[b]

117. ADB lead inception mission will be fielded after the loan effectivity and the PSU consultants have commenced the work in the country. Followed by ADB Project Administration Instruction, the ADB review missions will be conducted twice a year and annual review by all stakeholders will be conducted. Special Administration Mission and Supplementary Financing Appraisal Mission would be conducted if necessary. Midterm review mission will be conducted at the mid-point of the project implementation. Project completion review mission will be conducted when the project is completed. The principle functions of each mission[c] in general are indicated in the Project Administration Instructions.[d]

118. DOH is planning to conduct further diagnostic study on the needs for national and four provinces including Bougainville, Milne Bay, Eastern Highlands, and Western Highlands. The results of the diagnostic study which will be completed by October 2011 will help inform the inception mission discussions and implementation of the project.

119. The PSU will, through inclusion of a health information expert (in the ICT/ GIS firm), support DOH in monitoring key impact and outcome indicators and associated assumptions with corresponding target dates.

120. In addition to the project performance monitoring system, a further, significant mechanism for monitoring and evaluation will be the formative evaluation process.

121. The project has a strong performance monitoring focus with its emphasis on ICT and geo-mapping to strengthen and enhance existing DOH monitoring and reporting mechanisms. In addition, a formative evaluation will be conducted every 6 months. The project will establish a comprehensive project performance monitoring system to serve both DOH and ADB reporting requirements. The project monitoring and evaluation system will assess performance by:

(i) evaluating delivery of planned activities;
(ii) measuring project impacts;

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[b] ADB's project performance reporting system is available at: http://www.adb.org/Documents/Slideshows/PPMS/default.asp?p=evaltool

[c] TOR of the ADB joint missions will be discussed with participating mission members from cofinancing agencies.

[d] ADB. 2010. Project Administration Instruction. No.6.02. http://www.adb.org/Documents/Manuals/PAI/default.asp

(iii) measuring health, social, and economic benefits with a focus on the poor, women, and disadvantaged groups; and
(iv) monitoring the progress towards achievement of Millennium Development Goals and other NHP targets.

122. The formative evaluation will serve as a basis to prepare reports on project implementation and the rural health system strengthening process, improved use of resources, improved access to services (particularly for the poor), improved service quality, client satisfaction, and progress in achieving the Millennium Development Goals. Performance indicators are set out in the design and monitoring framework (above). Where feasible, indicators will be disaggregated by socioeconomic level and gender. The evaluation should include control groups in nonparticipating districts in the selected provinces or from other provinces. See the RRP linked document 18 for further explanation of formative evaluation.

2. Compliance Monitoring

123. The compliance status of loan covenants will be reported every 6 months and verified by ADB and cofinancier during joint review missions.

124. In addition to the standard assurances, the Government of PNG has given assurances, which will be incorporated in the loan, grant, and project agreements as applicable.

3. Safeguards Monitoring

125. As a Category C project relative to involuntary settlement and indigenous people, the project will have no negative impacts. Progress in implementing the environmental management plan will be reported annually.

4. Gender and Social Dimensions Monitoring

126. The implementation status of the Gender Action Plan will be included in the 6 monthly social monitoring reports sent to ADB. DOH, supported by PSU consultants, will supervise gender and social activities during design and construction works.

C. Evaluation

127. In addition to regular reviews, a detailed midterm review of the project will be carried out by December 2014 to assess the progress of each output, identify issues and constraints, and determine necessary remedial actions and adjustments. The midterm review will evaluate in detail the scope, implementation progress, implementation arrangements, safeguards issues, achievement of scheduled targets, and any other related or outstanding issues under the project as appropriate. Within 6 months of physical completion of the project, DOH will submit a project completion report to ADB and cofianciers.[e]

128. The joint midterm review will be timed to coincide with the feedback for the six monthly formative evaluations.

[e] Project completion report format is available at http://www.adb.org/Consulting/consultants-toolkits/PCR-Public-Sector-Landscape.rar

D. Reporting

129. DOH will provide ADB and cofinanciers with (i) every 6 months progress reports in a format consistent with ADB's project performance reporting system; (ii) consolidated annual reports including (a) progress achieved by output as measured through the indicator's performance targets, (b) key implementation issues and solutions, (c) updated procurement plan, and (d) updated implementation plan for next 12 months; and (iii) a project completion report within 6 months of physical completion of the project. To ensure that projects continue to be both viable and sustainable, project accounts and the executing agency audited financial statements, together with the associated auditor's report, will be adequately reviewed.

E. Stakeholder Communication Strategy

130. DOH will provide all critical and important information to various stakeholders in a manner easily understood by them. Special efforts will be made to provide information to the citizens, and proper compliance will be ensured with national legislation on rights to information.

131. The project preparation activities were guided by the priorities decided upon by the senior executive team of DOH. Focus group and stakeholder discussions were held in five provinces and indicated a range of health, social, and organizational concerns in the community and the health services, including the needs for:

(i) improved access to primary health care;
(ii) improved engagement with local communities, especially women; and
(iii) improved quality and organization of rural health services.

132. Provinces will be supported to conduct information campaigns on community health posts and strengthening the PNG rural health service delivery system to keep the public and staff engaged and informed. Public disclosure of all project documents will be made available through the development of a project website attached to the DOH website. The PSU manager, under the signature of DOH, will produce a short newsletter every 2 months to inform stakeholders of the progress being made by the project. Formative evaluation reports will be disseminated widely, including to other provinces with an interest in health system strengthening. Annual PNG health sector national conferences will be used to keep the staff of the health service and the public fully informed of developments and progress.

133. A project consultation and participation plan was prepared to ensure the participation of relevant stakeholder in each output activities. The plan is presented in the RRP linked document 20.

134. Special efforts will be made to provide information to citizens, and proper compliance will be ensured with national legislation on rights to information.

XI. ANTICORRUPTION POLICY

135. ADB reserves the right to investigate, directly or through its agents, any violations of the Anticorruption Policy relating to the project.[f] All contracts financed by ADB will include provisions specifying the right of ADB to audit and examine the records and accounts of DOH; the provinces; and all project contractors, suppliers, consultants, and other service providers. Individuals/entities on ADB's anticorruption debarment list are ineligible to participate in ADB-financed activities and may not be awarded any contracts under the project.[g]

136. To support these efforts, relevant provisions are included in the loan and project agreements and the bidding documents for the project.

137. **Governance and anticorruption.** The PNG government and the provincial governments will ensure that (i) the project is carried out in compliance with all applicable PNG anticorruption regulations and ADB's *Anticorruption Policy,* including cooperating fully with any investigation by ADB directly or indirectly of any alleged corrupt, fraudulent, collusive, or coercive practices relating to the project; and (ii) all relevant staff actively participate in training in PNG's anticorruption regulations and ADB's *Anticorruption Policy*.

138. Project risks have been identified in relation to lack of counterpart funding for recurrent O&M costs, delays in transfer of public funding to provincial and local level governments for the health sector, the chance of disruptions in decision-making authority and civil unrest due to mid-2011 elections, weaknesses in procurement controls and capacity, corruption and lack of capacity in public financial management, difficulties in retaining trained health worker staff in rural communities, and security concerns for civil works contractors in remote rural areas.

139. In accordance with ADB requirements, an assessment in the areas of public financial management, procurement, and anticorruption was undertaken, identifying significant risks in each.

140. To the extent possible, the project will be implemented through existing institutions and using country systems. To facilitate this, certain governance, fiduciary, and anticorruption safeguards have been incorporated into the project to mitigate the risk of diversion of funds and to enhance and strengthen governance, accountability, and transparency.

141. In particular, such transparency and accountability measures include (i) establishment of a publicly accessible project website within the existing DOH website wherein the borrower will disclose key project-related information including costs, safeguards, and procurement; and (ii) establishment of a grievance redress mechanism satisfactory to ADB for receiving and resolving stakeholder complaints,

142. Key project-specific measures to address procurement capacity and anticorruption risks will include the creation of a Project Evaluation Committee, including the project architect, PSU, and DOH internal auditors, to define the tender criteria for replicable small civil works in order to align them with NHP requirements prior to release of bids, and to approve or disapprove awards of contracts, subject to final ADB approval.

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[f] Available at http://www.adb.org/Documents/Policies/Anticorruption-Integrity/Policies-Strategies.pdf

[g] ADB's Integrity Office website is available at http://www.adb.org/integrity/unit.asp

143. Fiduciary operations risks, as discussed in para. 65 above, are addressed through ongoing public financial management reforms, use of direct payment for international contracts, and provision of specialized international procurement and accountancy consultants in the PSU.

144. Further project-specific governance safeguards to mitigate the risk of misuse of funds and to improve governance, accountability, and transparency will include (i) use of ADB procurement rules and extensive use of prior review; (ii) independent verification of the quantity, quality, and cost of works by the international supervision consultant; (iii) independent accounting support to develop capacity and to ensure, among other things, timely and rigorous reconciliations, orderly record keeping, and strict adherence to financial management policies and internal controls; (iv) independent external auditing of contracts, project accounts, and financial statements; (v) intensive supervision by ADB and other funding agencies; and (vi) forensic audits of any alleged corruption cases.

145. **Political and election-related risks.** There is a risk that a period of roughly 6 months surrounding the mid-2011 elections may involve delay or suspension of effective decision making at top levels of government while campaigning is under way. The proposed schedule of project readiness activity (Table 1) for seeking approval and effectiveness prior to the onset of this uncertain period from March 2012 to September 2012 will allow the project to capitalize on the current strong support levels from the government. To the extent that this risk does materialize, it will be broadly diversified and hedged, because the project involves eight provinces and nonstate actors and health service providers in each, as well as required preparedness criteria for infrastructure investment. Such diversification of geography and stakeholders makes it feasible to press forward in those areas that have demonstrated preparedness and where there is less election-period impact.

146. There may also be concerns over security in remote rural areas where small civil works must be undertaken, and the related concern that local communities will mistrust or not engage with the implementation of the NHP through the project. These may be mitigated through use of national competitive bidding and shopping to permit local labor to benefit from the project, and by building of cross-community alliances and buy-in for the project through the establishment of the partnership boards, which will particularly include representatives of the local government.

147. Staff attrition risks, as discussed in para. 9, will be managed through staff incentives including refurbishment or construction of adequate staff housing and ensuring appropriate clinical supervision for local CHW staff based on development of health services plans for the participating provinces and districts.

148. The risk assessment and risk management plan is in linked document 13.

149. **Project website**. The government, through DOH, will ensure that a section of its website is dedicated to the project in the first year of project implementation, and that it will disclose details of the project, including the audited project financial accounts; project progress; and procurement activities including the publishing of short-lists, invitations for bid, and contract awards.

150. **Ombudsman**. The existing Ombudsman institution, may be called upon to investigate any irregularities or complaints.

151. **Evaluation committee**. A committee, to include representatives of DOH and the PSU, and to be chaired by the Secretary, DOH, will be established to evaluate and give final approval

to the proposed tendering criteria for the civil works contracts to be tendered under the project whether at the central or local level, through the central tender board or provincial and district tender boards. The Evaluation Committee will also carry out spot checks, on a random, selective basis, of proposed awards of contracts as recommended by the tender boards at the provincial and central levels. The committee will meet as frequently as necessary to provide necessary input at the time of tendering contracts envisioned by the Procurement Plan, but during this period, no less than twice monthly.

152. **Internal audit**. The audit of the project will be included in the annual plan of work of the internal audit unit of DOH for each year during project implementation.

153. **Grievance redress mechanism**. Within 3 months of the effective date, the implementation staff will prepare a grievance redress mechanism, acceptable to ADB, and appoint an officer to receive and resolve complaints or grievances or act upon reports from stakeholders on misuse of funds and other irregularities, including those relating to interactions with communities. The implementation staff will inform stakeholders of their right to submit complaints or grievances relating to the project.

XII. ACCOUNTABILITY MECHANISM

154. People who are, or may in the future be, adversely affected by the project may address complaints to ADB, or request a review of ADB's compliance under the Accountability Mechanism.[h]

[h] For further information see http://compliance.adb.org/

XIII. RECORD OF PAM CHANGES

155. All revisions/updates during the course of project implementation should be retained in this section to provide a chronological history of changes to implemented arrangements recorded in the PAM.

Date: 09 August 2013

Procurement Plan

A. Basic Data

1. The table summarizes the basic information of the project.

Project Information	Data
Project number	41509
Project cost	$81.2 million
ADB loan	$20 million
Government of Australia represented by AusAID (Grant)	$40 million
OPEC Fund for International Development (Loan)	$9 million
JICA Volunteers (Grant – In-kind)	$1.2 million
World Health Organization (Grant – In-kind)	$1.0 million
Government of Papua New Guinea (Government of Finance)	$10 million
Executing agency	National Department of Health
Approval date of original procurement plan	September 2011
Approval of most recent procurement plan	2 May 2013
Publication for local advertisements	As required
Period covered by this plan	31 December 2014

B. Process Thresholds, Review, and 18-Month Procurement Plan

1. Project Procurement Thresholds for Goods and Works

2. Except as ADB may otherwise agree, the following process thresholds will apply to procurement of goods and works.

Procurement Method	To Be Used Above (Value US$)
Goods	
International competitive bidding (ICB)	>1,000,000
National competitive bidding (NCB)	>100,000 and </= 1,000,000 Usage subject to the provisions of NCB annex
Shopping	</=100,000
Works	
ICB	=/>3,000,000
NCB	>100,000 and <3,000,000 Usage subject to the provisions of NCB annex
Shopping	</=100,000

ICB= international competitive bidding, NCB = national competitive bidding.

2. Procurement Thresholds for Consulting Services

3. Except as ADB may otherwise agree, the following process thresholds will apply to procurement of consulting services.

Procurement Method	To Be Used Above (Value US$)
Quality and Cost-Based Selection (QCBS)	For the selection of firms
Quality-Based Selection (QBS)	For recruitment of consultants through firms or nongovernment organizations
Consultants Qualification Selection (CQS)	</=200,000
Single Source Selection (SSS)	</=100,000

3. ADB Prior or Post Review

4. Except as ADB may otherwise agree, the following prior or post review requirements apply to the various procurement and consultant recruitment methods used for the project.

Procurement Method	Prior or Post	Comments
Procurement of Goods and Works		
ICB works	Prior	
ICB goods	Prior	
NCB works	Prior	
NCB goods	Prior	
Shopping for works	Prior	
Shopping for goods	Post	
Recruitment of Consulting Firms and NGOs		
Quality- and cost-based selection (QCBS)	Prior	(80:20)
Quality-based selection (QBS)	Prior	
Other selection methods: Single source (SSS)	Prior	
Recruitment of Individual Consultants		
Individual consultants	Prior	

4. Goods and Works Contracts Estimated to Cost More than $1 Million

5. The following table lists goods and works contracts for which procurement activity is either ongoing or expected to commence within the next 18 months.[1]

General Description	Contract Value ($ millions)	Procurement Method	Prequalification of Bidders (Y/N)	Advertisement Date (Quarter/Year)	Comments
A. Goods					
1. Medical Equipment for CHP at Wanam, Nergil, Pae & Kwinga of Mul District – Western Highlands	0.10	Shopping	Yes	Q3 2012	Supplied by Boucher & Muir Ltd for $132,545
2. Medical Equipment for CHP at Gurney and Bubuleta of Alotau District – Milne Bay	0.10	Shopping	Yes	Q1 2014	
3. Medical Equipment for CHP at Kassi and Monokam of Kompiam/Ambum	0.10	Shopping	Yes	Q2 2014	
4. Medical Equipment for 2 facilities at Western Highlands	0.10	Shopping	No	Q3 2014	
5. Vehicles*	0.70	Shopping	No	Q3 2014	Purchased 9 vehicles for $430,691. 4 vehicles will be purchased in Q3 2014.

[1] No contracts shall be awarded from Civil Works (Package 3) until the OFID Loan Agreement shall have been duly executed and delivered.

General Description	Contract Value ($ millions)	Procurement Method	Prequalification of Bidders (Y/N)	Advertisement Date (Quarter/Year)	Comments
B. Works – Construction of CHP and staff accommodations					
1. Facilities at Kassi and Monokam in Kompiam-Ambum District of Enga	2.00	NCB	No	Q4 2013	NCB will be published in Nov '13
2. Facilities at Bonga and Alkena in Tambul-Nebilyer of Western Highlands	2.00	NCB	No	Q4 2013	NCB will be published in Dec '13
3. Facilities at Gurney and Bubuleta in Alotau District of Milne Bay	2.00	NCB	No	Q4 2013	NCB will be published in Nov '13
4. Staff housings in Talasia/Kandrean Districts of West New Britain	0.40	Shopping	No	Q2 2014	
5. Two facilities at Laiagam District of Enga	0.60	NCB	No	Q3 2014	
6. Staff housings in Central/South Region of A.R. Bougainville	0.40	Shopping	No	Q3 2014	
7. Staff housing/facilities at Central Region of A.R. Bougainville	2.00	NCB	No	Q3 2014	

No contracts shall be awarded from Civil Works (Package 3) until the OFID Loan Agreement shall have been duly executed and delivered.
Any goods storage fee should be waived by the suppliers.
*Total approved budget for vehicle is USD 1.5 million to be disbursed if needed until Q2 2018.

5. Consulting Services Contracts Estimated to Cost More than $100,000

6. The following table lists consulting services contracts for which procurement activity is either ongoing or expected to commence within the next 18 months.

