# SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

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| Country: | Papua New Guinea | Project Title: | Health Services Sector Development Program Subprogram 2 |
| Lending/Financing Modality: | Policy-based loan | Department/ Division: | Pacific Department/Social Sectors and Public Sector Management Division |

## I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

Poverty targeting: general intervention

**A. Links to the National Poverty Reduction and Inclusive Growth Strategy and Country Partnership Strategy**

The Papua New Guinea (PNG) Vision 2050 aims to achieve inclusive economic growth by transforming the economy, improving infrastructure, and enhancing human development; it identifies a healthy population as a driver of development and calls for better health care services.[a] The Medium Term Development Plan, 2018–2022 includes key result areas around improved service delivery, improved governance, and responsible sustainable development.[b] The Asian Development Bank country partnership strategy for PNG, 2016–2020 identifies health as a priority area for assisting the government in converting its resource wealth into higher human capital to drive inclusive and sustainable economic growth.[c] The Health Sector Services Development Program (HSSDP) will contribute significantly to poverty reduction, given that the health of women and men is directly linked to their human capital development, and productive capacity and will significantly improve the health and economic circumstances of PNG's largely rural population through better public finance management of funds to improve health service delivery.

**B. Results from the Poverty and Social Analysis during PPTA or Due Diligence**

1. Key poverty and social issues. Evidence from the 1996–2010 Household Income and Expenditure Survey suggests that, despite more than 11 years of sustained high average rates of economic growth, poverty did not decline between 1996 and 2010.[d] The national poverty rate remains around 37%, and health outcomes have either stagnated or deteriorated and PNG has the lowest life expectancy in the Pacific region. Access to health services is limited for the nearly 90% of people who live in rural areas because of poor roads and either non-existent or expensive transport. Where there is access, health infrastructure is often poor, service quality low, staff numbers inadequate, and medicine and medical supplies are frequently out of stock. About 60% of the burden of disease in PNG is from maternal and infant mortality, and communicable diseases. Women, who bear children and have primary childcare responsibility, are most affected. The program's focus on improving health services will ensure benefits to the poor, women, and children.
2. Beneficiaries. The primary project beneficiaries are men, women, and children who live in the rural parts of PNG. They will benefit greatly from better management of funds, institutions, and processes aimed at improving health service delivery. The better flow of intended funds will ensure health facilities are operational with appropriate medicine available. The poor, and other vulnerable groups such as women and children, persons with disabilities, the elderly, and those requiring urgent or life-saving medical attention stand to benefit the most from the HSSDP. Consultations with key stakeholders identified the following concerns: (i) lack of basic medicine in health centers; (ii) irregular power and water supply in health centers; (iii) staff absenteeism and poor attitudes; and (iv) costly, distant, and at times dangerous travel to access both basic and life-saving treatment from the provincial hospital.
3. Impact channels. Improving national and subnational frameworks will safeguard fund allocations to ensure essential health service delivery and other priority services during the current period of fiscal tightening. Project activities will continue to support (i) capacity development; (ii) the generation of evidence for strategic health sector budgeting, including through the review of sector funding; (iii) top-down resource allocation approaches, and (iv) bottom-up basic service costings for different health facilities in line with the PNG National Health Service Standards.
4. Other social and poverty issues. None.
5. Design features. The program policy reforms for subprogram 2 (March 2018 to September 2019) are focused around key reform areas: (i) national frameworks and public financial management enhanced; (ii) subnational health system management strengthened; and (iii) health service delivery components strengthened. Reform actions in subprogram 2 include (i) the Public Finances (Management) (Amendment) Act 2018 approved, key descriptive information about programs included in the national budget, and the National Procurement Act 2018 coming into force to strengthen procurement frameworks; (ii) new Provincial Health Authorities (PHAs) established with formal agreements signed, an acting chief executive officer appointed as well as a full board of directors that will include at least one woman, a PHA manual drafted to assist with management, budget planning for maintenance, and a new chart of accounts for PHAs that enables separate budgeting, accounting, and reporting for family, maternal, and child health services; and (iii) a plan for the reform of medicine procurement and distribution approved, and a standard operating procedure implemented to improve ordering of medicines and drugs, helped by the approval of a new drug catalogue.

