



Report and Recommendation of the President to the Board of Directors

Project Number 39033
March 2006

Proposed Asian Development Fund Grant
Papua New Guinea: HIV/AIDS Prevention and
Control in Rural Development Enclaves Project

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 20 March 2006)

Currency Unit	–	kina (K)
K1.00	=	\$3.00
\$1.00	=	K0.33

ABBREVIATIONS

ADB	–	Asian Development Bank
ARV	–	antiretroviral
AusAID	–	Australian Agency for International Development
CCM	–	Country Coordinating Mechanism (of the Global Fund)
FBO	–	faith-based organization
Global Fund	–	Global Fund to Fight AIDS, Tuberculosis and Malaria
HSDP	–	Health Sector Development Program
HSIP	–	Health Sector Improvement Program
M&E	–	monitoring and evaluation
MOA	–	memorandum of agreement
MTDS	–	Medium-Term Development Strategy 2005–2010
NAC	–	National AIDS Council
NACS	–	National AIDS Council Secretariat
NDOH	–	National Department of Health
NGO	–	nongovernment organization
NHASP	–	National HIV/AIDS Support Project
NRI	–	National Research Institute
NSP	–	National Strategic Plan on HIV/AIDS 2004–2008
NZAID	–	New Zealand Agency for International Development
PMGH	–	Port Moresby General Hospital
PNG	–	Papua New Guinea
SOE	–	statement of expenditures
STI	–	sexually transmitted infection
SWAp	–	sector-wide approach
TA	–	technical assistance
TB	–	tuberculosis
UNAIDS	–	Joint United Nations Programme on HIV/AIDS
VCT	–	voluntary counseling and testing
WHO	–	World Health Organization

NOTES

- (i) The fiscal year (FY) of the Government of Papua New Guinea and its agencies ends on 31 December. In this report FY before a calendar year, e.g., “FY 2006”, denotes the fiscal year.
- (ii) In this report, "\$" refers to US dollars.

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GRANT AND PROJECT SUMMARY

Beneficiary	Papua New Guinea
Classification	Targeting classification: Targeted intervention Sector: Health, nutrition, and social protection Subsector: Health programs, health systems Themes: Inclusive social development, capacity development, and private sector development. Subthemes: Human development, public-private partnership
Environment Assessment	Environmental Category: C
Project Description	<p>The Project proposes to help strengthen government leadership and the implementation of strategies to contain the spread of HIV among rural populations. The Project has four basic components.</p> <p>Component 1 entails 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. Health services will include voluntary counseling and testing (VCT), treatment and care (for sexually transmitted infections and HIV/AIDS) as well as the full range of primary health care services. Component 1 will also support the rehabilitation of rural health infrastructure, medical staff training, and leadership development for HIV/AIDS advocacy.</p> <p>Component 2 will develop local civil society organizations' competency to work with affected communities to address issues related to the epidemic, leading to sustainable behavior change programs. The Project will also support nationwide social marketing of condoms, which will be specifically structured to the characteristics of each region.</p> <p>Component 3 involves strengthening and expanding the sentinel surveillance system covering high- and low-risk populations and settings. The surveillance system will produce regular updates and ensure broad dissemination of information. In addition to the sero-surveillance, the system will also include behavioral change surveillance.</p> <p>Component 4 entails project management, including project planning, coordination with partners, monitoring, and evaluation.</p>
Rationale	The Project is consistent with the Government's Medium-Term Development Strategy 2005–2010 (MTDS) and the National Strategic Plan for HIV/AIDS 2004–2008, and is informed by the Government's ongoing work on the Human Development Strategy. It is also supported by ADB's Papua New Guinea (PNG) country strategy program and update and ADB's commitment to

poverty reduction and achieving the millennium development goals, Asian Development Fund (ADF) grant financing is necessary to facilitate the Project's focus on developing public-private partnerships and on strengthening government leadership in the fight against HIV/AIDS at all levels and within all agencies.

Impact and Outcome

In line with the MTDS, the expected impact is to control the spread of HIV/AIDS infection by 2015 and stabilize it by 2020. The outcome will be strengthened efforts of the Government in developing comprehensive responses to the HIV/AIDS epidemic, with a focus on establishing operational partnerships and linkages to restructure rural health services associated with development enclaves.

Cost Estimates

Total cost for the Project is estimated to be \$25 million equivalent.¹

Financing Plan

ADB will provide a grant of \$15 million from the Special Funds resources of ADB.

(\$'000)

Sources	Foreign Exchange	Local Cost	Total	%
ADB Grant	8,549.5	6,450.5	15,000.0	60
Government of PNG	0	3,000.0	3,000.0	12
Government of Australia	986.9	2,513.1	3,500.0	14
Government of New Zealand	986.9	2,513.1	3,500.0	14
Total Cost to be Financed	10,523.3	14,476.7	25,000.0	100

ADB = Asian Development Bank, PNG = Papua New Guinea.

Source: Asian Development Bank estimates.

Grant Amount and Terms

It is proposed that a \$15 million grant be provided from the Special Funds resources of ADB (ADF IX Grants Program) with terms and conditions substantially in accordance with those set forth in the draft Grant Agreement presented to the Board.

Period of Utilization

Up to 31 July 2010

Estimated Project Completion Date

31 January 2010

Executing Agency

National Department of Health (NDOH)

¹ The project cost estimates and its presentation in the RRP were negotiated and finally agreed at grant negotiations with the Government prior to the issuance of the staff instructions on 'Cost Sharing and Eligibility of Expenditures for Asian Development Bank Financing'. Therefore, the table distinguishes between foreign and local cost.

Implementation Arrangements

The Project will be implemented under the umbrella of PNG's national sector-wide Health Sector Improvement Program (HSIP). NDOH, in its capacity as project Executing Agency, will house the project coordinator, who will work in close association with the HSIP in all matters of project administration, as well as with the Country Coordinating Mechanism (CCM) established by NDOH for the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund). The CCM will review progress and guide project implementation, ensuring management and resource efficiencies are achieved with the Global Fund.

Project implementation will be performed by NDOH; the National AIDS Council Secretariat (NACS); provincial and district health offices, hospitals, and health facilities; the National Research Institute, World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS), nongovernment organizations (NGOs), a not-for-profit social marketing company and a separate company for behavioral change, and participating economic operators in rural development enclaves.

At the request of the Government, Australian Agency for International Development (AusAID), and New Zealand Agency for International Development (NZAID), ADB will engage the consultants and administer the two consultancy contracts under component 2.

The economic operators will provide oversight and manage the partnerships with the public health facilities in their communities and provide health services to their employees and the surrounding communities. NGOs, community-based organizations (CBOs), and faith-based organizations (FBOs) will be trained to deliver HIV prevention activities, behavior change and communication, VCT, treatment, and care, including home-based care.

Procurement

Grant-financed civil works, goods and materials will be procured in accordance with ADB's *Guidelines for Procurement*.

Project civil works are small and limited to the repair and upgrade of existing facilities. No land acquisition will be necessary. All civil works will be awarded either through local competitive bidding or, where circumstances warrant, through the direct engagement of the economic operators in the selected rural development enclaves.

Goods or materials valued at \$1 million or more will be procured through international competitive bidding, and those valued at over \$100,000 and under \$1 million will use either international shopping or local competitive bidding.

Direct purchase/negotiation or single tender may be employed when buying small or off-the-shelf items valued at up to \$100,000.

All condoms and related supplies for the social marketing program will be procured by the contracted not-for-profit company.

Consulting Services

ADB's *Guidelines on the Use of Consultants* and other arrangements suitable to ADB will apply in the selection and engagement of the consultants.

Two international companies/NGOs will be engaged, one to design, train, supervise and monitor the behavior change programs (to be carried out through local NGOs/CBOs/FBOs and communities), and the other to design the plan for and conduct the social marketing of condoms. In both cases, ADB will take responsibility for the engagement and ADB's quality- and cost-based selection (QCBS) will be applied.

Individual international consultants will be engaged under the Project by NDOH for the following positions: (i) project coordinator, (ii) HIV sero-surveillance specialist/epidemiologist, (iii) behavioral surveillance specialist, and (iv) procurement specialist.

Individual domestic consultants will also be engaged by NDOH for the following positions: (i) project accountant, (ii) field supervisor, (iii) trainer supervisors for surveillance, (iv) statistician, (v) data entry clerks, and (vi) interviewers.

Project Benefits and Beneficiaries

Benefits will include a decreased burden of HIV, improved overall health status of people in participating rural development enclaves, and expanded primary health care and community-based activities in rural areas. Other benefits will be public and private savings in health expenditures, including indirect costs as a result of reduced morbidity from emerging and endemic diseases, and productivity gains from improved education, especially through less absenteeism and reduced dropout rates.

The Project is pro-poor in its focus on delivering and expanding primary health care services in rural areas. By increasing the means for reducing the risks of HIV infection among the highest risk groups, the Project will increase the likelihood that low income people reduce their own risks to infection. Generally, men, women, and children will benefit equally from greater access to health care, but in some project areas women and children will be the primary beneficiaries of more accessible health services.

Several activities of the Project consist of community-level interventions, such as targeted behavior change programming through capacity development of communities and local civil society organizations. Women, including sex workers, will be major beneficiaries of these community interventions.

The Project has been designed to maximize the potential for sustainability given the limited time of the grant and the need for greater Government commitment to the HIV response. Each memorandum of agreement between the Government and a private sector operator will be structured to encourage sustainable cooperation and help strengthen the commitment of each party. The competencies developed by NDOH will ensure the establishment of new (post-project) public-private partnerships in the Government's continued comprehensive response to the HIV epidemic. By establishing a consortium of development partners to cofinance and support an independent, professional not-for-profit company to establish and run the social marketing program, this essential HIV prevention intervention becomes a collaborative effort and less dependent on any single partner's decision to continue after 4 years or not.

Risks and Assumptions

The Project will strive to work within and strengthen HSIP systems, but an alternative mechanism may be needed if the HSIP becomes dysfunctional.

PNG's health system over the past several years has experienced a diminishing ability to provide services, especially at the community level, because of insufficient supplies, inadequate supervision, and large numbers of nonperforming health staff members on payroll. Extensive reform of the health system is needed but unlikely to occur soon.

A major concern is the Government's absorptive capacity for the large influx of funds from the Global Fund, ongoing AusAID support, and the proposed ADB grant. The amount of funds to be disbursed and the number of program and project activities under the health sector could pose significant challenges to the Government at all levels. Extensive consultations and coordination have been undertaken with the key supporters of HIV/AIDS activities in PNG to ensure synergies and working partnerships and to avoid duplication. No new institutional structures are required for the Project.

A worsening economic situation will drive more women into transactional sex and high-risk behavior. Risks and assumptions appear in the design and monitoring framework in Appendix 1.

Map

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on (i) a proposed grant to the Independent State of Papua New Guinea (PNG) for the HIV/AIDS Prevention and Control in Rural Development Enclaves Project (the Project); and (ii) the proposed administration by the Asian Development Bank (ADB) of cofinancing for the Project to be provided equally on a grant basis by the governments of Australia and New Zealand.

II. RATIONALE: SECTOR PERFORMANCE, PROBLEMS, AND OPPORTUNITIES

A. Performance Indicators and Analysis

1. Background

2. About 47,000 people in PNG were infected with the HIV virus as of mid-2004.¹ A generalized HIV epidemic is under way, with prevalence rates among 15–49-year-olds at 3–4% in Port Moresby, well over 2% in other urban areas, and over 1% in rural areas. The HIV epidemic in PNG is at an advanced and critical stage: infection patterns, such as 15–30% annual increases in infection rates, are similar to those of the early stages of HIV spread in sub-Saharan Africa.² One forecast estimates that PNG's workforce could be reduced by 34% by 2020.³ Containment of the epidemic requires an urgent and long-term response, and therefore the Government of PNG has requested ADB for a grant to establish a project that will develop public–private sector partnerships to prevent and control the spread of the disease in rural HIV/AIDS “hotspots” around the country. Many of these hotspots are associated with local centers of economic activity (also known as “development enclaves”), such as mines, plantations, logging sites, fisheries, and ports, and therefore a comprehensive response to the threat of HIV/AIDS must include the participation of the private sector.

3. PNG's Medium-Term Development Strategy 2005–2010 (MTDS) focuses on export-driven growth supported by good governance, rural development, poverty reduction, and human resource development. The sectors identified as having the greatest export potential include agriculture (cocoa, coffee, copra, oil palm, and spices), fisheries, forestry, manufacturing, mining and other nonrenewable resources (e.g., petroleum and other fuels), services, and tourism. Many of these economic sectors typically comprise discrete rural enclaves, which generate local jobs and a cash economy, in stark contrast to their surroundings, where people rely on subsistence farming. However, these enclaves also inadvertently foster the exchange of goods and cash for sex among the mostly impoverished peripheral populations. High-risk sex behavior is associated with the surrounding populations of rural enclave development sites because of increasing poverty, and the areas around the enclaves are becoming HIV/AIDS hotspots. Therefore, a comprehensive response to the threat of HIV/AIDS must include the participation of the private sector.

¹ The 2004 National Consensus Workshop estimated that 25,000–69,000 people were infected with HIV in PNG, and then used the median estimate of 47,000 as an official figure. National AIDS Council and National Department of Health. 2004. *The Report of the 2004 National Consensus Workshop of Papua New Guinea*. Port Moresby, Papua New Guinea.

² Morris, Alan, and Rob Stewart. 2005. *Papua New Guinea: Analytical Report for the White Paper on Australia's Aid Program*. Australian Agency for International Development. (September).

³ O'Keefe, Annmaree, John Godwin, and Rob Moodie. 2005. *HIV/AIDS in the Asia Pacific Region: Analytical Report for the White Paper on Australia's Aid Program*. Australian Agency for International Development. (October).

4. The MTDS acknowledges that the fight against HIV/AIDS is not just a health issue or the Government's sole responsibility. The HIV epidemic threatens the country's economic and social fabric. The National Department of Health (NDOH) has developed a policy on broad-based and inclusive partnerships covering public-private arrangements with economic operators, civil society organizations, and development partners in the delivery of health care services. NDOH is also implementing a sector-wide approach (SWAp) that brings together all stakeholders in health under the Government's National Health Plan. The National HIV/AIDS Council (NAC) has prepared the comprehensive National Strategic Plan on HIV/AIDS 2004-2008 (NSP). At the core of the HIV/AIDS Prevention and Control in Rural Development Enclaves Project, and consistent with NDOH and NSP priorities, is the development of functional partnerships between public and private sectors and development partners, each assuming responsibility for a role or task where a comparative advantage exists.⁴

2. HIV/AIDS Statistics and Situation

5. HIV in PNG was first confirmed in six cases in 1987, and AIDS was reported in 1988. Since the mid-1990s, the HIV epidemic has been growing rapidly. At the end of 2004, a national consensus workshop reviewed all data. The final estimates of people 15-49 years old living with HIV in mid-2004 ranged from 24,528 (low scenario) to 46,744 (medium scenario) to 68,966 (high scenario). The estimated prevalence was 0.9-2.5%, with a median of 1.7% among 15-49-year-olds. Including people below and above that age range, the medium estimate of infected people in mid-2004 was 80,000, with a prevalence of about 1.5% of the total population.

6. These estimates indicate that a generalized, sexually transmitted HIV epidemic is under way. The ratio of males to females has been almost equal from the earliest years of the epidemic, and recently rates have risen among younger women. The prevalence rates among 15-49-year-olds are at least 3-4% in Port Moresby, well over 2% in other urban areas, and over 1% in rural areas. Because 83% of the population is rural, about 66% of those living with HIV can be expected to be in the rural areas.

7. Estimations based on available data and the rapidly rising intake of AIDS patients at hospitals indicates that the situation is becoming dire. The true extent of the problem country-wide is difficult to gauge as surveillance systems are poor, not designed for public health interventions, and do not include at-risk groups. About 60% of all cases are detected in Port Moresby, where most HIV testing takes place. It is likely that traditional high-risk groups, such as sex workers and their main clients, and men who have sex with men have higher concentrations of infections than most other social groups. Sexually active young people in general and people working or living in and around development enclaves are particularly likely to have higher prevalence of HIV.