General Description	Average Contract Value ($'000)	Recruitment Method	Advertisement Date (Quarter/ Year)	International or National Assignment	Comments
A. Firm/NGO					
1. Health Information System Strengthening with ICT & GIS Technology	2.38	QCBS (90:10)	Q4 2012	International	Proposals being evaluated and expected to award contract by Oct 2013 Awarded to Abt JTA Ltd on Apr '13 for $0.999m
2. Formative Evaluation	1.00	QCBS (80:20)	Q3 2012	International	
3. Health Promotion – Western Highlands	0.50	QCBS (80:20)	Q2 2014	International/ National	

General Description	Average Contract Value ($'000)	Recruitment Method	Advertisement Date (Quarter/ Year)	International or National Assignment	Comments
4. Health Promotion – Enga	0.50	QCBS (80:20)	Q2 2014	International/ National	
5. Health Promotion – Milne Bay	0.50	QCBS (80:20)	Q2 2014	International/ National	
6. Training – Western HIghlands	0.15	CQS/SSS	Q2 2014	National	
7. Training – Enga	0.15	CQS/SSS	Q2 2014	National	
8. Training – Milne Bay	0.15	CQS/SSS	Q3 2014	National	
9. Training – A.R. Bougainville	0.15	CQS/SSS	Q3 2014	National	
B. International Consultants					
1. Project Manager	0.50	Individual Selection (IS)	Q1 2012	International	Rob Akers for 22 months on Mar '12 for $0.76m
2. Dy Project Manageer/Quality Imp. Leader	0.50	IS	Q1 2012	International	Suzanne Syme for 22 months on May '12 for $0.508m
3. Procurement and Finance Specialist	0.50	IS	Q1 2012	International	Nanda Maharjan for 22 months on Apr '12 for $0.506m
4. Health Policy/Human Resource Specialist	0.50	IS	Q3 2012	International	Benjamin Day for 30 days on Oct '12 for $0.03m. HR Specialist is being processed.
5. Health System Specialist	0.50	IS	Q3 2013	International	Vicki Assenheim for 15 months on Jun '13 for $0.421m
6. Institutional Development Specialist	0.50	IS	Q3 2012	International	Trevor Gowland for 15 months on Oct '12 for &0.434m

General Description	Average Contract Value ($'000)	Recruitment Method	Advertisement Date (Quarter/ Year)	International or National Assignment	Comments
7. Environmental/Civil Engineer/Architect	0.50	IS	Q1 2013	International	Pragati Basnet for 16 months on Mar '13 for $0.314m
8. Social/Gender/ Community/Development Specialist	0.50	IS	Q1 2013	International	Kelwyn Browne for 15 months on Mar '13 for $0.413m
9. Health Promotion Advisor	0.50	IS	Q3 2013	International	Bernadette Masianini for 15 months on Oct '12 for $0.424m
C. National Consultants					
1. Health Mentor – Western Highlands/Enga	0.10	IS	Q2 2012	National	Davis Iwuga for 36 months on July '12 for $0.507m
2. Health Mentor – Eastern Highlands/Morobe	0.10	IS	Q2 2012	National	Enoch Posanai for 36 months on Jul '12 for $0.681m
3. Health Mentor – East Sepik/Milne Bay	0.10	IS	Q2 2012	National	Jack Purai for 36 months on Jul '12 for $0.490m
4. Health Mentor – West New Britain/A.R. Bougainville	0.10	IS	Q2 2012	National	Dr. Isaak Ake for 36 months on Jul '12 for $0.595m
5. HR Specialist	0.10	IS	Q1 2014	National	
6. Engineer/Construction Manager	0.10	IS	Q2 2012	National	Stanley Mando for 36 months on Jul '12 for $0.474m
7. Safeguards Specialist	0.10	IS	Q2 2013	National	Levi Masil for 18 months on

General Description	Average Contract Value ($'000)	Recruitment Method	Advertisement Date (Quarter/ Year)	International or National Assignment	Comments
8. Gender/GBV/ Promotions Specialist	0.10	IS	Q1 2014	National	Jun '13 for $0.188m
9. Senior Accountant	0.10	IS	Q2 2012	National	Dorothy Memti for 36 months on Jul '12 for $0.280m
10. Accountant	0.10	IS	Q2 2012	National	Donald Wari for 36 months on Jul '12 for $0.257m
11. Communication and Reporting Officer	0.10	IS	Q2 2012	National	Dorothy Pias for 36 months on Jul '12 for $0.273m
12. Support Staff for Civil Works	0.10	IS	Q2 2014	National	
13. Admin Assistant - PSU	0.10	IS	Q2 2012	National	Hedwig Sere for 36 months on Jul '12 for $0.128m
14. Admin Assistant - Provincial	0.10	IS	Q2 2012	National	Emmah Kalas for 36 months on Jul '12 for $0.128m
15. Admin Assistant/ Driver	0.10	IS	Q4 2012	National	Teresa Benedict for 36 months on Jul '12 for $0.128m

[a] Apply single source selection method when there is only one available.

C. Indicative List of Packages Required Under the Project

7. The following table provides an indicative list of all procurement (goods, works, and, consulting services) over the life of the project. Contracts financed by the borrower and others should also be indicated, with an appropriate notation in the comments section.

General Description	Estimated Value ($'000)	Estimated Number of Contracts	Procurement Method	Domestic Preference Applicable	Comments
Goods-Medical Equipments	1.46	12	ICB/Shopping		
Goods-Vehicles	1.52	12	Shopping		
Services	25.08	64	NCB/Shopping		
1. Health Information System Strengthening with ICT & GIS	2.23	1	QCBS		
2. Training	6.36	12	QCBS		
3. Workshop	0.57	8	CQS/SSS		
4. International Consulting Services	9.58	12	IS	Full	
5. National Consulting Services	3.41	20	IS	Full	

CQS = Consultant's qualification selection, GIS = geographic information system, ICB = international competitive bidding, ICT = information and communication technology, NCB = national competitive bidding, QCBS = quality and cost-based selection, SSS = single-source selection.

[a] Medical equipment, vehicles, boats, motorbikes, furniture.

[b] ADB. 2010. ADB Procurement Guidelines. Manila.

D. National Competitive Bidding

1. General

8. The procedures to be followed for national competitive bidding (NCB) should be those set forth and consistent with the provisions of section one of ADBs *Procurement Guidelines* as required by paragraphs 3.3 and 3.4 of the guidelines. In keeping with the project design, ADB's policy on the promotion of domestic industries should be applied where applicable. The NCB will conform to the provisions set in the Public Financial Management Act (PFMA) as issued in 1995 and amended in 2006, and the specific procedures prescribed in the Goods Procurement Manual and the Financial Instructions issued in 2006, with the clarifications and modifications described in the following paragraphs required for compliance with the provisions of ADB's *Procurement Guidelines.*

2. Eligibility

9. The eligibility of bidders will be as defined under Section I of the ADB guidelines; accordingly, no bidder or potential bidder will be declared ineligible for contracts financed by ADB for reasons other than those provided in Section I of the guidelines. Foreign bidders will be eligible to participate in bidding under the same conditions as national bidders. In particular, no domestic preference over foreign bidders will be granted to national bidders in bid evaluation, nor will foreign bidders be asked or required to form joint ventures with national bidders in order to submit a bid.

3. Participation in Bidding

10. Government-owned enterprises in Papua New Guinea (PNG) will be eligible to bid only if they can establish that they are legally and financially autonomous, operate under commercial law, and are not a dependent agency of the borrower/executing agency/implementing agency.

11. Foreign bidders will be eligible to participate in bidding under the same conditions as national bidders.

12. Bidding will not be restricted to preregistered firms, and such registration will not be stated in the bidding documents as a condition for the submission of bids. Where registration is required prior to award of contract, bidders (i) will be allowed a reasonable time to complete the registration process, and (ii) will not be denied registration for reasons unrelated to their capability and resources to successfully perform the contract, which will be verified through post-qualification.

4. Classification of Contractors; Qualification; Postqualification

13. Postqualification will be used unless prequalification is explicitly provided for in the loan agreement/procurement plan.

14. Bidding will not be restricted to any particular class of contractors, and non-classified contractors will also be eligible to bid. Qualification criteria (in case prequalification was not carried out) will be stated in the bidding documents, and before contract award, the bidder having submitted the lowest evaluated responsive bid will be subject to post-qualification.

5. Conflict of Interest

15. Bidders may be considered to be in conflict of interest with one or more parties in this bidding process if, including but not limited to, the following cases occur:

(i) they have controlling shareholders in common;
(ii) they receive or have received any direct or indirect subsidy from any of them;
(iii) they have the same legal representative for purposes of this bid;
(iv) they have a relationship with each other, directly or through common third parties, that puts them in a position to have access to information about or influence on the bid or another bidder, or to influence the decisions of the employer regarding this bidding process;
(v) a bidder participates in more than one bid in this bidding process; participation by a bidder in more than one bid will result in the disqualification of all bids in which the party is involved; however, this does not limit the inclusion of the same subcontractor in more than one bid;
(vi) a bidder or any of its affiliates that participated as a consultant in the preparation of the design or technical specifications of the contract is the subject of the bid; or
(vii) a bidder or any of its affiliates has been hired (or is proposed to be hired) by the employer or borrower as engineer for the contract.

6. Preferences

16. No preference will be given for domestic bidders and for domestically manufactured goods.

7. Advertising, Time for Bid Preparation

17. Invitations to bid will be advertised in at least one newspaper of national circulation or on a freely accessible and well-known website, allowing a minimum of 4 weeks for the preparation

and submission of bids. Such a 4-week period will begin with the availability of the bid documents or the advertisement, whichever is later.

18. Bidding of NCB contracts estimated at $500,000 or more for goods and related services, or $1,000,000 or more for civil works, will be advertised on ADB's website via the posting of the Procurement Plan.

8. Standard Bidding Documents

19. Until national standard bidding documents approved by ADB are available, bidding documents acceptable to ADB should be used.

9. Bid Security

20. If required by the bidding documents, bid security will be in the form of a bank guarantee from a reputable bank. A bidder's bid security will apply only to a specific bid and should not exceed K2,000.

10. Bid Opening and Bid Evaluation

21. Bidders may deliver bids, at their option, either in person or by courier service or by mail.

22. Bidders will not be allowed to amend their tenders after the closing date and time for submission of bids.

23. Bids will be opened in public, immediately after the deadline for submission of bids. No bid will be rejected during bid opening. The name of the bidder, the total amount of each bid, and any discounts will be read aloud and recorded in the minutes of the public bid opening.

24. Evaluation of bids will be made in strict adherence to the qualifications and evaluation criteria stipulated in the bidding documents

25. No bidder will be rejected merely on the basis of a comparison with the employer's estimate and budget ceiling without ADB's prior concurrence.

26. The contract will be awarded to the technically responsive bidder that offers the lowest evaluated price, and meets the qualifying criteria. In determining the lowest evaluated price, the following are to be considered: (i) bid price, as offered; (ii) arithmetical corrections on the bid price, if any; and (iii) monetary value of the evaluation criteria that are stated in the bidding document.

11. Rejection of Bids

27. Bids will not be rejected and new bids solicited without ADB's prior concurrence.

12. Extension of the Validity of Bids

28. In exceptional circumstances and with prior ADB approval, the procuring entity may, before the expiration of bid validity, request all bidders in writing to extend the validity of their bids. In such a case, bidders will not be requested nor permitted to amend the price or any other condition of their bid. Bidders will have the right to refuse to grant such an extension without

forfeiting their bid security, but bidders granting such an extension will be required to provide a corresponding extension of their bid security.

13. Disclosure on Contract Awards

29. At the same time that notification on award of contract is given, the borrower/executing agency/implementing agency will publish the following information on contract award on a free and open access website or other means of publication acceptable to ADB: (i) name of each bidder that submitted a bid; (ii) bid prices as read out at bid opening; (iii) name and evaluated price of each bid that was evaluated; (iv) names of bidders whose bids were rejected and the reasons for the rejection; and (v) name of the winning bidder, price it offered, as well as the duration and summary scope of the contract awarded. The executing/implementing agency will respond in writing to unsuccessful bidders that seek explanations on the grounds on which their bids are not selected.

14. No Negotiations

30. There will be no negotiations, even with the lowest evaluated bidder, without ADB's prior concurrence. A bidder will not be required, as a condition of award, to undertake obligations not specified in the bidding documents, or otherwise, to modify the bid as originally submitted.

15. Fraud and Corruption

31. ADB will declare a firm or individual ineligible, either indefinitely or for a stated period, to be awarded a contract financed by ADB, if it at any time determines that the firm or individual has, directly or through an agent, engaged in corrupt, fraudulent, collusive, coercive, or obstructive practices in competing for, or in executing, a contract financed by ADB.

16. Inspection and Auditing

32. Each contract financed from the proceeds of a loan/grant will provide that the contractor/supplier will permit ADB, at its request, to inspect its accounts and records relating to the performance of the contract and to have said accounts and records audited by auditors appointed by ADB.

17. Member Country Restriction

33. Bidders must be nationals of member countries of ADB, and offered goods must be produced in and supplied from member countries of ADB.

Summary Table of Consulting Services and Outline of Consultant's Terms of Reference

A. Consulting Services Required for each Output Include

Output	Consultant Description	Time (months) Total	
		International	National
1. National support	Health Policy/Human Resource Specialist (intermittent)	10	0
	Health Information System Specialist (intermittent)	30	0
	ICT/GIS firm (intermittent)	30	0
2. Local health system strengthening	Institutional Development Specialist (intermittent)	30	0
	Health System Mentors (full-time)	0	384
	Health System (clinical/population health) Specialist (intermittent)	20	0
3. Health human resource development	Health Human Resource Specialist (intermittent)	30	96
4. Community health facility upgrading	Environmental Civil Engineer/Architect (intermittent)	24	0
	Engineer/Construction Managers (full-time)	0	180
	Support Staff for Civil Work (full-time)	0	72
	Safeguards Specialist (Intermittent)	0	36
5. Health promotion	Health Promotion Advisors	24	90
6. Project support unit	Project Manager (full-time)	96	0
	Team Leader-information/evaluation/training (Continuum Quality Integration)	96	0
	Social/Gender/Community Development Specialist (intermittent)	20	90
	(Short term pool) including support to HSIP if necessary	30	60
	Procurement and Finance Specialist (full-time)	96	0
	Senior Accountant	0	96
	Accountant (Full-time)	0	96
	Communication and Reporting (full-time national)	0	90
	Administration-National/PSU (full-time)	0	96
	Administration-Provincial Support (full-time)	0	180
	Total Months	**536**	**1566**

B. Consultant's Outline Terms of Reference

1. More detailed position descriptions will be supplied prior to loan negotiations. Before any of the proposed consulting appointments are made, a contemporaneous assessment of the current need for the assistance will be undertaken by the PSU with the DOH, and if the need is still there, the potential use of expertise assistance already in the field from other donor partners will be considered in the first instance.

Consultants will require previous experience in the Papua New Guinea (PNG) context and commit for the duration of the project. Where possible, consultants who have an understanding of the PNG context and culture will be preferred for all positions. A key feature of all consultants' work is to build the capacity within the existing health structures to take on the specialized roles of the project by the time it finishes.

1. Health Policy/Human Resource Specialist (International, Intermittent, 46 person-months)

Objective/ Purpose of assignment
The consultant will provide overall support for the Department of Health (DOH) and provincial efforts to strengthen the rural health workforce. The work will be guided by the human resource (HR) consultants' recommendations made during the project preparatory technical assistance (PPTA). At the provincial level, the consultant will work through health mentors to build HR capacity at the district and community health post (CHP) levels.

Scope of work
- Support the development of a Health Human Resources Task Force (as recommended by the PPTA), and the implementation of the national HR plan.
- Provide technical advice to DOH in the development of the community health worker (CHW) curriculum.
- Assist provinces to undertake an HR audit.
- Provide technical advice to the training institutions on the training of community health workers (CHWs) in maternal health.
- In association with health mentors, support the selected provinces on delivering the key elements of HR strengthening at the provincial and district levels (see PPTA HR report).
- Develop a collegial working relationship with DOH counterpart; and support the development of 'inline' position in DOH by the end of the project.

Reporting
The consultant will report to the Project Manager.

Key relationships
- Project Manager
- DOH HR Leader and the unit
- Health Mentors
- HR personnel in selected provinces and provincial health division and authorities
- Training institutions

Expected outcomes
- CHPs and district facilities fully staffed with appropriately skilled staff; and
- Improvement in staff retention.

2. Health Information System Specialist (International, Intermittent, 30 person-months)

Objective/Purpose of assignment
The contract will support the development of the health information systems in the selected districts, including establishing baseline indicators, trialing improvements in data collection quality and timeliness, the introduction of cell phone technology, the use of geographic

information system (GIS) mapping to inform decision making, and the provision of appropriate information back to the health system and accountability bodies at the ward/district/provincial and national levels.

Scope of work

- Review existing data collection, analysis, and reporting systems in selected provinces and make recommendations to the province and DOH on system improvements.
- Support the provinces to develop routine collection of baseline outcome indicators.
- Support the trial of the use of mobile phones as an aid to data collection and reporting in two districts, and advise on the trial results in relation to the overall HIS system.
- Assist in the development of a seamless interface between data collection (manual and mobile health), national collections, and GIS systems.
- Assist in the development of timely, relevant, accessible information dissemination to the different layers of the health system, and to government accountability bodies and other stakeholders.
- Participate in and provide appropriate information for the formative evaluation process.
- Engage with the DOH health information counterpart and include her/him in activities where appropriate; and develop a collegial working relationship with the DOH counterpart; and support the development of an “in line” position in DOH by the end of the project.

Reporting

The consultant will report to the Project Manager

Key relationships

- Project Manager
- DOH HIS leader and the unit
- Health mentors
- Health Information System personnel in selected provinces.
- GIS and mobile health specialists.

