ADB

Report and Recommendation of the President to the Board of Directors

Project Number: 51035-001
April 2018

Proposed Programmatic Approach, Policy-Based Loan for Subprogram 1, and Project Loans Papua New Guinea: Health Services Sector Development Program

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 21 March 2018)

Currency unit	–	kina (K)
K1.00	=	$0.307
$1.00	=	K3.252

ABBREVIATIONS

ADB	–	Asian Development Bank
DOH	–	Department of Health
DOT	–	Department of Treasury
EMP	–	environmental management plan
IMF	–	International Monetary Fund
NHP	–	national health plan
PAM	–	project administration manual
PEFA	–	public expenditure and financial accountability
PFM	–	public financial management
PHA	–	provincial health authority
PMU	–	project management unit
PNG	–	Papua New Guinea
RPHSDP	–	Rural Primary Health Services Delivery Project
SDP	–	sector development program

NOTE

In this report, "$" refers to United States dollars.

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PROGRAM AT A GLANCE

1. Basic Data

Project Number: 51035-001

Project Name	Health Services Sector Development Program, Subprogram 1	**Department/Division**	PARD/PAUS
Country	Papua New Guinea	**Executing Agency**	Department of Treasury
Borrower	Papua New Guinea		

2. Sector

	Subsector(s)	ADB Financing ($ million)
✓ **Health**	Health sector development and reform	145.00
Public sector management	Public expenditure and fiscal management	50.00
	Total	**195.00**

3. Strategic Agenda

	Subcomponents
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive

Climate Change Information

Climate Change impact on the Project: Low

4. Drivers of Change

	Components
Governance and capacity development (GCD)	Institutional development Institutional systems and political economy Organizational development Public financial governance
Partnerships (PAR)	Bilateral institutions (not client government) Foundations Implementation International finance institutions (IFI) United Nations organization

Gender Equity and Mainstreaming

Effective gender mainstreaming (EGM): ✓

5. Poverty and SDG Targeting

Geographic Targeting	No
Household Targeting	No
SDG Targeting	Yes
SDG Goals	SDG3

Location Impact

Nation-wide: High

6. Risk Categorization: Complex

7. Safeguard Categorization

Environment: B **Involuntary Resettlement:** C **Indigenous Peoples:** C

8. Financing

Modality and Sources	Amount ($ million)
ADB	**195.00**
Sovereign SDP - Program (Regular Loan): Ordinary capital resources	100.00
Sovereign SDP - Project (Concessional Loan): Ordinary capital resources	49.90
Sovereign SDP - Project (Regular Loan): Ordinary capital resources	45.10
Cofinancing	**0.00**
None	0.00
Counterpart	**9.50**
Government	9.50
Total	**204.50**

Source: Asian Development Bank

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on (i) a proposed programmatic approach, (ii) a proposed policy-based loan for subprogram 1, and (iii) proposed project loans, all to Papua New Guinea (PNG) for the Health Services Sector Development Program (SDP).

2. The SDP combines a policy-based operation and a project investment to support critical whole-of-government and sector reforms with health sector investments. The policy-based loan will support fiscal policy, public financial management (PFM), and health sector reforms while safeguarding funding for basic services during a period of fiscal tightening. The project loans fill investment gaps to support PNG's progress toward universal health coverage.[1]

II. THE SECTOR DEVELOPMENT PROGRAM

A. Rationale

3. Despite a period of high economic growth, averaging 6% annually from 2006 to 2015, PNG is in the bottom quartile globally for life expectancy at 65 years and failed to achieve the Millennium Development Goals for maternal and child health.[2] The estimated burden of disease is dominated by chronic diseases, including strokes and heart disease, but also includes conditions of poverty such as pneumonia and neonatal conditions.[3] Weak information systems result in uncertainty about the leading causes of ill health, which hampers effective priority setting. PNG's poor health outcomes are a result of deteriorating health care services caused by a combination of volatile and unpredictable health financing as well as systemic weaknesses in regulatory frameworks, government systems, and national and health sector capacities.[4]

4. A sharp slowdown in economic growth in 2016 weakened global commodity prices, on which the PNG's economy is highly dependent, and underperforming domestic resource mobilization led to low budget execution rates, i.e., actual health expenditures were 32% lower than budgeted. Overall, health spending accounted for only 10% of total public expenditure and remained 37% below the spending peak of 2014, when an expansionary fiscal policy in expectation of growing resource revenues had led to significantly increased health financing, including the introduction of free primary health care.[5] The economic slowdown constrained investments in new health infrastructure and reduced the quality of existing service delivery.

5. Deficiencies in health sector governance, including an inconsistent legal framework and fragmented funds flows, undermine service delivery and blur the accountabilities of the various stakeholders. Weak PFM, both nationally and in the health sector, further erodes health services. A public expenditure and financial accountability (PEFA) assessment in 2015 highlighted weaknesses across the PFM cycle, with major issues in financial controls, accounting, reporting

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[1] Asian Development Bank (ADB). 2017. *Technical Assistance to Papua New Guinea for Preparing the Health Services Sector Development Program*. Manila.

[2] Asian Development Outlook database; and Sector Assessment (Summary): Health (accessible from the list of linked documents in Appendix 2).

[3] Institute of Health Metrics. 2016. *Global Burden of Disease Study. Country Profile: Papua New Guinea*. Seattle: University of Washington.

[4] S. Howes et al. 2014. *A Lost Decade? Service Delivery and Reforms in Papua New Guinea 2002–2012*. Canberra.

[5] Government of Papua New Guinea. 2013. *Free Primary Healthcare and Subsidized Service Policy*. Port Moresby.

and procurement, among others.[6] In the health sector, systemic weaknesses, including in oversight and performance management, and limited staff capacity in management and administration reduce the effective and efficient use of scarce resources.

6. The government is committed to the health sector and has identified health as one of the five key areas under the Alotau Accord II, which sets out the government's priorities up to 2022.[7] Health deliverables under the Alotau Accord II include (i) expansion of health infrastructure, (ii) improved medical procurement, and (iii) strengthened monitoring systems. Strategies for achieving universal health coverage are reflected in the National Health Plan (NHP) 2011–2020, and policies and standards to support these have been developed.[8] Dentralized service delivery is supported through the establishment and strengthening of provincial health authorities (PHAs), a key reform to align rural health and hospital services. More broadly, at the national level the government is implementing measures to strengthen policy development and PFM as part of their PEFA Road Map, 2015–2018.[9]

7. The SDP is aligned with the country partnership strategy, 2016–2020 of the Asian Development Bank (ADB), which identifies both the health sector and public sector management as focus areas for investment.[10] It builds upon ADB's long-term engagement in PNG in these sectors, and is consistent with ADB's health operations plan.[11] The SDP will support the implementation of PNG's Development Strategic Plan, 2010–2030 and the Medium Term Development Plan II, 2016–2017, thereby benefiting all sectors.[12] The medium-term plan links the national budget to the government's priorities and identifies key reform areas, including (i) PFM and the development of a medium-term fiscal strategy, (ii) subnational service delivery, (iii) innovative procurement strategies, and (iv) governance of the national budget process to improve allocative efficiency. The SDP will also support key priority areas of the NHP 2011–2020, including improving service delivery, and strengthening partnerships and health systems.