8. Thus far, PNG's overall response to the epidemic has been fragmented and uncoordinated. A review of the execution of the National HIV/AIDS Medium-Term Plan for 1998-2002, which encompassed a broad-based multisectoral approach, revealed little progress. A later attempt at developing a national strategic plan lacked prioritization and costing. The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) plans extensive treatment and testing but little in the way of evidence-based prevention programs. A new

⁴ Technical assistance (TA) worth \$175,000 was provided to develop the Project under TA 4583-PNG (ADB. 2005. *Technical Assistance to Papua New Guinea for the Preparation of HIV/AIDS Prevention and Control in Rural Development Enclaves Project*. Manila).

Australian Agency for International Development (AusAID) program is under development and is exploring new ways to address the problem.

9. It has long been recognized that mines, logging camps, fisheries plant, and other enclaves of economic production have high potential risk factors for HIV. HIV data from mines, as at Porgera and Ok Tedi, show increasing levels of infection in the workforce and surrounding communities. Out of 920 persons tested at Porgera Hospital in 2004, 7.7% were infected with HIV, and figures for 2005 (not yet complete) are expected to be even higher. Some of the mines have begun to respond but much more work is required. Particularly in the surrounding communities, denial, fear, and the widespread stigma associated with HIV continue to hamper prevention efforts.

10. All industries will need additional technical support to prevent HIV/AIDS. Logging companies, shipping and trucking companies, maritime industries, and others collectively represent a crucial axis of HIV spread. These and other economic enclaves, therefore, also represent a great opportunity for preventive interventions. Although home-based care, antiretroviral (ARV) treatment, and treatment for opportunistic infections such as tuberculosis (TB) are also greatly needed, effective prevention is of paramount importance.

3. Health Sector Financing, including HIV/AIDS

11. An important factor in the declining capacity of provincial and district governments to deliver quality health services has been the successive attempts at decentralization. Real expenditures on goods and services—critical for quality health care—decreased by almost 46% over 1997-2003. Real expenditures on recurrent capital items—crucial for maintaining equipment and capital stocks—have fallen nearly 90% to almost zero. However, real expenditures on staffing emoluments have increased 8% in real terms. By contrast, the total resources available for the response to HIV/AIDS are high in 2005 (well in excess of \$20 million; more than \$3.50 per capita). Less than 10% of this amount will come from the Government in 2005, with an anticipated reduction in funding over the next 5 years.

12. The total 2004 health expenditure of K475.3 million, not including that for HIV/AIDS, represented 11% of total government and development partner expenditure for the year. The Government's share of the total was 68.4%. Total health sector expenditure not including HIV/AIDS increased in nominal terms from K373.9 million in 2001 to K475.3 million in 2004, but in real terms decreased from K373.9 million in 2001 to K339.2 million in 2004. In real terms, expenditure declined from K69.8 per capita in 2001 to K58.6 in 2004.

13. Expenditure to fight HIV/AIDS is evolving. In 2002, about 90% of the about K40 million total expenditure on HIV/AIDS came from AusAID. The participating stakeholders in the prevention and control of HIV/AIDS have increased substantially in the past year. However, AusAID's relative weight is only just beginning to change. One of the new major additions of funding for HIV/AIDS is the Global Fund. The Agreement for HIV/AIDS, which was signed between the Global Fund and the Government on 30 June 2005, had a start date of 1 August 2005. The agreement provides for \$8.49 million to be released to NDOH, the principal recipient, over 2 years and managed through the Government's Health Sector Improvement Program (HSIP).

4. Development Partners and Assistance

14. PNG has attracted a variety of development partners concerned with HIV/AIDS.⁵ Resources available in 2005 for the fight against HIV, including the Global Fund, are about \$22 million, with less than 10% from the Government. AusAID has been the major contributor to HIV programs in PNG, and its focus has been the financing of the provincial AIDS committees, condoms, sexually transmitted disease training, voluntary counseling and treatment (VCT), surveillance, and high-risk settings. The other major donors include the European Union (a peer education project in high-risk settings), the British High Commission (working in East Sepik communities), United States Agency for International Development (USAID) (working with sex workers and men who have sex with men in selected locations), and recently, the People's Republic of China. The United Nations (UN) agencies, collectively coordinated by Joint United Nations Programme on HIV/AIDS (UNAIDS), have also contributed (see Appendix 2 on external assistance). The World Bank has invested in analytic work, and New Zealand Agency for International Development (NZAID) has begun to consider program investment.

15. Few international NGOs with strong professional reputations in the HIV/AIDS sector have been attracted to PNG. Donors usually implement their projects among communities through civil society organizations, which, with the exception of a few faith-based ones, are few, small, and struggling. Building local capacity to carry out various types of programs will require long-term, resident expertise; the transfer of knowledge and skills; and a high level of investment. Economic operators represent an untapped organizational unit capable of implementing HIV/AIDS programs with assistance. The demand from most of these economic operators for assistance is great.

B. Analysis of Key Problems, Lessons Learned, and Opportunities

1. Key Problems and Constraints

16. **Weak Governance.** Poor governance and inadequate public sector management are considered the main development problems in PNG.⁶ Redressing fiscal discipline is the most critical requirement, but there is little evidence of commitment to reform. These problems will continue to be addressed by the ongoing ADB-supported Financial Management Project and Public Service Program.

17. **High Levels of Associated Diseases.** The prevalence of sexually transmitted infections (STIs) is high in males and females, urban and rural (Supplementary Appendix 3). TB is also on the rise. Other countries' experience shows clearly that, as HIV infections increase, so do TB infections and deaths caused by TB/HIV co-infection. Hospitals in PNG are already reporting that the number of new TB patients is increasing. TB is now the main cause for admission in adult inpatient wards. National inpatient data for pulmonary TB from 1996 to 2000 showed a rise in registration of 21% (from 3,916 cases to 4,723) and in mortality. Therefore, any project on HIV/AIDS must also deal with primary health care issues as well.

18. **Growing At-Risk Groups.** The loss of traditional mechanisms of social control, in combination with the development of a cash economy and urbanization, has had an enormous impact on traditional sexual cultures. Today extramarital sex is common as is multi-partnered premarital sex, though no adequate survey research has measured the true levels of risk

⁵ See Appendix 2 for details on external assistance for HIV/AIDS in PNG.

⁶ ADB. 2004. *Country Strategy and Program Update (2004–2006): Papua New Guinea*. Manila.

behaviors. Sex workers in urban areas and urban-like enclaves represent the most at-risk group in the country. One study of rural and peri-urban women revealed that 55% of women stated they had at some time exchanged sex for money and/or goods, and 36% of men had paid for sex with cash. The clients of urban sex workers, who, in one study of Lae and Port Moresby, were most frequently businessmen, foreigners, police, miners, loggers, and security men, should also be considered at high risk. In addition to these groups of men, studies mention government workers, fishermen, sailors, and truckers.

19. Studies have shown that a large number of men (about 12% of rural or peri-urban men, according to one national study) at times have sex with men, with no implications for identity. Such men represent a large bridging population, having sex with both men and women.

20. The growing at-risk groups situation is further complicated by the near total absence of condoms in rural areas, where most people live and where most people infected with HIV are located. Moreover, general cultural reluctance to discuss sex and sexuality represents one of the most serious deficits in most AIDS educational efforts.

21. **Gender and Cultural Issues.** Gender and cultural, as well as institutional, issues also contribute to the epidemic. While religions and traditional cultures discourage extramarital sex, in many PNG cultures premarital sex has never been stringently prohibited, especially among males. Most development enclaves are staffed by a large majority of males. Their paydays attract many women willing to exchange sex for cash, and in some areas small brothels have emerged. In general, women are responsible for raising food for their families, and analysis of an earlier national nutrition survey showed that small cash incomes in the hands of women, rather than men, benefit children. The exchange of sex for material goods or services has traditional roots in some but not most areas, where it is clearly the lack of means to raise a cash income that motivates the rural sex trade.

22. **Challenges within the Health System.** Overall, PNG's health system is in a state of decline, with services becoming less accessible to rural people. Key health indicators such as immunization coverage and the ratio of doctors and nurses per 10,000 population are among the worst in the Pacific region (Supplementary Appendix 1). A functioning primary health care system no longer exists in much of the country. Specifically, the Government has not made substantial financial allocations to HIV/AIDS, leaving donors to determine the intensity and direction of the response. Technical capacity for HIV/AIDS work in all sectors is low, and prevention strategies over-emphasize awareness and knowledge for the general population in lieu of evidence-based targeted investments.

23. The HIV surveillance system is also problematic. Recent efforts have attempted to establish sentinel surveillance at antenatal clinics and STI clinics in 3–5 sites. However, the system has not been performing reliably and the data reflect unknown biases. Scanty supervision, a slow confirmation process and poor reporting have seriously hampered the effort. High-risk groups have not been included, and the surveillance has not evolved into second-generation mode, i.e., with the addition of at least one STI and properly sampled behavioral surveys.

2. Lessons Learned

24. **Donor Funding in the Health Sector.** Donors account for a vast share of the health sector's budget, and increasingly this funding is used for recurrent costs. However, much of donor financing of health is off budget and outside government systems, leading to a diverse

and fragmented health financing system.⁷ All sources of health financing clearly need to be integrated under the government systems to ensure a programmatic, rather than project-oriented, approach to health. The use of HSIP for this Project will help the Government plan and manage health funds and activities in more systematically.

25. Increased Coordination and Information Flows. Overall coordination and wider dissemination of information from various development partner-funded projects is needed for PNG's health sector. Health projects are often implemented in relative isolation from other, often complementary, projects. Many health projects report to their sponsor and government counterpart, but little of this information is distributed to other development partners and stakeholders. Donor coordination or harmonization is needed to combat the HIV epidemic and help the Government develop an integrated strategy.

26. Need for Greater Oversight and Transparency. A key lesson learned from the Establishment of Pilot HIV/AIDS Care Centers⁸ technical assistance (TA) is that greater oversight is needed for project implementation as well as regular reporting and improved transparency. For instance, drug stock-outs have been frequent in the HIV/AIDS care centers project because of weak management and insufficient inventory controls on drugs. Hence, the Project will develop direct links with these centers to facilitate improved supervision and management of their operations.

27. Condom Distribution Programs. Investment in effective modes of HIV prevention has been inadequate. The primary mode of transmission is through unsafe sex, indicating a great need for increased and improved condom use. In spite of previous efforts at social marketing to promote condom use and reduce the stigma of having HIV, condom use has not risen significantly. An earlier social marketing program started well with low-priced condoms, but later attempted to generate revenue by raising prices of condoms. Social marketing programs that aim to recoup costs have not been successful in PNG or elsewhere. The better programs depend on donor subsidies but use the full panoply of private sector marketing techniques, including extensive in-depth research repeated throughout the entire life of the project.

28. The current condom distribution effort by NAC secretariat (NACS) and AusAID's National HIV/AIDS Support Project (NHASP) has made progress mainly in selected urban areas and in terms of brand recognition, but the program's impact nationwide has been limited. First, the messages used do not reflect the totality and complexity of sexual behavior in PNG and the differences by region. Second, the entire campaign has been largely urban-biased (as has been the monitoring) and has had limited reach in rural areas, where most of the HIV is spreading. Third, the media campaign has not devoted sufficient attention to face-to-face contact with HIV-positive people, a technique that numerous studies have shown to be most effective.⁹

3. Opportunities

29. Developments in Health Institutions. Although many gaps remain in the national response to HIV/AIDS, there have been some positive developments. Recent government actions include the appointment of a new adviser to the Prime Minister on HIV/AIDS and placing

⁷ World Bank, AusAID, and ADB. July 2005. Health in Papua New Guinea: A Situation Assessment and Proposed Strategy. (Draft version 7); (For the Joint Human Development Strategy in PNG).

⁸ ADB. 2003. *Technical Assistance to Papua New Guinea for the Establishment of Pilot HIV/AIDS Care Centers*. Manila (TA 4208-PNG, approved 30 October for \$450,000).

⁹ Brown, L., K. Macintyre, and L. Trujillo. 2003. Interventions to Reduce HIV/AIDS Stigma: What Have We Learned? *AIDS Education and Prevention*. 15(1): 49-69.

the NAC under the Prime Minister's Department. With the successful application to the Global Fund, which is aimed primarily at developing ARV treatment programs, NDOH has become more involved than in the recent past. The Global Fund will enable NDOH to build up an HIV/AIDS unit consisting of several people compared to just one person before the grant was provided. Hence, the capacity for HIV/AIDS prevention and control within NDOH is expected to grow and support HIV/AIDS projects.

30. **Global Fund.** The Global Fund entered into an agreement on HIV/AIDS with the Government on 30 June 2005. The association with the Global Fund will strengthen the Government's response to the HIV epidemic. The Project will work closely with the Global Fund under the Country Coordination Mechanism (CCM), seeking synergies and undertaking complementary activities. The support from the Global Fund for ARVs and rapid HIV test kits will be critical inputs for the public-private partnerships for HIV/AIDS prevention and care in the development enclaves and surrounding communities. The partnerships established under the Project will simultaneously serve as highly needed outlets for distributing the Global Fund procurement items in rural areas. It will be critical, however, to ensure open and frequent communication and coordination among the various implementing agencies in the Project, for the Global Fund, and other major HIV/AIDS initiatives.

31. **Ongoing ADB-Assisted Initiatives and PNG Country Strategy Program and Update.** Under TA 4208 (footnote 8) a fully operational care center has been organized in the Port Moresby General Hospital (PMGH) providing treatment to about 150 patients as of July 2005. The clinic's establishment was a collaborative effort by NDOH, PMGH, World Health Organization (WHO), ADB, and AusAID. Care centers are programmed for urban government hospitals in Mount Hagen, Lae, and Rabaul, using the model and experience of the care center in PMGH. The Project will make use of these HIV/AIDS care centers in terms of referrals from the public-private partnerships and lower levels of public health facilities for advanced care of HIV/AIDS patients and HIV test confirmations.

32. **Partnerships with Private Sector.** The pre-fact-finding and fact-finding missions under the project preparatory TA revealed a high level of awareness in the private sector of the HIV/AIDS problem, its relationship with surrounding communities, and the need to embark immediately on HIV/AIDS prevention initiatives in and around the communities. Some of the larger economic operators provide varying degrees of health services to their staff and families, but many operators expressed their concern about how to tackle HIV/AIDS. The health services could be restructured to accommodate the peripheral populations and operate as a focal point for HIV/AIDS preventive services and initializing treatment and care for people living with HIV/AIDS. The public-private partnership will merge the Government's response to HIV/AIDS with the private sector's need to maintain a healthy, productive workforce and surrounding communities. Participation will be encouraged by the government but will be voluntary.

III. THE PROPOSED PROJECT

A. Impact and Outcome

33. In line with the MTDS and NSP, the expected impact will be "to have controlled by 2015, and stabilized by 2020, the spread of HIV/AIDS."¹⁰ The outcome will be strengthened by Government efforts to develop comprehensive responses to the HIV/AIDS epidemic, with a

¹⁰ The Government's version of the Millennium Development Goal 6, target 7, has been tailored to be more realistic for PNG and has been integrated into the MTDS.

focus on establishing operational partnerships and links to restructure rural health services associated with development enclaves.¹¹

34. Private sector health services provided by economic operators¹² to their staff and families will be restructured to accommodate the surrounding populations and will operate as a focal point for HIV/AIDS preventive services, VCT, and treatment and care. The public–private partnership will merge the Government’s response to HIV/AIDS with the private sector’s need to maintain a healthy, productive workforce and surrounding communities.

35. Integrating the fight against HIV/AIDS in other sectors in addition to health is a strategy that requires cooperation and partnership arrangements between key government agencies, private industry, development partners, and civil society organizations. Prevention will be the higher strategic priority. At the same time, core public health strategies will not be overshadowed by the HIV/AIDS response. Improved health services extended to surrounding populations will include maternal and child health services, immunization, malaria prevention, TB control, and health promotion.