Expected outcomes

- Baseline indicators routinely collected for selected districts;
- Coherent and sustainable development of data collection, data analysis, data presentation, and information dissemination in the selected provinces;
- Coherent development of HIS activities in the selected provinces with national HIS development;
- Provision of timely accurate and accessible health information to health workers and stakeholders at all levels; and
- DOH and provinces have the necessary skills to run future HIS activities.

3. GIS/ICT firm or individuals (International, Intermittent, 30 person-months)

i. Mobile Health Specialist

Objective/Purpose of assignment

This contract will support the development of HIS in the selected districts, including trialing the introduction of cell phone technology to aid data collection and development of its interface with GIS mapping.

Scope of work

- With the Health Information Specialist, review existing data collection, analysis, and reporting systems in selected provinces and make recommendations to the province and DOH on system improvement.
- Trial the use of mobile phones as an aid to data collection and reporting in two districts and assess its optimal role in the data collection system.
- Roll out mobile phone use for data collection and reporting to all 16 districts (subject to satisfactory trial results).
- Develop a seamless interface between data collection and GIS systems to assist in timely presentation of collected information in GIS formats.
- Explore other potential uses of mobile health in the selected districts, including fund transfers.
- Provide appropriate information for the formative evaluation.
- Engage with DOH counterpart and include her/him in activities where appropriate; develop a collegial working relationship with the DOH counterpart.
- Support the development of an "in line" position in DOH by the end of the project.

Reporting

The consultant will report to the Project Manager

Key relationships

- Project Manager/Quality Improvement Leader
- Health Information Specialist
- DOH ICT Leader and the unit
- Health mentors
- ICT personnel and the provincial health team or authorities in selected provinces
- GIS provider

Expected outcomes

- Appropriate and sustainable use of mobile health in selected district data collection;
- Timely, accurate, relevant data gathering in selected districts; and
- Provision of timely accurate and accessible health information to health workers at all levels.

ii. GIS Services

Objective/Purpose of assignment

This contract will support the development of the HIS in the selected districts with the provision of GIS mapping of health information. The PPTA has developed Mapping on population, facility, access in the specified districts. There is considerable potential to extend this to clinical indicators and risk factors.

Scope of work

- Identify the needs in the selected districts which are best met by GIS information mapping.
- Develop a seamless interface between data collection and GIS systems to assist in timely presentation of collected information in GIS formats.

- Develop automated “thematic” maps for core data elements, based on the indicators, for the selected districts.
- Develop “online” capability of geobooks to allow provincial staff to upload/edit data on line.
- Develop presentation formats that are suitable for communicating health-related information for the different stakeholders in the PNG health system.
- Participate in and provide appropriate information for the formative evaluation.
- Engage with DOH counterpart and include her/him in activities where appropriate; develop a collegial working relationship with DOH counterpart; Support the development of an “in line” position in DOH by the end of the project.

Reporting
The consultant will report to the Project Manager.

Key relationships
- Project Manager/Quality Improvement Leader
- Health Information and mobile health Specialists
- DOH Health Information/Statistics Leader and the unit
- Health mentors
- ICT personnel and the provincial health team or authorities in selected provinces.
- Health Information Specialist

Expected outcomes
- Geo-mapping technology used appropriately and sustainably in the selected provinces.
- Increased DOH understanding of GEO-Maps and their role in HIS.
- Improved communication of health information to a variety of stakeholders.

4. Institutional Development/Institutional Strengthening Specialists (International, Intermittent, 36 person-months)

Objective/Purpose of assignment
This consultant will facilitate partnership development in provinces and districts and decentralization of functions to facilities. The international consultant will have an extensive track record in the areas of process/change management and local governance (state-nonstate partnerships) in the PNG context. Experience with the preparation and monitoring of facility-based funding/output-based contract management modalities is highly desirable. For the first 12-18 months of the project, the international consultant will be assigned full-time to assist with the introduction, development, and gradual implementation of the “Alliance Partnership Agreement” and contract modality. In years 2-5, he/she will be expected to provide intermittent support to the alliance partnerships. The consultant will help define and support the health mentors, who will be the immediate interface with districts and providers for this work.

Scope of work
- Assess the physical, legal, policy, institutional, administrative, staffing, and fiscal environment in which the participating provincial and local governments operate (these are likely to differ from province to province).
- Build close rapport with key stakeholders in the participating provincial and local governments.

- Assess and review existing contractual and other agreements, and organizational arrangements in the selected provinces, in particular, those between districts and relevant health service funders and providers in the specified provinces.
- Asses the availability and capacity of potential nonstate health service providers (private sector, church organizations and NGOs).
- Organize workshops/training sessions for state and nonstate actors to introduce the concept and practicalities of “partnerships board/agreement” (and contract modalities if applicable).
- Facilitate strengthening of setting up partnership boards, provincial health authorities, or provincial health boards to take on the “partnership board” role.
- Support partnership formation, monitoring, and reporting, and where appropriate alliance contracting at the provincial and district levels.
- Support the application of direct facility funding (DFF) for health facilities.
- Assist with the preparation of tender documents for the delivery of civil works and training activities.
- Assist with the facilitation of partnership board meetings.
- Assist with the management of alliance agreements/contracts”.
- Advise the province and districts on management support and supervision approaches.

Reporting
The consultant will report to the Project Manager

Key relationships
- Project Manager
- Provincial and district health leadership and the team
- Health mentors

Expected outcomes
- Effective health partnerships operating in the selected provinces;
- Successful introduction of DFF to all facilities in the selected districts;
- Inception report (3 months); progress report (12 months); and training materials;
- Visit the participating provinces and districts twice a year (1.5 months per mission); and
- Consult with the participating alliance board members (and other relevant stakeholders) in the participating provinces and districts on lessons learned and challenges met in the implementation of the alliance partnerships and contracts.

5. Health Mentors (National, Continuous, 196 person-months)

Objective/Purpose of assignment
Health mentors will work alongside provincial and district health personnel to coordinate the work of the project with ongoing health activities and support the districts in the areas of supervision, HR, information, clinical services, management, and institutional strengthening. They will have an in-depth understanding of the PNG rural health system and its history; and will play a key role in ensuring that the project inputs do not overwhelm the absorptive capacity of the provincial and district health organizations and providers. They will have technical expertise in health service management, health services, and public health. They will have the capacity to develop long-term relationships with health workers at all levels in the province, as well as the ability to effectively contextualize the work of international consultants so that it is effective at the local level; and will have an in-depth understanding of the decentralization, local governance, and experiences with nonstate health service provision in PNG.

Scope of work

- In concert with the project manager, plan and supervise the project inputs, including the inputs from other consultants, with the various work programs and priorities of the different districts and provinces.
- Assist the institutional specialist with the introduction, development, and gradual implementation of the alliance partnership and contract modality.
- Work with CHPs to improve health worker practice.
- Work with district leadership on reviewing current health service performance data, identifying barriers to lifting achievement, and assisting the CHPs and in commissioning appropriate health worker professional development.
- Work with districts to support CHPs to develop annual plans covering all aspects of the CHP's operations, property maintenance, human resource use, etc. Assist the districts to develop management and clinical supervision. Assist the province and districts to include goals for health services and population level health improvement for their population.
- Work with district leaders and the HIS specialist on developing data and collection processes so that the CHP knows how well it is performing, and identify the areas needed for improvement. This process of building the capability of each CHP in self-review is essential both for strengthening the performance and also for sustainability.
- Bring groups of CHPs together so that they may share performance data among themselves to build communities of practice.
- Support periodic program reviews with the district leadership as part of the formative evaluation.
- Develop a consistent set of professional practices with the relevant international consultants. This set of practices will include skills in health service management, data analysis, diagnosis of health worker practice issues, health services, public health, and skills in working with diverse and remote populations.
- Develop in the selected provinces the necessary supervisory skills to continue their work.

Reporting

The consultants will report to the Project Manager.

Key relationships

- Project Manager
- Provincial and District Health Leaders and the team
- CHPs
- Project consultants
- Formative evaluation

Expected outcomes

- Effective health partnerships operating in the selected provinces; and
- Successful introduction of DFF to all facilities in the selected districts.

6. Health System (clinical/population health) Specialist (International, Intermittent, 24 person-months)

Objective/Purpose of assignment
This consultant will take an overview of health system development (including clinical, managerial, and community aspects) and work with the health mentors to provide strategic advice to provinces, districts, and providers on rural health system strengthening. The consultant will be familiar with the PNG context, the National Health Plan (NHP), as well as international best practice in health system strengthening.

Scope of work
- Support the development of provincial health services plans to guide district rural health strengthening efforts.
- Support a strong public health and population health approach to planning and provision of health services at the provincial, district, and provider levels.
- Support the development of district management capacity and capability.
- Participate in 6-monthly formative evaluations of the project.
- Support and train national and DOH staff.

Reporting
The consultant will report to the Project Manager.

Key relationships
- Project Manager
- Provincial and district health leaders and the team
- Health mentors
- Project consultants
- Formative evaluation

Expected outcomes
Population health improvement in selected districts consistent with the NHP.

7. Engineer/Construction Manager (National, Continuous, 192 person-months)

Objective/Purpose of assignment
This consultant will take responsibility for the building and refurbishment of health facilities in the selected districts. The consultant will have extensive experience in building rural facilties in PNG. The consultant will develop oversight of the civil works agreements for the rural health facilities, monitor their implementation, and ensure that specifications are followed. He/she will facilitate and monitor an initial audit of facilities and equipment. He/she will procure and deliver equipment and fixtures for the rural health facilities including periodic reviews of equipment inventories. In addition, the consultant will provide assistance to the HSIP management branch capital works section.

Scope of work
- Support the province to undertake a facilities audit.
- Provide advice to provinces on design, materials, logistics, and project management.
- Advise on the preparation of a facilities plan consistent with the provincial health services plan.

- Assess with providers their capability in terms of documentation, operational design, planning,m and management.[37]
- Devise and implement purchase of new, renovated facilities directly from health providers and with additional inputs where critical skills gaps have been identified.
- Supervise the inputs of the Environmental Civil Engineer/Architect and Safeguards Specialist.

Reporting
The consultant will report to the Project Manager.

Key relationships
Project Manager
Environmental Civil Engineer/Architect
Provincial facilities staff
Building contractors

Expected outcomes
High quality and sustainable CHPs built and refurbished in selected districts.

8. Environmental Civil Engineer/Architect (International, Intermittent, 24 person-months)

Objective/Purpose of assignment
Provide the project with advice on international best practices in relation to environmental and construction civil engineering. In particular, advise the project on design, energy sustainability, renewable energy sources, and environmental issues.

Scope of work
Provide technical support to the engineer/construction manager.
Advise on scope and specificity of building contracts.

Reporting
The consultant will report to the engineer/construction manager.

Key relationships
- Project Manager
- Engineer/Construction Manager
- Provincial and district health facilities staff
- Provincial and district health leaders and the team
- Builders

Expected outcomes
The project adopts international best practices in building design, sustainability, and environmental impacts.

[37] A key finding from the enclaves project was that the absence of critical skills meant projects did not progress. These areas (operational design, planning, and management) need to be identified in advance.

9. Safeguards Specialist (National, Intermittent, 36 person-months)

Objective/Purpose of assignment
The specialist will cover both environmental and resettlement issues under the project. He/she will work with and train contractors to assist them in proactively understanding their contractual requirements as set out in the initial environmental examination (IEE). The consultant is to be familiar with contract preparation, evaluation, and supervision so as to advise the PSU on the steps required to carry the environmental safeguards across to the bid and contract documents, the evaluation of bids, selection of the contractor, and the monitoring of the contractor's work.

Scope of work
- Oversee and manage the environmental and social impacts of project delivery, such that they are in all cases minimized, while staying within projected parameters. These parameters include all relevant laws and regulations of PNG.
- Review all building plans for their compliance with the IEE, and give advice and guidance to the PSU on all matters pertaining to the environmental impact of these facilities.
- Maintain a supervisory role over matters pertaining to the use of land and the allocation of land by provincial authorities for CHP construction that may have implications for social harmony and conflict avoidance.
- Review and analyze relevant available data and reports, review Land Assessment Framework (LAF) prepared for the project, and undertake field visits to the project sites.
- Undertake land assessment and prepare land assessment reports (LARs) in accordance with the LAF to confirm that the health facilities' land is owned by the government or a partner organization that runs such a facility.
- Facilitate organizing public consultations for disclosure of the LARs to the local communities, including providing information from the LAF, LARs, and other relevant project reports to local stakeholders in the local language.
- Finalize and submit LARs to ADB through the government for approval.
- Together with project counterparts (government or otherwise), supervise and monitor implementation of the LAF.
- Provide training to counterpart staff on project-related land issues and ADB's policy and procedural requirements on social safeguards.
- Take overall responsibility for implementation and monitoring of the project's social safeguard activities in compliance with ADB's Safeguard Policy Statement (2009).
- Provide the status of land issues in the quarterly and annual reports.

Reporting
The consultant will report to the Engineer/Construction Manager.

Key relationships
- Project Manager
- Engineer/Construction Manager
- Environmental Civil Engineer/Architect
- Provincial/district and provider facilities staff
- Builders
- Impacted communities

Expected outcomes
Environmental and resettlement issues effectively managed during the project.

10. Health Communications Adviser (International, Intermittent, 24 person-months)

Objective/Purpose of assignment

This consultant will work alongside the project support unit (PSU) from the initial stage of the project. The consultant will provide intermittent support over the duration of the project. The consultant will be expected to work full-time for 3 months at the start of the project. The consultant will assist the PSU to develop a set of standard documents to assist in the implementation of output 5 of the project. The international consultant will have an extensive track record in the area of health communication, especially in developing nations, and prior experience in PNG will be desirable. Experience in starting up a communications outfit within a new project is highly desirable. The consultant will help coach and support the National Communications Officer, who will be the full-time country-based personnel.

Scope of work

- Review and build on the concept note of output 5 into a program plan, adhering to the basic principles already stated.
- Assist the PSU in developing a set of selection criteria of contractors for outputs 2 and 3.
- Develop the terms of reference (TOR) for the contractor.
- Assist the PSU in developing a standard template to solicit proposals from contractors. These templates are likely to differ for the two components.
- Assist the PSU during the proposal assessment stage, to make sure that the proposals in are line with the objective of the project.
- Work together with the contractors to develop their program plan, especially to ensure that the gaps ascertained by the needs assessment are addressed.
- Provide technical assistance to contractors in developing communications materials for their campaigns (this could be required two times over the course of 7 years).
- Develop, together with the contractors and DOH's Division of Health Promotion, a training of trainers (TOT) manual for the village health volunteers (VHVs).
- Provide technical assistance to contractors to deliver TOTs.

Reporting

The consultant will report to the Project Manager.

Key relationships

- Project Manager
- DOH Health promotion leader and the unit
- Contractors and their community based partners
- Provincial health authorities

Expected outcomes

- Program design for output 5;
- Selection criteria for contractors;
- Standard proposal templates;
- TOT manual for VHVs; and
- Communications materials.

11. Project Manager (International, Full-time, 96 months)

Objective/Purpose of assignment
The Project Manager will be overall responsible for the project.

Scope of work
- Establish the PSU and ensure overall implementation of the project, fiscal management, monitoring, and reporting.
- Create and execute project work plans and revise as appropriate to meet changing needs and requirements.
- Ensure compliance with ADB regulations and procedures and local policies and laws.
- Ensure that the project is implemented according to the report and recommendation of the President (RRP) and any subsequent instructions/guidance from ADB.
- Identify resources needed and assign individual responsibilities.
- Minimize and manage risks to the project.
- Direct report of all consultant and employed staff.
- Liaise with sector leaders at the national, provincial, and district levels and with development partners.
- Oversee the transition of the PSU to DOH over the life of the project.

Reporting
Report to Project Director (Secretary for Health) and ADB Project Officer.
Provide monthly updates of project progress and activities in the field.

Key relationships
- ADB Project Officer
- Secretary for Health
- Senior Executive Managers, Provincial Administrators and Provincial Health CEOs and Health Advisers
- Direct report in PSU
- Cofinanciers
- Development partners

Expected outcomes
The project meets its goals of improving rural health service delivery in the selected districts.

12. Quality Improvement Leader (International, Full-time, 96 months)

Objective/ Purpose of assignment
This consultant will manage the inputs related to gender, HR, health information including ICT and GIS, and contract and oversee the formative evaluation. The consultant will have experience in project management and procurement, and will be familiar with both the state and nonstate health provider operating environment in rural PNG. The Quality Improvement Leader will provide leadership and direction to a team of consultants and firms to support the development of a quality improvement culture within the project areas.

Scope of work

- Ensure that the Gender Action Plan is reflected in all activities of the project.
- Oversee the formative evlauation contract and ensure that the formative evaluation is conducted 6 monthly.
- Provide management supervision for volunteers engaged in the project.
- Oversee the health information, ICT, and GIS contracts and support the consultants to develop an integrated approach to health information.
- Support the HR consultant; with advice, purchase HR training requirements of the project.
- Act as deputy for the Project Manager when required.

Reporting

The consultant will report to the Project Manager.

Key relationships

- Project Manager
- Consultants in the areas of responsibility
- JICA volunteers
- GIS/ICT firm
- Formative evaluation consultants

Expected outcomes

The specific project elements under his/her control are fully integrated into the project activities.

13. Social/Gender/Community Development Specialists (National Full-time; and International, Intermittent, 24 months)

Objective/ Purpose of assignment

The consultant will be responsible for developing performance and monitoring indicators of all project activities related to gender as well as GAP-specific activities, and for monitoring the implementation of Gender Action Plan (GAP) activities.

