



Initial Poverty and Social Assessment

Project Number: 39033
October 2005

ADF Grant-PNG:HIV/AIDS Prevention and Control in Rural Development Enclaves

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY (SPRSS)

A. Linkages to the Country Poverty Analysis

Is the sector identified as a national priority in country poverty analysis?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Is the sector identified as a national priority in country poverty partnership agreement?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Contribution of the sector or subsector to reduce poverty in Papua New Guinea:			
<p>The poverty situation in PNG is perceived to have dramatically increased in recent years. Although most of the poor live in rural areas, there are indications that poverty in urban areas has worsened due to growing rural to urban migration, which in turn was prompted by the poor delivery of basic social services and rising unemployment of school leavers in rural areas. The principal challenges for poverty reduction in PNG are the restoration of economic growth and the continued provision of basic services. These are in line with the priorities of the poor identified during the participatory assessment of hardship in 2001, namely access to jobs and income opportunities as well as improved service delivery and infrastructure.</p> <p>Over 30% of the population live in poverty, and government capacity to provide basic services is under great strain. Economic and social infrastructure is in disrepair, particularly for rural residents, denying them access to basic social and economic services. The national and provincial governments cannot meet the requirements of primary health care and other services, and the provincial system is being reformed to address this problem of service delivery. This has left the burden of rural health service provision largely to the churches, with limited but regular funding from government. Increasing unemployment and the stark absence of economic opportunities contribute to urban migration, squatter communities, and high levels of crime.</p> <p>Access to basic social services is poor. Health service performance is declining at all levels of service delivery. There is a growing loss of basic services infrastructure, particularly health aid-posts. Diseases control is inadequate, with low immunization coverage, increasing numbers of tuberculosis patients, and increasing HIV prevalence currently estimated at 1.6% among the 15 to 49 age group. The HIV/AIDS epidemic continues to grow unabated, with prevalence estimated at up to 4% in urban areas, and 1% in rural areas. The response to the HIV/AIDS epidemic has thus far been weak and ineffective, and unless the spread is controlled, there will be negative implications for economic growth and the fight against poverty.</p> <p>After making steady progress in improving the population's health status in the 1980s, Papua New Guineans have experienced an overall deterioration in their health status since the 1990s. Much of the decline is attributed to the dysfunctional health system, especially in rural areas and the district level. The rural health services were found to be in a state of "slow breakdown and collapse" in a 2001 review.¹ Hundreds of rural health facilities are either closed or not fully functioning. The district level health services are equally poor, with district health centers shut down or delivering extremely limited services at best. District level health facilities face extensive problems related to low capacities of health staff, limited training, a lack of supervision and support, inadequate equipment and supplies, and insufficient financial resources.</p> <p>The Project will assist in strengthening government leadership and the implementation of strategies to contain the spread of HIV among rural populations. The Project will extend support for a government leadership role to establish public-private partnerships with rural development enclaves focused on improving and extending health services to the surrounding communities of these development enclaves. Additionally, the Project will develop local civil society organizations' competency to work directly with affected communities to address issues related to the epidemic. In addition to the establishment of a national surveillance system covering all provinces, home-based care mechanisms will be developed as well as a condom social marketing program. By 2015 the project will have helped PNG control and by 2020 stabilize the spread of HIV/AIDS. Support of the health sector and the increasingly organized fight against HIV/AIDS are an integral part of the strategy to strengthen the delivery of basic services, especially to the rural poor.</p> <p>Achieving PNG's Medium-Term Development Strategy goal for controlling the spread of HIV/AIDS will require increased and sustained public investment in education and health. Levels of social indicators remain extremely poor, especially for women. Low life expectancy, high infant mortality, poor adult literacy, and low enrolment at all levels of education combine with low per capita income to make PNG's human development level the lowest of ADB's Pacific member countries.</p>			

¹ World Health Organization, *Western Pacific Country Health Information Profiles 2004 Revision*, WPRO: 2004.

B. Poverty Analysis

Targeting Classification: Targeted Intervention

What type of poverty analysis is needed?

Socio-economic conditions in PNG place its people in a vulnerable state and pose challenges to the government in meeting its commitment to the Millennium Development Goals. On a global scale, PNG ranks in the lowest one-third of all nations, and lowest among its Pacific neighbors, on the Human Development Index (HDI) [UNDP, 1999]. The country has a high fertility rate (4.8%) and a young population, with 42% under the age of 15. The infant mortality rate (82/1000 live births) and maternal mortality rate are among the highest in the world. Literacy is also very low, with only around 25% of the population being functionally literate [UNDP, 1999]. Around 85% of the population live in rural areas. The generally low status of women and the special health risk they face, as well as sexual violence, places them at a higher risk of HIV infection.