B. Outputs

36. The Project proposes to help strengthen government leadership and the implementation of strategies to contain the spread of HIV/AIDS, with a focus on rural populations. The Project has four components, which were designed in close coordination with ongoing and planned HIV/AIDS initiatives under the Global Fund (through NDOH), NACS, and the main development partners active in PNG. Many of the components’ activities are consistent with or directly support the NSP 2004–2008.¹³ The four components are the following:

1. Component 1: Establish Public–Private Sector Partnerships in Rural Development Enclaves and Interagency Partnerships

37. Component 1 comprises four elements: (i) public–private partnerships with rural economic operators to extend and improve rural health service delivery and HIV prevention and care; (ii) rehabilitation of rural health infrastructure for primary health care and upgrading of facilities required for HIV prevention, testing, and care; (iii) collaboration with WHO, NDOH, NACS, and partners’ training and protocols; and (iv) development of leadership for HIV/AIDS advocacy.

a. Public–Private Partnerships with Rural Economic Operators

38. Primary health care, including maternal and child health, and HIV/AIDS prevention and treatment will be expanded in rural areas by establishing public–private partnerships in rural

¹¹ “Development enclave” refers to a particular area in a rural setting that has a significant private sector investment employing a large number of people, becomes a cash economy in a generally subsistence rural economy in the surrounding communities, and typically becomes the major (or only) economic driver in the area. One investment project may dominate an entire district or provincial economy, making it a hub of economic activity.

¹² “Economic operator” refers to the core private industry in the development enclave, usually a single dominant mining operation, plantation, fisheries plant, or other such project. The owner or company may have headquarters and other project sites elsewhere in PNG or overseas, and the activity in the enclave is often run by a subsidiary that has negotiated land-use rights and royalties agreements with the land-owning clan.

¹³ The NSP 2004–2008 contains seven focus areas: (i) treatment, counseling, and care and support; (ii) education and prevention through behavior change; (iii) epidemiology and surveillance; (iv) social and behavior change research; (v) leadership, partnership, and coordination; (vi) family and community support; and (vii) monitoring and evaluation.

development enclaves. The private operator will support the extension of health services beyond their immediate employees and their families to the communities surrounding the development enclave. The local public health facilities and aid posts, where functioning, will continue to provide health services to the wider population, but the private operator will provide additional management and supervision support to the community health facility to ensure more effective services. Where local public health facilities are not functioning around an enclave, the Government and private operator will work together in rehabilitating the facilities and staffing them with appropriate health personnel (provided by government). Public–private partnerships for primary health care and HIV/AIDS prevention and treatment will be launched in at least four rural development enclaves and expand to more sites later.

39. The Project will enhance the Government’s capacity to initiate such partnerships and offer a range of inputs that will be negotiated and tailored to each development enclave’s needs. Each enterprise and development enclave is unique, defined by the cultural setting of surrounding communities, the type of enterprise, and their ongoing interaction. Template memoranda of agreement (MOAs) will be designed under the Project and approved by CCM for (i) partnerships with private sector economic operators; and (ii) civil society organizations providing at least one of the following: VCT, care, treatment, and training. Other template MOAs may be prepared as the need arises.

b. Rural Health Infrastructure and Supplies

40. The partnerships will require strengthened health infrastructure in the rural areas. The Project will upgrade health facilities in the pilot areas by repairing clinics, partitioning off counseling rooms for the privacy of VCT, supplying additional medical equipment and supplies, and providing vehicles for community outreach and emergency transport. The Government will contribute its normal staff, supplies, and equipment, but also ensure that rapid HIV test kits, STI medicines, and ARV treatment from the Global Fund are provided to enclave clinics and surrounding health facilities.¹⁴

c. Collaboration with WHO, NDOH, NACS, and Partners’ Training and Protocols

41. The public-private partnership arrangements are designed to coordinate with WHO, NDOH, NACS, and other partners’ training of health care providers and the development of protocols for VCT, HIV-related laboratory activities, and treatment. WHO is funding and conducting these activities through a separate project, but the proposed Project is meant to complement WHO, NDOH, NACS, and other partners’ work on training and protocols by providing equipment, supplies, and facilities upgrading in participating enclaves.

d. Developing Leadership for HIV/AIDS Advocacy

42. An important dimension of public–private partnerships for HIV/AIDS prevention is strong leadership. The Project will provide additional financial support to UNAIDS (PNG Office) for its ongoing efforts to develop leadership in HIV/AIDS advocacy by working with national, provincial, and district leaders. UNAIDS will also promote the “three ones” among central, provincial, and district government agencies, and among all stakeholders. The Project will help UNAIDS engage in technical dialogue with churches.

¹⁴ ARVs will only be distributed to clinics in the development enclaves that have appropriately trained health staff.

2. Component 2: Community Behavior Change, and Social Marketing of Condoms

43. Component 2 entails two sets of activities: (i) developing the competency of community and civil society organizations to work to address issues related to the HIV epidemic that lead to sustainable behavior change, and (ii) the social marketing of condoms throughout the country.

a. Strengthening Civil Society Organizations to Engage in Community Behavior Change

44. The Project will strengthen local civil society organizations and local communities in and around selected development enclaves to undertake long-term behavior change strategies and monitor behavioral change. The strategies will engage communities and develop HIV prevention programs for the workforce, residents, and settlers to change norms and behaviors to reduce exposure to HIV infection. Target groups will include the workforce, women who sell or exchange sex, their main clients/partners, and high-risk youth in the economic enclave and/or surrounding communities. This component will complement the work of the provincial AIDS committees, the European Union Sexual Health Project, and NHASP.

45. The Project will build the capacity of local agencies: NGOs, community-based organizations (CBOs), faith-based organizations (FBOs), and groups formed within the workplace or villages, to understand and manage the threat of HIV/AIDS. Private sector companies, unions, self-help groups, and others will be engaged to learn the principles of behavior change and how to implement them in their own environments. Wherever possible, structural interventions will be encouraged to complement group and individual behavior change programming. The behavioral change strategies will be closely linked with the STI treatment, VCT, and HIV care activities in component 1, with equipment and training provided to the partners. A monitoring system will be developed so that feedback is readily available for analysis and for adjusting the strategies.

46. Each community-based sexual risk reduction behavior change program will be culturally appropriate and tailored to local communities. This will ensure that specific customary behaviors of indigenous groups in the target areas are respected and addressed appropriately.

47. An international NGO or company with diverse expertise in behavior change programming will be engaged to work with each development enclave and the local communities to develop and implement the targeted behavior change strategies. The contracted NGO or company will develop the capacities of economic operators and local groups in the following areas:

- (i) main methods of proven behavior change programming;
- (ii) formative qualitative research in the workplace and surrounding communities;
- (iii) size estimations of at-risk groups;
- (iv) baseline and repeat surveys (behavioral and biomarkers, if possible) after which the enclave may be included in the national surveillance system;
- (v) targeted peer outreach with supervision and support;
- (vi) provision of "safe space," e.g., a drop-in or resource center;
- (vii) materials/media production specific to local lifestyles and beliefs and developed by local people;
- (viii) training health workers on managing clients (attitudes);

- (ix) providing information on research findings from PNG and suggested from around the world to the local people involved in behavior change programs and others in PNG to correct misperceptions related to HIV prevention; and
- (x) designing training for all stakeholders, including representatives of at-risk groups.

b. Social Marketing of Condoms

48. Changing high-risk behavior requires that affordable, quality condoms be available nationwide (see Appendix 3). Pooled funds cofinanced by ADB and the governments of Australia and New Zealand will enable a sufficiently large investment to be made for contracting a professional not-for-profit company to engage in the social marketing and distribution of condoms for an initial 4 years. The social marketing of condoms under the Project will complement, not replace, existing condom supply mechanisms carried out by NDOH, NAC, and the NHASP, essentially scaling up the effort nationwide and complementing HIV awareness efforts.¹⁵

49. The objectives of a national social marketing program include the following:

- (i) expanded condom sales among the general population and priority target groups through innovative, research-based, and professional marketing strategies;
- (ii) improved supply and accessibility of low-priced, high-quality condoms in all parts of the country;
- (iii) more equitable distribution of affordable sexual health products to assure access for rural and low-income groups;
- (iv) improved levels of adoption of safer sex behaviors among all sectors of society; and
- (v) increased participation of the private sector and public-private partnerships at all levels for wider distribution of social marketing products.

50. The contracted not-for-profit social marketing company will conduct repeated surveys and other forms of research, including in-depth qualitative research and size estimations of at-risk groups, to understand the potential consumers' beliefs and preferences and coverage needs. An assessment will also be made of the existing condom distribution program for the "Karamap" brand, including the potential for integrating it into the national social marketing program. The not-for-profit company will then develop a marketing strategy based on the research for (i) the general population, emphasizing rural areas; and (ii) high-risk groups or settings in urban and rural areas. Targeted programs for sex workers, youth, and men who have sex with men will also be included within the range of market sub-segments. The not-for-profit company will develop an efficient, stable, and secure distribution system able to deliver products to urban and rural outlets. Traditional outlets (wholesalers, pharmacies, food stores, hotel shops) and nontraditional outlets (guest houses, small kiosks, night clubs, bars, markets) are expected to be targeted distribution points. Thousands of such distribution points are required.

51. All condoms and other commodities for the social marketing program will be procured solely by the not-for-profit company to maintain constant supply and ensure consistent quality. Monthly marketing statistics will also be retrieved from a country-wide monitoring system for the socially marketed condoms. The program will include measuring behavior, knowledge, and attitude changes in representative sentinel sites throughout the country. The not-for-profit

¹⁵ The social marketing will also consider the lessons learned from the existing condom distribution programs and may roll them into the Project later.

company will hire, train, and supervise its own staff members as local teams for the various activities.

3. Component 3: Strengthen and Expand Surveillance System for HIV

52. Support will be given to strengthen and expand PNG's current, but limited, sero-surveillance system for HIV/AIDS (see Appendix 4). The initial step will be to facilitate the move of the surveillance system from NACS to NDOH as already planned by NACS. This will include capacity building for NDOH to assume HIV/AIDS surveillance. An HIV/AIDS surveillance unit within the Disease Control Branch of NDOH will be established to focus on sero-surveillance. The Project will review the system and prepare and implement a comprehensive plan to expand it to cover in a phased manner all provincial hospital-based antenatal clinics, STI clinics and blood banks, selected district hospitals/health centers, and participating enclaves. The plan will consider how to collaborate with WHO's in-country health surveillance activities and international networks.

53. To operationalize the surveillance system at the facility level, project activities will include providing training and equipment to hospitals, health centers, blood banks, and enclaves to conduct HIV/AIDS surveillance and communicate information to the appropriate level of authority. Protocols and reference manuals will be developed under component 3 and provided to the participating health facilities.

54. Complementing the sero-surveillance to be performed by NDOH, the Project will help the National Research Institute (NRI) develop technical capabilities to conduct behavioral surveillance related to HIV and STIs. Consultants and field interviewers will work under NRI to conduct behavioral surveillance and institutionalize the capacity at NRI. The Project will provide equipment to NRI for behavioral surveillance surveys and related research. Surveillance by NRI will be closely coordinated with NDOH's forthcoming role in HIV surveillance and feed into NACS's overall monitoring and evaluation (M&E) system.

55. An additional activity under component 3 is to support the implementation of the National Strategic Plan for Monitoring and Evaluation, 2006–2010. The HIV/AIDS surveillance system is one of several important parts of the overall national HIV/AIDS M&E system planned by NACS, and the soon-to-be launched system is only partly funded by AusAID and UNAIDS.

4. Component 4: Project Management

56. The Project will provide the following support to strengthen project management and implementation: (i) coordination and management support, (ii) project performance M&E system, (iii) procurement support, (iv) field supervision, and (v) accounting support. Consultants will be engaged to provide these forms of support to NDOH and other involved government bodies (Appendix 5). The project coordinator's functions will include liaison with stakeholders; data and document collection; support of international and domestic consultants; provision of logistics support; assistance in organizing Project training or workshops; provision of necessary information needed by CCM to review progress and make recommendations; and project M&E.

57. A procurement specialist will assist the Government's Central Supply and Tenders Board and NDOH with all the necessary procurement items and procedures, except the tender and selection process for engaging a not-for-profit company to perform social marketing and the behavioral change firm required under component 2. A field supervisor will regularly follow up in project sites—the rural development enclaves and the surrounding communities—to assess

progress and implementation, identify problems in implementation, and provide reports to the stakeholders. An additional accountant will be placed in the HSIP management branch to assist in project accounting, disbursements, reconciliation, and other functions.

C. Special Features

58. ADB helped establish the framework and the financial arrangements for a health SWAp through the Health Sector Development Program (HSDP).¹⁶ From 1998 to 2001, HSDP promoted health sector reforms and linkages between NDOH and the provinces. HSDP also fostered stronger NDOH leadership and improved cooperation between development partners. Building on the success of these initiatives, the Government committed itself to the HSIP, a proposed SWAp in the health sector. Billed as the cornerstone in the reform process of the public health sector, HSIP has broad recognition and acceptance by key development partners. ADB's association with the development of the SWAp is equally recognized.

59. The Health Partnership Arrangement, in support of the Government's steps toward a SWAp in the health sector, was signed in November 2004 by the ministers of health, treasury, national planning, and rural development (for the Government), and by AusAID, NZAID, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and WHO. The document is not legally binding but rather embodies the aspirations of the DPs for greater harmonization and coordination in the sector. ADB plans to sign the document.

60. In line with ADB's intention to become a signatory to the Health Partnership Arrangement, the Project will support the health sector SWAp to strengthen government systems and to endow NDOH with the capacity to undertake and monitor public-private partnerships in the fight against HIV/AIDS. Supporting this long-term reform process will require concerted management efforts and some degree of flexibility from all participants.

61. The Project seeks to attain higher levels of coordination among government, private sector, development partners, NGOs, CBOs, FBOs, and the affected communities by emphasizing partnerships in the response to the HIV/AIDS epidemic. Government-private sector partnerships have worked successfully in many developing countries but have not been tried in PNG. Government agencies involved in HIV/AIDS have not coordinated well in the past, and the Project intends to help bridge this gap. The coordination of projects and specific activities of development partners, such as WHO's VCT training and protocol development in rural areas, will result in more efficient use of resources and synergies, in turn fostering greater harmonization of activities under a single, broad national framework for HIV/AIDS.

62. The Project will develop a special relationship with the Global Fund. First, the Project will support the development of CCM, which was established under the Global Fund to oversee the administration of funds and activities. In addition to capacity building for the planned CCM secretariat, the Project's activities give additional substance to CCM's oversight functions. Second, the public-private partnerships in the development enclaves will provide critical outlets for Global Fund ARVs and rapid HIV test kits in rural areas. Early on, the Government must find numerous qualified facilities in the Global Fund to disseminate the ARVs and test kits. By providing qualified outlets, the Project will enhance the Government's ability to distribute Global

¹⁶ ADB. 1997. *Report and Recommendation of the President to the Board of Directors on the Proposed Loan and Technical Assistance Grant to the Papua New Guinea for Health Sector Development Program*. Manila (Loans 1516/1517(SF) – program loans and 1518(SF) associated investment loan).

Fund resources, help ensure that the full amount of the grant is used, and increase the likelihood that additional rounds of support from the Global Fund can be obtained.

63. Government support for the social marketing of condoms program (component 2b) is strong, with the endorsement of a consortium of development partners to cofinance this long-term initiative. The consortium comprises ADB, Government, AusAID and NZAID, is non-exclusive, and may accept other cofinanciers at any time. This collaborative mechanism is designed to ensure stability and sustainability for as long as the epidemic persists. The Government has requested ADB to lead in engaging the not-for-profit social marketing firm and managing the contract to help insulate this critical public health intervention from influences outside best practices in public health. NZAID and AusAID have indicated their staunch support for ADB to undertake the contracting and administration of the social marketing firm contract. Recognizing the complementary objectives of the two subcomponents under component 2, Government has requested that the international NGO/consulting firm for behavior change also be engaged and administered by ADB.