Scope of work

- Provide support to the health system consultant of the PSU in developing CHP policies and strategies that address women's access to CHPs, and assist with developing specific monitoring and evaluation tools to measure improved access by women.
- In coordination with PSU consultants, DOH, and provincial health authorities, develop a monitoring tool to ensure that constructed/renovated/upgraded CHPs or health facilities meet the standards specified under the national guidelines and the GAP during implementation.
- Provide support to the Institutional Development Specialist of the PSU and the health mentors for local health system strengthening, to ensure that all activities at the provincial and district levels are based on consultations that include equal representation of women and men, including establishment of CHP management committees.
- Provide support to the Human Resources consultant of the PSU in implementing the national Human Resources Plan and developing HR curriculum, and ensure that all plans and curricula address gender issues, including gender balance in the HR workforce, gender awareness as part of the curriculum, and specific training programs on extensive reproductive care services for women.

- Provide support for developing specific health promotion programs in selected provinces and ensure that all promotion activities (i) establish sex-disaggregated baselines; (ii) implement specific outreach activities involving both men and women; and (iii) programs include an established list of training including family planning, HIV/AIDS, and gender-based violence.
- Develop specific monitoring and evaluation indicators and targets for all GAP activities, in consultation with DOH, provincial and district officials, and other development partners, and establish performance and monitoring frameworks for GAP activities.
- Provide support to the project manager of the PSU in establishing baseline indicators that include sex-disaggregated data in all project activities, and monitor their progress throughout the implementation process.
- Provide inputs to the head of the PSU on the progress of GAP activities as well as sex-disaggregated data on all project activities, which will be incorporated into quarterly project progress reports.
- Provide or organize gender awareness training for all PSU staff, and all project management/implementation staff of DOH, participating provinces, and nonstate providers included in alliance contracts.

Reporting
The consultant reports to the Project Manager.

Key relationships
- Project Manager/Quality Improvement Leader
- Project consultants.
- Health mentors

Expected outcomes
The rural health services in the selected districts provide appropriate services to both genders.

14. Procurement and Finance Specialist (National, Full-time, 96 months)

Objective/ Purpose of assignment
This consultant will exercise purchasing oversight for the facilities to be built or renovated at the district level.

Scope of work
- Develop a procurement plan, strategy, and manuals in accordance with ADB and Government of PNG procurement laws and regulations.
- Plan and conduct procurement training for the implementation agencies' staff on the use of standard bidding documents, requests for proposals, evaluation reports, contracts and procurement guidelines.
- Maintain coordination of project activities and be responsible for following up with management on the achievement of all project-related procurement targets.
- Manage the advertising process involved in procurement, procurement correspondence, bid receipt, and bid opening in strict accordance with the agreed upon procurement procedures.
- Manage the project procurement filing system in a systematic manner.
- Participate in contract negotiations.
- Prepare and execute purchase orders and requisitions.
- Store proposals and related bank securities in a safe location.

- Prepare physical progress and overall procurement activity reports quarterly for the Project Manager.
- Be responsible for project financial management, ensuring compliance with ADB policies and procedures.
- Ensure that annual budgets are prepared in advance of the financial year based on interaction with relevant DOH and provincial government personnel and with engineers and other project-related staff.
- Assist the government and project experts in the design and implementation of direct facility funding for newly constructed or refurbished CHPs.
- Implement a computerized financial management system to track project expenditures and reconcile regularly with the Health Sector Improvement Program Financial Management Unit and the government PGAS system.
- Liaise with project/government external auditors and internal auditors and be responsible for ensuring timely presentation of the project financial statements for audit.
- Ensure that an annual audit is completed on the project in accordance with ADB requirements.
- Prepare and deliver training courses on financial management for project and government personnel directly involved in project activities including training on ADB financial management and procurement policies and procedures.
- Be responsible for project cash-flow management.
- Be responsible for management of foreign currency transactions and reconciliation.
- Manage and oversees the work of project accounting staff.

Reporting
This consultant reports to the Engineer/construction manager.

Key relationships
- Project Manager
- Engineer/construction manager
- Provincial/district/ provider facilities managers
- Building services providers
- DOH procurement officers.

Expected outcomes
- Purchases are made in timely manner; and
- Purchasing approach leads to best available value for money; purchasing functions are well integrated into other project activities.

15. Senior Accountant (National, Full-time, 96 person-months)

Objective/Purpose of assignment
The consultant will manage and maintain the accounts for the project and act as financial controller and adviser to the Project Manager.

Scope of work
- Maintain independent project accounts matching the government's chart of accounts, ADB classification, and additional data as required by the project.
- Maintain an audit-ready, detailed paper trail of all transactions involving project funds.
- Maintain an inventory of all capital assets procured under the project.

- Prepare standard monthly reports.
- Assist in the preparation of analytical reports as requested.
- Reconcile the independent project accounts with DOH HSIP Management Branch (MB) accounts (government systems); provide an opinion to project management as requested.
- Assist the HSIP MB in relation to budgeting, accounting, and reporting functions for the project.
- Follow up on procurement and payment processing by the HSIP MB; initiate and maintain tracking mechanisms as requested.
- Undertake field supervisory visits as requested; assist in tracking progress in project-assisted development enclaves.
- Prepare progress reports in relation to supervisory visits.
- Attend HSIP MB operations and management meetings as requested.
- Assist the Project Manager and the Project Procurement Specialist as requested.

Reporting
The consultant reports to the Procurement and Finance Specialist.

Key relationships
- Project Manager
- Procurement and Financial Specialist
- HSIP

Expected outcomes
- Effective financial management of the project
- Project runs on budget and on time

16. Administration –National /PSU Full time- 2 positions (196 months)

Objective/ purpose of assignment
To provide administrative support to PSU staff. One position will support the project manager, while the other will support the rest of the PSU staff.

Scope of work
- Provide support through use of Word, Excel, PowerPoint, and Outlook, with accurate word processing and data entry skills.
- Develop and manage administrative systems and procedures.
- Provide logistic support for travel, accommodations, and events.
- Support the team with written communications.
- Provide an interface with all stakeholders, based on effective verbal communication and interpersonal skills, with the ability to liaise with people at all levels in an informative, accurate, and positive manner.
- Assist the project manager with prioritization, organization, and the completion of work within established deadlines.
- Maintain a supportive environment for all team members and visiting consultants.

Reporting
To Project Manager

Key relationships
All PSU staff

17. Administration – Provincial Support (National, Full-time, 196 person-months)

Objective/Purpose of assignment
To provide administrative support to the selected provinces. One position will support the project manager, while the other will support the rest of the PSU staff. The position will supply adminstrative and/or clerical support for the selected provinces, including supporting the activities of the health mentor. The position is to support the provincial adminstration.

Scope of work
- Provide support through use of Word, Excel, PowerPoint, and Outlook, with accurate word processing and data entry skills.
- Develop and manage administrative systems and procedures.
- Provide logistic support for travel, accommodations, and events.
- Support the team with written communications.
- Provide an interface with all stakeholders, based on effective verbal communication and interpersonal skills, with the ability to liaise with people at all levels in an informative, accurate, and positive manner.
- Assist the project manager with prioritization, organization, and the completion of work within established deadlines.
- Maintain a supportive environment for all team members and visiting consultants.
- Maintain accurate records of program-related expenditure.

Reporting
The consultant reports to the Provincial Health leaders and staff.

Key relationships
- Provincial health leaders and team
- PSU staff
- Health Mentors

18. Pool Consultants (International, 36 months; and National, 60 months)

Objective/ purpose of assignment
Over the course of the project, needs will arise to fill critical skill gaps that may not be apparent at this stage. The consultant pool will allow the project the flexibility to fill critical skills gaps that handicap its progress. Other areas such as climate change, and short-term consultancy to advise on health impacts of climate, will be funded from this pool.

Scope of work
Determined once specific requirements identified

Reporting
Pool consultants will report to the Project Manager

Key relationships
To be determined

19. Formative Evaluation

Objective/purpose
A formative evaluation will be contracted to a firm or institution, rather than to a single consultant. It will have the following objectives:

- Provide independent feedback of information regarding the establishment of CHPs to project implementers to enable them to make refinements as the roll-out is in progress; Actively involve project implementers in ongoing project design.
- Act as an independent arbiter of milestone achievements within the alliance contract at the district level.
- Rapidly disseminate learnings from the implementation of the CHPs across PNG to other districts embarking on health system strengthening.
- Incorporate innovations occurring in other districts into the learning of the project.

Scope
The scope for the formative evaluation will include rural health services strengthening efforts across PNG, but with particular focus on the project sites (initially two districts in each of the five provinces). The evaluators will hold a meeting in PNG every 6 months.

Components
The formative evaluation will focus on the following areas, including sample research questions:

- Evaluating delivery of planned activities
  Is the project being implemented as planned? Are there unforeseen barriers/problems? Are there differences in the way the project is being implemented between districts? How do different stakeholders view the implementation? Have there been any major deviations from the timeline and budgets, and why? Are the expected outputs being achieved (CHP infrastructure built, outreach conducted, involvement of communities, women's participation)?
- Measuring project impacts
  Is the project achieving its immediate goals, as measured by changes in the indicators of short- and medium-term success (immunization coverage, percentage of births with skilled attendants, closer cooperation between partners, etc.)? Are there areas wherein better/faster results are being seen, and what factors are behind this? Are there any unexpected (positive or negative) effects from the project? What are the impacts for different stakeholders (communities, health workers, provincial officials)?
- Measuring health, social, and economic benefits with a focus on the poor, women, and disadvantaged groups
  What are the broader social and economic benefits/costs of the program so far (to providers, to patients)? Have user fees and other access barriers been reduced? Is the program working less well for some groups or in some areas? How do women and vulnerable groups view the project? What is the impact of the activities on service effectiveness and efficiency?
- Monitoring the achievement of Millennium Development Goals and other government targets.
  In the formative stage, the questions here will focus on whether the right data are being collected to report on these targets, how timely and complete they are, and how the flow of data from rural areas to the province/central level can be improved, as well as the flow of information back to frontline workers and communities.

GENDER ACTION PLAN

Outputs	Proposed Activities and Targets	Primary Responsibility
Output 1: National support for policy development		
National and selected provincial and district governments implement policies and standards for community health posts (CHPs).	• Ensure that CHP policies and standards include specific strategies such as necessary equipment for delivery, health workers' skills for antenatal care, and delivery to improve women's access to primary health care and reproductive health care. • Ensure that CHP policies and standards include specific monitoring and evaluation tools to measure improvement in women's access to health care including maternal and child care.	DOH, PSU, health policy/HR specialist, social/gender/community development specialists
Output 2: Sustainable partnerships between provincial governments and nonstate actors		
Sustainable partnership established between selected provincial government and nonstate actors for PHC services delivery	• Ensure that alliance agreements include provision to monitor equitable access to health services for women. • Ensure that at least 40% of established partnerships include NGOs or other local organizations that provide services to women as the primary target or client group. • Establish partnership board/health partnership board in each province with equal representation of men and women from wards in the CHP. • Provide gender awareness training to all partnership board members as part of management training catchment area.	Provincial government, provincial health authorities (PHAs), PSU, health mentors, institutional development specialist and social/gender/community development specialists
Output 3: Human resource development in the health sector		
Community health workers in project areas have the capacity to provide quality PHC services.	• Identify and recommend eligible and interested females from rural areas to participate in community health worker and nursing officer training (50% of trainees will be female). • Develop specific measures such as equal working environment and security, and recommend to retain trained female staff and to improve performance of health workers. • Develop training programs for all health workers on maternal and child health care and family planning to improve health care for women. • Ensure integrated family health care by community health workers (through outreach activities), including antenatal care and family planning (two outreach activities are conducted per community, per year).	DOH, PSU, human resource specialist and social gender/community development specialists
Output 4: Community health facility upgrading		
Selected provincial and district governments upgraded selected rural health facilities	• Ensure that existing facilities are renovated or new CHPs are built with separate rooms/spaces for women's private consultation and examination and for childbirth. • Ensure that all CHPs and renovated health facilities are provided with medical equipment and supplies necessary for antenatal care, childbirth, postnatal care, and other reproductive care services.	Provincial governments, PHAs, PSU, architect/construction manager, social gender/community development specialists, and health system specialist

Output 5: Health promotion in local communities		
Local communities in project areas are aware of maternal and child health, HIV, sanitation, and gender issues.	• Through existing programs by NGO, churches, or civil society, introduce a village health volunteer (VHV) program to conduct outreach and health promotion activities in rural communities. Ensure that these activities are conducted for both men and women (at least 30% of activities are conducted for men). • Develop VHV training modules on antennal care, safe birth, and postnatal care, including when and how to refer pregnant women with risk factors to health facilities for delivery. Include training modules on family planning, child immunization, STIs, HIV/AIDS, domestic violence, and gender awareness. • Train village leaders in healthy community development on primary health care and gender awareness.	Provincial governments, PHAs, PSU, health promotion specialist, and social/gender/community development specialists
Output 6: Project management and Monitoring and Evaluation		
Effective project management. services rendered	• Ensure the employment of social/gender/community development specialists to oversee the implementation, monitoring, and reporting of the GAP at both the national and provincial levels. • Provide or organize gender awareness training to all staff members of the PSU, all management staff in participating provinces, nonstate providers in alliance agreements; • Train management staff in provinces and districts, nonstate health providers, and those in health worker training and health promotion activities on collection of sex-disaggregated data and monitoring of these data. • Ensure that all district and community consultations include equal representation of men and women. • Ensure that baseline and periodic monitoring surveys collect, analyze and report sex-disaggregated data for all project outputs.	DOH, PSU, social/gender/community development specialists

IMPLEMENTATION ARRANGEMENTS

The GAP will be implemented by implementing agencies (DOH for outputs 1 and 6, and provincial governments or PHAs for outputs 2-5) and a team of consultants in PSU who will be in charge of each output, with assistance from the social/gender/community development specialists. In addition, other experts will support to ensure the gender-related activities and targets. The experts include social/gender/community development specialists, health policy specialist, HR specialist, institutional development architect/construction manager consultants, health mentors, and health promotion program specialist. The head of the PSU will be responsible for the overall implementation of the GAP, and the social/gender/community development specialists will be responsible for monitoring and reporting on the progress of GAP implementation.

The PSU project manager, team leader information/evaluation/training, and social/gender/community development specialists will be responsible for developing specific performance and monitoring indicators for GAP activities. Social/gender/community development specialists will ensure the collection of sex-disaggregated data for all project activities, as well as GAP activities, and establish baseline data to monitor the progress of all project outputs and GAP activities.

The executing agency, supported by the PSU, will report on the progress of GAP activities in regular progress reports on overall project activities to ADB and the Government of Papua New Guinea. The formative evaluation team, in consultation with the social/gender/community specialists, PSU project manager and team leader, and the executing agency and implementing agencies, will analyze sex-disaggregated data and incorporate the findings in project progress reports.

ADB = Asian Development Bank, CHP = community health post, GAP = Gender Action Plan, HIV/AIDS = Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome, HR = human resources, NGO = nongovernment organization, PHC = primary healthcare, PSU = project support unit, STI = sexually transmitted infections.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
Impact Improved health of rural population in the project areas	By 2020, improvements in the project area from a 2006 baseline: Maternal mortality rates decreased from 733 per 100,000 to 360 Infant mortality rates decreased from 57 per 1,000 live births to 35, with sex and socioeconomic quintiles disaggregated Neonatal mortality rates decreased from 29 per 1,000 live births to 18, with sex and socioeconomic quintiles disaggregated Child under 5 mortality rates decreased from 75 per 1,000 live births to 44, with sex and socioeconomic quintiles disaggregated	Demographic health survey Census National health information system	**Assumptions** Local governments are committed to and set priorities on improving rural health-care services and referral networks. Political stability is maintained. **Risk** Poor governance, issue of fragility, and institutional factors affect returns on health-care investments and the performance of health-care services.
Outcome Selected provinces, in partnership with non-state service providers, delivering high-quality PHC to rural residents, in particular women and children	By 2018: Health-care service utilization rates increased annually for antenatal care, family planning, deliveries at facilities, and immunization for rural women and children in selected districts, compared with the baseline in 2011[a] At least 32 CHPs providing child, maternity, and other public health-care services with qualified community health workers PHC funding per capita increasing by 5% in real terms in selected provinces compared with the baseline in 2011	National health information system National Economic Fiscal Commission's survey and research (www.nefc.gov.pg) Provincial coordinating and monitoring committee District and facility level activity reports Provincial annual reports	**Assumptions** Improved health-care system performance will reduce maternal, infant, and child deaths. Improving 32 CHPs will have a significant impact on health outcomes at the district level. **Risks** System improvements do not affect maternal death rates. Issues of fragility and factors outside the health sector deteriorate, worsening health outcomes. Improvements are not generalized across other health-care facilities in the district.
Outputs 1. National and selected provincial and district governments implementing policies and standards for community health posts	By 2018 (except where otherwise indicated): National, 8 provincial and 16 district governments adopted CHP policy by Q4 of 2014	Regular facility audits Annual human resource audit in selected districts Review of health	**Assumptions** The government continues to support CHP policy for implementation. Strengthening PHC service delivery through CHPs remains a priority for both the national and

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
	CHPs in 16 districts with access to real-time health information through information technology by the fourth quarter of 2014.	information available at CHPs, health centers, and at the district level	subnational governments, as well as of other stakeholders. **Risks**
2. Sustainable partnership established between selected provincial governments and non-state actors for delivering PHC services	16 selected districts delivering health-care services based on partnership agreements by 2015	District contracts	Some provinces and districts fail to commit to CHPs or provide human resource or budgetary support for them. The project becomes downsized because funding from cofinanciers is not provided on time.
3. Community health workers in project areas with the capacity to provide quality PHC services.	50% of facilities use direct facility funding by Q4 of 2018. The number of community health workers skilled in maternal medicine increased by at least 10% in selected districts compared with 2011 baseline, and at least half are women [a] Maternal and child health-care by trained health workers increased by 10% in selected districts compared with 2011 baseline [a]		The fragile security situation in the country impedes mobility and timely and effective implementation.
4. Selected provincial and district governments upgraded selected rural health facilities	At least 32 CHPs and 160 health-care facilities in the selected provinces built or upgraded with water and electricity available 24 hours a day, seven days a week At least 32 CHPs and 160 health-care facilities equipped with furniture, fittings, and medical and nonmedical equipment, including a maternal health set by CHP policy document and policy on biomedical equipment		
5. Local communities in project areas aware of maternal and child health, HIV, sanitation, and gender issues	At least 50% of women actively engaged in two health promotion and gender programs at selected project sites Antenatal care coverage (both 1st and 4th antenatal care visits) improved in selected project districts measured by gap between baseline and national goal narrowing by 50% by 2018		
6. Effective project monitoring, evaluation and management, services rendered	Project activities completed on schedule by 30 October 2019Government completion report by 30 October 2019.		