8. The SDP modality maximizes ADB's value addition by (i) combining critical reforms to remove bottlenecks in the health service delivery chain and ensuring that resources are available, allocated, and used more sustainably and efficiently through a programmatic approach with three subprograms over 2018–2020, each financed by a policy-based loan, with (ii) project financing to

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6 International Monetary Fund (IMF). 2015. *Papua New Guinea: Public Expenditure and Financial Accountability Assessment*. Washington, DC; and Sector Assessment (Summary): Public Sector Management (accessible from the list of linked documents in Appendix 2).

7 Government of Papua New Guinea. 2017. Alotau Accord II.

8 Government of Papua New Guinea. 2010. *National Health Plan 2011–2020*. Port Moresby; Government of Papua New Guinea. 2015. *National Health Service Standards*. Port Moresby; and Government of Papua New Guinea. 2017. *National Service Delivery Framework*. Port Moresby.

9 Government of Papua New Guinea. 2015. *Public Expenditure and Financial Accountability Road Map, 2015–2018*. Port Moresby; and Government of Papua New Guinea. 2007. *Provincial Health Authority Act.* Port Moresby.

10 ADB. 2015. *Papua New Guinea: Country Partnership Strategy, 2016–2020*. Manila.

11 ADB. 2006. *Report and Recommendation of the President to the Board of Directors: Proposed Asian Development Fund Grant to Papua New Guinea for the HIV/AIDS Prevention and Control in Rural Development Enclaves*. Manila; ADB. 2011. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Administration of Grant and Loan to Papua New Guinea for the Rural Primary Health Services Delivery Project*. Manila; ADB. 2016. *Technical Assistance to Papua New Guinea for Supporting Public Financial Management (Phase 3)*. Manila; ADB. 2014. *Technical Assistance for Mapping Resilience to Fragility and Conflict in Asia and the Pacific*. Manila; ADB. 2012. *Technical Assistance to Papua New Guinea for Supporting Public Financial Management (Phase 2)*. Manila; and ADB. 2015. *Health in Asia and the Pacific: A Focused Approach to Address the Health Needs of ADB Developing Member Countries—Operational Plan for Health, 2015–2020*. Manila.

12 Government of Papua New Guinea. 2010. *Papua New Guinea Development Strategic Plan, 2010–2030*. Port Moresby; and Government of Papua New Guinea. 2015. *Medium Term Development Plan II, 2016–2017*. Port Moresby.

fill the immediate gaps in essential health infrastructure, systems, and capacity that the ongoing Rural Primary Health Services Delivery Project (Rural Health Project) has identified.[13] Both components are mutually reinforcing: investments help operationalize reforms in the short term, while reforms maximize utilization and sustainability of investments in the medium and long term. Further, working with central agencies provides a unique opportunity for the health sector in PNG to address PFM challenges via a problem-driven approach.

9. ADB has been working closely with the International Monetary Fund (IMF), the World Bank, and the Government of Australia to support the PNG government in strengthening its macroeconomic policy and PFM. The support by the IMF and the World Bank for domestic resource mobilization and monetary and fiscal policy advice complements ADB's support. Australia provides support for expenditure and revenue reforms. The PFM working group and the quarterly meetings of the health development partners facilitate coordination, while the SDP's policy reform matrix adds value by helping prioritize and align assistance in fiscal policy, PFM, and health sector reform across development partners.[14]

B. Impact and Outcome

10. The impact of the SDP will be affordable, accessible, equitable, and high-quality health services for all citizens developed, in alignment with the vision of the NHP 2011–2020. The outcome will be a more sustainable and efficient health care system achieved.[15]

C. Outputs

11. The SDP will have three outputs, each of which will be achieved through an interconnected policy-based program and project investment supporting reform and investment from the national level through to the provincial and district levels. The scope of each is summarized below. The policy matrix is in Appendix 4. All 15 reform actions under subprogram 1 have been completed.

12. **Output 1: National frameworks and PFM enhanced.** Output 1 will support the long-term sustainability and effective use of health sector financing. Under subprogram 1, the policy actions address weaknesses identified in the PEFA assessment and will (i) ensure adequate domestic health financing within a sustainable overall resource envelope by approving the Medium Term Fiscal Strategy; (ii) approve an amendment to the Public Finances (Management) Act to expand coverage to statutory authorities such as PHAs; (iii) initiate procurement reforms; (iv) implement the integrated financial management system as the sole system for budgeting, accounting, and financial reporting of all public funds in 43 national government entities and five statutory authorities; and (v) prepare a health system governance discussion paper on the overarching regulatory frameworks for the health sector with recommendations for law reform.[16] Under subprograms 2 and 3, the government will continue to promote fiscal responsibility and safeguard health sector funding within the medium-term fiscal strategy and the national budget, implement budget reforms to improve fund flow monitoring, support the implementation of a new procurement act, and prepare a consolidated health services and administration law.

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[13] The project will finance phase 2 of the Rural Health Project (footnote 11).

[14] Development Coordination (accessible from the list of linked documents under Appendix 2). The World Bank is processing a development policy operation for late 2018 consideration by the ADB Board of Directors with a likely focus on revenue generation and PFM reform.

[15] The design and monitoring framework is in Appendix 1.

[16] Links between Public Financial Management Reform Priorities and the Sector Development Program (accessible from the list of linked documents under Appendix 2).

13. The project will support the government with the preparation of (i) health service delivery cost estimates, to safeguard adequate public resources for the health sector; and (ii) the next NHP (2021–2030), which will continue the systematic strengthening of the health sector.

14. **Output 2: Subnational health system management strengthened.** Output 2 will support decentralized health service delivery by focusing on capacity building of staff in management, PFM, and reporting; and contribute to the better alignment of functions, resources, and accountability.[17] Subprogram 1 policy actions will support the further rollout of the PHA model in one province and the direct transfer of consolidated health funding to PHAs. Subprograms 2 and 3 will (i) continue the rollout of PHAs, (ii) standardize and guide the management and responsibility of PHAs, and (iii) continue to support the direct and timely flow of finance from the national level to PHAs. Strengthened PHA capacity will enable better budgeting and stronger monitoring through midyear budget execution reports, in full compliance with PFM frameworks.

15. The project will support the implementation of the integrated public health model that links community health posts, health centers, and district hospitals; and provide consulting services to capacity build PHAs through the development of the PHA operations manual, to standardize service delivery, and a suite of development programs. These programs, including leadership and management courses, will target all PHA board members, executive district and middle managers, clinical staff, and corporate service analysts to raise their skills and improve the systems and processes of (i) corporate and clinical governance; (ii) leadership and management, including PFM; and (iii) effective use of integrated data in decision making, for better service delivery. PHAs' financial management systems will be strengthened, with an intention to integrate them into the national integrated financial management system. As a result, PHAs will be able to develop improved provincial and district health information profiles, corporate plans and comprehensive budgets, financial statements, and annual management and performance reports. A PHA monitoring framework will be supported at the Department of Health (DOH).