D. Cost Estimates

64. Total project cost, including physical and price contingencies, taxes, and duties, is estimated to be \$25 million. About 42%, or \$10.5 million, of the project cost is in foreign exchange, and 58% (\$14.5 million equivalent) is in local currency (Table 1). Cost estimates by component and by financier appear in Appendix 6 and procurement packages are in Appendix 7.¹⁷

Table 1: Cost Estimates by Component
(\$ million)

Component	Foreign	Local	Total
A. Base Cost			
1. Public-private sector partnerships	2.60	3.00	5.60
2. Community behavior change and social marketing	4.24	7.19	11.42
3. Strengthen and expand surveillance	1.57	1.81	3.38
4. Project management	1.08	0.41	1.49
Subtotal (A)	9.48	12.40	21.89
B. Duties and Taxes			
Subtotal (B)	0.00	0.72	0.72
C. Contingencies			
Physical contingencies ^a	0.18	0.23	0.41
Price contingencies ^b	0.86	1.13	1.99
Subtotal (C)	1.04	1.36	2.40
Total	10.52	14.48	25.00

^a Five percent and 10% physical contingencies used for equipment/vehicles and civil works, respectively.

^b Based on the latest Asian Development Bank international and Papua New Guinea cost escalation data.

E. Financing Plan

65. ADB will provide a grant of \$15 million from the Asian Development Fund to help finance the Project. The Government's cost sharing, including cofinancing from other development partners, will cover the remaining \$10 million. The Government's direct contribution amounts to

¹⁷ The project cost estimates and its presentation in the RRP were negotiated and finally agreed at grant negotiations with the Government prior to the issuance of the staff instructions on 'Cost Sharing and Eligibility of Expenditures for Asian Development Bank Financing'. Therefore, the table distinguishes between foreign and local cost.

\$3 million equivalent, or 12% of total project cost. Cofinancing totaling \$7 million from the governments of Australia (\$3.5 million) and New Zealand (\$3.5 million) for the social marketing of condoms subcomponent will be provided on a grant basis and will be administered by ADB. In the event that further bilateral or other assistance materializes during project implementation, all parties have accepted that this could be used to offset the Government's direct counterpart funding obligations.

Table 2: Financing Plan
(\$'000)

Sources	Foreign Exchange	Local Cost	Total	Percentage
ADB Grant	8,549.5	6,450.5	15,000.0	60
Government of PNG	0.0	3,000.0	3,000.0	12
Government of Australia	986.9	2,513.1	3,500.0	14
Government of New Zealand	986.9	2,513.1	3,500.0	14
Total Cost to be Financed	10,523.3	14,476.7	25,000.0	100

ADB = Asian Development Bank, PNG = Papua New Guinea.

Source: ADB estimates.

F. Implementation Arrangements

1. Project Management

66. NDOH has a policy of harmonizing and integrating projects into regular services and not creating separate project management units. The Project will therefore be implemented under the umbrella of the HSIP, the national SWAp for health sector development. The HSIP systems were originally established in 1998 under the ADB-supported HSDP, and later extended to allow other development partners to include their funds in the SWAp.¹⁸ The HSIP (formerly HSDP) trust account has been a success since 1998. This secure channel of provincial health funding operates parallel to Government financial systems but follows nearly identical procedures, and is highly regarded by Government and development partners. The HSIP management branch manages funds from the Global Fund, AusAID, NZAID, and ADB. The HSIP was critical in securing Global Fund monies for malaria (round 2) and HIV/AIDS (round 4). NDOH manages the HSIP in partnership with development partners. Accounting is supported by an international accounting firm, reporting is monthly, and HSIP operations are subject to regular audits. It is increasingly owned by NDOH.

67. NDOH will be the project Executing Agency, and together with the project coordinator (an individual consultant based within NDOH) will work in close association with the HSIP in all matters of project administration, as well as with CCM. Exceptionally, so as not to overburden the NDOH and HSIP in an area where they lack expertise and experience, and in recognition of the special arrangement established by the consortium of development partners to cofinance and support the social marketing of condoms program, the Government has requested that ADB engage the consultant for the behavioral change and communication program and the social marketing of condoms program and administer both contracts under component 2. The Government has also requested that all reporting by contractors of ADB be provided to NDOH and CCM.

¹⁸ See Loan 1516-PNG/1517-PNG (SF) and the associated investment loan, Loan 1518-PNG(SF). ADB has funds in the HSIP trust account.

68. At the joint request of the Government, AusAID, and NZAID, ADB will engage the consultants and administer the consultancy services under the two consultancy contracts required for component 2. ADB will also institute all operational links between these two consultancy contracts. For the contracted companies, the framework of general terms and conditions contained in the TA framework agreement (6 May 1996) between the Government and ADB will apply.

69. CCM will review progress and guide project implementation, ensuring that management and resource efficiencies are achieved with the Global Fund. The secretary of health chairs CCM. ADB has been given an active seat on CCM. CCM meetings will be held at least quarterly. The Project will help support and develop the CCM secretariat. CCM has functioning technical working groups for HIV/AIDS, TB, and malaria. The group for HIV/AIDS will review and advise on the Project's technical aspects.

70. NDOH will review and be a signatory to partnership arrangements embodied in MOAs between the Government and (i) rural economic operators, (ii) civil society organizations, and (iii) any other related agencies, covering respective responsibilities in relation to project objectives and activities.

71. The Project will be implemented by NDOH, NACS, provincial and district health offices, hospitals and health facilities, NRI, WHO, UNAIDS, NGOs, a not-for-profit social marketing company, a firm for behavioral change, and participating economic operators (see implementation arrangements and structures in Appendix 8). NDOH will be responsible for implementing a comprehensive, nationwide HIV surveillance system. NACS will facilitate a seamless and timely transfer of existing data and files of the current HIV surveillance system to NDOH. NDOH and NACS will cooperate in the production and distribution of data and analytical information on the evolution of, and response to, the HIV/AIDS epidemic. Implementation of the national M&E system will be supported by the UN's joint program for an HIV/AIDS M&E enhancement support project. The Project will support and contribute to the implementation of the M&E system by working with this joint program. NRI's behavioral surveillance will also feed into the overall M&E system.

72. ADB will select the not-for-profit social marketing company in conformity with ADB's guidelines. The consultancy selection committee will evaluate the proposals using a quality- and cost-based selection method. ADB will transfer the installment payments directly to the contracted not-for-profit company upon clearance being given by its Pacific Regional Department.

73. The Project will develop the capacity of NDOH to negotiate with the participating economic operators to establish individual public-private partnerships. A template MOA will be used to define respective roles and responsibilities, inputs, and expected outputs. Subsidiary public-private relationships will also be included to capture the network of participants involved in the response to HIV/AIDS.

74. Under the MOA with selected rural economic operators, rural health facilities in communities around the development enclaves will be rehabilitated to provide primary health care services, including prevention of HIV, VCT, and care of people with HIV. The economic operators will provide oversight and manage the partnerships with the public health facilities in their communities and provide health services to their employees and the surrounding communities.

75. The Project will help NDOH support and/or contract selected NGOs, CBOs, and FBOs in delivering and/or training in HIV prevention, VCT, treatment and care, including home-based care. Evidence-based performance will guide the selection process of NGOs, CBOs, and FBOs engaged to assist NDOH.

76. In matters related to the development of counseling, testing, treatment, and care protocols, and adaptation for implementation in one or more PNG contexts, WHO will help NDOH establish standards to be applied under the Project. Similarly, in-service training programs of the above functions will be facilitated by WHO under the responsibility of NDOH. The Project will support and make use of NDOH–WHO competencies in VCT, treatment, and care training, including home-based care.

77. The Project will work with NDOH, WHO, and provincial hospitals to develop hospital referral centers patterned on the model established by the Heduru Clinic at PMGH. The Project will also help develop public–private partnerships between provincial hospitals and rural economic operators.

2. Implementation Period

78. The Project will be implemented over 4 years, and is expected to start in February 2006 and end in January 2010. The first 3 months will focus on fielding consultants and recruiting staff, reviewing baseline data for M&E, detailed project planning, engaging consultants for the social marketing and behavioral change subcomponents, and signing and activating MOAs between the Government and economic operators. The implementation schedule is in Appendix 9.

3. Procurement

79. Grant-financed civil works, goods and materials will be procured in accordance with ADB's *Guidelines for Procurement*. Project civil works are small and limited to the repair and upgrade of existing facilities, requiring no land acquisition. The small civil works are unlikely to attract foreign bidders, and therefore civil works will be awarded through local competitive bidding or, where circumstances warrant and for contracts valued at under \$100,000, through the direct selection of those economic operators participating in the Project. The Government will submit details of the number and scope of civil works for ADB approval before withdrawing funds for civil works expenditures.

80. Goods and materials valued at \$1 million or more will be procured through international competitive bidding, and those valued at over \$100,000 and under \$1 million will use international shopping or local competitive bidding. Direct procurement may be used when buying small off-the-shelf items valued at less than \$100,000.

4. Consulting Services

81. International and local consultants will be recruited, either as companies or as individuals, to implement certain aspects of the Project. The consultants will be engaged in accordance with ADB's *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB for the engagement of domestic consultants.

82. Individual international consultants will be engaged by NDOH for the following positions: (i) project coordinator, (ii) HIV sero-surveillance specialist/epidemiologist, (iii) behavioral

surveillance specialist, and (iv) procurement specialist. (See Appendix 9 for the number of person-months for each position.)

83. Individual domestic consultants will be engaged, also by NDOH, to fill the following positions: (i) project accountant; (ii) field supervisor; (iii) trainer supervisors for surveillance; (iv) statistician; (v) data entry clerks; and (vi) interviewers. (See Appendix 9 for the number of person-months for each position.)

84. Two international companies will be engaged by ADB under component 2. ADB will also administer both contracts. Under the first contract, a company will be engaged to design, train, supervise, and monitor the behavior change programs carried out through local NGOs, CBOs, FBOs, and communities. Under the second contract, a company will be engaged to design the plan for, and then conduct the social marketing of condoms. The condoms and related supplies for the social marketing program will be procured by the contracted company. Contenders for both contracts under component 2 are expected to include not-for-profit companies and international NGOs. These consultants will be recruited using ADB's quality- and cost-based selection method.

85. NDOH will ensure that qualified staff members are assigned to the Project, and any voids will be filled with additional qualified consultants.

5. Anticorruption Policy

86. ADB's anticorruption policy¹⁹ was explained to and discussed with the Government and NDOH. Consistent with its commitment to good governance, accountability, and transparency, ADB reserves the right to investigate, directly or through its agents, any alleged corrupt, fraudulent, collusive or coercive practices relating to the Project. To support these efforts, relevant provisions of ADB's anticorruption policy are included in the grant regulations and the bidding documents for the Project. In particular, all contracts financed by ADB in connection with the Project shall include provisions specifying the right of ADB to audit and examine the records and accounts of the NDOH and all contracts, suppliers, consultants, and other service providers as they relate to the Project.

6. Disbursement Arrangements

87. All funds originating from the cofinanciers, i.e., the governments of Australia and New Zealand, will be paid to ADB and will be used exclusively for meeting payments to the not-for-profit company engaged under component 2 (ii) for the social marketing of condoms. At the request of the Government of PNG, ADB will take responsibility for administering the funds provided by Australia and New Zealand, and for managing the social marketing contract.

88. All proceeds of the grant not required for component 2 of the Project may be disbursed through the imprest account, which may be pooled in the HSIP trust account, which operates under the oversight of the HSIP management branch. All proceeds of the grant thus deposited in the imprest account (within the HSIP trust account) shall be managed, replenished, and liquidated in accordance with ADB's *Loan Disbursement Handbook*²⁰ (January 2001), and detailed arrangements agreed on between the Government and ADB. The initial amount to be

¹⁹ ADB. 1998. *Anticorruption Policy: Description*. Manila.

²⁰ ADB. 2001. *AB's Loan Disbursement Handbook*. Manila

deposited into the HSIP trust account shall be based on the estimated expenditures for the first 6 months of project implementation, not exceeding the ceiling of \$1 million.

89. Using the funds deposited into the imprest account (within the HSIP trust account), the HSIP management branch will undertake procurement on behalf of NDOH, NACS, UNAIDS, qualified NGOs, FBOs, CBOs, participating private economic operators, and any other relevant parties based on arrangements under approved MOAs (see flow of funds in Appendix 10).

90. The imprest account is for the sole use of this Project. Since the imprest account is pooled within HSIP trust account, all funds through the imprest account need to be recorded separately, accounted for, and audited. NDOH, with the supervision of the department's external auditor, will submit to ADB the liquidation of all expenditures for the Imprest Account quarterly or more frequently, depending on the use of the funds. A statement of expenditures (SOE) and project financial report showing the source and use of funds, certified by the project director/manager or the representatives of the Project and endorsed by the external auditor shall be attached to the withdrawal application. Any amount not disbursed from the imprest account or any amount not disbursed for an eligible expenditure will be returned to ADB in the currency of the original payment (US dollars).

91. The EA, through the HSIP management branch director, will formulate expenditure estimates for each year of implementation based on project activities. The budgets will be reviewed and updated quarterly. All budgets will be reviewed and approved by CCM before implementation. In accordance with ADB's *Loan Disbursement Handbook* (January 2001), the SOE procedure will be used for reimbursing eligible expenditures and liquidating advances to the HSIP trust account to ensure speedy project implementation. The ceiling on SOE is \$100,000 per payment.

7. Accounting, Auditing, and Reporting

92. The Government will ensure that sound accounting and auditing standards according to internationally accepted practices are applied by NDOH and all other project implementing agencies. The HSIP trust account is subjected to rigorous annual audits by a professional auditing firm. These audit reports will be made available to the Government, ADB, CCM, NDOH, and all implementing agencies. Accounting will be carried out by HSIP management branch with guidance from the Department of Finance. Annual audits of all NDOH activity will be conducted by the auditor general or delegated to a professional auditing firm operating under the auspices of the auditor general.

93. The HSIP secretariat will submit the auditors' reports, copies of the certified accounts, and related financial statements, including auditors' opinions on the use of grant proceeds, compliance with grant covenants, and the SOE procedure to ADB within 6 months after the close of each fiscal year.

94. All implementing agencies will provide quarterly reports to NDOH. NDOH will then submit quarterly progress reports on project implementation to CCM, ADB, and other relevant stakeholders. The EA will prepare the reports and address necessary improvements for project activities and institutional development aspects of the Project. The quarterly progress reports will have information on the physical progress of activities, status of compliance with grant covenants, organizational and financial issues, the proposed program of activities, and expected progress in the next 3 months. The reports will be widely disseminated and shared with all stakeholders.

8. Project Performance Monitoring and Evaluation

95. Data will be collected to monitor progress in achieving the project objectives. Specifically, the EA and the project coordinator will jointly develop a project performance M&E system that will provide the Government, ADB, AusAID, and NZAID with information on (i) technical performance of the Project; (ii) measures of project impact, including social and economic benefits; and (iii) progress toward targets and goals identified in the project design and monitoring framework and the MTDS. Some baseline data already exist, such as the quarterly routine case reporting and periodic sentinel surveillance activities, the report of the 2004 National Consensus Workshop, AIDS indicator surveys, 2000 demographic and health survey, NHASP surveys and reports, reports from the four STI clinics (Mt. Hagen, Port Moresby, Goroka, and Lae), and others. When necessary, particularly in the enclaves and the surrounding communities, the Project will conduct baseline surveys within the first year of operations. The social marketing not-for-profit company will also conduct its own research to establish baselines and subsequent measures throughout the project. All reports will be submitted by the EA to CCM, ADB, AusAID, NZAID, and other key development partners throughout project implementation; these reports will include indicators of project completion, delivery, and benefits.