**C. Poverty Impact Analysis for Policy-Based Lending**

1. Impact channels of the policy reforms. Policy reforms in subprogram 2 will safeguard fund allocation and improve the use of funds received by PHAs during a period of fiscal tightening. Health service delivery will be improved through (i) the development of manuals and templates that provide guidance to PHAs and (ii) capacity building provided by the project investment of the sector development program.

2. Impacts of policy reforms on vulnerable groups. The policy reforms will impact the poor and other vulnerable groups, including women and children, through more reliable health service delivery, particularly for the estimated 7 million people who live in rural areas.
3. Systematic changes expected from policy reforms. Systemic changes such as better public finance management at the national level as well as at PHAs along with better managed partnerships in the health sector will improve rural health care and encourage access, preventing loss of lives among pregnant women, their babies, and sick children.

## II. PARTICIPATION AND EMPOWERING THE POOR

1. Participatory approaches and project activities. Social safeguard issues are not considered significant for subprogram 2. At the impact level, the program is aligned with PNG's Medium Term Development Plan, 2017–2036 (footnote b). The formulation of the development plan involved extensive consultations with a wide range of stakeholders from local and national government, development partners, and community groups.
2. Civil society organizations. As part of its reform efforts, the government consulted with civil society organizations representing sectors affected by policy reform actions. These consultations, which are led by the government, involve national and sector-specific consultations.
3. The following forms of civil society organization participation are envisaged during project implementation, rated as high (H), medium (M), low (L), or not applicable (NA):

**H** Information gathering and sharing **M** Consultation **NA** Collaboration **NA** Partnership

4. Participation plan. ☐ Yes. ☒ No.

The government will carry out participatory elements under specific reform activities, reflecting the policy-based nature of the support.

## III. GENDER AND DEVELOPMENT

Gender mainstreaming category: effective gender mainstreaming

**A. Key issues.** Poor and deteriorating health indicators in PNG are largely associated with women and their limited access to reproductive health services. Gender inequality in the country's health care system is demonstrated by (i) a high percentage of women with an unmet need for contraception (at least 50%); (ii) a high maternal mortality ratio (215 maternal deaths per 100,000 live births) and high infant mortality rate (43.8 per 1,000 live births) (endnote h); (iii) low rates of supervised deliveries in health facilities (40%); (iv) a limited number of skilled professionals supervising deliveries; and (v) lack of proper postnatal care. While project components will continue to address these issues through the implementation of the gender action plan, subprogram 2 will focus on some of the fundamental barriers to better quality health services: adequate budget and financial and health system management processes for the health service at the national and PHA levels. To date, the budgeting process has included limited consultation with civil society and a lack of transparency with civil society (including women and women's organizations) on budgeting processes, expenditure, and performance. Budget templates and reporting have not allowed for tracking against gender indicators. Furthermore, despite the fact that women are disproportionately affected by limited health services, particularly in rural areas, they have had little say in health service management.

**B. Key actions.** Subprogram 2 will promote sustainable health service delivery for men, women, and children in poor rural communities by ensuring efficient and effective financial and health system management processes are in place. The program particularly benefits women and children by: (i) **prioritizing health sector budget allocations**, including maternity and child health services, and reproductive healthcare and family planning—including mandating budget to cover basic maintenance for facilities; (ii) **ensuring women are involved in decision making** by appointing at least one female director (out of nine) on the board of directors for all PHAs; (iii) **providing information** through the PHA manual, covering issues such as key laws and policies pertaining to PHAs, the roles and responsibilities of the board, and PHA finances to board members (female board members across the Pacific have fed back that a lack of information and training is a key barrier to their active participation on boards); (iv) introducing new PHA and public hospital regulations that include merit-based selection and performance requirements to support the appointment of more women in senior positions such as chief executive officer, and ensuring **gender responsive leave entitlements,** including maternity and breastfeeding leave; (v) supporting actions that will allow for **gender responsive tracking and budgeting** in subprogram 3 and future years. At a national level, separate budget line items for family, maternal, and child health will allow the Department of Treasury to track spending in these areas. At a decentralized level, the approval of a new chart of accounts for use by the PHAs will allow for gender responsive budgeting analysis through tracking-program and facility-based activities for family, maternal, and child health services at a local level. In addition, 2017 annual financial and performance reports for at least 7 PHAs include sex-disaggregated data to allow for gender responsive budget analysis; (vi) **revising and approving the drug catalogue and medical procurement practices** to ensure better stock of essential drugs based on World Health Organization best practice. This includes stocking of contraceptives and essential maternal and neonatal medication; and (vii) **improving the framework for monitoring health partnerships** so that it includes tracking information on health partnerships with a gender focus. In addition, actions on transparency, e.g., publishing of financial and performance management reports of PHAs support good governance and provide vital information to civil society, including women's organizations, to inform discussions and engagement on budgeting and quality health service delivery. Please note that other gender actions continue to be progressed through the gender action plan as part of project activities.