16. **Output 3: Health service delivery components strengthened.** Output 3 supports the effective delivery of quality health services by investing in NHP priorities for rehabilitating rural health care infrastructure, improving the availability of medical supplies, building capacity for clinical governance, supporting new health partnerships, and strengthening information systems through digitalization. Subprogram 1 policy actions will (i) refine the medical catalogue to facilitate procurement and inventory management, (ii) institutionalize the mSupply[18] tender management module, and (iii) update the database of active health partnerships. Subprograms 2 and 3 will continue to reform medical supplies and increasing the use of information systems to increase accountability and ultimately improve health service delivery.

17. The project reinforces policy actions by (i) strengthening the procurement and distribution of medicines providing benefits to the most remote parts of the country; (ii) developing health sector partnerships across PHAs, district development authorities, churches, and the private sector to ensure a comprehensive service delivery framework; (iii) rolling out the digital health information system nationally and using its data for decision making; and (iv) upgrading health facilities, which reflects the bulk of the project investment, including at least two district hospitals and six health centers in accordance with the National Health Service Standards, which will benefit more than 250,000 people living in these remote areas. Project activities to complement civil works will include (i) engaging with local communities and provincial and district authorities to support effective and sustainable transformational change in health awareness and health-

[17] Financing the Front Line (accessible from the list of linked documents under Appendix 2).

[18] mSupply is a digital logistics system implemented in PNG with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

seeking behaviors (e.g., immunization); (ii) training of maternal health workers in project facilities on essential obstetric care, integrated management of childhood illness, and safe birthing; and (ii) other priority clinical upskilling. The project will also support health facility management and maintenance training, and periodic assessment of project facilities to ensure that they continue to meet National Health Service Standards.

D. Development Financing Needs, and Investment and Financing Plans

18. The program considers the government's financing needs, the availability of alternative financing, including the estimated financial support from other development partners, and debt sustainability.[19] The IMF estimates that the government's net borrowing requirements between 2018 and 2020 amount to about $2.4 billion. The government has requested $300 million in financial assistance in the form of a programmatic approach, comprising three loans from ADB's ordinary capital resources of $100 million each for subprograms 1, 2, and 3, to help finance the program. The remaining gap will be filled mostly through concessional foreign borrowings, including budget support operations and project loans in the pipeline from other development partners. The policy-based loan will provide budget financing that enables the continuous funding of essential health and other basic services as well as priority activities outlined in the government's development policy letter (Appendix 3). The loan for subprogram 1 will have a 15-year term, including a grace period of 3 years, an annual interest rate determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility, a commitment charge of 0.15% per year, and such other terms and conditions set forth in the draft loan agreement. The loans for subprogram 2 and 3 are in the pipelines for 2019 and 2020, respectively.

19. The project investment is estimated to cost $104.5 million (Table 1). Detailed cost estimates are included in the project administration manual (PAM).[20]

Table 1: Project Investment Plan

Item		**Amount** ($ million)[a]
A.	**Base Cost**[b]	
	1. Output 1: National frameworks and public financial management enhanced	0.5
	2. Output 2: Subnational health system management strengthened	9.1
	3. Output 3: Health service delivery components strengthened	67.4
	4. Project monitoring and management	11.4
	Subtotal (A)	**88.4**
B.	**Contingencies**[c]	**7.8**
C.	**Financing Charges During Implementation**[d]	**8.3**
	Total (A+B+C)	**104.5**

[a] Includes taxes and duties of $6.42 million to be financed from Asian Development Bank loan resources. Such amount does not represent an excessive share of the project cost.
[b] In mid-2017 prices.
[c] Physical contingencies computed at 10.0% for civil works. Price contingencies computed at 6.5%: this includes provision for potential exchange rate fluctuation under the assumption of a purchasing power parity exchange rate.
[d] Includes interest and commitment charges. Interest during construction for the regular ordinary capital resources (OCR) loan has been computed at the 5-year forward London interbank offered rate (LIBOR) plus a spread of 0.5% and maturity premium of 0.1%. Commitment charges for the regular OCR loan are 0.15% per year to be charged on the undisbursed loan amount. Interest rate for the concessional OCR loan has been computed at 2.0% per year.
Source: Asian Development Bank estimates.

20. To help finance the project, the government has requested loans totaling $95.0 million from ADB's ordinary capital resources, consisting of (i) a regular loan of $45.1 million, which will

[19] International Monetary Fund Public Information Notice (accessible from the list of linked documents in Appendix 2) approved by the IMF in place of an assessment letter.
[20] Project Administration Manual (accessible from the list of linked documents in Appendix 2).

have a 25-year term, including a grace period of 5 years, an annual interest rate determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility, a commitment charge of 0.15% per year (the interest and other charges during construction to be capitalized in the loan), and such other terms and conditions set forth in the loan agreement. Based on the government's choice of the straight-line repayment option, the average maturity is 15.25 years, and the maturity premium payable to ADB is 0.10% per year; and (ii) a concessional loan of $49.9 million, which will have a 25-year term, including a grace period of 5 years, an interest rate of 2.0% per annum during the grace period and thereafter (the interest and other charges during construction to be capitalized in the loan), and such other terms and conditions set forth in the loan agreement. The financing plan is in Table 2.

Table 2: Financing Plan

Source	**Amount** ($ million)	**Share of Total** (%)
Sector development program		
Asian Development Bank		
Ordinary capital resources (program) (regular loans)	300.0	74.2
Ordinary capital resources (project) (regular loan)	45.1	11.1
Ordinary capital resources (project) (concessional loan)	49.9	12.3
Government of Papua New Guinea	9.5	2.3
Total	**404.5**	**100.0**
Subprogram 1 and project investment		
Asian Development Bank		
Ordinary capital resources (program) (regular loan)	100.0	48.9
Ordinary capital resources (project) (regular loan)	45.1	22.1
Ordinary capital resources (project) (concessional loan)	49.9	24.4
Government of Papua New Guinea	9.5	4.6
Total	**204.5**	**100.0**

Note: Percentages may not sum precisely because of rounding.
Source: Asian Development Bank estimates.

E. Implementation Arrangements

21. The implementation arrangements are summarized in Table 3 and described in detail in the PAM (footnote 20).

Table 3: Implementation Arrangements

Aspects	**Arrangements**		
Implementation period	For the project: June 2018–May 2025 For the programmatic approach (policy-based loans): Subprogram 1: January 2017–February 2018 Subprogram 2: January 2018–December 2018 Subprogram 3: January 2019–December 2019		
Estimated completion date	For the project: 30 May 2025 For the policy-based loan for subprogram 1: 31 Juy 2018		
Estimated loan closing date	For the project: 30 November 2025 For the policy-based loan for subprogram 1: 30 October 2018		
Management			
(i) Oversight body	Program steering committee: Secretary, Department of Treasury (chair) Secretaries of health, finance, and planning and monitoring (members)		
(ii) Executing agency	Department of Treasury		
(iii) Key implementing agencies	For the project: Department of Health For the policy-based loan: Department of Treasury, Department of Health, and Department of Finance		
(iv) Implementation unit	Project management unit under Department of Health, total of 10 staff (for the project)		
Procurement	International competitive bidding	1 contract	$2,650,000
	National competitive bidding	38 contracts	$52,630,000
	Shopping	9 contracts	$750,000

Aspects	Arrangements		
Consulting services	QCBS 90:10	283 person-months (5 contracts)	$9,360,000
	ICS	390 person-months (15 contracts)	$8,417,500
	SSS	482 person-months (12 contracts)	$6,335,097
Retroactive financing and/or advance contracting	The government has not requested approval of retroactive financing or advanced contracting.		
Disbursement[a]	The project loan proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) and detailed arrangements agreed upon between the government and ADB. The proceeds of the policy-based loan will be disbursed to the government in accordance with the provisions of *ADB's Loan Disbursement Handbook*. The proposed $100 million policy-based loan under subprogram 1 will be withdrawn once relevant conditions have been met by the government.		