9. Project Review

96. CCM will include the Project in its own quarterly reviews. In addition, ADB and CCM (which includes Government representation) will jointly carry out project supervisory missions every 6 months. Before each visit, a progress report will be updated. ADB reviewers will examine records of M&E activities and meet with central and local governments, community leaders, and project beneficiaries. Two years after the Project starts, CCM will undertake a comprehensive midterm review to (i) examine the scope, design, implementation arrangements, and other relevant issues in light of the Government's development of HIV/AIDS strategies and policies; (ii) assess the Project's progress and achievement of the objectives; (iii) identify problems and constraints; and (iv) recommend any required modifications, restructuring, and reallocations. The Government will issue invitations to ADB, AusAID, and NZAID to participate in this midterm review.

IV. PROJECT BENEFITS, IMPACTS, ASSUMPTIONS, AND RISKS

A. Benefits and Impacts

97. **Project Benefits and Beneficiaries.** Improvements in labor quality and productivity resulting from decreased infectious diseases will lead to accelerated economic growth. The WHO Commission on Macroeconomics and Health 2001 suggested that "...investments in health should be a central part of an overall development and poverty reduction strategy," as each 10% improvement in life expectancy at birth is associated with an increase in economic growth of at least 0.3–0.4% per year. Hence, the project outcomes should be better general health status, reduced poverty because of higher economic growth, and progress toward achieving the HIV/AIDS-related millennium development goal (see Appendix 11).

98. The Project's economic benefits will come from (i) public and private savings in health expenditures, mainly from prevention of HIV and endemic diseases but also from early treatment of infections; (ii) productivity gains from an increased lifespan and reduced mortality; and (iii) productivity gains from improved education achievements, especially through less absenteeism and reduced dropout rates.

99. The Project aims to improve the health of the rural poor, focusing on primary health care and community-based HIV prevention. Low-income people are more likely to be exposed to higher risks of HIV infection for several reasons, mainly because they enter into sex work more often than higher-income people, incur STIs that are often left untreated, are more exposed to reused needles, and more often receive transfusions of untested blood. HIV-positive pregnant women have less access to services that prevent transmission to babies. By increasing the means available for reducing the risks of HIV infection among the highest-risk groups, the Project will increase the likelihood that low-income people will reduce their own risks for infection. While generally men, women, and children will benefit equally from greater access to health care, women and children will be major beneficiaries of these expanded services in enclaves that employ mostly men and do not provide health services to their families. Female sex workers in the communities will be a major target for behavior change programming, and they will receive greater access to STI treatment and condoms. Children will particularly benefit from expanded immunization services provided by either the enclave clinics or the restarted public health facilities. Even if households are not poor before a member contracts HIV, loss of employment and the high cost of treatment will push many deep into poverty.

100. **Sustainability.** The Project has been designed to maximize the potential for sustainability given the limited time of the grant and the need for greater Government commitment to the HIV response. Should the efficiencies of the cost-sharing arrangements and the assigned responsibilities under component 1 be respected, and the partnerships prove to be beneficial to all parties, they will more likely be sustainable. The partnerships intend to “formalize” this link between the Government and private sector at the community level, as they both have mutually reinforcing interests in preventing the spread of HIV. The MOAs between them will be structured to encourage sustainable cooperation and help strengthen the commitment of each party. Under component 2, the behavior change strategies linked to the public–private partnerships will be reviewed in terms of reduction in morbidity and mortality. The evaluation of the strategies will inform decisions to continue and expand this intervention.

101. Other measures incorporated to enhance sustainability include the following:

- (i) An effective social marketing of condoms program will be required for the duration of the epidemic (under component 2). By establishing a consortium of development partners to cofinance and support an independent, professional not-for-profit company to establish and run the social marketing program, this essential HIV prevention intervention becomes a collaborative effort and less dependent on any single partner’s decision to continue after 4 years or not. The relative levels of participation by Government and individual development partners may change over time, while the sustainability of the program is ensured.
- (ii) The social marketing of condoms program, supported by the Government, AusAID, NZAID, and ADB, is an opportunity to work together on a unified public health intervention supporting concerted and coordinated action. The consortium and cofinance modalities and arrangements should be examined during the midterm review to assess their long-term viability beyond the life of the Project. All cofinanciers should participate in the eventual restructure exercise to ensure the sustainability of the condom social marketing program and its transition to full Government ownership.
- (iii) Strengthening and expanding systems and participating sentinel sites comes under component 3. The long-term sustainability of the systems will require developing appropriately trained and committed NDOH and NRI counterpart

staff. While the initial costs to establish functioning systems are borne by the Project, the long-term supervisory and maintenance costs of the surveillance system are important and must be included in NDOH and NRI annual plans and recurrent budgets.

- (iv) Under component 4, the project coordinator, procurement specialist, field supervisor, and project accountant will work within the HSIP management branch where they will endeavor to strengthen the skills and competencies of government staff through association and participation in all activities. NDOH management will be similarly associated with all partnership negotiations and arrangements as well as in M&E. The competencies developed by NDOH will ensure the establishment of new (post-project) public-private partnerships in the Government's continued comprehensive response to the HIV epidemic.

102. **Social and Gender Analysis.** Gender issues loom large in the HIV situation. The social and economic status of women is very low, and poverty motivates many women to sell or exchange sex for cash and other goods or services. The epidemic has been rather evenly divided among males and females from its inception, but recently infections among females of the age group 15–25 have been rising disproportionately. The burden of caring for the sick and providing food for families falls heavily on women. A few organizations have been working to improve women's rights but little progress is evident.

103. **Environment.** The Project is categorized as "C" and should not have significant adverse environmental effects. In general, the Project will finance preventive medical activities and rapid blood testing, which leave limited by-products. The Government also has regulations on medical waste management. Project supervision will closely monitor the issue of medical wastes.

B. Risks

104. **Health Sector Improvement Program.** The Project will strive to work within and strengthen HSIP systems, but an alternative mechanism may be needed if the HSIP becomes dysfunctional.

105. **Commitment to Health Sector Reform.** PNG's health system over the past several years has become less and less able to provide services, especially at the community level, because of insufficient supplies, inadequate supervision, and large numbers of nonperforming health staff members on the payroll. Extensive reform of the health system is necessary but unlikely to occur soon. The new public–private partnership approach to be initiated under the Project is a new strategy for PNG to overcome the limitations of public health finance and nonperforming health staff members. The partnership approach must have full Government backing to ensure its success.

106. **Limited Absorptive Capacity.** A major concern is the Government's absorptive capacity for the large influx of funds from the Global Fund, ongoing AusAID support, and the proposed ADB Asian Development Fund grant. The amount of funds to be dispersed and the number of program and project activities under the health sector could pose significant challenges to the Government at all levels.

107. **Increasing Economic Hardship.** A worsening economic situation will drive more women into transactional sex and high-risk behavior. Behavioral change programming in communities and for targeted groups such as sex workers is expected to be effective in altering

high-risk behavior. Behavioral change will be reinforced by the widespread availability of condoms through the social marketing program.

V. ASSURANCES

A. Special Assurances

108. In addition to the standard assurances, the Government will give, or cause to be given, certain assurances for inclusion in the Grant Agreement. Among these will be the following:

- (i) **Annual national budgets.** The Government, through the Department of Treasury and Department of National Planning and Rural Development has ensured/will ensure that \$3.9 million (in kina equivalent), including its own counterpart funds, has appeared/will appear in the national budget for FY2006 as being allocated for the Project. The Government will take the required measures at the appropriate times to ensure that the Project's budget is taken into account in the Government's annual planning and budgeting process, and included in all national budgets through to and including FY2010.
- (ii) **HIV surveillance system and surveillance personnel.** The Government, through NDOH, will support and maintain at least the same number of surveillance sites and surveillance personnel as exist at the completion of the Project for a minimum of 4 years after the Project's completion.
- (iii) **Waiver of import duties and taxes.** The Government, through the Internal Revenue Commission, will ensure that all health hardware items (e.g., condoms and personal lubricants) for the Project's social marketing component are imported into PNG free of all taxes and duties, and released promptly to the consulting company engaged by ADB to administer this subcomponent.
- (iv) **Recurrent budget for HIV/AIDS prevention.** The Government will ensure that its recurrent allocation for HIV/AIDS prevention in its annual budget will increase by 20% year on year throughout the life of the Project.
- (v) **Project steering committee.** The CCM created for the Global Fund will constitute a steering committee for the Project. The Government will ensure that the CCM will at regular intervals review progress and guide implementation under the Project.
- (vi) **Hospital referral centers.** The Government will roll out three regional referral centers for STIs and HIV/AIDS at Mt. Hagen, Angau Memorial, and Nonga Base Hospitals, in addition to Heduru Clinic at PMGH.
- (vii) **Local health facilities and the private sector.** The Government will take all steps to ensure the smooth and timely delivery of all management and supervisory assistance pledged to local health facilities by economic operators in participating rural development enclaves pursuant to their respective MOAs with the Government.

Environmental considerations. The Government, through NDOH, will ensure that the rehabilitation and operation of all health facilities involved in the Project comply with all applicable laws and regulations of Papua New Guinea and ADB's environment policy.²¹

B. Condition for Grant Effectiveness

109. Grant effectiveness will be dependent upon ADB, AusAID, and NZAID reaching mutually satisfactory understandings with each other and with the Government with regard to the necessary cofinancing. The execution of a written agreement or agreements recording the agreed arrangements will be a condition for the effectiveness of the Grant Agreement.

VI. RECOMMENDATION

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

- (i) the grant not exceeding the equivalent of \$15,000,000 to the Independent State of Papua New Guinea, from the Asian Development Fund, for the HIV/AIDS Prevention and Control in Rural Development Enclaves Project, with terms and conditions as are substantially in accordance with those set forth in the draft Grant Agreement presented to the Board;
- (ii) the administration by ADB of a grant not exceeding the equivalent of \$3,500,000 to the Independent State of Papua New Guinea for the purpose of the social marketing of condoms subcomponent of the Project to be provided by the Government of Australia on a grant basis; and
- (iii) the administration by ADB of a grant not exceeding the equivalent of \$3,500,000 to the Independent State of Papua New Guinea for the purpose of the social marketing of condoms subcomponent of the Project to be provided by the Government of New Zealand on a grant basis.

Haruhiko Kuroda
President

28 March 2006

²¹ ADB. 2002. *Environment Policy*. Manila.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p>Impact To control by 2015 and stabilize by 2020 the spread of HIV infection</p>	<ul style="list-style-type: none"> Prevalence rate no longer increasing by 2020 	<ul style="list-style-type: none"> Annual health statistics reports HIV sentinel surveillance system Statistical surveys and qualitative surveys 	<p>Assumption</p> <ul style="list-style-type: none"> Effective collaboration of NDOH, NACS, UNAIDS, WHO, private sector, and other stakeholders under a common framework <p>Risks</p> <ul style="list-style-type: none"> Partnerships are not sustained beyond length of Project Government unable to absorb and properly manage growing level of funds for HIV/AIDS Loss of Global Fund for HIV/AIDS
<p>Outcome</p> <p>1. Strengthened government of PNG in responding to the HIV epidemic</p> <p>2. Community behavior change away from high numbers of concurrent partners and toward increased use of condoms</p>	<p>By 2011:</p> <ul style="list-style-type: none"> Increased government financial allocation to HIV/AIDS prevention by 20% year on year Condom use in the participating enclaves increases 50% over baseline (to be established) by end of project All health staff in participating enclaves pass accreditation for VCT and ARV services, including outreach 70% of rural health facilities in participating enclaves that were not functioning in 2005 now fully functional and providing comprehensive PHC 10% increase year on year in use of VCT services by rural populations in participating enclaves (compared to baseline year) The number of people appearing for sexually transmitted diseases at clinical facilities increased by 10% over previous year 	<ul style="list-style-type: none"> Government expenditures and budget data Project reports and field assessments Development partners' reports on HIV/AIDS Global Fund progress reports submitted by government or CCM Qualitative surveys in rural communities NACS M&E reports Final project evaluation 	<p>Assumptions</p> <ul style="list-style-type: none"> Condoms are widely available throughout the country Global Fund continues in PNG Policies are enabling and effectively implemented Collectively, with other donors and programs, 50-60% of people practicing high-risk sex are reached with adequate behavior change programs <p>Risks</p> <ul style="list-style-type: none"> 2007 elections distract attention from fighting HIV/AIDS Poverty continues to increase

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
	<ul style="list-style-type: none"> In participating economic enclaves and their surrounding populations, increased use of condoms by 20% and reduced proportion of people with concurrent partners by 10% over measured baseline by year 2; an additional 25% and 15%, respectively, by end of Project. 		
<p>Outputs</p> <p>1. Functioning public-private sector partnerships in rural development enclaves improving and extending health services.</p> <p>2. National social marketing of condoms program established, and behavior change programs established in partnership enclaves.</p> <p>3. Strengthened and expanded national sentinel surveillance system for HIV.</p> <p>4. Project management established within NDOH</p>	<ul style="list-style-type: none"> At least six public-private partnerships entered into At least two partnerships fully functioning within first year of Project Annual increase, by at least 10%, of surrounding community populations with adequate access to basic health services Behavior change programming activities in participating enclaves are established, supervised, and monitored within 6 months of signed MOA All enclaves are included in national social marketing scheme Selected sentinel sites reporting to national sentinel surveillance system within 2 years of Project start Other 3 regional STI/HIV/AIDS clinics reporting to NACS' monitoring system within 3 months of their startup 	<ul style="list-style-type: none"> Project reports and field assessments Baseline surveys Community health surveys Behavioral change surveys National HIV/AIDS surveillance system records 	<p>Assumptions</p> <ul style="list-style-type: none"> Private sector is willing to extend medical services to surrounding communities and to partner with local health facilities Behavioral change programming activities are acceptable to and undertaken with participating communities Other development partners contribute sufficient financial support for social marketing of condoms NDOH can provide sufficient new or existing staff for the HIV/AIDS surveillance unit <p>Risks</p> <ul style="list-style-type: none"> Government unwilling to allow private sector supervision and management of local public health facilities Government unable to provide adequate staff, medicines and supplies, and equipment to local public health facilities and provincial hospitals Global Fund ARVs and rapid HIV test kits do not reach enclaves and surrounding communities HSIP unable to disburse funds efficiently

Activities with Milestones	Inputs
<p>1. For Establishing Public-Private Partnerships in Rural Enclaves</p> <p>1.1 Design template MOA for public-private partnerships by March 2006</p> <p>1.2 Initially establish at least two public-private sector partnerships in rural development enclaves to expand PHC, including maternal and child health, and HIV/AIDS prevention and treatment by December 2006</p> <p>1.3 Rehabilitate rural health facilities for primary health care and upgrade and equip enclave health facilities for HIV prevention and care activities within 6 months of signed MOA</p> <p>1.4 Support WHO, NDOH, NACS, and their partners to train health care providers in rural development enclaves for VCT, HIV-related laboratory activities, and treatment; assess quarterly</p> <p>1.5 Support UNAIDS/UNDP to undertake HIV/AIDS advocacy skills for members of the Special Parliamentary Committee on HIV/AIDS Advocacy and other targeted leaders at all levels of government; assess on quarterly basis</p> <p>2. For Community Behavior Change and Social Marketing of Condoms</p> <p>2.1 Contract one international NGO or firm to work with each development enclave and local community-based NGOs/CBOs/FBOs to develop and implement the targeted behavioral change program strategies by April 2006</p> <p>2.2 Conduct baseline surveys within two months of signed MOA</p> <p>2.3 Initiate development of skills and techniques of NGOs/CBOs/FBOs to conduct long-term BCC and monitoring of behavioral change in targeted districts by September 2006</p> <p>2.4 Contract one international social marketing organization by March 2006</p> <p>3. For Strengthening and Expanding National HIV/AIDS Surveillance System</p> <p>3.1 Contracts for consultants executed by March 2006</p> <p>3.2 Complete transitional plan for moving system to NDOH and begin implementation</p> <p>3.3 Establish HIV/AIDS surveillance unit in NDOH, and behavioral surveillance unit in NRI by June 2006</p> <p>3.4 Complete expanded system design and begin implementation of surveillance system in phased manner</p> <p>3.5 Training of staff in facilities included in national HIV/AIDS surveillance system as facilities come online</p> <p>3.6 Equip facilities included in surveillance system and prepare protocols and reference manuals by December 2006</p> <p>4. Project Management</p> <p>4.1 Contract for project coordinator executed by March 2006</p> <p>4.2 CCM review meetings, ongoing</p> <p>4.3 Manage and coordinate Project activities, ongoing</p> <p>4.4 Manage relationships with cofinanciers, ongoing</p> <p>4.5 Monitor and evaluate project progress and outputs, quarterly</p> <p>4.6 Submission of reports</p>	<ul style="list-style-type: none"> • ADB \$15.0 million • Government of PNG \$3.0 million • Government of Australia \$3.5 million • Government of New Zealand \$3.5 million

ADB= Asian Development Bank, BCC= behavior change and communication, CBO= community-based organization, CCM= Country Coordinating Mechanism, FBO= faith-based organization, HIV/AIDS= human immunodeficiency virus/acquired immunodeficiency syndrome, MOA= memorandum of agreement, NDOH= National Department of Health, NACS= National AIDS Council Secretariat, NGO= nongovernment organization, NRI= National Research Institute, PHC= primary health care, PNG= Papua New Guinea, UNDP= United Nations Development Program, VCT= volunteer counseling and testing, WHO= World Health Organization.