☐ Gender action plan ☒ Other actions or measures ☐ No action or measure

**IV. ADDRESSING SOCIAL SAFEGUARD ISSUES**

**A. Involuntary Resettlement** **Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

1. Key impacts. Key policy actions will not result to any involuntary resettlement and cause any physical and economic displacement.
2. Strategy to address the impacts. Not applicable.
3. Plan or other Actions.

☐ Resettlement plan
☐ Resettlement framework
☐ Environmental and social management system arrangement
☒ No action
☐ Combined resettlement and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Social impact matrix

**B. Indigenous Peoples** **Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

1. Key impacts. There are no indigenous peoples considered as distinct and vulnerable, per the definition in the Safeguard Policy Statement (2009) of the Asian Development Bank (ADB), who will be affected by the policy actions.

Is broad community support triggered? ☐ Yes ☒ No

2. Strategy to address the impacts. Not applicable.
3. Plan or other actions.

☐ Indigenous peoples plan
☐ Indigenous peoples planning framework
☐ Environmental and social management system arrangement
☐ Social impact matrix
☒ No action
☐ Combined resettlement plan and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Indigenous peoples plan elements integrated in project with a summary

**V. ADDRESSING OTHER SOCIAL RISKS**

**A. Risks in the Labor Market**

1. Relevance of the project for the country's or region's or sector's labor market, indicated as high (H), medium (M), and low or not significant (L).

[L] unemployment [L] underemployment [L] retrenchment [L] core labor standards

2. Labor market impact. Not applicable.

**B. Affordability**

The program does not negatively impact the affordability of goods and services.

**C. Communicable Diseases and Other Social Risks**

1. The impact of the following risks are rated as high (H), medium (M), low (L), or not applicable (NA):

[NA] Communicable diseases [NA] Human trafficking
☐ Others (please specify) _____
2. Risks to people in project area. None.

**VI. MONITORING AND EVALUATION**

1. Targets and indicators. The design and monitoring framework includes indicators targeting fiscal management improvement through the approval of Public Finances (Management) (Amendment) Act 2018, the Procurement Act 2018 coming into force, and development of a national budget in line with the International Monetary Fund's Government Financial Statistics Manual 2014, which includes activities for family, maternal, and child health services. As each PHA is established, it is appointed an acting chief executive officer and a board that includes at least one woman. The PHAs have developed budgets to ensure ongoing maintenance of health services infrastructure and a chart of accounts. A technical working group has been established to oversee medicine procurement and distribution reform, all local area medical stores and provincial hospitals are using the digital logistics management and information systems as their sole source of stock control and order management, and a partnership framework has been approved.
2. Required human resources. ADB staff will monitor performance targets and indicators.
3. Information in the project administration manual. Not applicable.
4. Monitoring tools. Not applicable.

Source: Asian Development Bank.

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[a] Government of PNG. 2009. *Papua New Guinea Vision 2050*. Port Moresby.
[b] Government of PNG. 2018. *Medium Term Development Plan 3 2018–2022*. Port Moresby.
[c] ADB. 2015. *Country Partnership Strategy: Papua New Guinea, 2016–2020*. Manila.
[d] Government of PNG, National Statistical Office. 2011. *Household and Income Expenditure Survey: Tables and Statistics*. Port Moresby.