An estimated 40% of PNG's population now lives on less than \$1 a day, up from 25% in 1996.² Formal employment prospects are minimal in the current business environment—formal employment has risen by only 1.5% since 1996. The complex land tenure system and the low prospects for land reform offer few alternatives in the informal sector. The rising poverty rate is linked to high levels of crime and violence. General development continues to be hampered by the poor nationwide peace-and-order situation. The highlands region remains unstable, and security in urban areas appears to have worsened. In response to the worsening situation, the government has produced a national poverty reduction strategy, which has been used in the formulation of the Government's Medium-Term Development Strategy (MTDS), which has a strong poverty focus.

Indicators for the health-related Millennium Development Goals (MDGs) between 1990 and present demonstrate mixed results. Poverty has not been reduced over the past 10 years, and the national target for reduction between 1996 (baseline year) and 2015 is a modest 3% instead of the MDG target of 50%. The HIV prevalence rates in pregnant women and the general adult population have been growing at a considerable pace since HIV/AIDS was first discovered in PNG and show no signs of slowing down. The figure of infants with low birth weight from 1998-2003 was 11% of all births, and 35% of children under 5 were reportedly moderately or severely underweight in 1995-2003.³

Communicable diseases are the main cause of morbidity and mortality in PNG, and they account for approximately 50% of the country's mortality.⁴ The leading diseases have been pneumonia, hepatitis, malaria, diarrheal diseases, tuberculosis, and meningitis. Malaria and pneumonia combined account for one-third of all recorded deaths.⁵ However, HIV/AIDS is also one of the leading causes of hospitalization (and subsequently deaths), accounting for 60% of bed occupancy at Port Moresby General Hospital.

Socio-economic realities, behaviors molded by cultural and sexual practices, and the gender dimensions of the HIV/AIDS epidemic in PNG present ideal conditions for the rapid spread of HIV/AIDS and other sexually transmitted infections (STIs). This is already evident with the exponential growth of the epidemic over the last fifteen years. All sectors of society need to work together by taking positive steps in addressing the epidemic in the next five to ten years.

The goal of the grant is to assist the government of PNG in their fight against HIV/AIDS and their effort to meet the MTDS target for HIV/AIDS control. The grant will support the government to take the fight against HIV/AIDS to the rural population surrounding development enclave sites. Many of PNG's economic sectors typically comprise discreet rural enclaves which generate local employment and a cash economy in stark contrast to surrounding populations which rely on subsistence farming. These development enclaves foster the exchange of goods and cash for sex among the peripheral populations. High-risk sex behavior is characteristically associated with the surrounding populations of rural enclave development sites.

The poverty analysis will help to ensure that the investments are pro-poor, whereby the poor and disadvantaged groups benefit proportionately. The Project reduces vulnerability risks of the poor and disadvantaged groups from becoming further marginalized. The analysis should also include a needs assessment that identifies (i) the existing burden of disease of the poor and disadvantaged groups; (ii) possible strategies to optimize their use of services; and (iii) the current capacity of the health system to effectively address their health needs. The analysis should also examine partnership arrangements to enhance the sustainability of the regional delivery of basic health services.

² ADB, *Country Strategy and Program Update 2004-2006 Papua New Guinea*, January 2004.

³ UNICEF, http://www.unicef.org/infobycountry/papuang_statistics.html

⁴ WHO, CHIPS, 2004.

⁵ WHO, CHIPS, 2004.

C. Participation Process

Is there a stakeholder analysis? Yes No

A stakeholder analysis was conducted to identify key project stakeholders, their project-related interests, and the ways in which they affect or complement project feasibility and success. The Project design also linked with the mechanisms used for the Global Fund to Fight AIDS, Malaria and Tuberculosis (GFATM), which released the first tranche for HIV/AIDS in August 2005. ADB was recently included as a member of the GFATM Country Consultative Mechanism (CCM). Primary institutional stakeholders include the National Department of Health, the National AIDS Council, the Special Parliamentary Committee on HIV/AIDS Advocacy, churches, NGOs, private sector, and business associations involved in fighting HIV/AIDS. Other institutional stakeholders are the various development partners, such as AusAID, New Zealand AID, UNAIDS, UNDP, UNFPA, UNICEF, and World Health Organization. Primary non-institutional stakeholders include the poor, children, other vulnerable groups, and sex workers and their clients. The preparation of the Project involved an analysis of the community-based organizations involved in HIV/AIDS prevention and care, and the establishment of linkages with these organizations to ensure comprehensive community programs.