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EXTERNAL ASSISTANCE FOR HIV/AIDS IN PAPUA NEW GUINEA

1. The total resources available in 2005 to combat the HIV epidemic are estimated to be about \$22 million.¹ Specific annual budgets for individual projects and investments are not available in some cases, but the following major external contributions give an indication of the current support:

- (i) Australian Agency for International Development (AusAID) is investing \$30 million for 2000–2005. These funds have been supporting implementation of the Medium-Term Plan 1997–2003 (MTP) and now the new National Strategic Plan 2004–2008 through the National HIV/AIDS Support Project (NHASP) in 20 provinces.
- (ii) ADB has contributed \$450,000 to fund a pilot project on treatment and care for HIV/AIDS.² ADB has also provided about \$1 million for HIV activities under Loan 1925.³
- (ii) The Global Fund approved in June 2005 a grant of \$8.49 million to PNG for 2 years for scaling up its HIV/AIDS prevention, care, and treatment. The grant became effective in August 2005. The first year of the grant Global Fund will disburse about \$4.1 million to National Department of Health through the Health Sector Improvement Program and over \$4.3 million the second year.
- (iii) United States Agency for International Development (USAID) channels support to Papua New Guinea through its Asia and the Near East Regional HIV/AIDS and Infectious Diseases Program, and the implementation is performed by the USAID-supported Family Health International. Its yearly budget is \$1 million.

2. The following table summarizes the various external agencies active in the fight against HIV/AIDS and their main programs:

Table A2: External Aid Programs to Fight HIV/AIDS

Name of Agency	Type of Agency	Main Programs
Global Fund	Multilateral	ARV program, VCT, youth
AusAID	Bilateral	NHASP supporting NACS, PACS, condom social marketing, surveillance, research and other activities; NHSSP – procurement and distribution of condoms, STI drugs, and clinic construction
USAID	Bilateral	Targeted intervention, sex workers, MSM, 2-3 cities, Save the Children/FHI
British Government Community Fund	Bilateral	Community mobilization, through NGOs, Madang, ESP, WHP
Asian Development Bank	Multilateral	HIV awareness for fisheries and new cannery installation, Wewak; purchase of limited amount of ARVs and Pilot HIV/AIDS Care Centers
European Union	Multilateral	Peer Education–High Risk groups: to reach 10,000 in 7 provinces (until 2007)

¹ Asian Development Bank estimate.

² ADB. 2003. *Technical Assistance to Papua New Guinea for the Establishment of Pilot HIV/AIDS Care Centers*. Manila. (TA 4208).

³ ADB. 2002. *Report and Recommendation of the President to the Board of Directors to the Papua New Guinea for Coastal Management and Development Project*. Manila (Loan 1925).

Name of Agency	Type of Agency	Main Programs
World Health Organization	Multilateral	Promotion of ART Health worker training-STIs
UNFPA	Multilateral	HIV prevention with 300 sex workers in Port Moresby through World Vision (finished) Reproductive health training Curriculum development UPNG sexual health; female condom promotion
UNDP	Multilateral	Advocacy and policy dialogue at the national level; work place support/legal rights for PLWHAs (ILO); integration of gender dimensions into HIV/AIDS programs (UNIFEM)
UNICEF	Multilateral	Support for PMTCT; Village leadership, Karkar, Trobriands (finished); School-based and out-of-school education; KAP studies, community needs assessment; Orphan studies, policies
UNAIDS	Multilateral	Support NSP, M&E training; Strengthening NGOs for ART; APLF workshop PLWHAs, health workers
International Federation of the Red Cross	International NGO	Training volunteers, AIDS awareness
APHEDA	Trade Unions	Strategic plan, union pilot projects
Catholic Agencies	Faith-based	Treatment, VCT and PMTCT at few selected sites; day care for orphans and street children, Port Moresby; counseling, Wewak, Mt. Hagen
Catholic Medical Mission Board	Faith-based	5 PMTCT centers, VCT, nevirapine, training
Caritas	Faith-based	Care centers
World Vision New Zealand	Faith-based	Home-based care
Anglicare	Faith-based	VCT with hospitals, PLWHA support; fund; youth awareness program, school, out-of-school, Port Moresby; Central; construction workers /AusAID roads & bridges; Business house awareness, Madang, Lae, Hagen, Port Moresby; peer education settlements, Port Moresby VCT care center opened 2004
HOPE YWCA	Faith-based	Community and school awareness, Port Moresby
ADRA	Faith-based	Awareness, Lae
Mines	Private Sector	Collaboration with PNGIMR-Porgera, Ok Tedi; peer education training by EU/NHASP

ADRA = Adventist Development and Relief Agency International, APHEDA = Union Aid Abroad APHEDA, the overseas humanitarian aid arm of the Australian Council of Trade Unions (ACTU), APLF = Asia Pacific Leadership Forum, ART = antiretroviral therapy, ARV = antiretroviral, ESP = East Sepik Province, EU = European Union, FHI = Family Health International, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, ILO = International Labor Organization, IMR = Institute for Medical Research, KAP = knowledge, attitude and practice, M&E = monitoring and evaluation, MSM = men who have sex with men, NACS = National AIDS Council Secretariat, NGO = non-government organization, NHASP = National HIV/AIDS Support Project, NHSSP = National Health Systems Strengthening Project, NSP = National Strategic Plan, PAC = provincial AIDS committee, PLWHA = people living with HIV/AIDS, PMTCT = Prevention of Mother to Child Transmission, PNG = Papua New Guinea, STI = sexually transmitted infection, UNDP = United Nations Development Programme, UNFPA = United Nations Population Fund, UNIFEM = United Nations Development Fund for Women, UPNG = University of Papua New Guinea, VCT = voluntary counseling and testing, WHP = Western Highlands Province, YWCA = Young Women's Christian Association.

Source: ADB Consultant.

3. While the list of agencies and their respective activities appears long and varied, most initiatives are small or have limited coverage except for those by AusAID, ADB, the Global Fund, and WHO. Moreover, there has been little coordination among external agencies. The Project strives to achieve greater harmonization with other development partners—AusAID and NZAID—through a cofinanced, nationwide social marketing of condoms program, while also coordinating activities and resource inputs from other major projects or programs such as the Global Fund and WHO’s health staff training and protocol development for HIV testing and treatment. Efforts have been made to bring together the Project, Global Fund (through NDOH), and WHO’s respective activities at the participating development enclaves to ensure efficient use of resources and harness comparative advantages (see model in Supplementary Appendix 3).

SOCIAL MARKETING OF CONDOMS FOR PAPUA NEW GUINEA

1. With a rapidly increasing HIV epidemic, Papua New Guinea (PNG) has inadequately invested in effective modes of prevention.¹ Despite over a decade of HIV control activities, prevalence continues to rise. Transmission through unsafe sex is the primary mode in PNG, indicating a great need of increased and improved condom use. In spite of a recent effort at social marketing for both condom use and reduction of stigma, condom use has not risen significantly and over half of all people surveyed in follow-up market surveys believe HIV-positive people “deserve what they get.” Churches and others continue to resist the use of condoms; accredited voluntary counseling and testing (VCT) centers can be found that refuse to promote or give out condoms even to positive persons married to negative spouses. This lack of support for condom promotion is evidence of the positioning of ideology over evidence-based public health strategies, a situation not restricted to PNG but one with dangerous consequences. Active education of stakeholders and the populace requires a major effort to counter such negative influences.

A. Why Social Marketing?

2. In a rigorous review of HIV/AIDS prevention strategies, the Cochrane Collaboration, a nonpartisan international organization that prepares and promotes scientific reviews of public health strategies, found that programs that included the distribution of male condoms for AIDS prevention were effective interventions in high-risk groups and the general population.²

3. The concept of social marketing was invented by a public health expert in India over 30 years ago and adapted by a person working for CARE in India. The first demonstration was with family planning commodities. It has evolved and grown, and now has several iterations. Social marketing of one or more branded condoms, carried out by professionals, has had remarkable success in many countries. Internationally successful social marketing companies work with the private sector and cooperate with government.

4. The main aim is to make a health product attractive and commonly used, just as a company might do with toothpaste. The aim is not to scare people into using the product, nor is it to moralize about their behavior; it is very simply driven by the aim to sell the product, with the knowledge that doing so, in the case of condoms, means providing protection against HIV and STIs for whole populations. For this reason, delivering condoms into every possible outlet in all urban and rural areas is extremely important as it helps to desensitize the product on a national basis.

5. Social marketing messages or packaging are not determined by bureaucrats or authorities. They are determined by the consumer through research, segmented into different markets, in order to follow the best practices of marketing in the private sector. These products are for sale in the formal and informal marketplace and have to compete with others in that market. The largest social marketing companies have managed to be successful even in Catholic and Islamic countries where objections have been loud and vocal. The best social marketing companies find ways to manage their relationships with government and other stakeholders to enable the success of a product.

¹ A full version of this appendix is in the supplementary appendixes, which are available upon request.

² The Cochrane Collaborative Review Group on HIV Infection and AIDS. 2004. *Evidence Assessment: Strategies for HIV/AIDS Prevention, Treatment and Care*. (January).

6. Over time, in most countries, condom promotion leads to significant levels of condom use, often beginning with the most at-risk groups. In less at-risk groups, both partner reduction and condom use contribute to a significant reduction in risk.

B. Lessons Learned

7. Condom use, in conjunction with the reduction of partners, has repeatedly been shown to have significant impact on generalized HIV epidemics. Various mechanisms have been tried for the distribution and sale of condoms to increase use, and gradually key lessons learned from around the world and in PNG have been accumulated.

8. The purchase of condoms at low, subsidized prices is more effective and more sustainable than free distribution. When people purchase condoms at easily accessible and convenient locations, their use is more likely than when they are distributed free. This has been shown in a national study in Cameroon that examined the issue and found that free condoms were easier to access for those who never had tried condoms before, but socially marketed low-price condoms were preferred by all others and was associated with greater actual use.³ In PNG, free public sector condoms are often not distributed at all and sit on shelves until they expire.

9. For a large social marketing program to be successful, government must be fully committed and supportive. Greater understanding of the nonprofit nature of this type of effort must be assured. Funding mechanisms must be simplified and smooth, with no chance of delays that will interrupt activities or supplies. Condom and other commodities must be purchased by the social marketing company in order to maintain control of supply and quality. And there must be long-term commitment.

10. Resistance to the promotion of condoms among village leaders and church spokesmen is widespread. The alternative they offer, abstinence, has not been shown to be a preferred or statistically effective strategy.⁴ Also, there are no studies or other evidence to support the ideologically motivated assertion that condoms promote promiscuity. A recent review of the research in condom distribution, condom promotion, and sexual health education interventions and their effects on sexual behavior by Christian Aid, the official relief and development agency of 40 British and Irish church denominations, found ample evidence that these interventions do “not hasten sexual debut or increase the number of sexual partners” and that “used correctly, condoms are effective in preventing HIV infection among young people who are sexually active.”⁵

11. Another lesson learned is that social marketing programs that aim to recoup costs have a record of failure, including an earlier project run by the Futures Group in PNG. The better programs depend on donor subsidies but use the full panoply of private sector marketing techniques, including extensive in-depth research repeated throughout the entire life of the project.

³ D. Meekers. 1997. “*The Implications of Free and Commercial Distribution for Condom Use: Evidence from Cameroon.*” PSI Research Division, *Working Paper No. 9*. PSI.

⁴ Simbayi, L., J. Chauveau, and O. Shisana. 2004. “Behavioural Responses of South African Youth to the HIV/AIDS Epidemic: A Nationwide Survey,” *AIDS Care*, 16(5): 605–618.

⁵ Garvey, Mary. 2003. *Dying to Learn: Young People, HIV and the Churches*. United Kingdom. (Global Advocacy and Policy Division, Christian Aid).

12. The latest social marketing effort in PNG has faced a number of problems. First, when begun in 2000, it was located within the NACS and had an intermittent consultant. Message development was reportedly highly constrained in that WHO prescribed what should be the main message (ABC: abstinence, be faithful, or use condoms) rather than permitting the development of messages from the minds and voices of the populace. Abstinence may have had multilayered meanings to the WHO or the consultant (e.g., delay) but the message was translated into *"No ken kuap,"* which in Pidgin simply means "Don't have sex"—not a preferred option in any study of responses to AIDS education, despite numerous countries' attempts to use this message.

13. Universally, a "one size fits all" approach to communication about sexual behavior has been repeatedly shown to fail. The ABC message does not suit the vast majority of adults, tends to be sex-negative, only promotes condom use for those with multiple partners, and incorrectly leads people to believe that simply being faithful to one partner is protective. Other messages used in the current program reinforce the often-heard incorrect notion that *pamuk pasin* (promiscuity)—as opposed to unsafe sex—is the culprit in the spread of HIV, further stigmatizing and marginalizing those in greatest need of services. Overall, the messages used do not reflect the real nature of sexual behavior in PNG and therefore have not "struck home."

14. The current campaign in PNG has been largely urban-biased (as has been the monitoring) and has never directed any messages, visually or verbally, to the conditions of life in most rural areas, where most HIV-infected people live. While sports stars were used in media campaigns, their influence can hardly be considered national, in that TV media reaches a very small proportion of the country.

15. At least an equally great problem appears to be the availability of condoms where and when people need them. Distribution of the branded "Karamap" condom has been problematic. It is difficult to find these condoms in stores in larger urban areas, such as Madang or Daru, let alone in rural spots. The latest survey (March 2005) from the NHASP-supported social marketing campaign found that 29% of people surveyed disagreed and 37% agreed they could find condoms when they perceived they needed to. Even trained peer educators, trained under either the European Union Sexual Health or the NHASP programs, have no steady supply of condoms to sell.

16. Other key lessons learned so far in PNG include the following:

- (i) Prices were not controlled, and at some places in Port Moresby the supposedly subsidized condom pack was being sold for K2.
- (ii) Frequently NGOs purchase condoms and then give them to retail outlets to give out free, as do provincial AIDS committees. Retailers complain that it makes no sense for people to purchase condoms if the same branded condom is widely distributed free. Much confusion and uncontrolled pricing as well as the positioning of public versus private sector condoms have marred this recent social marketing effort.
- (iii) Other reasons for the lack of progress in condom acceptability and usage appear to be related to the frequently documented discordance between knowledge and behavior as well as intention and behavior.
- (iv) The social marketing work was further handicapped by directing part of its resources to a media campaign to diminish stigma. Worldwide this has never

worked and the most effective means has been shown in numerous studies to involve face-to-face contact with HIV-positive people.⁶

17. It is fair to say that an inadequate investment in highly professional social marketing expertise underlies the results of the program. Although the major components were similar to that done elsewhere, the level of investment did not allow the intensity of high-quality research, or the number of personnel needed for promotion, sales, and distribution that might have directed decision making in a different way at an earlier date. It is also clear that prior research on the same topics were not used in preparing the research and message development components.