ADB = Asian Development Bank, ICS = individual consultant selection, SSS = single-source selection, QCBS = quality- and cost-based selection.
Source: Asian Development Bank estimates.

22. As various project activities under the SDP will include a continuation of the Rural Health Project, the existing project management unit (PMU) established for the Rural Health Project at the DOH will continue with the implementation of the SDP project investment.[21] Over a period of 18 months, the PMU will have dual accountabilities as they simultaneously close the Rural Health Project and incrementally launch the SDP project investment, thus leveraging the institutional knowledge and established relationships. The DOH will extend the contracts of all PMU staff for the full duration of the SDP project investment through contract variations selected on Single Source Selection. During the overlapping period between the Rural Health Project and the SDP project investment, 80% of the value of the PMU staff contract will continue to be funded by the Rural Health Project and 20% will be funded under the SDP project investment. All consultants will be recruited following ADB's *Guidelines on the Use of Consultants* (2013, as amended from time to time).

III. DUE DILIGENCE

23. Through improved health system stewardship, better PFM, and evidence-based planning, the population of PNG (about 8 million) is expected to benefit from the SDP. Direct health facility upgrades will benefit at least 250,000 people.

A. Technical

24. The technical feasibility was found to be adequate after examination of the project's compatibility with local conditions in rural health. Facility design plans prepared under the Rural Health Project incorporate function, engineering, environmental, security, and economic aspects; and include infection and fire control, accident prevention, and access ramps. Resource-efficient measures, including solar panels, effective health care waste management systems, and rainwater capture, will be adopted. The digital health information system is endorsed by DOH as the national information system and will support real-time data collection and report generation.

B. Economic and Financial

25. **Economic analysis.** The majority of project resources will be allocated to upgrading health facilities. Quantified project benefits include (i) greater productivity with reduced incidence and severity of illnesses resulting in fewer lost days of work; (ii) productivity gains from reduced mortality, particularly among mothers and newborn infants; (iii) improved productivity with fewer

[21] The PMU is for the project only. The program steering committee will be responsible for implementation of the SDP.

work days lost to caring for sick relatives and attending funerals; (iv) household savings from lower travel costs; and (v) shorter waits for health services. The proposed project yields an economic internal rate of return of 10.1%, exceeding the economic opportunity cost of capital for social sector and poverty-targeting projects of 6.0%. The project is considered economically viable. Based on the total disability-adjusted life years lost to the leading childhood and maternal illnesses and infectious diseases, the economic losses in 2015 are estimated to be 9.6%–19.3% of gross national income, which can be interpreted as the upper limit of the impacts of the SDP through health gains.

26. The benefit–cost ratio for the combination of reform measures is estimate at 4.6:1.0. Sensitivity analysis results confirm that the economic viability is not particularly sensitive to unexpected cost escalations. Under stress scenarios regarding realization of quantified benefit streams, the economic viability is generally maintained. The main risk is a scenario where productivity gains are not realized from reducing illnesses following project implementation, a highly unlikely scenario. Efficiency gains from the combination of improvements to regulatory frameworks and systems, and capacity development supported by the project are expected to generate extra fiscal space, which in turn can be channeled toward more productive expenditure.

27. **Financial sustainability.** The financial analysis demonstrates that the government has the intention and potentially sufficient resources to meet the maintenance needs of at least eight upgraded health facilities in the future. Together with commitments to ring-fence funds from the Department of Treasury (DOT), the capability of provincial governments to maintain the sites and allocate financing for operations and maintenance are a determining factor in the finalization of facility locations.

C. Governance

28. The financial management assessment was conducted in accordance with ADB's guidelines and identified several financial management risks in staffing, information systems and funds flow. The overall inherent risk was assessed to be substantial, and project risks were also assessed to be substantial. Effective mitigation of these risks will be supported by continuing with the demonstrated structures established under the Rural Health Project.[22]

29. A project procurement risk assessment was undertaken revealing that DOH and provincial governments are capable of preparing and managing ADB-funded procurements. The larger and more complex procurement under the project will increase the number of procurements and contracts to be managed by the PMU, compared with the Rural Health Project. Adequate PMU staffing and the continuation of selected Rural Health Project PMU staff who have proven technical expertise and competencies in procurement will mitigate any risks stemming from this.

30. ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with DOT (the executing agency) and the implementing agencies. The policy requirements and supplementary measures are described in the PAM (footnote 20).

D. Poverty and Social

31. Health-seeking patterns are influenced by a variety of factors, including availability of medicines, distance to and cleanliness of health facilities. The expansion of rural health services under the project (with an estimated catchment of 250,000 persons) will support people-centered health services and improve access by reducing travel time and costs as well as the quality of

[22] Risk Assessment and Risk Management Plan (accessible from the list of linked documents in Appendix 2).

care, which is critical according to the conducted poverty and social assessment, whereby communities stressed the importance of proximity because of cultural and cost considerations. The upgrade of health facilities will also create 200 temporary jobs. Selection of health facilities to be upgraded will be on the basis of a transparent selection criteria to be defined by the Project Steering Group which will continue under the PMU (para 22).

32. **Gender.** Women and children typically access health services more than men. The project is categorized as effective gender mainstreaming. A gender action plan was prepared and agreed with the government.[23] Key gender features include establishing gender-friendly health facilities, upskilling the health workforce on reproductive health and maternal health, training in gender-based budgeting, and implementing sex-disaggregated reporting.

E. Safeguards

33. **Environment.** The project is *category B* for environment. An environmental assessment and review framework and initial environmental examination, including an environmental management plan (EMP), was prepared. The project will include small-scale physical works on existing health facility sites and is not anticipated to have significant or irreversible negative environmental impacts. The anticipated impacts and risks are localized, small-scale, and most will occur during the construction stage and can be readily mitigated with measures set out in the EMP. Some operational environmental impacts are anticipated, including solid and medical waste, wastewater, noise, fugitive dust, and occupational health and safety. These environmental impacts are anticipated to be minor and will be managed through the conventional operation and maintenance practices, health and safety codes, and health care waste management that are included in the EMP. The project will establish a grievance redress mechanism to resolve complaints or issues. The capacity of implementing agency will be built to carry out environmental safeguard and compliance measures, along with capacity to manage related risks and implementation of the environmental assessment and review framework.