Is there a participation strategy? Yes No

A participation strategy is integrated into the overall project design. The Project entails various types of formal partnerships to ensure widespread participation. Several partnership agreements will be signed between the government and participating development enclave operators for primary health care and HIV/AIDS prevention and care. There will also be a formal agreement among the development partners for pooling funds for the social marketing of condoms.

D. Gender Development

Strategy to maximize impacts on women:

PNG is a diverse nation with many different cultures, languages, traditions, and sexual practices that expose women differentially to the risk of HIV infection. In many cultures, women form an underclass, with reduced access to food, cash, and other resources. Women's representation at all levels of the economy and government is very limited. The churches have played a significant role in social change in Papua New Guinea, reaching the remotest rural areas and providing almost 50% of health and educational services, but they usually encourage male dominance as a Christian value. Levels of domestic and sexual violence are high, with few services to address the needs of affected women.

While almost equal numbers of men and women are reported to have HIV in PNG, women are increasingly infected at a younger age. Women are disadvantaged by greater levels of illiteracy and lack of access to cash incomes. Because of the difficulties of economic survival, many women trade sex for money or other goods. In some circumstances, sexual transactions are brokered by male relatives, in traditional fashion, although more organized Asian-style prostitution has begun to be seen.

In rural areas, some women walk many hours to reach a government center where men with paychecks may pay for sex, in order to purchase used clothes for their children or pay school fees. Rural poverty in many areas is extreme and drives many women to migrate into cities or settle near economic enclaves where earning money may be possible. Stigma adheres to sex working women, and their social capital is reduced with families and communities. When these women develop AIDS, they are often abandoned by families. There are many other women who are essentially faithful wives but acquire infections from unfaithful husbands, yet it is they who are shut out from family support. In some cases, these women have been burned, neglected, and killed. In Port Moresby, their children are abandoned at the hospital in increasingly large numbers. Catholic and a few other faith-based agencies are working to reduce this impact at the village-level, but their services only reach a small proportion of those in need. Although a national media campaign has been carried out to reduce stigma associated with HIV/AIDS, there appears to be very little impact, particularly in rural areas.

In light of the current situation in PNG, the Project will deal with these issues directly as part of the enclave-oriented design. First, an assessment will be made to understand how women in the workplace, as well as those in settlements (in-migrants) and the surrounding villages are affected by the HIV epidemic. Second, specific activities will be developed to work with the economic operators, families, men, and women to reduce the differential impact on women and girls. The behavioral change strategies in the communities and in peer groups (e.g., sex workers) will benefit women and reduce their exposure to HIV by reducing high-risk behavior among women and their male partners. Also, the promotion of condom use and condom availability in rural areas will further protect women from the risk of HIV. Another set of activities in the Project that will benefit women is STI treatment. Greater accessibility to STI treatment services and drugs is an important aspect in HIV prevention. Men employed in the development enclaves are normally provided access to health services from the operator's clinic, but their family members are not always included. By expanding the private operators' health services to more people in the community and rehabilitating non-operational public health clinics in rural areas, far

more women will receive primary health care, STI treatment, and HIV care.

Has an output been prepared? Yes No

E. Social Safeguards and Other Social Risks

Item	Significant/ Not Significant/ None	Strategy to Address Issues	Plan Required
a. Resettlement	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None	The Project does not support any new civil works. Limited repairs and upgrading of existing health facilities will be supported. Land acquisition and resettlement is not expected.	<input type="checkbox"/> Full <input type="checkbox"/> Short <input checked="" type="checkbox"/> None
Affordability	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None	Issues pertaining to affordability are not expected to arise in the Project. The Project will improve quality and provide drugs and health services, thereby reducing health-related expenditures for the poor.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Labor	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None	Labor is not a potential issue. The Project is expected to slightly increase the number of health workers and train existing health workers in project-related activities.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Indigenous Peoples	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None	As PNG comprises predominantly indigenous peoples, an ethnic minority plan is not needed. The Project is not expected to have adverse effects on any particular group of indigenous people. Component 2 of the Project will design and manage culturally appropriate community-based sexual risk reduction behavior change programs tailored to local communities. Differences in cultural, traditional, and customary practices will be incorporated in the Project activities.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Other Risks and/or Vulnerabilities	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None	No other issues are expected.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No