C. Restarting the effort

18. While the promotion of condom use may not be the only valuable behavioral strategy, without a massive effort at getting condoms to the people where and when they need them at very low prices, it is unlikely that the epidemic can be contained. It is proposed that a large investment in social marketing is made so as to attract an internationally known social marketing agency. For several reasons, a major aim must be the promotion and distribution of condoms in rural areas: (i) nearly all major economic enclaves, sites of high risk, are in rural or even remote rural areas; (ii) studies conducted under the auspices of the WHO Global Programme on AIDS showed little difference in levels of risk behavior among young people in rural and urban areas in PNG and elsewhere;⁷ and (iii) most people living with HIV/AIDS are in the rural areas.

19. Social marketing is a very culturally sensitive, consumer-oriented enterprise. Repeated surveys and other forms of research, including in-depth qualitative research and size estimations of at-risk groups, are needed to understand the potential consumers' beliefs and preferences in detail and coverage needs. Advertising can include but not be dependent on mass media. Events can be staged, theatrical methods used, multiple face-to-face communication methods through teams of communicators, mobile video units, boats on rivers or other waterways, outdoor media, cartoons, clothing, and other printed media are the more common modes of advertising. Many more can be invented as needed.

20. Monthly marketing statistics must also be retrieved from a country-wide monitoring system. A wide variety of distribution points, both traditional (wholesalers, pharmacies, food stores, hotel shops) and nontraditional (guest houses, small kiosks, night clubs, bars, markets) are required for success. Many thousands of such distribution points will be required. Setting up such a distribution system requires considerable expertise in management and large national and local teams. Internal social marketing within high-risk group interventions is also an excellent method of distribution, with sex workers selling to other sex workers or clients in the context of targeted outreach programs. Such programs often have drop-in centers, dedicated clinics and other services that attract persons who are selling sex, permit the development of a sense of solidarity, and promote norm change. Similar targeted programs for youth or men who have sex with men are also included within the range of market sub-segments in large social marketing programs.

⁶ Brown, L., K. Macintyre, and L. Trujillo. 2003. "Interventions to Reduce HIV/AIDS Stigma: What have we Learned?" *AIDS Education and Prevention*, 15(1): 49–69.

⁷ Dowsett, G., et al. 1998. "Changing Gender Relations Among Young People: the Global Challenge for HIV/AIDS Prevention," *Critical Public Health*, 8(4): 291–309.

21. The costs of transport and other services in PNG are great and considerable funds will be required. It is suggested that funds be secured on the order of \$2 million–\$3 million per year for 4 years, in the first instance, in order to make such a contract attractive to an internationally reputable company.

22. The strategies of social marketing companies differ as do their levels of success. For fruitful HIV investment, it is important to hold a company accountable for assuring that its condoms are reaching the most at-risk people, as each sexual act covered by condoms among people with a large number of multiple partners (about 15% of the population), has the greatest impact on the epidemic. Therefore, while the number of condoms sold is a valuable indicator, other indicators are also required.

23. The monitoring of behavior change related to condom use requires excellent sampling as small changes may not be significant and one can only be certain there is success (or failure) based on the production of sound 90% or 95% confidence intervals. Obtaining these means every person interviewed in a survey must have an equal chance of being selected as every other person. If registration of selected sections of the population is needed for this, as is done for the demographic and health surveys, then it is done for social marketing as well.

24. Fairly large numbers of local persons are usually hired, trained and supervised as local teams for these activities. Sales teams are also hired, trained and supervised by geographical area. Therefore, funds for local staff on various levels must be nearly equal to that of expatriate staff.

25. Those companies that bid will describe their methods and should demonstrate their prior success rates using those methods. The terms of reference must not set out a detailed list of activities, but those who will be reading these bids should have prior experience with large social marketing investments. Much depends upon the skills and knowledge of the person selected as country director, and the TOR should specify that CVs of potential country directors are submitted for comment or even that candidates visit the country. Even very well-known and usually successful companies have poor programs if the wrong person is placed in-country.

26. Social marketing companies soon become a major part of the national response to HIV in all countries where their methods are sound and successful. They sit on the CCMs in most of Asia and Africa and take part in national strategic planning and other discussions involving all the stakeholders.

IMPROVING HIV SURVEILLANCE IN PAPUA NEW GUINEA

1. In 1998, UNAIDS and others revamped the classification of HIV epidemics and recommended surveillance methods. The resulting format was called “second-generation surveillance” and included behavioral surveillance as well as markers of other sexually transmitted diseases in addition to HIV.¹ In 2004 another meeting was held to review more recent experiences and new techniques for surveillance, and to discuss their strengths and weaknesses.² For PNG, where surveillance has not been rationalized in relation to its epidemic, the opportunity exists to update the methodology and develop skills in-country, which will enable PNG to collect the data needed to guide and develop prevention programs intelligently.

2. Surveillance worldwide has had a large impact by keeping the epidemic in the spotlight. Improving surveillance in PNG will enable better formulation of policy, improved national estimates, more rational advocacy, guidance for programs on prevention and care, identification of research questions, delineation of marginalized groups, and the use of these data for broader monitoring and evaluation purposes. The purpose of surveillance is to enable an effective public health response to the HIV epidemic, and all populations under surveillance must be offered effective prevention and care programs. Surveillance must combine behavioral data on the same groups and catchment areas in which HIV sero-sampling takes place. Recently, linked behavioral and serological data have proved acceptable to collect (without individual identification) among youth, antenatal mothers, and other groups. An increasing number of national household surveys have been carried out as well. Some surveys have had high levels of refusals, but others have not.

3. Over the past decade, PNG’s surveillance has depended largely on the passive collection of samples, often unreported or very tardily reported in the national figures. More recently a lapsed attempt at sentinel surveillance has been revived with the annual collection of blood samples at several urban, hospital-based antenatal clinics (ANCs). ANC data are not, however, as representative as often implied. ANC data are inadequately adjusted for age, male-female ratios, and rural vs. urban prevalence differences. In some countries, the average ANC prevalence levels are close to those found in national household surveys. However, in PNG only 40% of all HIV samples have ages recorded and approximately 60% of pregnant women never attend a clinic. Under these conditions, it is likely that the difference between actual national prevalence and urban ANC prevalence will differ. Recent experience shows that, where most national surveys are carried out, they show that the epidemic is not as generalized as estimated.

4. These findings have important implications for the allocation of resources. While there are data to show that some rural areas along main roads, for example in the Asaro Valley of Eastern Highlands in PNG, have very high levels of sexually transmitted infections (STIs) among women, other community-level studies in other rural areas (e.g., Hawain area of East Sepik Province) do not exhibit as high STI levels. No surveillance among the most at-risk groups such as sex workers or their clients has begun. Targeting resources where they will have the most impact requires adequate data. PNG does not have adequate data on HIV/STI prevalence or risk behaviors among urban youth; urban or rural sex workers; or documented client groups such as government workers, police, security men, miners, or loggers. Strategic

¹ Joint United Nations Programme (UNAIDS)/World Health Organization (WHO). 2000. *Guidelines for Second Generation HIV Surveillance*. Geneva: UNAIDS/WHO.

² HHS/CDC/GAP/United States Agency for International Development/WHO/UNAIDS/European Union. 2005. *New Strategies for HIV Surveillance in Resource-Constrained Countries*. Addis Ababa.

sentinel surveillance would cover these groups and use the surveillance as a way to monitor the impact of targeted behavior change interventions.

5. PNG has not yet been able to conduct the targeted interventions with high-risk people that would provide venues through which sentinel surveillance could be achieved. This must be developed as soon as possible. For the next several years, however, reliance on ANC and sexually transmitted disease clinic data will be insufficient to estimate with accuracy the distribution and rates of infection throughout the country. A national survey, attached to a much needed Demographic and Health Survey (DHS), is required at this time. PNG is greatly in need of characterizing its epidemic accurately.

6. The principal limiting factor, however, is capacity to plan surveillance systems, collect data, use data, advocate with data, and to design and implement effective, targeted behavior change programs for the people the data reveal need them. To build that capacity, long-term technical assistance by highly competent persons in serological and behavioral epidemiology is needed. Experience in other countries (e.g., Bangladesh) has demonstrated that a well-conducted annual surveillance can be implemented and institutionalized in 2–3 years. A person with advanced skills will be needed to consolidate and analyze all the collected data for many years to come, but there are ways to train such persons over time. Several Papuan New Guineans with backgrounds in social science and epidemiology should be selected to learn all the skills needed to carry out surveillance and, ideally, their institutions should maintain their posts into the future.

7. A recent DHS+ in Cameroon revealed that levels of HIV were twice as high among educated than uneducated women and men, a finding that may be counter-intuitive to some observers. In South Africa, HIV surveillance among youth showed 60% of those saying they had no risk of HIV were already infected. PNG is a complex nation, and its epidemic, if well described, is likely to be complex in its distribution, intensity, and nature as well. We do not know what we would find in PNG if we had proper sampling both for behavioral and serological data, but whatever they might be, the findings would send clear signals to policymakers, planners, NGOs, and others as to where they must work and with whom, which is a far better and more strategic manner of allocating resources over the next 5–10 years than that taking place.

OUTLINE TERMS OF REFERENCE FOR CONSULTING SERVICES

Field	Qualifications	Assignments
Component 2: Community behavior change and social marketing of condoms		
HIV/AIDS dedicated NGO, firm, or consortium (international principal, 40 person-months, and international assistant 26 months; also 121 months of national consultants)	At least 10 years experience and proven successes in HIV/AIDS behavior change in developing countries. Experience with sex workers, persons practicing transactional sex, MSM, and other high-risk groups required	<ul style="list-style-type: none"> (i) Develop a community participatory plan addressing differences in cultural, traditional, and customary behavior of target areas (ii) Based on community participatory plan, design and manage culturally appropriate community-based sexual risk reduction behavior change programs tailored to local communities, including the most vulnerable people (iii) Develop the capacities of community leaders and organizations to engage in behavior change to reduce high-risk behavior (iv) Develop capacities of sex workers and others with concurrent partners in enclaves to lead prevention programs among their peers (v) Assist in setting up appropriate "safe spaces" for prevention activities, including VCT, for at-risk groups (vi) Develop and implement M&E framework to measure effectiveness of programs
Component 3: Strengthen and expand surveillance system for HIV/AIDS		
HIV surveillance specialist/epidemiologist (international, 40 person-months)	PhD (or equivalent) in epidemiology, health-related science, or public health administration. At least 10 years specialized experience in HIV/AIDS prevention and care, managing and conducting HIV epidemiologic research, developing surveillance systems and laboratory diagnostic services, and evaluating HIV prevention programs in developing countries.	<ul style="list-style-type: none"> (i) Examine the existing HIV/AIDS surveillance system and provide suggestions about improving representation and accuracy in both low and high-risk populations (ii) Assist NDOH in developing and implementing expanded collection and information system for sero-surveillance (iii) Prepare appropriate formats, procedures, guidelines, and mechanisms for target group participation and periodic collection and processing of sero-surveillance data (iv) Conduct sero-surveillance in appropriate sentinel sites (v) Develop and administer training programs for central, and provincial and, when appropriate, enclave HIV/AIDS surveillance staff, including training the relevant staff to understand the meaning of returned epidemiological analyses (vi) Assist participating enclaves and community facilities in setting up their laboratory facilities for sero-surveillance (vii) Report with the BSS person on the evolution of sero-surveillance data including (a) HIV/AIDS prevalence among target groups (e.g., sex workers) and sampled communities; and (b) incidence of STIs among the same targets groups, if possible (viii) With the BSS expert, analyze data from the sero-prevalence surveys to identify the pattern of HIV/AIDS epidemic (ix) Based on the analysis of the data, prepare reports presenting the key findings and their implications for HIV/AIDS prevention and care strategies in PNG
Behavioral surveillance/social scientist (international, 40 person-months)	PhD in behavioral epidemiology or related field. Minimum of 8 years experience with HIV-related research, both qualitative and quantitative, and monitoring and evaluation of community-based projects.	<ul style="list-style-type: none"> (i) Develop and maintain BSS in harmony with HSS as executed by the NDOH (ii) Teach assigned counterparts research ethics and techniques of pre-survey formative research, mapping, sampling, questionnaire construction, survey planning, interviewer selection and training, field supervision, data handling, and management (iii) Analyze behavioral results and write full reports as well as reader-friendly summaries (iv) Implement effective results dissemination processes for all stakeholders, including affected populations

Field	Qualifications	Assignments
Statistician (domestic, 36 person-months)	Trained statistician, preferably Master's level. Proven ability to use STATA or EPI-INFO (statistics packages that can handle cluster samples with design effects)	(i) Help plan sampling frames for HIV sero-surveillance and behavior change surveillance in communities and nationally (ii) Oversee data entry clerks and quality of double entry data (iii) Help process and analyze data with HIV Surveillance specialists
Field interviewers (15 domestic, 240 person-months)	Local language skills, plus Pidgin and/or English speech and reading skills	Conduct face-to-face interviews under supervision
Surveillance training supervisors (2 domestic, 72 person-months combined)	Masters in community or public health or epidemiology. At least 5 years public health experience, including at least 2 years experience in HIV/AIDS	(i) Support the HIV/AIDS surveillance specialist/ epidemiologist in preparing curriculum and administering training of provincial and local health staff in collection and processing of data at sero-surveillance sites (ii) Conduct periodic follow up and supervision of provincial and local health staff involved in sero-surveillance (iii) Assist in implementing the guidelines and essential tools in sero-surveillance sites (iv) Assist the HIV/AIDS surveillance specialist/ epidemiologist in disseminating the findings and recommendations of the epidemiological results
Component 4: Project management		
Project coordinator (international, 42 person-months)	Master's degree or higher in management, public health, health economics, or related fields. Minimum of 10 years experience in HIV/AIDS project management and coordination in developing countries.	(i) Facilitate the overall implementation of the Project and ensure ongoing project management, fiscal management, monitoring, and reporting (ii) Oversee all project operations and reporting, including compliance with ADB regulations/procedures and local policies and laws; ensuring monitoring, evaluation and regular reporting on project activities to stakeholders (iii) Assist the EA and IAs in preparing their respective work plans, timetables, and budgets for project implementation, and ensure necessary coordination among them (iv) Assist EA and IAs in establishing operating procedures for all project activities, disbursement, reporting, and monitoring and evaluation (v) Supervise work of international and domestic consultants (vi) Coordinate with ADB to ensure smooth fund flow (vii) Ensure that the Project is implemented according to the RRP/TOR and any subsequent instructions/guidance from ADB
Procurement specialist (international, 12 person-months)	Master's degree or higher in public administration, business management, law, or equivalent. At least 10 years experience in procurement, preferably in the health sector. Must have experience in managing bid cycles and organizing procurement packages, pre-qualification of bidders, marking and evaluating proposals to ensure transparent bidding and award processes.	(i) Provide support to the Central Supply and Tenders Board and the EA on all aspects of procurement, and coordinate all procurement activities (ii) Advise and support equipment and supplies procurement, civil works (facility upgrading) contracts, office and clinic equipment and supplies, and other goods and consultant services (iii) Assist in negotiation of MOAs between government and private sector operators

Field	Qualifications	Assignments
	Experience with government procurement policies, procedures, and practices also required. Experience with ADB procurement guidelines preferred.	
Field supervisor (domestic, 40 person-months)	Medical degree plus Master's degree in Public Health and 7 years experience in the field of clinical care to include clinical management, TB, and ARVs.	(i) Support project coordinator by conducting follow up and supervision of project activities in provinces, districts, and development enclaves (ii) Prepare progress reports summarizing activities undertaken to date, key problems and lessons learned in implementation, quality assessment of activities, and plan of activities for each locality over the next 3 months. Submit reports to the project coordinator and assist in dissemination to stakeholders
Project accountant (domestic, 40 person-months)	Bachelor's degree or higher in accounting and minimum 5 years experience in business or government accounting, particularly preparing financial statements	(i) Assist HSIPMB in accounting functions for the Project (ii) Tasks include preparing budgets, supporting financial statements, processing invoices for payment, liaison with the auditor, and other accounting/financial functions assigned by HSIPMB

ADB = Asian Development Bank, ARV = antiretroviral, BSS = behavioral surveillance specialist, EA = executing agency, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, HSIPMB = Health Sector Improvement Program management branch, HSS = HIV/AIDS surveillance specialist, IA = implementing agency, M&E = monitoring and evaluation, MOA = memorandum of agreement, MSM = men who have sex with men, NDOH = National Department of Health, NGO = non-government organization, RRP = Report and Recommendation of the President, TB = tuberculosis, TOR = terms of reference, VCT = voluntary counseling and testing.