Activities with Milestones	Inputs
1. National and selected provincial and district governments implementing policies and standards for community health posts	ADB: $20 million Asian Development Fund loan Government: $10 million
1.1 Develop and finalize CHP policy, standards, strategy draft paper by Q2 2012.	
1.2 Develop communication tools and training materials by Q4 2012.	
1.3 Each province prepares strategies to implement the policy on health services and CHP by Q2 2013.	
1.4 Assess health information system and ICT situation by Q3 2012.	
1.5 Design an ICT program with GIS feature by Q1 2013.	

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

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

[a] District baseline data will be established during year 1 of project implementation, and the targets for each district will be based on that data.

Source: Asian Development Bank.

List of Documents Prepared by PPTA 7400 Team

Topic	Description	Last updated
Access to Health Facilities Data	Based on the projected 2008 population from the 2000 census, this estimates the number of people with no access to health facilities, and with access only to Aid Posts.	July 10
CHP advocacy documents: • Radio • GIS • Infrastructure	These short documents have been prepared by the PPTA to help describe the CHP concept to a wider audience. There is a brief for radio advocacy, GIS and Infrastructure.	Nov 10
Community engagement in PNG (PowerPoint)	This is a powerpoint description of examples of successful community participation and community development in health from across PNG.	Jan 11
Community Engagement in five communities in PNG	This is a written description of examples of successful community participation and community development in health from across PNG.	Jan 11
Community Health Post Policy	This is an in depth policy discussion of the Community Health Post concept. Its starting point is the NDoH policy as outlined in the National Health Plan. It includes a log frame for contracting CHP services.	Nov 10
Community Health Posts in Brief	Brief description of CHPs	Dec 10
Direct to Facility Funding	This is a report on the NDoH initiative to introduce direct to facility funding to Bougainville.	Nov 10
Economic Analysis	This document explores the costs and benefits over the life of the project.	Oct 10
Environmental safeguards	The Initial Environmental Evaluation explores the impact of the project on the physical and socioeconomic environment. It includes recommendations on how the impacts can be addressed.	Feb 11
Facilities Audit example	This spreadsheet describes the result of a facilities audit that was undertaken in Madang province. It gives an overview of the state of health facilities in the province. This information is essential for planning health services.	
Facilities Audit tool (large facilities)	This is one of the facilities audit tools developed by Aaron Summerfield for the NDoH.	Mar 11
Facilities audit tool (small facilities)	This is one of the facilities audit tools developed by Aaron Summerfield for the NDoH.	Mar 11
Formative evaluation	This describes the requirements of a formative evaluation, which will form an integral part of the project.	Aug 10
Gender Action Plan	This document describes the specific outputs, activities and responsibility for the project in relation to addressing gender issues.	Nov 10
GIS	A concept note on the use of GIS in PNG.	Nov 10
GIS (PowerPoint)	Background to implementing GIS in PNG health system.	Oct 10

Topic	Description	Last updated
Health mentoring	This describes the health mentoring role which will be a key instrument of health service improvement.	Jan 11
HR review	This is a review of PNG's Human health resources, and includes recommendations.	Dec 10
ICT and health information	Description of Projects, ICT, and GIS components.	Oct 10
ICT in health in Fiji	Description of introduction of ICT in communicable disease surveillance in Fiji, 2010.	Jul 10
Partnership and Alliance contracting	The report outlines an approach the rationale for alliance contracting.	Oct 10
PNG Health Partnerships (including contracting template)	This WHO document discusses the relationship between government and nongovernment (churches, NGOs, private) health organization in PNG. It also includes a template to guide organizations in the contracting process.	Jan 10
PNG National Health Plan 2011-2020	This plan provides the overall strategic policy for the project	Aug 10
Poverty and Social Analysis A7	This report looks at the community perspective of rural health services and community health posts. It is based on data collected through interviews and consultations with stakeholders in five provinces, Sandaun, Madang (Momase Region); Western Highlands (Highlands Region); Bougainville (Islands Region); Oro (Southern Region).	Nov 10
Poverty Reduction and Social Strategy (Summary)	This is a report to ADB which summarizes the approach the project takes to address poverty, gender and social issues.	Nov 10
Resource tool for CHPs - Instruction sheet	This instruction sheet is used in conjunction with a spreadsheet resourcing tool, to help identify what resources are required to establish a CHP. It will estimate the specific costs of a CHP, and the total cost, as well identify who bears this cost. The main costs of CHPs are the ongoing operating costs, especially the cost of health workers.	Nov 10
Resourcing Tool for CHPs - Spreadsheet	This spreadsheet provides a resourcing tool, to help identify what resources are required to establish a CHP. It will estimate the specific costs of a CHP, and the total cost, as well identify who bears this cost. The main costs of CHPs are the ongoing operating costs, especially the cost of health workers.	Nov 10
Interim Report	The interim report for the ADB PPTA 7400 project about strengthening rural primary health delivery services in PNG.	Feb 11

CHP = community health post, GIS = geographic information system, HR = human resources, ICT = information and communication technology, NDoH = National Department of Health, NGO = nongovernment organization, PNG = Papua New Guinea, PPTA = project preparatory technical assistance, WHO = World Health Organization.

PNG: Rural Primary Health Services Delivery Project 2011-2019 with an Emphasis on its Alignment with AusAID's Development Strategy 2011-2015

ABBREVIATIONS

ADB	-	Asian Development Bank
AusAID	-	Australian Agency for International Development
CBSC	-	Capacity Building Service Centre
CHP	-	community health post
CHW	-	community health worker
DFF	-	direct facility funding
DOH	-	department of health
EARF	-	environmental assessment and review framework
FMA	-	financial management assessment
GIS	-	geographic information system
HIV/AIDS	-	human immunodeficiency virus/acquired immune deficiency syndrome
HSIP	-	Health Sector Improvement Program
ICB	-	international competitive bidding
ICT	-	information and communication technology
IEE	-	initial environmental examination
JICA	-	Japan International Cooperation Agency
NCB	-	national competitive bidding
NGO	-	nongovernment organization
NHP	-	National Health Plan
OFID	-	OPEC Fund for International Development
O&M	-	operation and maintenance
PHA	-	provincial health authority
PHB	-	provincial health board
PHC	-	primary health care
PAM	-	project administration manual
PNG	-	Papua New Guinea
PPTA	-	project preparatory technical assistance
PSU	-	Project Support Unit
UNICEF	-	United Nations Children's Fund
WHO	-	World Health Organization

I. STRATEGIC CONTEXT

1. The government's long-term Vision 2050, its Development Strategic Plan 2010–2030, and its Medium Term Development Plan 2011-2015 aim to transform PNG's health system, to achieve the health Millennium Development Goals, and to improve PNG's ranking on the Human Development Index.[1] In support of the government's approach and in line with ADB's operational plan for health,[2] ADB's Country Partnership Strategy for PNG 2011-2015 includes health as one of the priority areas.[3]

2. The project will support the Government of PNG in implementing its National Health Plan (NHP) 2011-2020 as it relates to rural health. The project aims to increase the coverage and quality of PHC services for the rural population by strengthening the rural health system at the provincial and district levels.

3. ADB has provided support for the PNG health sector since the 1980s. The recently completed Health Sector Development Program[4] established the Health Sector Improvement Program (HSIP) trust account in 1998, which became a major mechanism for administering extended development assistance to the health sector.[5]

4. The HIV/AIDS Prevention and Control in Rural Development Enclaves Project[6] is nearing completion. It has successfully built innovative partnerships with non-state service providers to improve rural PHC service delivery in PNG. Under that project, local health authorities in five provinces established partnerships with six large private companies in rural areas to improve 120 rural health facilities and provided training programs for health workers and communities for HIV/AIDS prevention. As a result, there has been a significant increase in the number of patients for PHC services in the project areas.

5. Building on the lessons and experience of the ongoing project, the proposed project will establish and develop partnerships between state and non-state health service providers (including the private sector, churches, nongovernment organizations, and civil society) at the provincial and district levels to strengthen the rural PHC system.

6. The project is supportive of AusAID's strategic direction. It will:

(i) focus mainly at the sub-national level – selected provinces and districts and rural facilities - where service delivery responsibility is concentrated, and engage directly with provincial government, and through them rural health services providers; churches, NGOs, government and the private sector;
(ii) work through existing financing of infrastructure, training of existing health personnel, introduction of new technologies (ICT and GIS), support for supervision and mentoring, with explicit reliance on government funding for sustainable operational expenditure.
(iii) operate inside GoPNG programs at the National, Provincial and District level.
(iv) directly align with the National Health Plan (2011-2020) and the Australia-PNG Health Delivery Strategy 2011-2015.

[1] The Human Development Index for PNG was 137 out of 169 in the 2010 report by UNDP.
[2] ADB. (2008) *An Operational Plan of Health for Improving Health Access and Outcomes Under Strategy 2020*. ADB. Manila.
[3] Health Sector Assessment was conducted in 2010. See RRP Linked Document No. 2.
[4] ADB (1997) *Health Sector Development Program*. Manila.
[5] See RRP Linked document No. 4 Development Coordination.
[6] ADB. (2006) *Grant 0042-PNG: HIV/AIDS Prevention and Control in Rural Development Enclaves.* ADB Manila.

A. Critical health development issues

7. The health status of the population of PNG has deteriorated over the last two decades due to severe neglect of the health system, especially in the rural areas, where 87% of the population live. An estimated 40% of rural health facilities have closed or are not fully functioning. Limited resources, deteriorating infrastructure, poorly trained and motivated staff in the health sector, and inadequate and declining access to basic health services are among the main reasons for the decline.

8. PNG ranks 137th out of 169 countries in the United Nations Development Programme's 2010 Human Development Index. The country has high levels of poverty and weak health indicators, particularly for maternal and child health: The infant mortality rate is 57 per 1,000 live births, and the maternal mortality rate is 733 per 100,000 live births.[7] The main health problems continue to be communicable diseases, with malaria, tuberculosis, diarrheal diseases, and acute respiratory disease as the major causes of morbidity and mortality. PNG has a generalized HIV epidemic, driven predominantly by heterosexual intercourse. The epidemiological profile of PNG, with a heavy burden of communicable diseases, indicates that very significant gains in health outcomes could be achieved with simple and effective interventions focused on PHC and health promotion. Over the planning period, the NCD burden will also intensify. While some hospital services, e.g., for maternal complications, are essential, more than 80% of health problems can be addressed adequately and at less cost through effective delivery of PHC. The current poor health status of the rural population points to a weak PHC system with a lack of outreach services such as immunization of children and providing women with the basic support required for safe delivery.

9. The provinces and districts are responsible for delivering health services through hospitals, health centers, health sub-centers, and aid posts. The 1998 Organic Law on Provincial and Local-level Governments[8] significantly decentralized responsibility for delivering health services to the provinces and districts. However, the law did not adequately address how to implement the changes. In the health sector, only operational responsibilities have been devolved, while capital investments remain centralized in the public investment program. Provinces are allocated a percentage of net government revenue in staffing and health sector function grants, which cover operational but not capital investment costs. As a result, resources, authority, and competency are poorly matched to decentralized responsibilities.[9]

B. Challenges in the health system

10. Disparities exist across and within provinces in access and utilisation of health services. Children in rural areas are twice as likely to die from health conditions compared to urban counterparts. And while the context is different in every province, health indicators are influenced by systemic factors:

C. The physical environment[10]

11. PNG has a very challenging terrain with the bulk of its population spread across mountainous areas with sparse road infrastructure and maritime populations that are widely dispersed over large areas. Transport presents logistical challenges on both land and sea,

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

8 Government of PNG. 1998. *Organic Law on Provincial Governments and Local-level Governments.*

9 See also ADB. 2003. *Country Assistance Program Evaluation.* Manila.

10 For a full description of environmental issues see RPHSD document: PPTA7400 (2010)- Initial Environmental Examination: Rural Primary Health Service Delivery Project (available from ADB).

contributing to the high cost of delivering services. This hinders patient referrals, outreach and supervisory visits, as well as supplies and supervision.

D. The social and political environment[11]

12. PNG has multiple languages and cultures, and comparatively recent development of national systems of government, a weak sense of nationhood.[12] It is a very decentralized society, with decentralization enshrined within its constitution,[13] so while systems of national government are weak, it has been described as the most democratic society in the world due to the extent of citizen involvement at the local level.[14] In some localities law and order problems discourage health workers from taking on assignments and lead to the closure of health facilities, and domestic violence is a significant issue in most communities.[15] There are significant weaknesses in all the WHO defined health system building blocks.

E. Finances

13. There has been persistent under-investment in health, and where investment is occurring, it either does not reach through to the facility level, or if it does it arrives late. Health care financing is fragmented, with multiple uncoordinated funders, both from government (MPs, Provinces, DPM, DOH, tax credit schemes) and nongovernment (donors, churches, patients).[16] The failure to deliver operational resources to facilities has seen the mushrooming of patient charging mechanisms, as health workers seek to raise revenue from local communities. Many of these charging mechanisms (such as penal charges for victims of violence and user charges for maternal health care) are at variance with the government's policy intentions.

F. Governance and management

14. Health sector governance is weak and fragmented. Multiple government agencies control different parts of the health sector, (such as the department of personal management controlling the workforce) and the provincial hospital is institutionally separate from the rural health services, except in the two provinces that have formed Provincial Health Authorities. The relationship between the government and the churches who provider half the rural health services is weak.[17] There is a serious disconnect between the different layers, (National, Provincial, District, Facility), with little flow through of national policies and decisions to the peripheral level, and a lack of system response to issues identified locally. Community engagement in health decision making is variable.[18]

G. Health Human Resources[19]

15. PNG is regarded as an HRH crisis country with an inadequate number of nurses, doctors or midwives per 1000 population (0.58 in DOH, 2010). The backbone of the service is provided by community health workers (7,868) and nurses (3,279). These cadres mainly work in rural areas and are mainly women. In addition midwives (nurses with additional 1 year education) and Health Extension Officers (health workers positioned with a skill level

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[11] For a full description of the social environment see: PPTA7400 –Poverty and social analysis for community health posts (available from ADB).

[12] Governance Reform in Papua New Guinea**,** Francis Fukuyama accessed 23/07/11. www.sais-jhu.edu/faculty/fukuyama/Governance

[13] Government of PNG. 1998. Organic Law on Provincial Governments and Local-level Governments.

[14] Ibid. Fukuyama.

[15] Poverty and Social Analysis

[16] Health Partnerships in PNG. WHO (WPRO) 2010.

[17] Health Partnerships in PNG. WHO (WPRO) 2010.

[18] PPTA 7400 - Poverty and Social Analysis.

[19] PPTA 7400 - Strengthening Primary Care Services in Rural Areas in Papua New Guinea: Addressing Human Resources for Health.

between a nurse and a doctor) are working in rural areas. PNG counts currently only 293 midwives and 460 Health Extension Officers (HEO); often HEO's work in administration and management.

16. Although the official data clearly show a severe staff shortage, so far it is unclear where (in which districts and in which facilities) staff shortage exists and where health care workers are underutilized. A workload study implemented in 2001-2002 demonstrated that staff could work more efficiently if they were to be redistributed[20] and that staff in a number of health facilities was underproductive.[21]

H. Health Services

17. Health service provision is fragmented into a number of vertical programs that are poorly integrated.[22] Service configuration at the rural facility level are as likely to reflect international donor concerns as local population need, with HIV, STI being well housed and staffed, whereas maternal health services largely neglected.[23]

18. Health coverage in critical areas is poor (immunisation, supervised deliveries, outpatient visits, family planning acceptors) and has shown no improvement over the last five years.[24]

I. Information

19. There is a large quantity of data collected on health activity, but low levels of analysis, long time delays before data is compiled, concerns with accuracy, and infrequent translation into useable information for clinical and management purposes. The accuracy of recent population surveys (DHS) have been called into question due to sampling errors.

J. Drugs and supplies

20. There is a very weak drug and supply distribution system, with an erratic supply of essential drugs to facilities,[25] poor stock management at the facility level, and decreasing national confidence in the scope for improved performance.

K. Beyond Building Blocks

21. Of more importance than the weakness in the 'building blocks" is the crisis in the softer elements of the PNG health systems. The "culture" of health services (e.g., caring approaches to clients, sterile procedures, stock handling) has been lost in many facilities, and there is a loss of institutional memory of when the service worked effectively. Staff at all levels of the system have lost hope of the service improving, trapped in a cycle of planning and planning, and policy statement after policy statement, with no coherent activity resulting from the planning activities, and no trust that the systems of government will ever deliver the resources they require to meet the needs of the people.

