



# Technical Assistance Report

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Project Number: 37736  
December 2006

## Papua New Guinea: Health Sector Support (Financed by the Japan Special Fund)

Asian Development Bank

## CURRENCY EQUIVALENTS

(as of 30 October 2006)

Currency Unit	–	kina (K)
K1.00	=	\$0.3315
\$1.00	=	K3.0165

## ABBREVIATIONS

ADB	–	Asian Development Bank
AusAID	–	Australian Agency for International Development
HR	–	human resource
HSIP	–	Health Sector Improvement Program
MTDS	–	Medium-Term Development Strategy
NDOH	–	National Department of Health
NHIS	–	National Health Information System
NGO	–	nongovernment organization
NZAID	–	New Zealand Agency for International Development
PNG	–	Papua New Guinea
SWAp	–	sectorwide approach
TA	–	technical assistance

## TECHNICAL ASSISTANCE CLASSIFICATION

<b>Targeting Classification</b>	–	Targeted intervention
<b>Sector</b>	–	Health, nutrition, and social protection
<b>Subsector</b>	–	Health systems
<b>Themes</b>	–	Inclusive social development, governance, capacity development
<b>Subthemes</b>	–	Human development, public governance, organizational development

## NOTES

- (i) The fiscal year (FY) of the Government of Papua New Guinea ends on 31 December.
- (ii) In this report, "\$" refers to US dollars.

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<b>Director</b>	I. Bhushan, Pacific Operations Division (Area B), PARD
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## I. INTRODUCTION

1. The Government's Strategic Plan for the Papua New Guinea (PNG) Health Sector 2006–2008<sup>1</sup> was developed recognizing the significant areas of reform outlined in three key foundation documents: (i) the Government of PNG Medium-Term Development Strategy 2005–2010 (MTDS), (ii) the National Health Plan 2001–2010, and (iii) the National Department of Health (NDOH) Medium-Term Expenditure Framework. In tandem, under the Government's priorities for public sector reform,<sup>2</sup> the first priority addresses the urgent need to reduce costs and waste in national and provincial government administrations, and to correct the underlying weaknesses that fail to control spending and prevent waste. Creating fiscal space is a principal tenet in the MTDS. Identified as a core objective of the public sector reform program is the "right sizing" of the public sector with a view to making service delivery more affordable and efficient.<sup>3</sup>

2. The MTDS recognizes primary health care as a fundamental requirement for both social and economic development. As such, the focus of health expenditure over the medium term remains on primary and preventive health care, with priority accorded to services in rural areas. The design and monitoring framework is in Appendix 1.

3. The programming discussions in 2005 between the Government and the Asian Development Bank (ADB) identified the decline in the delivery of basic health services and rural health infrastructure as a core issue to be addressed through a potential project for ADB financing, and a project preparatory technical assistance (TA) was included in ADB's country strategy and program update 2005–2006.<sup>4</sup> In both the reconnaissance<sup>5</sup> and the TA fact-finding<sup>6</sup> missions, the Government concurred with the TA impact and outcome targets, and the key activities under the proposed TA. A presentation<sup>7</sup> to NDOH senior executive management and to development partners revealed both strong support and some reservations, resulting in the proposed project preparatory TA being requalified as advisory TA. Additional consultations were held with the Australian Agency for International Development (AusAID) and the New Zealand Agency for International Development (NZAID), and the TA subsequently found support with NDOH's Health Sector Program Committee.<sup>8</sup> Importantly, the recent PNG Independent Health and Monitoring Review Group findings and recommendations<sup>9</sup> are in agreement with this TA.

## II. ISSUES

4. The overall deterioration in health status since the 1990s is attributable in part to the increasing nonperformance of the public health system, especially in rural areas and at the district

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<sup>1</sup> The Strategic Plan for the PNG Health Sector 2006–2008 establishes four public health strategic directions: (i) fully immunize every child under 1 year old, (ii) reduce malaria prevalence in malaria endemic districts, (iii) reduce maternal mortality in the districts with high maternal deaths, and (iv) reduce rate of increase in HIV and sexually transmitted infections (STI). The public health strategic directions are further supported by two management strategic directions: (i) improve the leadership and management of the public health sector to achieve public health strategic directions, and (ii) improve the organizational performance of NDOH and provinces to support public health sector strategic directions.

<sup>2</sup> Government of Papua New Guinea. 2003. *A Strategic Plan for Supporting Public Sector Reform in Papua New Guinea 2003–2007*. Waigani (p. 13).