34. **Involuntary resettlement.** The project is *category C* for involuntary resettlement. It is not expected to cause any physical or economic displacements as it will involve upgrades of existing health infrastructure on government-owned or church-leased land. A resettlement framework was prepared for unanticipated impacts, and due diligence for the first proposed subproject confirm that it is located on government-owned land and will not require land acquisition or resettlement. No involuntary resettlement impact is associated with the policy actions under the program. All key stakeholders were consulted and will continue to be consulted during implementation.

35. **Indigenous peoples.** The project is *category C* for indigenous peoples. It is not expected to impact any vulnerable group of indigenous peoples as defined by ADB's Safeguard Policy Statement (2009). The subprojects will not require an indigenous peoples plan, but will ensure that the local communities actively participate and receive culturally appropriate benefits. No indigenous people impacts are associated with the policy actions under the project.

F. Risks and Mitigating Measures

36. The overall risk is substantial, but manageable when applying the mitigating measures. Integrated benefits and impacts are expected to outweigh the costs. Major risks and mitigating measure are summarized in Table 4 and described in detail in the risk assessment and risk management plan (footnote 22).

[23] Gender Action Plan (accessible from the list of linked documents in Appendix 2).

Table 4: Summary of Risks and Mitigating Measures

Risks	Rating	Mitigating Measures
Macroeconomic	High	Policy reforms supported through the three subprograms will trigger the release of budget support funds that will help ease the foreign exchange imbalance.
Weak governance and sustainability of reforms	Substantial	DOT committed to ring-fencing resources for the health sector and improving sustainability of financing under the Medium Term Fiscal Strategy. Institutional and governance reforms will be accelerated through policy actions, and project training will clarify mandates and accountabilities, determine O&M requirements, and build capacity for asset management.
Weak PFM and insufficient resources for O&M	Substantial	Policy actions will contribute to allocative and technical efficiency, funds flow (including counterpart financing), and PFM improvements that will prioritize, channel and efficiently use resources for O&M at the PHA and facility levels.
Lack of transparency in procurement and operations, and weak accounting	Substantial	The PMU will assist DOH and the PHAs with procurement activities and ensure that evaluation committees adhere to the required standard. Continuity of consultants in the PMU (experts continuing on from RPHSDP) with demonstrated results in compliance with procurement processes and auditing will assist DOH and PHAs in maintaining a high degree of compliance and efficiency.

DOH = Department of Health, DOT = Department of Treasury, O&M = operation and maintenance, PHA = provincial health authority, PFM = public financial management, PMU = project management unit, RPHSDP = Rural Primary Health Services Delivery Project.
Source: Asian Development Bank.

IV. ASSURANCES

37. The government and DOT have assured ADB that implementation of the SDP shall conform to all applicable ADB policies, including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, and disbursement as described in detail in the PAM and loan documents. The government and DOT have agreed with ADB on certain covenants for the SDP, which are set forth in the loan agreements.

V. RECOMMENDATION

38. I am satisfied that the proposed loans would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve:

(i) the policy-based loan of $100,000,000 to Papua New Guinea for the Health Services Sector Development Program, from ADB's ordinary capital resources, in regular terms, with interest to be determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility; for a term of 15 years, including a grace period of 3 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft policy-based loan agreement presented to the Board;

(ii) the project loan of $45,100,000 to Papua New Guinea for the Health Services Sector Development Program, from ADB's ordinary capital resources, in regular terms, with interest to be determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility; for a term of 25 years, including a grace period of 5 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft project loan agreement presented to the Board; and

(iii) the project loan of $49,900,000 to Papua New Guinea for the Health Services Sector Development Program, from ADB's ordinary capital resources, in concessional terms, with an interest rate of 2.0% per year during the grace period and thereafter; and such other terms and conditions as are substantially in accordance with those set forth in the draft project loan agreement presented to the Board.

Takehiko Nakao
President

26 April 2018

DESIGN AND MONITORING FRAMEWORK

Impact the Program is Aligned with
Affordable, accessible, equitable, and high-quality health services for all citizens developed (National Health Plan 2011–2020)[a]

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
Outcome A more sustainable and efficient health care system achieved	By end 2024: a. Average annual provincial health expenditure as a proportion of estimated need increased to at least 80% for 2023–2024 (2013–2014 baseline: average of 53.5%) b. Proportion (%) of children under 1 year of age who have received three doses of DPT3-Hib-HepB vaccine increased to at least 80% in 2023–2024 (2015–2016 baseline: average of 49%) c. Proportion (%) of births attended by skilled personnel at health facilities increased to at least 50% in 2023–2024 (2015–2016 baseline: 38%) d. Average annual percentage of months that facilities do not have a shortage of any of eight essential supplies for more than 1 week in any month increased to at least 85% for 2022–2023 (2015–2016 baseline: average of 69%)[b]	a.–d. Annual DOH SPAR reports	Internal or external shocks undermine fiscal consolidation, the safeguarding of health spending, and policy reform efforts. Changes in priorities of government shift resources away from identified reform areas.
Outputs 1. National frameworks and PFM enhanced	**Program targets** Programmatic approach 1a. Acts and supporting regulations on PFM, procurement, and health brought up-to-date (2016 baseline: Public Finances [Management] Act, 1995 with amendments; Provincial Health Authority Act, 2007; Public Hospitals Act, 1994; National Health Administrations Act, 1997) Subprogram 1 1b. A medium-term fiscal strategy for 2018–2022 approved by cabinet and published (2016 baseline: not approved) **Project targets** 1c. National Health Plan 2021–2030 approved by DOH (2017 baseline: not approved)	1a. Acts published in the Papua New Guinea National Gazette 1b. Medium-term fiscal strategy 1c. National health plan	Changes in the administrative procedures and personnel leads to poor coordination between ministries
2. Subnational health system management strengthened	**Program targets** Programmatic approach 2a. PHAs established in 22 provinces by 2023 (2017 baseline: 11 PHAs)	2a. PHA establishment agreements	

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
	Subprogram 1 2b. 2018 national budget allocates health function grants under PHA votes (2017 baseline: not approved)	2b. 2018 national budget	
	2c. PHA boards include at least one woman from women's organizations or an organization with proven track record on gender work (Baseline: 11 PHAs; 20 when all PHAs implemented after June 2018)	2c. PHA establishment agreements	
	Project target 2d. At least 10 staff annually (5 men; 5 women) in each of the established PHAs with increased knowledge in budget preparation and monitoring, (2017 baseline: not applicable)	2d. Annual project reports	
3.Health service delivery components strengthened	**Program targets** Programmatic approach 3a. The percentage of project facilities requisitioning monthly from the area medical stores increased to at least 85% for 2022–2024 (2015–2016 baseline: 0%)	3a. DOH electronic health information system	
	Subprogram 1 3b. Revised medical catalogue published (2017 baseline: not published)	3b. Medical catalogue	
	3c. 100% of health partnerships and memorandums of understanding in effect as of November 2017, compiled at the national and subnational levels, by province and partner category, including which partnerships have a gender equity focus (2017 baseline: 80% of national partnerships make gender equity considerations)	3c. DOH SPAR reports, project reports	
	Project targets 3d. eNHIS implemented and sex-disaggregated data entered in all 89 districts (2017 baseline: eNHIS implemented and data entered in 18 districts in 5 provinces)	3d. Annual project reports	
	3e. At least two level 4 and six level 3 gender-sensitive health facility infrastructure upgrades completed and commissioned (2017 baseline: not applicable)[d]	3e. Annual project reports	
	3f. 100% of clinical health workers (both men and women) in project-upgraded facilities with increased knowledge in essential obstetric care training course (2017 baseline: not applicable)	3f. Annual project reports	