22. There has been a failure to marry the systems and processes and solutions (such as planning and policy documents) with the reality of implementation within the social, political

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[20] Aitken I, Bhattarai HR, Kolehmainen-Aitken RL, Newbrander W, O'Neil M, Pollock J (2002), *Papua New Guinea, Human Resource Development Strategy Final Report: Realigning and enriching skills of a workforce that cannot be enlarged,* USA:MSH

[21] Health Partnerships in PNG.

[22] Independent Monitoring Review Group (2007) Report No.3: Review of the Sector-wide Approach and Technical Assistance.

[23] Health Partnerships (2010).

[24] Annual Sector Review District Performance 2006 – 2010.

[25] Annual Sector Review District Performance 2006 – 2010.

and physical environment. The key relationships – between government and people, between health workers and communities, between layers of the health system, are weak and at times dysfunctional[26] and counter productive.

II. HOW THE PNG HEALTH SYSTEM OPERATES

A. Health system governance and political environment

23. Government and church institutions are the major providers of health services, both financed primarily from public sector funds. Since 1995 the health sector operates within a decentralised system of national, provincial and local-level government.[27] National Department of Health (DOH) has responsibility for funding national and provincial hospitals, procuring and distributing drugs to provinces, and setting and maintaining minimum medical standards. Central agencies are responsible for releasing funds to provinces, monitoring national expenditure, and funding the salaries of all health workers. Provinces are responsible and have relative autonomy for managing the primary health care system: rural hospitals, health centres, aid posts. MPs receive approx K2 million a year to support health infrastructure and sanitation at the local level.

B. National Health Plan 2011 – 2020

24. PNG launched its National Health Plan (NHP) 2011-2020 in August 2010. The NHP focuses on 'getting back to basics' and strengthening primary health care for the rural majority and urban disadvantaged. It is clearly aligned to the priorities of PNG's Medium Term Development Plan (MTDP) and other national plans.

25. The plan sees a central role for Community Health Posts as the mechanism for transforming rural health service delivery, which in turn is a planning priority.

26. The plan has a funding pathway, seeing increased health sector investment up to K1.4 million annually. This has been approved by NEC, however there is inconsistency in the government's response; MTDP does not re-prioritise resourcing of the health sector (i.e., no nominal increase from current levels).

C. Role of non-state actors

27. The NHP prioritizes increased engagement with non-state actors. Recently, the Government has signed a Church State partnership, and it plans to establish public private partnerships (PPPs) with major mining ventures that then outsource service delivery.[28]

28. Churches run approximately half of all health facilities (outpatient services) in rural areas and employ 23% of all health workers.[29]

29. A review of health partnerships[30] indicated that the churches are largely excluded from effective engagement in policy development at all levels, and they have a desire to "exist" within the governments thinking. Some of the issues confronting government services such as the failure of the delivery to facilities of government allocated funding for facilities (health function grants) apply to both church and government run facilities.

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[26] Dr. Alice Street (2011)*Rethinking Health Systems in Papua New Guinea: Lessons from the Field*, University of Sussex, UK. (preliminary report).
[27] PNG (1995) Organic Law on Provincial and Local Level Government.
[28] Thomason & Hancock (2010) Making the Papua New Guinea Resources Boom Count, p1. p11-12.
[29] GoPNG (2010) National Health Plan 2011-2020: Volume 1 Policies & Strategies, p22.
[30] Health Partnerships.

30. The private sector is increasingly involved with delivery of health services. The ADB enclaves program (HIV/AIDS Prevention and Control in Rural Development Enclaves Project)[31] successfully built innovative partnerships with non state service providers to improve rural PHC service delivery in PNG. Under that project, local health authorities in five provinces established partnerships with six large private companies in rural areas to improve more than 120 rural health facilities and provided training programs for health workers and communities for HIV/AIDS prevention. As a result, there has been a significant increase in the number of patients for PHC services in the project areas.

III. HOW THE PROJECT INCORPORATES LESSONS LEARNED FROM AUSTRALIAN AND INTERNATIONAL EXPERIENCE[32]

31. Government is key to building sustainable health services for the poor, through its role in financing, regulating and outsourcing affordable and quality services;

i. The project directly supports and follows the leadership of the government's NHP and the project PSU will be an "in line" unit in the DOH. At the provincial level, the province (PHA or PA) is the implementing agent. Key decisions (eg selection of provinces and districts) are taken by government authorities. Sustainable operational expenditures generated by the project's activities are negotiated in advance with the government. See output 6.

32. Engagement strategies should be informed by and address political drivers and incentives;

ii. There is strong national political support for strengthening the rural health sector. Incentivizing closer church/ government alliances for health will strengthen the political power of rural health services. Supporting local community engagement, including developing district level health service plans and engaging local MPs and local government will also strengthen the health sector. The project intends to explicitly use the infrastructure investment as leverage to; develop partnerships, develop district level health services plans, and increase long term funding of rural health services. See output 2.

33. Improving health outcomes is beyond the health sector and needs to be linked to public sector reforms and demand for better governance by community and civil society;

iii. The project puts considerable emphasis on community engagement in the implementation and planning of health services, and includes support for civil society organisation to address issues such as gender inequality and domestic violence. See output 5.

34. Technical assistance needs to be proportionate, targeted and part of a broader package of support;

iv. The project has 18.2% of the resource as the indicative allocation to consultancy services. This includes a number of areas (health policy, HR, health information system, safeguard, gender, project monitoring, evaluation and management, health promotion, institution capacity development) where expertise in PNG is absent or extremely limited. As the availability of expertise changes, an assessment will be conducted as part of the inception visit on the specific needs for consultancy support at that time. The major consultancy involving nationals relates to the contracting of health mentors (see description below), who will be

[31] ADB. 2006. *Grant 0042-PNG: HIV/AIDS Prevention and Control in Rural Development Enclaves.* Manila.
[32] The following points are taken from: Australia – PNG Health Delivery Strategy 2011–2015.

senior health professionals with extensive experience in the PNG health system. See discussion in this document on consultants.

35. Policy influence is essential, must be strategic and requires having the right people in country with a mix of international, local knowledge and skills, and continuity in staffing;

v. The focus of the project is implementation rather than strategic policy, with the exception of National HR support where DOH has specifically requested international policy support.[33] Consultants will be employed for 4 years (subject to satisfactory performance). There will be a mix of international and national consultants. See discussion in this document on consultants.

36. AusAID's designs and strategies need to systematically address gender and poverty, and operate within PNG's decentralised context (i.e., focus support at the right levels);

vi. The project will focus at the peripheral level; province, district and rural health facility. A specific operational response to addressing gender equity has been developed.[34] Poverty analysis[35] has been undertaken and the recommendations incorporated into the design. See output 5.

37. AusAID should work towards greater use of PNG financial systems to better leverage overall resource allocation and reduce inefficiencies with parallel systems;

vii. Loan and grant disbursement will generally be made through a combination of direct payments and the use of an imprest account and special project accounts. The special project accounts will be established within the Governments HSIP trust account as with prior ADB projects with DOH.[36] The special project accounts will be managed, replenished, and liquidated in accordance with the imprest account procedures as outlined in ADB's Loan Disbursement Handbook (January 2007, as amended from time to time), and detailed arrangements agreed upon in the PAM between the government and ADB.[37] The funding mechanism to utilize HSIP will be reviewed by the joint review missions' consideration given to other funding mechanisms when these are recommended by IMRG or other independent reviews.

38. Health and HIV services can be better integrated at the point of service delivery;

viii. The project takes a health service strengthening approach rather than focusing on a specific disease or intervention. It supports rural primary health care services being built to respond to the diverse needs of the community it serves. This includes the integration of HIV services.

39. Poor quality monitoring and evaluation affect's AusAID's ability to tell a coherent story, hold PNG to account, and maintain public good will for the aid program in PNG;

ix. The project places considerable emphasis on monitoring (GIS, mHealth, Health Information consultant) and will work within and support the DOH monitoring

[33] PPTA 7400-Strengthening Primary Care services in rural areas in Papua New Guinea: Addressing Human Resources for Health.
[34] RRP Linked Document No.9. Gender Action Plan.
[35] PPTA 7400 - Poverty and Social Analysis.
[36] ADB. 2006. *Report and Recommendation of the President to the Board of Directors: Proposed Asian Development Fund Grant Papua New Guinea: HIV/AIDS Prevention and Control in Rural Development Enclaves Project.* Manila. (Grant-0042 PNG for $22,000,000 approved on 25 April 2006, cofinanced by the Government of Australia and the Government of New Zealand).
[37] RRP Paragraph 26.

framework. The formative evaluation will be able to tell a continuing story of the progress of the project over time. See output 1, HIS, and mhealth GIS support.

40. AusAID needs to develop a more sensible approach to risk management, which balances development, fiduciary and reputational risks.

x. The project has developed a risk register,[38] and will manage the risks actively through the PSU and through the formative evaluation process. Innovations (such as DFF, mHealth) are likely to succeed in some settings and fail in others. The formative evaluation will provide early warning of impending success and failures and precipitate appropriate management responses.

IV. HOW THE PROJECT INCORPORATE LESSONS LEARNED FROM PREVIOUS ADB EXPERIENCE

41. The on-going Enclaves Project is nearing completion, having successfully constructed 120 facilities in 6 provinces through engagement with economic operators (EO). Although final analysis of the program is yet to be completed, the following issues have informed the structure of the proposed project:

a. The Enclaves project has demonstrated the effectiveness of EOs as the entry point for system strengthening. However, the limited number of EOs, (they only operate in specific locations in some provinces) and their separation from government systems is a limitation in wider system strengthening efforts.

42. The current project uses the government structures as the entry point, (Province as IA), and all existing providers in a specific district. It is driven by a service plan to which is developed and owned by all stakeholders.

b. The economic operators' ability to strengthen health services (as opposed to building/renovating health facilities) largely depended on the existing health service provision culture of the company. Oil Search excelled at strengthening local services, where as other EOs were less successful.

43. The current project focuses on all health providers in the area (Government, Church, NGO, Private (EO)) who are currently actively engaged in health service provision and will include any new providers with a committed interest in service provision at district level (e.g., NGOs).

c. The enclaves project was less successful in building the relationship with district health services, and government led supervision of health facilities.

44. The current project's point of entry is the province and the district, district level service planning is being actively encouraged, and priority is given to building supervision into the routine activities of the districts.

d. The enclaves project encountered difficulties in ensuring that all facilities built had full complement of staff and sufficient commitment from the government of operating and recurrent expenditure.

45. The current project has developed a tool[39] that enables the calculation of capital and recurrent resource requirements of rural health facilities. The tool is being used in the district

[38] PAM Linked document, Risk management.
[39] PPTA 7400: Provincial rural health facility costing tool.

health services plan to cost recurrent expenditure, and will be used to inform the agreement with provinces on sustainable funding. .

e. The capacity and previous experience of the EOs in building facilities varied. Sometimes critical skills (project management/ design) were missing, hindering progress.

46. The current project will more critically explore the competencies of construction firms, and ensure that essential skill sets are available for each of the proposed projects. Given the expectation of more complex construction requirements, pre-qualification of firms will be considered and design solutions shared across the project.

V. DEVELOPMENT OUTCOMES THAT THE PROJECT WILL BE ABLE TO CONTRIBUTE

A. Theory of change

47. Health system strengthening is a process of continuous development to improve performance of existing Health Systems. The project has been informed by growing amount of international evidence on how to strengthen health systems, and how to scale up health interventions effectively. The management of big improvements in the performance of complex health systems is a difficult task anywhere, but is further complicated by the extremely diverse cultural and geographical settings operating in PNG, and the rapidly changing nature of these as a consequence of the development process.

48. The groups to consider holding influence over the provincial and district health system include donors themselves, formal government processes and officials at different levels (National, Provincial LLG) , MPs, Churches, health workers, clans and wontoks, professional groups (Nurses and CHWs), informal civil servant groupings, and private sector interests. The relative importance of these groups differs from community to community (e.g., some districts, the extractive industry may be the major influencer) and over time. As noted previously, there is a fragmented funding system, such that no one player or organization has a controlling influence on the peripheral health system, and no player or organization has successfully galvanized support required to make sustainable improvements. A national strategy and subsequent policy are being used in an environment where political parties themselves seldom have policies, and few people engage with written documentation in general, and seldom with government policy directives. This requires an approach more like gardening (supporting the conditions for growth and development) rather than engineering (where there is in existence a direct connection between policy and implementation).

B. Expected Results

49. The project's outcome is that selected provinces, in partnership with non-state service providers, deliver quality PHC for rural population (particularly to women and children). By 2018:

(i) Health service utilization rates increased annually for antenatal care, family planning, facility-based deliveries, immunization for rural women and children in selected districts, compared with baseline in 2011.[40]

(ii) At least 32 CHPs provide child health, maternity, and public health services with qualified community health workers.

(iii) Primary health care (PHC) funding per capita increased by 5% (real terms) in selected provinces compared with the baseline in 2011.

[40] Baseline data at district level will be established during year 1 of the project implementation. Based on the baseline data, the target will be set for each district.

C. Program interventions and approach

50. The project outputs are aimed at empowering and resourcing the peripheral level of this complex system. It is assumed that if all the health system building blocks were addressed at the facility level, then performance would markedly improve. Of these, the project focuses directly on partnerships, facilities, HR, information, supervision, training, health promotion and community engagement.

51. The epidemiological profile of PNG, with a heavy burden of communicable diseases, indicates that very significant gains in health outcomes could be achieved with simple and effective interventions focused on PHC and health promotion. While some hospital services, e.g., for maternal complications, are essential, more than 80% of health problems can be addressed adequately and at less cost through effective delivery of PHC. The current poor health status of the rural population points to a weak PHC system with a lack of outreach services such as immunization of children and providing women with the basic support required for safe delivery.

52. The project will contribute to improved health of the rural population in the project areas. It will make improvements in both the supply and demand sides, and strengthen the policy and legal framework for health services at all levels. The outcome will be that the selected provinces, in partnership with non-state service providers, will more efficiently deliver quality PHC to the rural population (particularly to women and children).

1. Output 1 - National policies and standards

53. The project will assist the Department of Health (DOH) to develop and implement policies, standards, and strategies for CHPs and human resource strengthening in the health sector within the framework of the NHP. It will assist the DOH in its provincial planning and coordination functions, including facility and asset management, human resource audits, staff retention, and the planning of health services. The project will provide improved health information systems, through application of information and communication technology (ICT) and geographic information system technology. This support will (i) increase the availability of relevant information for all levels of the health sector, (ii) enable provincial and district level local governments to monitor performance in the health sector, and (iii) improve logistics for the supply of drugs at the local level.

54. Expected outcomes: National, eight provincial and 16 district governments adopted CHP policy by Q4 2018.

2. Output 2 - Sustainable partnerships between provincial governments and non-state actors

55. Non-state actors provide large proportion of health services in PNG, with funding from state sources. Despite this, the relationship between the two is generally weak and non-state actors are excluded from policy engagement at levels. By working through the envisioned partnerships, this will help to build human resource capacity in the health sector, and improve health information and monitoring systems. This will revitalize rural health facilities and strengthen the existing rural PHC system in PNG.

56. The project supports the stewardship role for government (both national and provincial) in building partnerships to improve the performance and effectively involve the Church, NGO and private sector. These institutional arrangements are essential for the effective performance of a sector that relies heavily on trust based relationships between actors.

57. The project will:
    (i) help the provincial and district governments to develop and formalize existing or new partnerships with non-state providers of health services. This will facilitate greater coordination and efficiency among the diverse providers as well as increased consistency and accountability of such providers. In particular, it will assist provincial governments to formalize partnerships and negotiate and implement agreements (including monitoring and evaluation tools and targets) with non-state actors.
    (ii) assist participating provinces to set up facility base funding in selected districts to enable them to better use funds provided by the government.

58. Expected outcomes:
    (i) 16 selected districts deliver health care services based on partnership agreements by 2015.
    (ii) 50 percent of facilities use direct facility funding by Q4 2018.

3. Output 3 - Human resource development in the health sector

59. PNG's health workforce suffers from inadequate staffing numbers across all health cadres, as well as issues with distribution and efficiency. To address this issue, the project will:
    (i) strengthen the skills of health personnel in rural communities.
    (ii) provide upskilling and capacity training for existing health workers and training for district and provincial managers on facilities management and clinical supervision in all participating districts.
    (iii) address performance and retention issues of the health workers.

60. Expected outcomes:
    (i) number of maternity skilled community health workers increased by at least 10% in selected districts compared with baseline in 2011.
    (ii) MCH activities by trained health workers in selected districts increased by 10% compared with baseline in 2011.

4. Output 4 - Community health facility upgrading

61. Health infrastructure needs across PNG are significant. Health facilities are not maintained and many health facilities are closed, particularly in rural areas. Lack of water and sanitation impacts on infection control, and inadequate staff housing does little to attract and maintain health staff.

62. To address this issue, the project will:
    (i) build/upgrade two CHPs, and upgrading and refurbishing of eight rural health facilities in each of the 16 participating districts.
    (ii) provide medical equipment and small vehicles (cars, boats or motorbikes).
    (iii) upgrade staff housing; install or upgrade sanitation facilities; provide waste management facilities; and establish renewable energy supplies for the selected health facilities.

63. Expected outcome:
    (i) at least 32 community health posts and 100 health facilities in selected provinces will be built or upgraded, with electricity, water and sanitation. They will also be equipped with furniture and both medical and non-medical equipment, including a maternity health set (to relevant PNG standards)

5. Output 5 - Health promotion in local communities

64. The project will increase women's involvement in all aspects of delivering health services at the community level. Through health promotion programs, it will support existing and new initiatives by civil society organizations to increase knowledge on sanitation, primary health i.e., maternal and child health and HIV, and gender in local communities.