<sup>3</sup> Government of Papua New Guinea. 2005. Resource Mobilization, Public Sector Reform and Expenditure Management. In *Medium-Term Development Strategy 2005–2010*. Waigani.

<sup>4</sup> ADB. 2005. *Country Strategy and Program Update (2005–2006): Papua New Guinea*. Manila. The TA first appeared in *ADB Business Opportunities* on 12 July 2005.

<sup>5</sup> P37736 Health Sector Support Reconnaissance Mission, 13–17 February 2006.

<sup>6</sup> P37736 Health Sector Support Fact-Finding Mission, 6–17 March 2006.

<sup>7</sup> Government of Papua New Guinea-Development Partner Health Summit, held 5 June 2006 in Port Moresby.

<sup>8</sup> Health Sector Program Committee meeting held 19 September 2006.

<sup>9</sup> PNG Independent Health Monitoring Review Group. 2006. *Aide Memoire*, First visit, 2–13 October.

level. Rural health services were found to be in a state of “slow breakdown and collapse” in a 2001 review.<sup>10</sup> Rural health care infrastructure and staffing management are declining. For example, over 300 aid posts were closed between 1995 and 2000, affecting mainly people in lower asset quintiles and those living in remote areas; there are fewer doctors and health extension officers (HEOs) at rural health facilities and fewer community health workers (CHWs) working in aid posts—a 25% reduction between 1987 and 2000. Ambulatory care is decreasing and will have a negative impact on health outcomes. The number of outpatient visits per person per annum declined from 2.39 in 1988 to 1.49 in 2003. The reduction in access to ambulatory care combined with declining infrastructure is likely to contribute to poorer health outcomes.

5. The capacity of provincial and district governments to deliver quality health services to their rural populations has declined and continues to do so. An important factor in this decline has been the successive attempts to decentralize the provision of services. In particular, the aid post system—designed to reach the most remote rural populations—has suffered from a lack of commitment from both provincial and district governments and national government efforts to reduce casual staff in times of fiscal crisis. The closure of aid posts is continuing: while 75% of the original number of aid posts was still open in 1995, only 63% were open in 2000. Data for subsequent years is problematic, but the trend is believed to be continuing and may be accelerating. As the coverage of basic services shrinks, unmet demand from rural populations is increasing.

6. NDOH, with central agencies and development partner support, is progressively implementing a sectorwide approach (SWAp). While the overall strategy to strengthen NDOH and provincial-level management and to focus on a small number of core programs is essential, it may not be sufficient to produce the desired outcomes. To avert the consequences of a gradually disappearing public health system, greater attention will be necessary at the district and community levels, drawing on consultation and participation strategies to challenge prevailing attitudes and instill a sense of ownership. Recognizing the condition and performance of rural health services is not uniform across the nation; local solutions should be developed for local issues. Where rural health services are well supported and functioning, additional and complementary support would be appropriate. In villages where access to health services is limited, or where aid posts have long been closed, grassroots consultations should be undertaken to establish the underlying causes and suggest possible new arrangements that would deliver health services at the village level.

7. The difficulties experienced by provincial, district, and local level governments to supervise, support, and manage the aid post workforce and to retain functioning health workers in the public system have resulted in a costly but poorly performing public health system. One option to help achieve the desired primary health outcomes for which the aid post system is responsible would be to share their functions with a cadre of independent practitioners at the village level and supported by village oversight. Many health workers currently lost to the system are providing informal, unrecognized, and unsupported services, often in their native village. An opportunity exists to examine informal rural health service mechanisms, their performance, viability, and acceptance by rural primary stakeholders. The initial poverty and social analysis is in Appendix 2.

### **III. THE TECHNICAL ASSISTANCE**

#### **A. Impact and Outcome**

8. Implementation of the recommendations in the final report will lead to the improved health of rural populations through the achievement of the health-related Millennium Development Goals

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<sup>10</sup> Public Sector Reform Management Unit. 2001. *Functional and Expenditure Review*. Waigani.

(MDGs) (reduced maternal and child mortality; malnutrition; and communicable diseases such as HIV, tuberculosis, and malaria). Health sector performance will be improved by halting, then reversing the decline in rural-based health services. Support will be provided in close collaboration with NDOH; central agencies; and provincial, district and local governments to strengthen the delivery of rural health services under NDOH's current and future strategic plans on the basis of (i) structural and policy reform to reverse the decline in available health services at the village level; (ii) human resource development and management; (iii) procurement, distribution, and availability of essential pharmaceutical supplies in all rural areas; and (iv) building the capacity of NDOH management to cover the above areas, and monitoring and evaluation through support of the National Health Information System (NHIS). A possible future project could be in the form of a 15-year, multitranche sector development program including program and project financing, and with bilateral and/or multilateral cofinancing.