Key Activities and Milestones
Program
Not applicable

Project Management Activities
1. National frameworks and PFM enhanced (Q2 2018–Q4 2022)
1.1 Develop standard operating costs for health facility levels 2–4 based on National Health Service Standards (Q2 2018–Q2 2019).[d]
1.2 Support health institutional and legislative framework review and drafting processes (Q2 2018–Q4 2019).
1.3 Review progress against the objectives and strategies of the National Health Plan, 2011–2020, and support consultative development of a successor sector plan (Q1 2020–Q4 2020).
2. Subnational health system management strengthened (Q2 2018–Q4 2022)
2.1 Develop a model PHA manual, training approach, and course materials (Q2 2018–Q1 2019).
2.2 Build capacity for PHA and facility staff in integrated suite of training programs, including in governance and management; planning; and financial management, including gender-responsive budgeting, monitoring, and reporting (Q4 2018–Q4 2022).
2.3 Develop a PHA monitoring and support framework for DOH (Q3 2018–Q4 2019).
2.4 Build capacity of DOH staff in governance and management, and PHA monitoring and support (Q3 2018–Q4 2022).
2.5 Create provincial health information profiles (Q4 2019).
2.6 Facilitate PHA chief executive officers' annual meetings and national forum, bringing together PHAs and relevant central government departments in 2020 (Q1 2019–Q4 2022).
2.7 Assess and strengthen PHA financial management information systems (Q3 2018–Q4 2020).
3. Health service delivery components strengthened (Q2 2018–Q4 2024)
3.1 Strengthen medical supplies procurement arrangements and capacity (Q3 2018–Q4 2020).
3.2 Design and support implementation of provincial distribution solutions for drugs and other medical supplies (Q4 2018–Q4 2023).
3.3 Support partnership engagement between provinces and districts, and with nongovernment health sector partners (Q1 2019–Q4 2022).
3.4 Contract vendor and implement national eNHIS rollout, inclusive of training in effective use (Q4 2018–Q4 2021).
3.5 Prepare facility master plans for target provinces (Q3 2018–Q4 2019).
3.6 Award contracts for infrastructure upgrades and supervising construction (Q1 2019–Q4 2023).
3.7 Implement health awareness-raising strategy at civil works sites (Q4 2019–Q2 2024).
3.8 Train maternal health care workers in project facilities on essential obstetric care (Q4 2019–Q4 2023).
3.9 Support model referral guideline development and tailoring of guidelines to project provinces (Q2 2019–Q4 2020).

Inputs

Asian Development Bank

Program loans:	$100 million (regular loan) for subprogram 1
	$100 million (regular loan) for subprogram 2
	$100 million (regular loan) for subprogram 3
Project loans:	$45.1 million (regular loan)
	$49.9 million (concessional loan)

Government of Papua New Guinea

Project:	$9.5 million

Assumptions for Partner Financing
Not applicable

DOH = Department of Health, DPT3 = diphtheria-pertussis-tetanus vaccine, eNHIS = electronic national health information system, PFM = public financial management, PHA = provincial health authority, Q = quarter, SPAR = sector performance annual review.

[a] Government of Papua New Guinea. 2010. *National Health Plan 2011–2020: Transforming our Health System towards Health Vision 2050*. Port Moresby.

[b] Essential medical supplies comprise Depo-Provera injections (family planning), ergometrine (maternal health), measles vaccines, oral rehydration solutions (diarrheal disease), oxygen, amoxicillin tablets, artemisia combination, and baby books.

[c] The timelines for performance indicator targets are applicable to all three outputs.

[d] Health facility service levels refer to community health posts (level 2), health centers (level 3), and district hospitals (level 4).

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=51035-001-3

1. Program Loan Agreement: Ordinary Operations
2. Project Loan Agreement: Ordinary Operations
3. Project Loan Agreement: Ordinary Operations (Concessional)
4. Sector Assessment (Summary): Health
5. Project Administration Manual
6. Contribution to the ADB Results Framework
7. Development Coordination
8. Financial Analysis
9. Economic Analysis
10. Country Economic Indicators
11. International Monetary Fund Public Information Notice
12. Summary Poverty Reduction and Social Strategy
13. Gender Action Plan
14. Initial Environmental Examination
15. Environmental Assessment and Review Framework
16. Land Acquisition and Resettlement Framework
17. Indigenous Peoples Planning Framework
18. Risk Assessment and Risk Management Plan
19. List of Ineligible Items

Supplementary Documents

20. Sector Assessment (Summary): Public Sector Management
21. Financing the Front Line
22. Sector Development Program Impact Assessment
23. Links between Public Financial Management Reform Priorities and the Sector Development Program

DEVELOPMENT POLICY LETTER

INDEPENDENT STATE OF PAPUA NEW GUINEA

MINISTER FOR TREASURY

DEVELOPMENT POLICY LETTER

15th March 2018

Mr. Takehiko Nakao
President
Asian Development Bank
Philippines

Dear President Nakao,

Development Policy Letter – Papua New Guinea: Health Services Sector Development Program

This letter outlines the development priorities and major policies of the Government of Papua New Guinea. The Government is committed to continue critical reform initiatives to strengthen public financial management and Provincial Health Authorities for the improvement of health service delivery and the development of Papua New Guinea more broadly. This letter should be read in conjunction with the attached Policy Matrix in which we have identified the key initiatives for attention over three subprograms to be implemented between 2017–2020. These initiatives are crucial to create a sustainable system that will support ongoing health service delivery and we propose that their implementation be supported by a policy-based program as part of the wider Sector Development Program with three subprograms.

The proposed budget support of $100 million for subprogram 1 is complemented by an ambitious development expenditure program under the new government, initiated through the government budget and expected to continue in subsequent budgets over the medium term. Social sectors remain the spending priority of the new government. In a difficult time of fiscal consolidation, the Government protected the health budget from major cuts and prioritized selected critical service delivery components, including:

- A 6% increase in allocations for hospital management services from K484 million in 2016 (actual) and K483 million to K511 million in 2017;
- an increase of over 40% in the allocation for medical supplies and equipment from K181 million in 2016 (actual) and K176 million in 2017 (budget) to K248 million in 2018, including a new allocation of K21 million for life-saving malaria drugs and test kits, tuberculosis drugs, and vaccines;
- a new allocation of K28.5 million for the Cancer and Heart Institute to support the fight against non-communicable diseases;
- a new allocation of K50.0 million for district hospital redevelopment and improvements to strengthen health service delivery to the rural population; and
- full primary health service funding, including health function grants, through Provincial Health Authorities in ten provinces and set up grants for additional four Provincial Health Authorities that have been newly established.