65. Expected outcomes:

(i) at least 50% of women actively engaged in two health promotion and gender programs in selected project sites.

(ii) Antenatal care coverage (1st and 4th visits) improved in selected project districts (by gap between baseline and national goal decreased by 50% by 2018).

6. Output 6 – Project monitoring, evaluation and management.

66. The project will support project planning, reporting, coordination with development partners, and monitoring and evaluation. It will establish a project support unit (PSU) in the DOH. A formative evaluation[41] every 6 months will inform stakeholders of project progress, impact and experiences, including cross-cutting aspects such as gender and climate change.

67. The project hopes to get a synergistic impact from other donor activities (AusAID on national HRH numbers and medicines supply) and use the leverage of the project to access sustainable funding from the national and provincial government.

68. Provided all these building blocks are addressed, it is assumed that these activities will boost morale and performance at the peripheral level, and that this success (in 16 districts) will invigorate government structures and used to support system strengthening in the other 73 districts. In other words, it hopes to give practical and visible expression to the government's higher level policy intent.

69. The fragmentation of the system is addressed through partnership building, the importance of the district level health services plan and its support by all key stakeholders, the use of timely and accurate information and performance, and the use of communication tools such a GIS mapping, and direct support to strengthening the community interface. The way that common understandings are built and conflicts of interest are negotiated will strongly influence the pathways of the ongoing health-system development.[42]

70. Key principles in the design are that of adaption and of rapid learning about what works and what does not. The principal of adaption is important as the conditions that are currently observed are likely to be different from the conditions operating over the lifetime of the project. The implementation approach is designed to adapt appropriately to these as yet unforeseen changes in the system in which it is operating, and not adopt a rigid, formulaic approach. Creation of a learning culture, both at the individual and intuitional level is vitally important. The issue of who does the learning is also critical – many projects help inform donor experience, but often neglect the more important aspect of what is learned by the health workers themselves. The project introduces a number of innovations into the rural PNG PHC sector – these will meet with variable levels of success, but all will contribute to the systems understanding of what works.

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41 A formative evaluation focuses on improving or enhancing a project while it is ongoing.

42 Bloom, G. and Ainsworth, P. (2010) *Beyond Scaling Up: Pathways to Universal Access to Health Services,* STEPS Working Paper 40, Brighton: STEPS Centre.

D. System Constraints

71. Alongside the focus on adaption and learning, the project has identified constraints both within and outside the health system as a scale up[43] of this magnitude is attempted. These constraints include the absorptive capacity of the system,[44] (see HR report) particularly the Health HR capacity, the management and governance capacity (See Social report, inception report, health partnerships), the barriers to change that are likely to be encountered at household, community, and health service level (see Social report, health partnerships report), as well as the impacts on other sectors, including the macro economy and the environment.

72. Macroeconomic impacts increase as the size of the project has grown, and its impact on overall health system financing has increased. Risks[45] of donor contributions leading to a decrease in government investment in the sector are being addressed by the following mechanism. When the initial agreements are entered into with the provinces, EA will require and ensure to ADB an explicit commitment from the province on a sustainable funding path for any facilities that are built or upgraded. Reinforcing this, the program investments largely avoid operational funding. The investments will increase capacity, but the sustainable operating costs of this increased capacity (in health workers and facilities) will be met by the provincial and national governments, and agreement on this is reached in advance of the investment being made.

73. The project, as it gathers momentum, will pay particular attention to equity (including gender equity and disability) and quality, as these dimensions can be lost if they do not remain central to the change process. This focus will particularly be seen through data collection and information presentation, and in the focus of the formative evaluation (See RRP Linked Document No 9: Gender Action Plan).

74. ADB has undertaken a problem tree analysis[46] and note the need for strong governance and leadership given the myriad of interested parties in this development, who will impact both positively and negatively. The skills of the leadership and governance are a major factor, both in negotiating through the change process and setting the priorities for action. The immediate priority will be the development of the governance and leadership capacity, the workforce development, and the health services development.

E. Sequencing

75. The approach of the project is for it to operate inside the DOH, and for its overall vision and policy direction to follow that of the National Health Plan 2011 to 2020. In recognition of the decentralized nature of the society and the health system, the formal agreements will be both with the national government, but also with the provincial governments in which the project is operating.

76. The pace of implementation will be largely dictated by the enthusiasm and capacity for the project at the provincial level. Different provinces have different capacities (and enthusiasm) – some provinces will progress relatively quickly through the phases, others will take longer. It is essential that this principle, that development occurs at the rate the province dictates, is adhered to.

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[43] Lindsay J Mangham* and Kara Hanson (2010) *Scaling up in international health: what are the key issues?* Health Policy and Planning 2010;25:85–96 doi:10.1093/heapol/czp066.

[44] PPTA 7400 - *Strengthening Primary Care services in rural areas in Papua New Guinea: Addressing Human Resources for Health.*

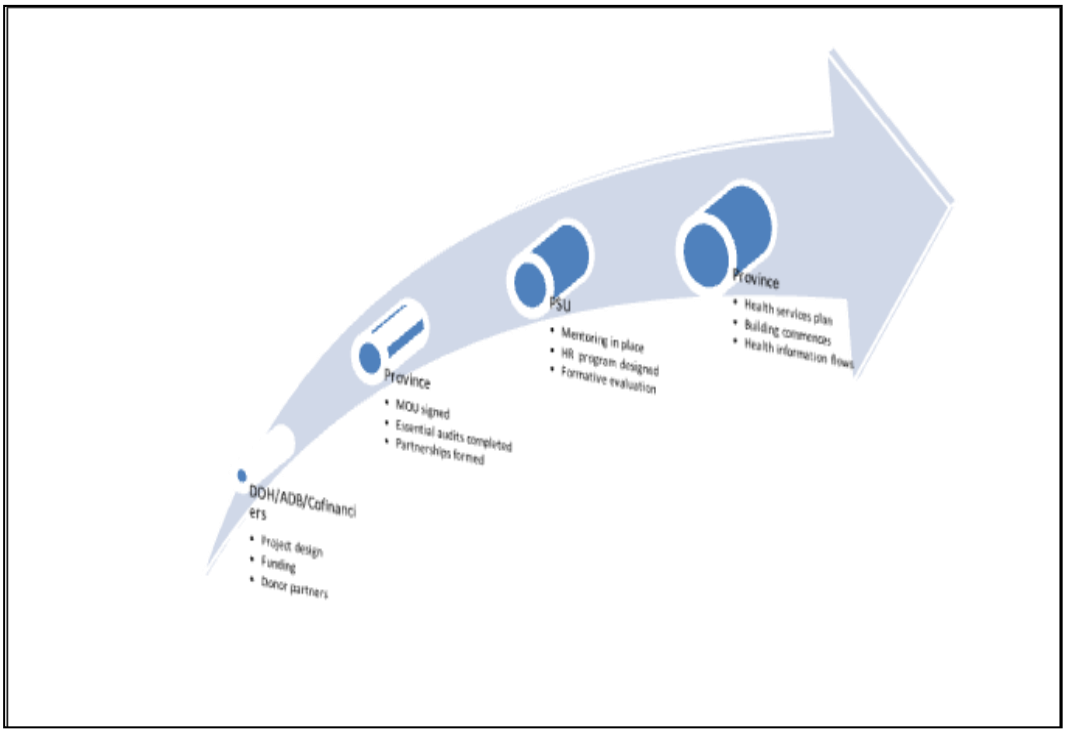
[45] Lu C, Schneider MT, Gubbins P, Leach-Kemon K, Jamison D, Murray CJL(2010). *Public financing of health in developing countries: a cross-national systematic analysis*. *Lancet* 2010; 375: 1375-1387.

[46] RRP Linked Document No. 2, Summary Sector Assessment: Health.

77. The overall sequence of steps in the initial phase is described in the following diagram. This sequence may differ in different provinces, but the overall sequence will be agreed, and the Project needs the flexibility to both speed and impede development if local circumstances dictate.

78. The Partnership development between providers in the selected district and an agreed health services plan for instance is a specific and necessary step before investment in infrastructure can occur. This sequence is explicit in the MOU agreement.

Figure 1: Sequencing of key events



79. Governance and leadership elements of the project include the DOH, the PSU situated inside the DOH, and provincial health office, the health service provider organisations, health workers at facilities and community leaders.

80. The overall leadership will rest with the Secretary for Health, and his nominated SEM member, executive manager for strategic policy. The PSU will sit within the Policy branch of the DOH, but have extensive links with other branches, including HR, facilities, standards, information, finance, medical supplies.

Our Assumptions	Resources	Activities & Outputs
Our thinking about how and why this type of initiative should work	Funding, Existing Organisations, Potential Partners, Staff, Supplies, Volunteers, Time, Facilities,	Process, Techniques, Tools, Events, Technology and Actions aimed at a certain population

Strong support from government. It has been requested by the government and is consistently seen by government as a very high priority.

Taking a "health system strengthening" approach that focuses on the elements of the National Health Plan will improve the rural health systems performance, at the facility, district and provincial level will help energise a system that is currently failing.

Seeking agreement on sustainable funding and sector partnership arrangements prior to investment with each province will help to address two long standing system weaknesses.

Progressing the project in each province at the rate determined by the province will improve provincial ownership and create incentives as proactive provinces will be able access resources earlier.

Establishing Community Health Posts and using them effectively will positively contribute to support for a key element of the NHP (hence supporting government's leadership), and impact on reducing the infant and maternal morbidity and mortality.

Introduction of new technologies (ICT, GIS) will increase timeliness and accuracy of reporting, increase use of information at all levels, and help raise rural health workers morale.

The government of PNG will have sufficient resources to support a strengthened rural health sector in the medium term. A strengthened sector will create demand pressures on government resources.

The focus of other donors (such as AusAID's support for government on national training of health workers and medical supply systems) will improve supply and complement the HSS of this project.

Supporting a learning environment through the formative evaluation will enable the PNG system to learn from its own experience.

The project will form the core of the government's approach to rural health system strengthening and be rolled out over the other 89 districts.

Most communities have existing VHV/Health Islands/Community development programs which will benefit from sustained support.

Supporting community role in planning and implementation of health services will improve people centred delivery.

National and selected provincial and district governments implement policies and standards for community health posts.

Sustainable partnership established between selected provincial governments and nonstate actors for PHC services delivery

Community health workers in project areas have the capacity to provide quality PHC services.

Selected provincial and district governments upgraded selected rural health facilities.

Local communities in project areas are aware of maternal and child health, HIV, sanitation, and gender issues through health promotion programs.

Effective project monitoring, evaluation and management, services rendered.

Indicators

Partnership agreements completed in 8 provinces.

Health services plans at district level complete in 8 provinces.
Facilities built, equipped, occupied.

Staff training courses completed.
ICT, mHealth introduced.

Management and clinical supervisory visits to facilities.

Direct to Facility Funding mechanisms and training supported
Health promotion activities, VHVs, community engagement in health services supported.

Community supported to engage in health services.

Formative evaluation meetings held every 6 months.

Programs include gender, disability focus.
(Impact population 1.2 million)

Immediate Outcomes → Medium Term Outcomes → Long Term Outcomes

Effective provision of rural primary health services in partnership with non-state service providers

Improved health status of rural population

Indicators

Increasing immunization coverage

Increasing supervised deliveries

Increasing OP visits per district and per facility.

Skilled health workers in Maternity care, IMAI and IMCI

Increased outreach activities

Increased family planning uptake

Communities getting more involved in own health and health services

Effective partnerships and more cooperation

Increased government/ provincial funding of rural health sector at facility level.

Key stakeholders supportive of service plans

Improved accuracy, relevance and timeliness of information collection

DMF Indicators

At least 32 CHPs provide child health, maternity, and public health services with qualified community health workers.

National, 8 provincial and 16 district governments adopted CHP policy by Q4 2014.

CHPs in 16 districts have access to IT-based real-time health information by Q4 2014.

16 selected districts deliver health care services based on partnership agreements by 2015.

At least 32 community health posts and 160 health facilities in the selected provinces built/upgraded with 24 hours, 7 days water supply and power source and equipped with furniture, fittings, and medical and nonmedical equipment including a maternal health set by CHP policy document and policy on biomedical equipment

Effective working relations between service providers, the communities and other partners

Well run health service delivery
80% of deliveries assisted by trained health worker.

Healthy mothers and children

Good rapport with communities
Improved performance of staff with good skills, improved retention

Adequate finances for essential

Increased confidence in government systems and processes.

Improved skills and performance of NDoH/provinces at project implementation.

DMF Indicators

Health service utilization rates increased annually for antenatal care, family planning, facility-based deliveries, immunization for rural women and children in selected districts, compared with baseline in 2011.

Primary health care (PHC) funding per capita increased by 5% (real terms) in selected provinces compared with the baseline in 2011.

50% of facilities use direct facility funding by Q4 2018.

Number of maternity skilled community health workers increased by at least 10% (at least 50% women) in selected districts compared with baseline in 2011.

Maternal and Child Health activities by trained health workers in selected districts increased by 10% compared with baseline in 2011.

At least 50% of women actively engaged in two health promotion and gender programs in selected project sites.

Antenatal care coverage (both 1st and 4th visits) improved in selected project districts measured by gap between baseline and national goal decreasing by 50% by 2018

Project ties are completed on scheduled by 30 October 2019.

Government completion report by 30 October 2019

Indicators

Reduced maternal and infant mortality

Communities satisfied with services being received

Adequately trained, performing and skilled health staff

Adequately supplied drugs, vaccines and medical supplies

Well nourished children

Improved population control

DMF indicators

Maternal mortality rates decreased from 733 to 360 per 100,000.
Infant mortality rates decreased from 57 to 35 per 1,000 live births (sex and socioeconomic quintiles disaggregated).

Neonatal mortality rates decreased from 29 to 18 per 1,000 live births (sex and socioeconomic quintiles disaggregated).

Child (under 5) mortality rates decreased from 75 to 44 per 1,000 live births (sex and socioeconomic quintiles disaggregated).

F. Provincial preparation for the project

81. The provincial selection was made by the Government of PNG. ADB project preparatory technical assistance (PPTA) provided advice on health needs and service capacity in the provinces. The provincial selection procedures included extensive consultations and self-nomination by the provinces.

82. The project is seen as the first stage of the government's Rural Health Service Transformation Project[47] with the clear intention of rolling the project out to additional districts and provinces as government and external funds become available. Therefore, the proposed project will select only two districts in a province. Project sites within each province will be determined by the government in accordance with the agreed upon selection criteria for outputs. Criteria for selection of districts and facilities have been agreed in the MOUs with the GoPNG.[48]

83. The PPTA is engaged in preparing the provinces for this intervention including workshops to spur the development of district level health services plans. The district health services plans focus the capacity and location of new or upgraded facilities, in relation to the likely health needs over the next decade. Population and population growth, infrastructure developments, the gaps between existing and required performance, and likely capital and operational costs are considered. The provinces are also preparing baseline data to support the district planning process.

84. The two tangible activities that are expected before investment in facilities are the formal establishment of a partnership board that involved significant non state providers and a health services plan that has the support of stakeholders.

85. The following table summarises the state of preparedness of the different provinces at 24/07/11.[49]

	ARB	**Enga**	**EHP**	**ESP**	**Milne Bay**	**MP**	**WHP**	**WNB**
Engagement and support from PA	High	vHigh	High	vLow	High	Med	High	High
Engagement with significant non-state providers	Med	High	vHigh	Med	High	Med	High	High
Progress developing Partnership agreement	Low	Med	High	Low	High	Low	High	Med
Completed Health Services planning workshop	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Active engagement	na	High	High	High	High	Low	High	na

[47] This is the term used by Secretary Malau.
[48] See MOUs prepared by ADB fact-finding mission in November 2010 and ADB appraisal mission in March 2011 and included in the PAM.
[49] Based on assessment by PPTA team, Ake and Matheson.

	ARB	Enga	EHP	ESP	Milne Bay	MP	WHP	WNB
with Districts /Regions								

86. The state of preparedness of the provinces varies, although the majority are well prepared for the beginning of the project. Features of well prepared provinces (such as Enga) include highly committed Provincial Administrator (PA), good engagement from Church, NGO or private providers, engagement of all districts in health service planning.

87. Two provinces, Morobe and East Sepik, present a number of challenges that the province will have to meet before the project takes effect. Although both provinces have high levels of health need, the approach being taken by the project is not to proceed without explicit support from the political and administrative leadership of the province, and demonstrated engagement of all key stakeholders in service provision in the province. The health service planning workshops are yet to be held in Bougainville and West New Britain.

88. Four of the project provinces, Bougainville, Milne Bay, Eastern Highlands, Western Highlands, are focus provinces for AusAID. AusAID will support the DOH to do further diagnostic work on the needs of these provinces, which will help inform this project's implementation. A close working relationship with AusAID will be maintained by the PSU in relation to the inputs for these provinces in particular to ensure donor efforts are well coordinated.

G. How will the project deliver its contribution?

89. The project will support project planning, reporting, coordination with development partners, and monitoring and evaluation. It will establish a project support unit (PSU) in DOH. A formative evaluation every 6 months will inform stakeholders of project progress, impact, and experiences, including cross-cutting aspects such as gender and climate change.[50]

1. Project Support Unit

90. The project will establish PSU to support project planning, reporting, coordination with development partners, and monitoring and evaluation. This unit will be used by the DOH as the germinal element of its "Rural Health System Transformation Project" where it intends to cluster and coordinate donor and government health system strengthening activities. It is the government's intention to build on the experience and expertise of the project to strengthen the remaining 73 districts. The PSU's overall approach will be focused on implementation, and the creation of an information-rich learning environment throughout the project's sphere of influence. The PSU will be part of DOH, directly reporting to a senior executive team member, and will be closely connected to relevant sections of DOH, with the intention of being fully absorbed into DOH over the life of the project. The PSU will deploy local and international consultants, JICA volunteers, as well as health mentors who will focus on system improvement in the districts and provinces. The PSU will help the DOH to prepare a PSU exit strategy with milestones within 12 months after project effectiveness and exit strategy milestones will be monitored by the formative evaluation to ensure the absorption of PSU in DOH.