9. The outcome of the TA will be a report with key recommendations obtained through a diagnostic process examining the demand for health services among rural populations and the causes of the government's failure to deliver public health services. The core activities to produce this outcome include (i) establishing the status of rural health services in at least six districts to serve as a basis for policy formulation, (ii) conducting consultations and participatory planning to determine grassroots' perceptions and demand for village-based health services, (iii) reviewing the conditions and capacity of NDOH and central agency systems to support rural health infrastructure and basic services delivery, (iv) reviewing and evaluating current ongoing strategies and activities designed to reverse the current decline in rural health infrastructure and basic services delivery, (v) determining the support and strengthening needed by NDOH and central agency systems to reverse the decline in rural health infrastructure, and (vi) preparing a final report for consideration of the Government and development partners. Following the diagnostic stage, the TA will focus on the areas of human resource (HR) policy and development, HR management in rural settings, logistics and support mechanisms for rural health staff, and monitoring and evaluation for management purposes. The recommendations will also address existing initiatives and their possible support and integration. Required SWAp arrangements to support a long-term initiative to restore rural health services will be examined with a view to improve the current health SWAp and strengthen government and development partner collaboration.

## **B. Methodology and Key Activities**

10. The assessment of the current state of rural health services will cover at least six districts: two remote and disadvantaged districts, two of average standing, and two well-performing districts. The districts will also be representative of the country's four regions. Village-based consultations will be organized and seek to determine local issues and potential solutions from a grassroots perspective in planned collaboration with TA 6319.<sup>11</sup> Local-level and provincial governments will participate in the process. Workshops will be held with government and development partner stakeholders to assist in policy dialogue and reformulation of rural public health systems and support arrangements that respond to the rural populations' needs and are viable in the long term. Diverse diagnoses and multiple proposed solutions are anticipated. The Government's District Services Improvement Program may provide the means for developing long-term support of rural health services.

11. Ongoing rural health service delivery reform and improvement efforts operating in PNG will be reviewed for their impact on improving health service delivery in a sustainable manner. Lessons

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<sup>11</sup> ADB. 2006. *Technical Assistance for Pilot Strengthening of Civil Society Participation in Development in the Pacific*. Manila.

learned and their inclusion in the final recommendations will inform strategies and developments addressing the reversal in the decline of rural health services.

12. In-service training, an NDOH responsibility, will be reexamined in light of establishing training mechanisms and facilities to support rural-based health workers and potentially a program to select and train community-supported health workers to practice in their home or spouse's village. Several possibilities will be examined, including (i) the opening, management, and financial viability of the Laloki in-service training facility;<sup>12</sup> and (ii) contracting nursing officer training schools and community health worker training schools, many operated by faith-based organizations (FBOs), to upgrade the skills of selected candidates and to maintain their skills through periodic in-service training.

13. A system for procuring and distributing aid post medicine kits has operated since 1998. While there are remaining issues, in particular the distribution of kits to the respective aid posts, rural health services—where they are still open and operational—have usually been adequately supplied with essential medicines. System improvements, especially internal control mechanisms, and the possible extension of the system to village level-independent practitioners, with due attention paid to lessons learned, would constitute a government subsidy to primary health services at the village level. Once operational, the distribution network could also provide a conduit for preventive health care goods and services and health promotion activities.

14. Appropriate and sustainable supervisory mechanisms will be examined and developed. Village council participation in selecting and assigning health workers who seek to establish a practice in their native or spouse's village would allow for community oversight mechanisms. Districts being developed under the District Services Improvement Program may also be qualified to undertake an appropriate supervisory role.

15. Establishing new HR arrangements for rural health services would require NDOH to demonstrate leadership by setting the right example. Attempts over the years to improve the performance of NDOH's Human Resource Branch have been less than successful. The attempts were usually tied to projects of short duration. The longer term sector program approach offers opportunities, given the measured pace required to undertake lasting reforms. The Government's Concept payroll system would be strengthened to improve accuracy and governance as well as to produce standard and reliable HR management information. The new arrangements would also present the opportunity to introduce modern licensing practices for both government and independent health workers.

16. The performance of NHIS under NDOH's Monitoring, Research and Evaluation Branch is gradually deteriorating in the absence of supervision and HR management, as well as inadequate attention paid to logistics, computer and skills upgrading. The information reported by NHIS is of critical importance to HR management and in measuring performance against the strategic plans. Long-term sustained support and development may be appropriate and will be examined under the proposed TA.