At the same time, we are pursuing three complementary strategies that commence with the 2018 budget and will extent into the medium-term: (i) halt the declining revenue trend and lift collections onto a higher sustained rising trend over the medium term; (ii) reign back locked-in and less productive expenditure categories onto more sustainable paths to create space for a lift in more productive capital spending that will get the economy moving significantly forward again; and (iii) improve debt management and cost of financing, and correct the foreign exchange imbalance.

I therefore seek ADB's favorable consideration of Papua New Guinea's subprogram 1 loan for US$100 million. The Government has agreed to substantive policy actions in the policy matrix that need to be accomplished and commits to fulfilling the actions prior to the proposed ADB Board consideration in April 2018. The below table outlines the government priorities and how they map to the agreed policy actions in subprogram 1.

Government Reform Priorities	Policy Actions
Output 1: National frameworks and public financial management enhanced	
Upstream Public Financial Management (PFM) • PEFA road map • National Health Plan (NHP) Strategies 3.1.1 + 3.5.5 • Medium Term Development Plan 2	• Medium Term Fiscal Strategy prepared based on a deficit reduction plan • Budget allocations safeguarded for health • Release of the FY 2018 Budget estimate of Revenue and Expenditure using the International Monetary Fund's Government Finance Statistics Manual
Downstream PFM • PEFA road map • NHP Strategies 2.2.2 + 3.3.2	• Integrated Financial Management System implementation at national level • Public Finances (Management) Act amendment to extend and better define coverage • Procurement Bill development to address critical gaps in the legislative framework
Health sector NHP Strategies 3.5.6 + 3.5.8	• Health legal review discussion paper
Output 2: Subnational health system management strengthened	
PHA rollout NHP Strategy 1.1.7	• Establish additional Provincial Health Authorities (PHA)
Health funds flows NHP Strategies 1.1.3 + 3.1.3	• Increasing direct transfers to PHAs (including health function grants, hospital & HR allocations for primary health services) • At least one health expenditure review meeting held in 2017
Output 3: Health service delivery components strengthened	
Drug procurement and distribution NHP Strategies 1.1.2, 3.3.1 + 3.3.4	• Update medical catalogue • Review and update outstanding procurement orders • Full use of mSupply system for logistics management or drugs
Health partnerships NHP Strategies 2.1.1, 2.1.2 + 2.2.1	• Update partnerships database

I am confident that the Government's strong leadership and ownership of the reforms, supported by financial assistance from ADB, and effective development partner collaboration over the medium term, will result in the successful implementation of reforms to create long term fiscal sustainability and improved health service delivery for Papua New Guineans.

Yours sincerely,

Honorable CHARLES ABEL, MP
Deputy Prime Minister and Minister for Treasury

Date: 15th March 2018

POLICY MATRIX

Reform area	Subprogram 1	Subprogram 2	Subprogram 3
	Policy Actions	**Tentative Policy Actions**	**Tentative Policy Actions**
Reform Area 1: NATIONAL FRAMEWORKS AND PUBLIC FINANCIAL MANAGEMENT ENHANCED			
1.1 Fiscal framework and prioritization of aggregate budget allocations improved	1.1.1 Cabinet have approved and published the Medium Term Fiscal Strategy (MTFS) 2017-2021, as prepared and submitted by Department of Treasury (DOT) which: (i) targets a balanced budget based on a deficit reduction plan that aligns to the MTFS (2017-2021), and (ii) aligns budget allocations with agreed national and sectoral priorities.	1.1.1 DOT shall have maintained an updated MTFS that adheres to the identified targets.	1.1.1 DOT shall have maintained an updated MTFS that adheres to the identified targets.
	1.1.2 Parliament has approved budget allocation for FY2018, in line with the MTFS (2017-2021), to safeguard essential health service delivery and other priority sectors.	1.1.2 Parliament shall have approved budget allocation for FY2019, in line with the MTFS (2017-2021), to safeguard essential health service delivery and other priority sectors.	1.1.2 Parliament shall have approved budget allocation for FY2020, in line with the MTFS (2017-2021), to safeguard essential health service delivery and other priority sectors.
1.2 National Public Finance Management (PFM) regulatory framework, systems and processes improved	1.2.1 Parliament has: (i) approved an amendment to the Public Finance (Management) Act (PFM Act) that extends and defines the Act's coverage to public and statutory bodies (including Provincial Health Authorities [PHAs]), and (ii) loaded the PFM Act Amendment on its website.	1.2.1 Department of Finance (DOF) shall have: (i) reviewed the legal framework for public financial management (including the finance manual and instructions) to identify further gaps in the PFM Act in line with the Public Expenditure and Financial Accountability (PEFA) Road Map, 2015–2018; and (ii) prepared a list of reforms to the legal framework for public financial management. (ii) DOF shall have approved the list of reforms to the legal framework for public financial management.	1.2.1 DOF shall have implemented reforms to the legal framework for public financial management, as outlined in the review completed under subprogram 2.

Reform area	Subprogram 1	Subprogram 2	Subprogram 3
	Policy Actions	**Tentative Policy Actions**	**Tentative Policy Actions**
	1.2.2 DOT have released the FY2018 Budget Estimate of Revenue and Expenditure using the International Monetary Fund's Government Finance Statistics Manual (GFSM) 2014 as an update to the previously used GFSM 1986.	1.2.2 DOT shall have implemented improved budget processes through the use of GFSM 2014 in the budget FY2019, including: (i) restructured national budget formats that allow for tracking of allocations and in-year budget reporting by sector (e.g., using Classifications of the Functions of Government at the spending agency level, and program level for agencies that cover two or more functions); and (ii) systematic inclusion of key descriptive information at the program level (without expanding the length of budget documentation) and performance information by department/spending agency in the national budget.	1.2.2 DOT shall have continued to implement improved budget processes, classification and formats, including: (i) a better integrated budgeting process for recurrent and capital spending; and (ii) revised instructions for District Service Improvement Program (DSIP) and Province Service Improvement Program (PSIP) grants, which ensure alignment of investments with service plans of national and subnational sector agencies and allow tracking of funds by sector.
	1.2.3 DOF has fully implemented the new government Integrated Financial Management System (IFMS) as the sole system for budgeting, accounting and financial reporting of all public funds in 43 national government entities and 5 statutory authorities.		
1.3 National procurement reform	1.3.1 DOF shall have submitted to the National Executive Council (NEC) the proposed Procurement Policy, which addresses critical gaps in the legislative framework for procurement, including the establishment of an independent regulatory function and complaint redress mechanism.	1.3.1 DOF shall have approved an implementation plan for the Procurement Act.	1.3.1 DOF shall have completed the actions as outlined in the Procurement Act implementation plan approved under subprogram 2.
1.4 Health legal framework improved	1.4.1 Department of Health (DOH) has released a discussion paper to stakeholders which: (i) examines all health system laws and other laws affecting the health system,	1.4.1 DOH shall have: (i) endorsed actions arising from options in the discussion paper with clear delivery timelines and	1.4.1 DOH shall have: (i) drafted a consolidated and comprehensive health services and administration law, to replace the existing numerous health system laws, which provides for arrangements for health system design, functions and

