SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	Papua New Guinea	Project Title:	Health Services Sector Development Program Subprogram 3
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. While the full impact of the coronavirus disease (COVID-19) is to be determined, it is anticipated to lead to a contraction of gross domestic product (GDP) of around 5% in 2020.

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 shows 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 38%, and health outcomes have either stagnated or deteriorated. PNG has one of 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 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 from HSSDP are men, women, and children who live in the rural areas of PNG who will benefit from improved management of funds, institutions, and processes aimed at increased health service delivery. Improved efficiency 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 of health workers and managers, (ii) increased real-time information for strategic health sector budgeting, (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 3 (September 2019 to December 2020) 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 3 include (i) Public Finances (Management) (Amendment) Act 2018 published, the completion of a public expenditure and financial accountability assessment, reforms related to the implementation of the National Procurement Act 2018 and the disbursement of a COVID-19 support package; (ii) four 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, the PHA manual updated including modules on public financial management and gender responsive budgeting, audits of PHAs; and (iii) increased coverage of the digital health information systems, rolling procurement plans and the implementation of Emergency Preparedness and Response Plan for COVID-19.

C. Poverty Impact Analysis for Policy-Based Lending

1. Impact channels of the policy reforms. Policy reforms 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 the development of manuals and templates providing guidance to PHAs and capacity building provided by the project investment.

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 PHA level 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 3. 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), (iii) low rates of supervised deliveries in health facilities (32%), and (iv) lack of proper postnatal care. In terms of gender and health system financing, to date, 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.

The COVID-19 crisis is likely to exacerbate existing gender inequalities and the challenges that women face in accessing quality health services. Gender-based violence (GBV) prevalence is among the highest in the world with 68% of women disclosing an experience of physical or sexual violence, or both, by an intimate partner in their lifetime. Research from other contexts highlights that GBV is likely to increase in frequency and severity as a result of COVID-19, and accessing support and services becomes more difficult when movement is restricted. In addition, given the existing strains to health services (pre-COVID-19), COVID-19 may impact other essential health services. E.g., by diverting funding from essential services; services not adequately prepared to provide safe (for health workers and patients) services that minimize the risk of spreading COVID-19; women not presenting to health clinics for essential services like prenatal care because of COVID-19-related concerns; and lack of transport to services due to lockdown restrictions.

B. Key actions. Project components will continue to address these issues through the implementation of the gender action plan. Subprogram 3 will focus on (i) fundamental barriers to better quality health services, and (ii) supporting women and girls during COVID-19. In terms of addressing the fundamental barriers to better quality health services, gender actions include (i) ensuring there is adequate budget and financial and health system management processes for the health service at the national and PHA levels; (ii) 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; (iii) 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; (iv) a number of gender-responsive budgeting actions including a new module on gender-responsive budgeting in the PHA Manual, gender-responsive budgeting training to PHA executives and board for all 22 provinces, financial and performance reports that include sex-disaggregated data for FY2018 (11 PHAs) and for FY2019 (12 PHAs) and the approval of an annual reporting template for all PHAS to use for FY2020 that will take advantage of the accessibility of all PHAs to standard sex-disaggregated data and of gender-responsive budgeting and reporting guidance as part of the PHA manual; and (v) sex- and age-disaggregated data collected for all immunization programs (this was not previously collected) and data collection in all PHAs expanded to include the collection of data on interpersonal physical violence. This has been accompanied with training to service providers on how to ensure the safe, confidential and respectful collection and input of this sensitive data.

COVID-19 gender actions include (i) the activation and weekly coordination meetings of the UN/Government Protection cluster and GBV sub-cluster; (ii) PPE for health workers; (iii) gender-sensitive COVID-19 communication and community engagement plans, including targeted messaging for pregnant and breastfeeding women, information on gender-based violence referral pathways and advice for health providers relating to women's rights to sexual and reproductive health care irrespective of COVID-19 status; and (iv) a ministerial instruction that notes that all other health services must continue to be delivered to communities despite the COVID-19 pandemic. This addresses risks related to ensuring essential health services for women, such as maternal and reproductive health services, continue during COVID-19. Other gender actions continue to progress 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 reflects the policy-based nature of the program, with performance indicators targeting improvements in fiscal management and health service delivery. A post-program performance framework has been developed to track ongoing reform that will leverage the work done during the three subprograms.
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.

[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.

Source: Asian Development Bank.