### **C. Cost and Financing**

17. The TA is estimated to cost \$944,000 equivalent. The amount of \$850,000 equivalent will be financed on a grant basis by the Japan Special Fund, funded by the Government of Japan. The

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<sup>12</sup> Built under ADB. 1997. *Report and Recommendation of the President to the Board of Directors on Proposed Loans and Technical Assistance Grants to Papua New Guinea for the Health Sector Development Project*. Manila (Loans 1516-PNG/1517-PNG[Sf]/1518-PNG[Sf], approved on 20 March), commonly called the HRD Project, for \$10 million.

NDOH and participating decentralized governments will contribute \$94,000 equivalent to finance counterpart staff support, office accommodation, and facilitation of workshops and consultations. Detailed cost estimates are in Appendix 3. The Government has been advised that approval of the TA does not commit ADB to financing any ensuing project.

#### **D. Implementation Arrangements**

18. NDOH will be the Executing Agency for the TA. The TA will be guided by the Health Sector Program Committee, a Health Sector Improvement Program (HSIP) management committee, which includes director-level NDOH members and development partner representatives. The TA will also report to various government and development partner bodies as needed, including the biannual Government-Development Partner Health Summit. The HSIP Management Branch will provide support in the day-to-day activities of the TA and in coordinating with other stakeholders. NDOH will provide logistical support to the consultants such as providing them with necessary data and organizing appointments.

19. Continued participation of AusAID, NZAID, World Health Organization (WHO), and other bilateral, multilateral, and United Nations (UN) development partners supporting the Government's health SWAp will be sought. The scope and duration of an eventual program will necessitate broad-based support and cofinancing. Incorporating a large-scale program into the HSIP is expected to strengthen the HSIP, lending it both greater predictability and stability.

20. The TA will require a minimum of 18 person-months of international and 20 person-months of national consulting services to carry out the study. The areas of expertise include health systems analysis and development, consultation and participation of stakeholders, and economic analysis. Appendix 4 gives the outline terms of reference.

21. The TA will be carried out by an international consulting firm in association with a national firm or a team of national individual consultants. The firm will be engaged in accordance with ADB's *Guidelines on the Use of Consultants* (April 2006, as amended from time to time), using the quality-based selection method (QBS) and a simplified technical proposal (STP). The QBS is justified because of the exploratory nature of the TA, and the technical and economic uncertainty associated with the project. The consultants will supply ADB and the Government with six copies of the inception report and final report. An electronic version will also be provided.

22. The TA will be implemented over a 12-month period including an initial diagnostic phase involving consultation and participation of rural populations, and health systems evaluations, followed by the recommendations/design phase using the HSIP, and in collaboration with all health sector stakeholders. The TA will begin in March 2007 and end February 2008.

#### **IV. THE PRESIDENT'S DECISION**

23. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$850,000 on a grant basis to the Government of Papua New Guinea for Health Sector Support, and hereby reports this action to the Board.

## DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<b>Impact</b> <ul style="list-style-type: none"> <li>Reduced child mortality (MDG 4)</li> <li>Improved maternal health (MDG 5)</li> <li>HIV/AIDS, malaria, and other diseases under control (MDG 6)</li> </ul>	<ul style="list-style-type: none"> <li>PNG adjusted MDG indicators and targets</li> </ul>	<ul style="list-style-type: none"> <li>MDG reports produced by UNDP</li> <li>DHS</li> </ul>	<b>Assumption</b> <ul style="list-style-type: none"> <li>Long-term social, economic, and political stability maintained</li> </ul>
<b>Outcome</b> <ul style="list-style-type: none"> <li>Broad-based policy discussions between government and development partners informed by a road map for policy reform and an investment plan</li> </ul>	<ul style="list-style-type: none"> <li>NDOH and HSIP endorsed recommendations by March 2008</li> </ul>	<ul style="list-style-type: none"> <li>Final report submitted</li> </ul>	<b>Assumption</b> <ul style="list-style-type: none"> <li>Sustained commitment of government, development partners, and other stakeholders to proposed reforms</li> </ul>
<b>Outputs</b> <ul style="list-style-type: none"> <li>A report defining a comprehensive reform process including ADB's participation in restoring basic health services to PNG's rural populations</li> </ul>	<ul style="list-style-type: none"> <li>An initial draft report submitted 4 months after consultant deployment</li> <li>A final draft report completed within 12 months of project start</li> </ul>	<ul style="list-style-type: none"> <li>Consultant report</li> </ul>	<b>Assumptions</b> <ul style="list-style-type: none"> <li>Consistent political will and clear leadership arrangements by Government</li> <li>Continued cooperation of government agencies and stakeholders</li> </ul> <b>Risks</b> <ul style="list-style-type: none"> <li>Lack of support from relevant government agencies</li> <li>Disruptions and delays due to 2007 national elections</li> </ul>
<b>Activities with Milestones</b> <p>1.1. Design and test a survey instrument, with participation of the Monitoring and Research Branch of NDOH, to establish (i) current district/rural level health services, (ii) recent evolution and causes of change in district/rural level health services ( 2 months after start)</p> <p>1.2. Design and test a consultation and community-based discussion framework to establish (i) grassroots experience and perceptions of government/church health services; (ii) demand for village-based basic health services; and (iii) possible new arrangements and level of buy-in with respect to community support, community supervision/evaluation, and willingness to pay ( 2 months after start)</p>			<b>Inputs</b> <ul style="list-style-type: none"> <li>JSF financing: \$850,000</li> <li>Government financing: \$94,000</li> </ul>