91. The PSU will operate with a similar arrangement to the current enclaves project, wherein the PSU is responsible for ensuring compliance with all ADB financial management issues and the DOH HSIP financial management unit is responsible for the timely processing

[50] A formative evaluation focuses on improving or enhancing a project while it is ongoing. See further information in Linked Document No.18. Annual reviews will be conducted with all stakeholders together with ADB lead joint review mission.

of transactions through the government's financial management system. While the arrangements under the enclaves project were satisfactory, some improvements are included for the new project due to the increased scale. A senior project manager will be engaged to manage the project activities. This manager will be recruited through quality- and cost-based selection and agreed upon by ADB and the government. The project accounting function will engage one international finance and procurement specialist with supporting accountants in the PSU. Accounting assistants will be engaged to support the selected provincial governments with project financial management and disbursement requirements. All PSU staff will receive training in ADB policies and procedures to help ensure compliance with ADB financial management and disbursement requirements. The PSU will be further supported through the recruitment of one senior procurement specialist and an appropriate administration quota as agreed upon by the project manager, ADB, and the government.

92. The DOH internal audit function will complete regular audits of the project receipts, expenditures, and procurement practices in all project locations. Where the DOH internal audit function lacks the capacity to perform these activities, the internal audit activity will be outsourced to private sector suppliers.

93. The health mentors will act as ambassadors to the project, and will assist the districts to improve work practices of front line health workers, improve interaction between health workers and community, and improve way information is collected and used to refine service delivery.

2. Use of Consultants

94. The project will require both national and international technical assistance particularly in the initial phases of the project, where the project is being asked to spearhead the DOH's broader health system strengthening activities which form the basis of the National Health Plan. The required technical and implementation expertise is currently not available to the DOH. The project will progressively transition its TA components into in line positions over the course of the project. There were a number of requests from the government and the provinces for technical assistance in areas closely related to the project. At the national level, the absence of experience or expertise at program implementation prompted the senior DOH personnel to request the PSU (based on the enclaves experience) to form the core of its health strengthening activities. The parlous state of national HR policy capacity prompted the request for international HR support at the national policy level. The absence of specialised skills (health information, geography, IT) at the district level prompted requests for expertise in this area. Where possible, maximum use is made of existing expertise that is being provided by other donors, such as health system strengthening and maternal health (from WHO), and health facility audits (from AusAID).

95. Before any of the proposed TA appointments are made, a contemporaneous assessment of the current need for the assistance will be undertaken by the PSU with the DOH, and if the need is still there, the potential use of expertise assistance already in the field from other donor partners (such as AusAID) will be considered in the first instance.

96. Mindful of the concerns around the effectiveness of TA in PNG, [38] and internationally[39] [40] the following principles have been developed to guide their use in the project:

[38] Review of the PNG-Australia Development Cooperation Treaty (1999) 19 April 2010.
[39] www.dfid.gov.uk/r4d/PDF/Outputs/Consultation/ResearchStrategyWorkingPaperfinal_capacity_P1.pdf, p. 5.
[40] World Bank Independent Evaluation Group - *Using Training to Build Capacity for Development* (2008) http://lnweb90.worldbank.org/oed/oeddoclib.nsf/DocUNIDViewForJavaSearch/2FC8FD5D72AF3541852574EF0068760F/$file/training_full_eval.pdf.

97. The following principles will be applied to the TA.

(i) The TA will be contracted to the PSU, which is an inline group in the project coordination unit (aka Rural Health System Transformation Unit) in the planning division of the DOH.
(ii) Decisions regarding the initiation of TA positions will be made on the basis of a contemporaneous assessment of the need, and consideration of existing donor TA support.
(iii) The primary line of reporting for all TA positions is to the DOH.
(iv) The project TA will focus on project implementation, not corporate processes.
(v) Direct government funding of TA positions will progressively replace project funding in the later years of the project.
(vi) Levels of TA support will be monitored and reported 6 monthly, and progress towards transition into DOH structures and decline in the proportionate spend on TA are part of the monitoring framework.
(vii) Assisting the transition to inline government positions will be a specific requirement of all TA contracts.
(viii) Individual TA contracts will be long term (4 years) subject to satisfactory performance.
(ix) The impact of the projects TA on long term PNG health system capacity and capability will be part of the TOR for the formative evaluation.

98. The consultant and PSU positions include specialist expertise in: Health Policy/Human Resource, ICT/GIS firm, Institutional Development, Health Systems, Environmental Civil Engineer/Architect, Engineer/Construction Managers, Safeguards Specialist, Health Promotion, Project Manager, Team Leader (Continuum Quality Integration), Social/Gender/Community Development, Procurement and Finance Accountancy, Communication and Reporting, Administration support.

99. Health System Mentors will play a key role: These will be senior, respected PNG health workers who will work alongside the provinces to assist in bringing about the health service culture change that this project hopes to initiate. They will play a key role in identifying the needs of individual facilities so that the projects inputs are appropriately targeted. A key function will be their advocacy for the use of information as a tool for continuous learning.

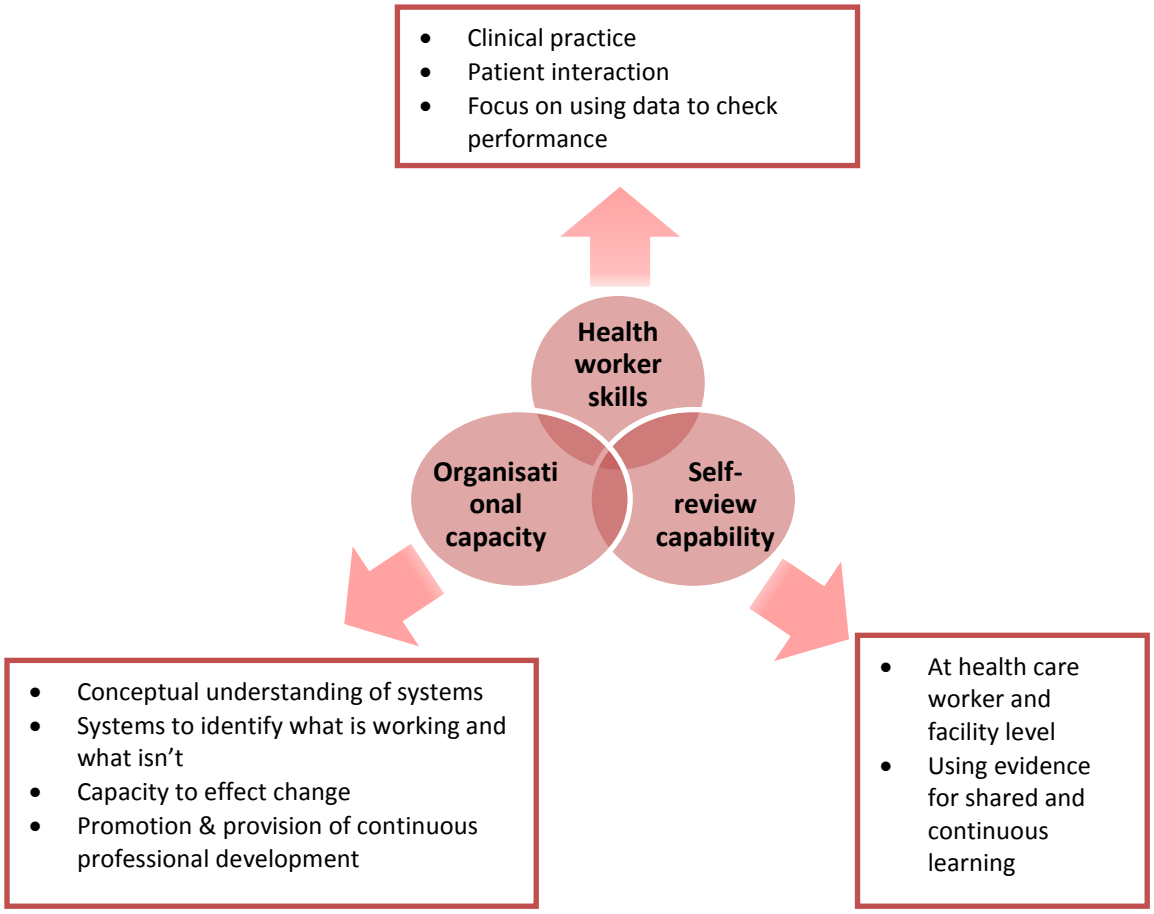
100. The majority of the consultant support will operate across the project and not in specific districts or provinces. Three provinces have requested assistance with health information systems at the provincial level, and JICA volunteers have been approached to meet this request. Each province will maintain one administrative position to specifically support the project.

H. Performance management and communications

101. Project performance monitoring will be carried out using the targets, indicators, assumptions, and risks in the design and monitoring framework including how beneficiaries will be involved in project monitoring and/or evaluation.

102. The PSU will, through inclusion of a health information expert, support DOH in monitoring key impact and outcome indicators and associated assumptions with corresponding target dates. In addition to the project performance monitoring system, a further, significant mechanism for monitoring and evaluation will be the formative evaluation process, which will be conducted every 6 months (see RRP linked document 18).

Figure 1: Domains of Capacity that Health Mentors Seek to Strengthen



103. ADB lead inception mission will be fielded after the loan signing and the PSU consultants are commenced the work in the country. Followed ADB Project Administration Instruction, the ADB lead join review missions will be conducted twice a year and annual reviewed by all stakeholders will be conducted together with the join review mission. Special Administration Mission and Supplementary Financing Appraisal Mission would be conducted if necessary. Midterm review mission will be conducted at the mid-point of the project implementation.[41] Project completion review mission will be conducted when the project is completed.[42]

I. Project Review Missions

104. ADB missions conducting a detailed review of the overall progress of the project based on the PPR format and any other information are classified as review missions.

105. Conducted 6 monthly, their principal functions are to review the project implementation and identify/address issues in consultation with the EA, IA, PSU and other stakeholders. Key areas for review include project implementation schedules, review DMF indicator progress, project expenditures, procurement and disbursement, project budgetary allocation, counterpart funding, and loan covenants (see further details in the ADB Project Administration Instruction 2010).

[41] TOR of the ADB joint missions will be discussed with participating mission members from cofinancing agencies.
[42] ADB. 2010. Project Administration Instruction. No.6.02. http://www.adb.org/Documents/Manuals/PAI/default.asp

J. Joint annual provincial review

106. To facilitate learning of lessons, an annual review of at the provincial level will be conducted jointly by relevant donors and the GoPNG. This will be done across the eight provinces involved in the project.

K. Midterm Review (MTR) Mission and Project Completion Review Mission

107. In addition to regular reviews, a detailed midterm review of the project will be carried out at the mid point of the project implementation period to assess the progress of each output, identify issues and constraints, and determine necessary remedial actions and adjustments. The midterm review will evaluate in detail the scope, implementation progress, implementation arrangements, safeguards issues, achievement of scheduled targets, and any other related or outstanding issues under the project as appropriate. A position paper and/or terms of references of the mission members will be prepared with AusAID input.

108. Within 6 months of physical completion of the project, DOH will submit a project completion report to ADB and cofinanciers. Project completion review mission will be conducted after receiving the project completion report, 6-12 months after the project completion.

L. Risk management

109. The major project risks have been identified[43] including financing delays, increased instability from the elections, lack of peripheral capacity, partnership weaknesses. These risks and mitigating measures are summarized in Table X below.

Table X: Summary of Risks and Mitigating Measures

Risks	Mitigating Measures
Financing delays and lack of counterpart funds for asset operation and maintenance at provincial and local level	• The government provides an assurance in the loan agreement to provide appropriate levels of counterpart recurrent funding. • Site selection criteria require evidence of appropriate levels of recurrent funding through the Health Function Grant.
Risk of reduction in availability of decision-making authority in government needed for project implementation around 6-8 months surrounding national elections, scheduled for June 2012; risk of civil unrest	• The risk is diversified over eight participating provinces, permitting the project to place adaptive emphasis on less affected areas during the election period. • The project aims to identify key decision points to be accelerated prior to the election period. • Site selection criteria require preparatory milestones to have been met. The project will accelerate in those more progressive provinces, where the site selection criteria can be satisfied notwithstanding pending elections. • The project emphasizes partnership in health services delivery with nonstate providers (churches and private sector), whose capacity to carry out decisions is not directly affected by election disruptions.
Insufficient levels or quality of government staff and community health workers for project implementation and operation of CHPs	• The PSU supports the executing agency and implementing agencies. • The government covenants in the loan agreement to make available appropriate numbers of CHP staff; this is also a site selection criterion. • Output 1 supports the government in developing a staff incentive program; and output 3 will provide training in supervision and management. • Output 4 includes staff housing as part of the civil works component, an

[43] RRP Linked Document No.13 Risk Assessment and Risk Management Plan.

Risks	Mitigating Measures
and other health facilities, especially in remote rural areas	incentive for staff retention. • The project supports the preparation and delivery of a comprehensive rural health services training plan including training of trainers. • Explicit agreement by provinces regarding sustainable human resource and recurrent costs for the new and upgraded facilities .
Insufficient acceptance of the local level partnership modality	• Partnership boards under output 2 will be established prior to the agreements for effective cooperation. • Consultations will be held among stakeholders including provincial and local government authorities, private service providers, churches, civil society, and communities.
Lack of civil works contractors and delays in civil works due to security concerns, including in relation to election disruptions	• Transparency in the selection of facility sites and civil work contractors, including consultations with local communities. • Community buy-in, and hence enhanced security, to be developed through community participation in the partnership boards, which are a precondition for civil works. • Disruptions surrounding elections in 2012 are not likely to interfere with civil works, which are estimated to commence in Q4 2012.
Lack of capacity in fiduciary functions	• Majority of project support will be through direct payment. • Procurement, accountancy expertise via PSU • Provide capacity development training by international procurement PSU consultant on financial management and ADB disbursement procedures for EA.

110. There also risks related to all program outputs which will be actively managed by the PSU and the DOH. The Direct to Facility Funding initiative for instance. This is a government initiative, aimed at overcoming the problems at the facility level of the timeliness and quantity of operational money. A pilot is being conducted in Bougainville, using donor funds. A number of provinces are expressing an interest in the approach, and the project will support its controlled introduction. It should be noted that the funds concerned in the scale up will be government sourced funds, (unlike the pilot) not the project funds. The project will support the province and district to train and equip the facilities for this activity. The risks that will need to be managed include failure to release funds, failure to spend effectively at the facility level, failure to adequately account for expenditure.

111. Risk mitigation strategies will be a core responsibility of the PSU.

M. Budget Framework

112. To increase aid effectiveness, the Government of PNG has recommended that all donors, including the AusAID, channel their support for improving rural health services delivery through the project.

113. The estimated cost of the project is $81.2 million inclusive of taxes and duties. The project cost includes physical and price contingencies, and interest charged during implementation. Table 1 summarizes the investment plan. Detailed cost estimates by expenditure category and by financier are in the project administration manual (PAM).

Table 1: Project Investment Plan
($ million)

Item			Amount[a]
A.	**Base Cost**[b]		
	1.	Output 1 - National policies and standards	2.90
	2.	Output 2 - Sustainable partnerships	5.32
	3.	Output 3 - Human resource development in the health sector	7.34
	4.	Output 4 - Community health facility upgrading	28.82
	5.	Output 5 - Health promotion in local communities	8.71
	6.	Output 6 - Project monitoring and evaluation, and management	16.93
		Subtotal (A)	**70.02**
B.	**Contingencies**[c]		**9.53**
C.	**Financing Charges During Implementation**[d]		**0.85**
D.	**ADB Management Fee**		**0.80**
		Total (A+B+C+D)	**81.20**

ADF = Asian Development Fund, AusAID = Australian Agency for International Development, OFID = OPEC Fund for International Development, PNG=Papua New Guinea. .

[a] Includes taxes and duties of $3.12 million to be financed from ADB and the government. ADB will finance all taxes on those expenditures 100% financed by ADB and AusAID.

[b] In mid-2010 prices.

[c] Physical contingencies computed at 10% for civil works and 6% for equipment and training. Price contingencies computed at 1% on foreign exchange costs and domestic cost escalation factors for PNG for local currency costs.

[d] Based on standard ADF terms.

Source: Asian Development Bank estimates.

Table 2: Financing Plan
($ million)

Source	**Type**	**Amount**	**Share of Total** (%)
Asian Development Bank	ADF Loan	20.00	24.63
Government of Australia represented by AusAID*	Grant	40.00	49.26
OFID**	Loan	9.00	11.09
JICA Volunteers***	Grant	1.20	1.48
World Health Organization***	Grant	1.00	1.23
Government of Papua New Guinea	GF	10.00	12.31
	Total	**81.20**	**100.00**

ADF = Asian Development Fund, AusAID = Australian Agency for International Development, GF = government finance, JICA = Japan International Cooperation Agency, OFID = OPEC Fund for International Development, WHO = World Health Organization.

Notes:

* The grant will be administered by ADB.

** The OFID board is expected to approve the cofinancing in December 2011. The loan will be partly administered by ADB. *** JICA and WHO contributions will be in-kind.

Source: Asian Development Bank.