Reform area	Subprogram 1 Policy Actions	Subprogram 2 Tentative Policy Actions	Subprogram 3 Tentative Policy Actions
	(ii) identifies issues for health system governance, and (iii) develops options on health system governance for the consideration of stakeholders.	(ii) submitted draft policy paper on health system governance and submitted to NEC for approval.	responsibilities of various stakeholders, funding, partnerships and administration, and (ii) submitted the draft law to Parliament.
Reform Area 2: SUBNATIONAL HEALTH SYSTEM MANAGEMENT STRENGTHENED			
2.1 Health institutional arrangements strengthened	2.1.1 DOH has established one PHA in 2017 with: (i) signed Provincial Health Partnership Agreement between DOH and the relevant provincial government, (ii) organizational structure approved by the Department of Personnel Management, and (iii) CEO and Board of Directors appointed. At least one Director of the Board of Directors shall be a woman.	2.1.1 DOH shall have: (i) ensured full compliance by all existing 11 PHAs (including the one established in 2017) with the signed Provincial Health Partnership Agreements, and (ii) established all additional 10 PHAs, for a total of 21, with signed Provincial Health Partnership Agreements, approved organizational structures, and functioning governance and management arrangements.	
		2.1.2 DOH shall have approved PHA regulations and model by-laws, and all existing 11 PHA Boards shall have endorsed them for use.	2.1.2 All PHA Boards, newly established under subprogram 2, shall have endorsed the PHA regulations and model by-laws for use.
		2.1.3 DOH shall have endorsed the PHA Manual, outlining guidelines for (including but not limited to) HR, Finance (including gender-responsive budgeting), Governance and Board procedures.	2.1.3 DOH shall have all new PHAs established under subprogram 2 endorse the use of the PHA Manual.
2.2 Health sector funds flows	2.2.1 Parliament has approved FY2018 budget, showing: (i) direct transfers to 10 PHAs that include provincial and district hospital funding; and	2.2.1 Parliament shall have approved FY2019 budget showing direct transfers to all existing PHAs including provincial and district hospital funding.	2.2.1 Parliament shall have approved FY2020 budget showing direct transfers to all existing PHAs including provincial and district hospital funding.

Reform area	Subprogram 1	Subprogram 2	Subprogram 3
	Policy Actions	**Tentative Policy Actions**	**Tentative Policy Actions**
	(ii) provision of set-up funding for additional 4 PHAs.		
		2.2.2 DOH will coordinate with PHAs to ensure that every PHA has separate line items in the PHA budget for FY2019 to cover basic maintenance on: (i) the provincial hospital, and (ii) the network of rural facilities included under the PHA.	2.2.3 DOH shall have monitored: (i) budgeting and actual expenditure for FY2020 against the health facility maintenance budget lines for each PHA to ensure adequate spending is allocated, and (ii) quality of health facility maintenance.
	2.2.3 NEC has approved the DOH submission for the direct transfers of Health Function Grants to PHAs.		
2.3 Health sector planning and budgeting		2.3.1 All established PHAs shall have prepared and published comprehensive plans and budgets with facility break downs for FY2019 that capture all resources (regardless of expenditure authority and funds flows) for subnational health service delivery, including DSIP and PSIP funding.	2.3.1 All established PHAs shall have prepared and published comprehensive plans and budgets with facility break downs for FY2020 that capture all resources (regardless of expenditure authority and funds flows) for subnational health service delivery, including DSIP and PSIP funding.
		2.4.1 DOH shall have monitored PHAs to ensure (i) mid-year budget execution reports for FY2018 have been prepared and submitted to DOT for at least 7 additional PHAs, and (ii) published the annual financial and performance reports for FY2017 for the same PHAs.	2.4.1 DOH shall have monitored PHAs to ensure (i) mid-year budget execution reports for FY2019 have been prepared and submitted to DOT for at least 10 additional PHAs, and (ii) published audited annual financial and performance reports for FY2018 for the same PHAs.
		2.4.2 DOT confirm submission of quality mid-year budget execution reports for FY2018 for at least 7 additional PHAs.	2.4.2 DOT confirm submission of quality mid-year budget execution reports for FY2019 for at least 10 additional PHAs.

Reform area	Subprogram 1	Subprogram 2	Subprogram 3
	Policy Actions	**Tentative Policy Actions**	**Tentative Policy Actions**
2.5 Health sector internal and external scrutiny	2.5.1 DOT has held at least one health expenditure review meeting in 2017.	2.5.1 DOT shall have: (i) held at least 1 health expenditure reviews in 2018 and published the review reports; (ii) submitted recommendations to the Secretary-level Central Agencies Coordinating Committee (CACC) and published minutes of the CACC meeting; and (iii) published decisions form CACC in the annual Budget Strategy Paper.	2.5.1 DOT shall have: (i) held at least 1 health expenditure reviews in 2019 and published the review reports; (ii) submitted recommendations to the Secretary-level CACC and published minutes of the CACC meeting; and (iii) published decisions form CACC in the annual Budget Strategy Paper.
			2.5.2 Auditor General's Office shall have: (i) audited, directly or through a contracting out arrangement, at least five PHAs that receive primary health and hospital service funds; and (ii) published the audit reports on its website.
Reform Area 3: HEALTH SERVICE DELIVERY COMPONENTS STRENGTHENED			
3.1 Medical supplies procurement and distribution efficiency improved		3.1.1 Cabinet shall have approved a plan for reform of medicine procurement and distribution.	3.1.1 DOH shall have implemented reform of medicine procurement and distribution as per the plan approved under subprogram 2.
	3.1.2 DOH has completed a review of current outstanding medicine and medical supply orders to determine the baseline of outstanding order volume and value, and has compared to the current requirements, with a view to retract redundant orders.		

Reform area	Subprogram 1	Subprogram 2	Subprogram 3
	Policy Actions	**Tentative Policy Actions**	**Tentative Policy Actions**
	3.1.3 DOH has approved a draft revised drug catalogue (Part 1) based on the World Health Organization's (WHO) essential medicines and packaging requirements and submitted it to the Pharmaceutical Advisory Committee for final approval.		
	3.1.4 DOH has mandated the use of the mSupply tender management module as a condition for all medicine procurement and payment, through the issue of an instruction to the Medical Supplies and Pharmaceuticals Branch.	3.1.4 DOH shall have included budget for ongoing maintenance and delivery of mSupply in the budget request for FY2019.	3.1.4 DOH shall have included budget for ongoing maintenance and delivery of mSupply in the budget request for FY2020.
		3.1.5 DOH shall have developed a strategy for the "pull system" for medical supplies, and have submitted the proposal to NEC for NEC's endorsement. The pull system for medical supplies shall include: (i) standard operating procedures; (ii) an implementation plan; and (iii) a capacity building plan across PHAs to ensure effective implementation.	3.1.5 DOH shall have implemented the pull system as per the implementation plan approved under subprogram 2.
3.2 Health partnerships	3.2.1 DOH has compiled a list of all Health Partnerships and MOUs in effect as of November 2017; at the national and sub-national levels; by province and partner category, indicating which partnerships have a gender equity focus.	3.2.1 DOH shall have implemented reporting systems and procedures for all partners covered under Heath Partnership Agreements and MOUs.	