**Activities with Milestones**

- 1.3. Include in the consultation and community-based discussion framework two components targeting (i) village councils/elders and (ii) women representatives
- 1.4. Conduct investigations 1.1 and 1.2 in at least six districts with decentralized government participation ( 9 months after start)
- 1.5. Prepare a summary report for each district to be broadly disseminated among all stakeholders and including a district-level presentation/workshop for each district covered (1 month after conclusion of survey)
- 1.6. Prepare a comprehensive report covering the findings of all districts and reviewing trends and possible emerging consensus among stakeholders (10 months after start)
2. Review current major initiatives in the health sector addressing rural health services delivery with the use of recent evaluations/reports and interviews. Relate these initiatives to the findings of the other activities and factor into the final recommendations (6 months after start)
3. With the participation of NDOH Policy and Planning Branch and HR Branch, assess all preservice and in-service training schools and their levels of output. Determine the required investments and recurrent costs to make the Laloki In-service College operational. Examine private sector options such as using established nursing colleges and CHW schools. Prepare a summary report of the options to be broadly disseminated among all stakeholders and include an NDOH in-house presentation/workshop (3 months after start)
- 4.1. Working with NDOH HR Branch and the Department of Personnel Management and the decentralized governments of the districts covered in section 1, examine licensing options of private practitioners, community participation in the licensing process, and related supervisory, evaluation and skills-maintenance programs (6 months after start)
- 4.2. Review HR management practices and systems to improve on transparency and governance issues, to produce information of management value acceptable for dissemination to all central agencies (6 months after start)
- 4.3. Prepare a summary report examining options for support by NDOH and development partners under the HSIP. Undertake broad dissemination of results using a presentation/short workshop format (8 months after start)
5. With the participation of NDOH Medical Supplies Branch and PNG-based private sector pharmacies, review past and current experience with the aid post medicine kit program. Examine options to extend the aid post kit system to village-based private practitioners. Review cost, reliability, and sustainability determinants. Prepare a summary report examining options for support by NDOH and development partners under the HSIP. Undertake broad dissemination of results using a presentation/short workshop format (6 months after start)
6. Conduct an exercise to compare the results obtained in the six districts (section 1) with available information under NHIS. Using a consultative approach involving the participation of all Monitoring and Research Branch staff, determine a course of action and the resources necessary to restore NHIS to its former performance levels. Prepare a summary report examining options for support by NDOH and development partners under the HSIP. Undertake broad dissemination of results using a presentation/short workshop format (8 months after start)
7. Invite the participation of other key development partners including AusAID, NZAID, EU, WHO, and others in the design process and ensure a continued dialogue with government centered on the HSIP and the sectorwide approach to restoring rural health services (Ongoing)

ADB = Asian Development Bank, AusAID = Australian Agency for International Development, CHW = community health worker, DHS = Demographic and Health Survey, EU = European Union, HIV/AIDS = Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome, HR = human resource, HSIP = Health Sector Improvement Program, JSF = Japan Special Fund, MDG = Millennium Development Goal, NDOH = National Department of Health, NHIS = National Health Information System, NZAID = New Zealand Agency for International Development, PNG = Papua New Guinea, UNDP = United Nations Development Programme, WHO = World Health Organization.

## INITIAL POVERTY AND SOCIAL ANALYSIS

### A. Linkages to the Country Poverty Analysis

<b>Is the sector identified as a national priority in country poverty analysis?</b>	<input checked="" type="checkbox"/> Yes  <input type="checkbox"/> No	<b>Is the sector identified as a national priority in country poverty partnership agreement?</b>	<input checked="" type="checkbox"/> Yes  <input type="checkbox"/> No
<p><b>Contribution of the sector or subsector to reduce poverty in Papua New Guinea:</b></p> <p>The poverty situation in Papua New Guinea (PNG) is perceived to have dramatically increased in recent years. Although most of the poor live in rural areas, there are indications that poverty in urban areas has worsened due to growing rural-urban migration, which in turn was prompted by the poor delivery of basic social services and rising unemployment of school leavers in rural areas. The principal challenges to poverty reduction in PNG are the restoration of economic growth and the continued provision of basic services. Those are also the priorities of the poor identified during the participatory assessment of hardship in 2001, namely access to jobs and income opportunities, and improved service delivery and infrastructure.</p> <p>The Department of Health and stakeholders, including the Asian Development Bank (ADB), agree to a core set of issues that undermine the health status of the PNG population. These are limited resources, deteriorating infrastructure, and inadequate and declining access to basic health services. These issues are exacerbated by widespread inefficient management, low staff morale, and poor community support for health services. Individuals and communities are not encouraged to improve and maintain their own health.</p> <p>Support for the health sector is an integral part of the strategy to strengthen the delivery of basic services, especially to the rural poor.</p>			

### B. Poverty Analysis

**Targeting Classification:** Targeted intervention

<p><b>What type of poverty analysis is needed?</b></p> <p>The goal of the project is to achieve progress in meeting all health-related Millennium Development Goals. Many rural aid posts have closed across the nation; loss of health infrastructure is also reported to include health centers, both government and church-based. The incapacity to supervise and manage the aid post workforce and to retain functioning health workers in the public system has increased costs and resulted in a nonperforming system.</p> <p>The purpose of the TA is to support the government in addressing the decline in basic health services throughout rural PNG. The project proposes to selectively address this issue under new arrangements that promote both improved and sustainable management and oversight, and greater ownership of health services by staff, communities, and individuals. Local solutions will be developed with the participation of all stakeholders; innovative arrangements will be considered and adopted where appropriate.</p> <p>Poverty analysis will help ensure that the investments are pro-poor, the poor and disadvantaged groups benefit proportionately, and the project reduces the vulnerability of the poor and disadvantaged groups. The analysis should also include a needs assessment that (i) identifies the existing burden of disease of the poor and disadvantaged groups and possible strategies to optimize their use of services; and (ii) assesses the current capacity of the health system to effectively address their health needs. The analysis should also examine public-private partnership arrangements to enhance the sustainability of the regional delivery of basic health services.</p>
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### C. Participation Process

<b>Is there a stakeholder analysis?</b>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
<p>A stakeholder analysis is required to identify key project stakeholders, their project-related interests, and the ways in which they affect project feasibility and success. Primary stakeholders include representatives from the rural poor and vulnerable groups at the village level, selected health staff, union representatives, representatives of local churches, and nongovernment organizations. Secondary stakeholders would include decentralized government and relevant central government agencies, and development partners. A Consultation and Participation (C&amp;P) plan will be developed under the TA.</p>		

**Is there a participation strategy?**  Yes  No

A participation strategy will be required to establish the new village-level service delivery arrangements, and define the nature and levels of cooperation and collaboration of the many stakeholders. This will help ensure strong political support, ownership through active consultation with and participation of groups concerned, productive feedback, and the necessary long-term sustainability to achieve the project impact.

#### D. Gender Development

**Strategy to maximize impacts on women:**

In the consultation and participation process, village-based women will be addressed as a separate primary stakeholder group, insulated from outside pressures.

**Has an output been prepared?**  Yes  No

#### E. Social Safeguards and Other Social Risks

Item	Significant/ Not Significant/ None	Strategy to Address Issues	Plan Required
<b>Resettlement</b>	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None	No resettlement is expected in the Project.	<input type="checkbox"/> Full <input type="checkbox"/> Short <input checked="" type="checkbox"/> None
<b>Affordability</b>	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None	The project is designed to improve access to basic health services at the village level by the rural poor and vulnerable groups. The issue of user fees will be raised. If user fees are ever introduced, they will be negotiated between the health provider and the local population.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Labor</b>	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None	Labor is not expected to be a potential issue. The project will help strengthen the capacity of the health system, including human resources management, to deliver basic health services to the rural poor.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Indigenous Peoples</b>	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None	PNG comprises predominantly indigenous peoples with less than 2% exceptions in urban areas. The study will cover six districts and the proposed reform process will be national (all 89 districts) with reforms addressing local issues with local solutions.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Other Risks and/or Vulnerabilities</b>	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None	The project is expected to have no adverse effect on the environment. Risks related to waste disposal would be insignificant.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

**COST ESTIMATES AND FINANCING PLAN**  
(\$'000)

<b>Item</b>	<b>Total Cost</b>
<b>A. Asian Development Bank Financing<sup>a</sup></b>	
1. Consultants	
a. Remuneration and Per Diem	
i. International Consultants	339.70
ii. National Consultants	77.40
b. International and Local Travel	74.40
c. Reports and Communications	26.00
2. Equipment <sup>b</sup>	17.50
3. Training, Seminars, and Conferences	
a. Facilitators	18.00
b. Training Program	6.00
4. Surveys	176.80
5. Miscellaneous Administration and Support Costs	43.80
6. Contingencies	70.40
<b>Subtotal (A)</b>	<b>850.00</b>
<b>B. Government Financing</b>	
1. Office Accommodation	36.00
2. Remuneration and Per Diem of Counterpart Staff	58.00
<b>Subtotal (B)</b>	<b>94.00</b>
<b>Total</b>	<b>944.00</b>

<sup>a</sup> Financed by the Japan Special Fund, funded by the Government of Japan.

<sup>b</sup> Equipment comprise information technology hardware and software, which will be turned over to the Executing Agency after project completion.

Source: Asian Development Bank estimates.

## OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. An international consulting firm in association with a national consulting firm or a team of national consultants will be engaged to provide a total of 38 person-months consulting services. The scope of services will include, but will not necessarily be limited to, the following.

### A. Sector Analysis and Health Systems Development

2. **Project Management Specialist/Economist/Team Leader** (international, 10 person-months). The project management specialist will be a health systems specialist with extensive experience as team leader in designing and managing health projects involving public-private partnerships. Experience and sound knowledge in health systems design including human resource (HR) management systems, in-service training programs, medical supplies procurement and distribution systems, and health information systems are required. The team leader will (i) have demonstrated communication skills in interacting with Government, the private sector, civil society, nongovernment organizations (NGOs), and development partners; (ii) have experience with consultation and participation processes, preferably in the Pacific region; and (iii) preferably have extensive knowledge of Papua New Guinea's (PNG) economy and social issues including gender issues.

3. To attain the outputs, the team leader will undertake the following tasks:

(i) General:

- (a) Assist the Government (National Department of Health [NDOH], Department of National Planning and Monitoring, Department of Personnel Management, and Department of Treasury, and provincial, district, and local-level governments), development partners, civil society organizations, and private sector enterprises to conceptualize the overall project framework.
- (b) Build a sense of ownership, support, and cooperation across government agencies, development partners, and civil society for a shared interest and responsibility in basic health services delivery at the village level.
- (c) Define the common interests and grounds for public-private cooperation in providing rural health services.
- (d) Organize and supervise all surveys, studies, and workshops conducted under the technical assistance (TA).
- (e) Be responsible for the collective work of the consulting team, ensuring all required reports are submitted on schedule, including a report defining the Asian Development Bank's (ADB) possible role in restoring basic health services in PNG's rural populations.

(ii) Specific:

- (a) Promote the participation of development partners in implementing the TA with the objective of strengthening the Health Sector Improvement Program (HSIP) and sectorwide approach mechanisms, and arriving at a consensus on future reforms. Undertake, with the assistance of the social development expert and Monitoring and Research Branch (MRB) staff, surveys and sector analysis in six districts including consultation with and participation of rural populations and a stakeholder analysis; and organize local workshops to disseminate findings. Undertake, with the assistance of relevant government agencies and development partners, a review of

- current projects/initiatives designed to improve rural health services delivery. Assess the major efforts in light of their current and potential impact to reverse the decline in rural health services.
- (b) Assess NDOH's capacity to establish appropriate training programs and the required inputs to organize and maintain the programs making use of existing assets (Loloki In-service College), and develop alternate private sector options with, in particular, nursing colleges and community health workers schools sponsored by faith-based organizations.
  - (c) In consultation with the Department of Personnel Management and the NDOH Human Resource (HR) Branch, assess licensing options of nongovernment health practitioners and the potential for community participation; develop supervisory mechanisms with community involvement and a possible relationship with the government's District Services Improvement Program.
  - (d) Review existing documentation on the performance of the aid post medical kit system, further establish the nature of the issues at the district level, develop possible new mechanisms to extend the medicine kit system to health practitioners at the village level, examine the feasibility of using private sector pharmaceutical companies and local private transport networks.
  - (e) Undertake a review of the National Health Information System (NHIS) by capitalizing on work with the NDOH MRB, the surveys, and a comparison of NHIS data with survey results. In consultation with all MRB staff, determine a course of action and necessary resources to bring NHIS to its former level of performance.
  - (f) Submit an inception report no later than 4 months after consultant deployment. Prepare a summary report for each district to be disseminated among all stakeholders and include a district-level presentation/workshop for each district covered. Prepare and submit a final report comprising a thorough review of all health systems and ongoing reforms, findings on district-level consultation and participation, and a road map for policy reform.

4. **Government Health Systems Specialist** (national, 12 person-months). The specialist will (i) have extensive knowledge and experience in government health systems at national and subnational levels, and supporting central agency systems including the Department of Personnel Management, Departments of Treasury/Finance, and Department of National Planning and Monitoring; (ii) be familiar with public service issues at the district and local government levels; (iii) assist the team leader in reviewing all government systems and in all participatory processes; and (iv) have good communication and computer skills. Primary responsibilities will include, but will not be limited to, the following:

- (i) Under the guidance of the team leader, liaise with government officials, NGOs, the private sector, development partners, Papua New Guinea Resident Mission (PNRM) and other team members to assist in coordinating activities.
- (ii) Assist in arranging and attending all requested meetings, preparing briefing notes, and writing up summaries of outcomes of meetings.
- (iii) Assist with travel arrangements and accompany the team leader on field missions around the country as needed.

- (iv) Assist in preparing a stakeholder analysis and participatory meetings with stakeholders.
- (v) Assist in preparing and disseminating reports on the organization of workshops and all associated logistics.

## **B. Consultation with and Participation of Stakeholders**

5. **Social Development Specialist/Survey Specialist** (international, 8 person-months). The specialist will (i) have extensive experience using participatory processes in conducting surveys in developing societies; (ii) have a good understanding of PNG social development issues including gender issues; and (iii) be responsible for developing survey instruments, selecting local survey staff, training them, and supervising the following survey activities:

- (i) In collaboration with the NDOH MRB, undertake a desk review of all available information in the NHIS on rural health infrastructure, personnel, and service delivery statistics.
- (ii) With MRB participation, design and test a survey instrument to establish the current level of district health infrastructure, staffing, and health services delivery, and recent evolution and causes for change.
- (iii) In collaboration with technical personnel under TA 6319: Pilot Strengthening of Civil Society Participation in Development in the Pacific, design and test a consultation and community-based discussion framework to establish (a) community experience with and perceptions of government/church health services; (b) demand for village-based health services; and (c) possible new arrangements and level of buy-in with respect to community support, community supervision/evaluation, and willingness to pay. The discussion framework will be applied to two distinct community groups: village council/elders, and women's representatives.
- (iv) Undertake a sector analysis on a district basis; prepare a report including a district-level stakeholder analysis.
- (v) Organize with the team leader a district-level workshop for each district to disseminate survey results and discuss possible future options in an open forum.
- (vi) Assist the team leader in preparing a report covering the results for all participating districts and an analysis of the proposed arrangements; compare and contrast the findings with existing government information and perceptions.
- (vii) Assist the team leader in organizing and holding workshops with stakeholders including subnational government, NDOH and central agencies, development partners, the private sector, NGOs, and labor representatives.
- (viii) Participate in the review of NHIS and in formulating recommendations to restore its functional capacity to produce reliable and timely information.
- (ix) Contribute to the overall process of evaluating existing systems, distilling new proposals, and making final recommendations for resuming delivery of basic health services to rural populations.

6. **Survey Field Supervisor** (national, 8 person-months). The survey field supervisor will (i) have extensive knowledge and experience in conducting surveys in rural PNG; (ii) be familiar with public service issues at the district and local government levels; and (iii) have good communication and computer skills. The field supervisor will assist the survey specialist in managing the survey team and in making local arrangements for transport, accommodation,

carriers, translators, and other logistical arrangements. Primary responsibilities will include, but will not be limited to the following:

- (i) Support the survey specialist in making all necessary logistical arrangements and in supervising the survey team.
- (ii) Assist the survey specialist with local payment for goods and services required in the six participating districts.
- (iii) Assist with data entry and preliminary analysis, and assist the survey specialist with local stakeholder discussions.
- (iv) Assist in preparing results for dissemination and workshops.