COSTS BY COMPONENT AND FINANCIER
(\$ '000)

Item	ADB Financed				Government of PNG Financed				Social Market Consortium	
	Pub/Priv Partner	BCC & Social Mkt	Expanded Surv	Project Manager	Pub/Priv Partner	BCC & Social Mkt	Expanded Surv	Project Manager	Social Marketing	Total
I. Investment Costs										
A. Civil Works	2,592.0	0	0	0	288.0	0	0	0	0	2,880.0
B. Equipment	1,131.3	0	249.0	0	125.7	0	27.7	0	0	1,533.7
C. Vehicles	694.8	0	46.8	0	77.2	0	5.2	0	0	824.0
D. Training and Workshops	1,035.0	0	0	0	115.0	0	0	0	0	1,150.0
E. Social Marketing	0	1,140.1	0	0	0	1,596.1	0	0	6,384.6	9,120.9
F. Behavior Change NGO	0	2,301.9	0	0	0	0	0	0	0	2,301.9
G. Consulting Services										
1. International Consulting	100.0	0	1,080.0	0	0	0	0	0	0	1,180.0
2. National Consulting	0	0	462.0	0	0	0	0	0	0	462.0
3. International Travel	0	0	240.0	0	0	0	0	0	0	240.0
4. Domestic Travel	0	0	951.7	0	0	0	20.0	0	0	971.7
Subtotal Consulting	100.0	0	2,733.7	0	0	0	0	0		2,853.7
H. Project Management	0	0	0	1,494.2	0	0	0	55.8	0	1,550.0
Total Investment Costs	5,553.1	3,442.0	3,029.5	1,494.2	605.9	0	52.9	55.8	6,384.6	22,214.1
II. Recurrent Costs										
1. Salaries	0	0	0	0	43.6	0	345.8	0	0	389.5
Total Recurrent Costs	0	0	0	0	43.6	0	345.8	0	0	389.5
Total Base Project Costs	5,553.1	3,442.0	3,029.5	1,494.2	649.5	1,596.1	398.7	55.8	6,384.6	22,603.6
Physical Contingencies	348.7	0	14.5	0	40.8	0	1.9	0	0	405.9
Price Contingencies	457.4	291.3	256.9	112.4	53.5	153.9	45.6	4.2	615.4	1,990.5
Total Project Costs	6,359.2	3,733.3	3,300.9	1,606.6	743.8	1,750.0	446.2	60.0	7,000.0	25,000.0

ADB= Asian Development Bank, NGO= nongovernment organization, PNG= papua new guinea.
Source: Asian Development Bank estimates.

PROCUREMENT PACKAGES

Description	Indicative Packages	Contracts	Base Cost Estimates ^b (\$ '000)	Mode of Procurement	Responsible Agency
1. Civil works	6 ^a	36	2,880	LCB	NDOH
2. Computer/medical equipment	8	16	1,534	IS / LCB	NDOH
3. Vehicles	8	8	824	IS / LCB	NDOH
4. Social marketing	1	1	9,121	ICB	ADB
5. Behavior change	1	1	2,302	ICB	ADB

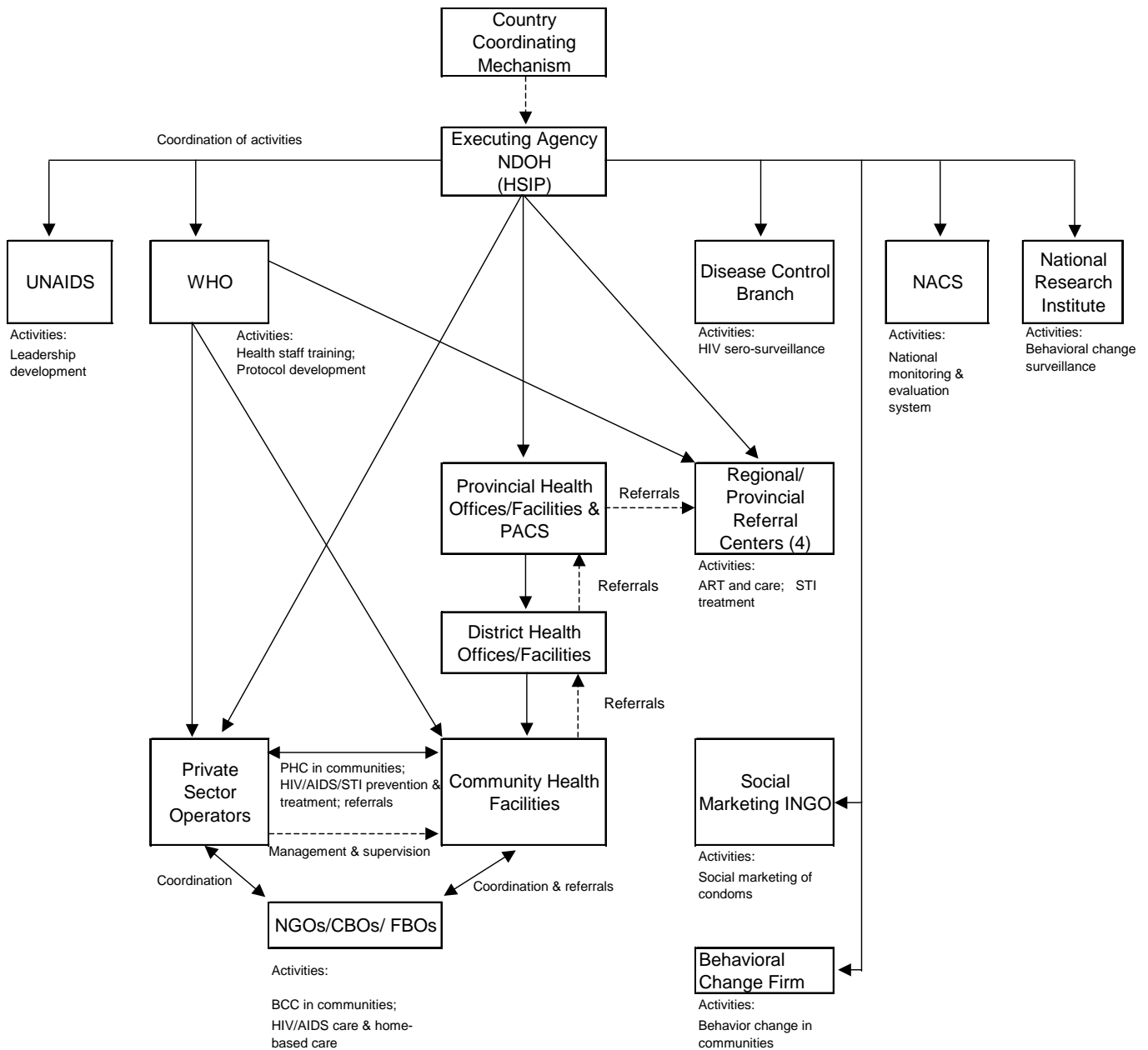
ADB = Asian Development Bank, DP = direct purchase, ICB = international competitive bidding, IS = international shopping, LCB = local competitive bidding, NDOH = National Department of Health

^a Dependent upon the number of public-private partnership Memorandum of Agreements.

^b Includes tax.

Source: Asian Development Bank estimates.

IMPLEMENTATION ARRANGEMENTS AND STRUCTURES



HIV = human immunodeficiency virus, HIV/AIDS = human immunodeficiency syndrome, HSIP = health sector development program, INGO = international non-government organization, NACS = National Aids Council Secretariat, NDOH = National Department of Health, PACS = Provincial Aid Committee, UNAIDS = Joint United Nations Programme on HIV/AIDS, WHO = World Health Organization.

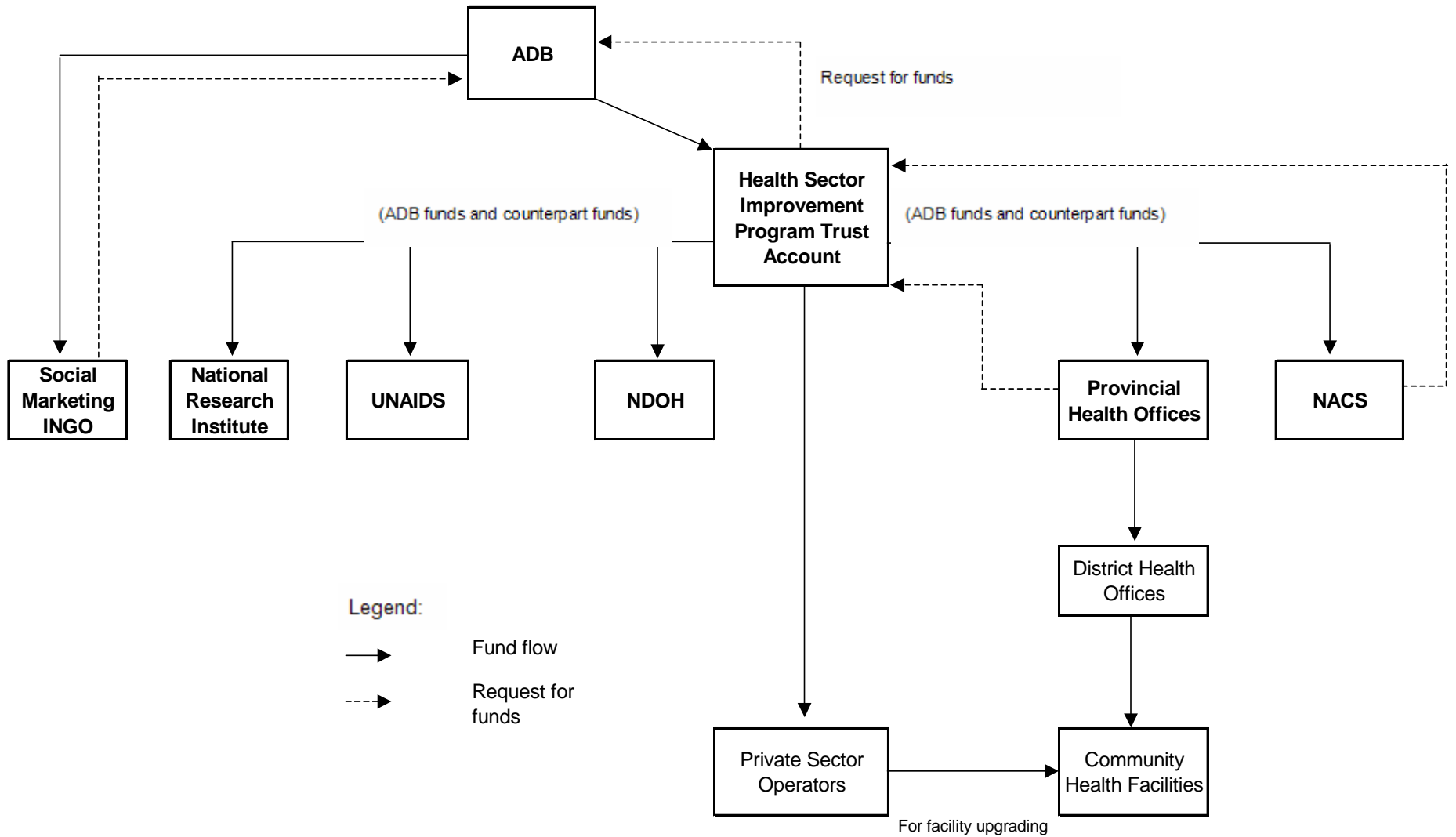
Source: Project Officer.

IMPLEMENTATION SCHEDULE

Activity / Task	2006				2007				2008				2009			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Establishing Public-Private Partnerships																
1.1 Design template MOA for partnerships																
1.2 Establish public-private partnerships																
1.3 Rehabilitate health facilities and equipment																
1.4 Training - VCT, lab. and treatment (NDOH/WHO)																
1.5 Support leadership development (UNAIDS)																
2. Community Response and Prevention																
2.1 Behavior change programs																
Contract int'l NGO / firm																
2.2 Implement BC prgs / training national NGOs																
2.3 Social marketing of condoms																
Secure DP cofinancing																
Contract one int'l social marketing firm																
Market research / condom procurement / advert.																
3. Strengthening HIV/AIDS Surveillance System																
3.1 Contract international consultants																
3.2 Plan and complete transition of system to NDOH																
3.3 Establish surveillance unit in NDOH																
Establish behavior surveillance unit in NRI																
3.4 Complete expanded system design																
Prepare protocols and reference manuals																
Organize equipment procurement and prep.																
Phased implementation																
3.5 Training of staff on surveillance system																
4. Project Management																
4.1 Contract project coordinator																
4.2 CCM review meetings																
4.3 Manage and coordinate project activities																
4.4 Manage relationships with cofinanciers																
4.5 Monitoring and evaluation of progress and outputs																
4.5 Submission of reports																

advert = advertisement, CCM = country coordination mechanism, DP = development partner, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, int'l = international, lab = laboratory, MOA = Memorandum of Agreement, NGO = non-government organization, NDOH = National Department of Health, NRI = National Research Institute, prep = preparation, prgs = programs, STI = sexually transmitted infection, VCT = voluntary counseling and testing.

FLOW OF FUNDS



ADB = Asian Development Bank, INGO = international nongovernment organization, NACS = National AIDS Council Secretariat, NDOH = National Department of Health, UNAIDS = Joint United National Programme on HIV/AIDS.
 Source: Project Officer.

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

A. Linkages to the Country Poverty Analysis

<p>Is the sector identified as a national priority in country poverty analysis?</p> <p style="text-align: right;"> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No </p>	<p>Is the sector identified as a national priority in country poverty partnership agreement?</p> <p style="text-align: right;"> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No </p>
<p>Contribution of the sector or subsector to reduce poverty in Papua New Guinea:</p> <p>Poverty in PNG is perceived to have dramatically increased in recent years. Although most of the poor live in rural areas, urban poverty has worsened because of 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: 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 is declining at all levels of delivery, as is basic service infrastructure, particularly health aid posts. Disease control is inadequate, with low immunization coverage, increasing numbers of tuberculosis patients, and increasing HIV prevalence estimated at 1.6% among the 15–49 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, economic growth and the fight against poverty will suffer.</p> <p>After steadily improving in the 1980s, people's health has deteriorated overall since the 1990s mainly because the health system, especially in rural areas and at the district level, is dysfunctional. A 2001 review found rural health services to be in a state of "slow breakdown and collapse".¹ Hundreds of rural health facilities are either closed or not fully functioning. District health services are equally poor, with health centers shut down or delivering extremely limited services at best. District health facilities face extensive problems: 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 help strengthen government leadership and implement 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 surrounding communities. The Project will develop local civil society organizations' competency to work directly with affected communities to address issues related to the epidemic. A national surveillance system covering all provinces will be established, and home-based care mechanisms as well as a condom social marketing program developed. 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 integral to 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. 2004. *Western Pacific Country Health Information Profiles 2004 Revision*. WHO/Office of the Western Pacific Region

B. Poverty Analysis**Targeting Classification: Targeted intervention****What type of poverty analysis is needed?**

Socioeconomic 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 index². The country has a high fertility rate (4.8%) and a young population, with 42.0% under the age of 15. The infant mortality rate (82/1,000 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 functionally literate (footnote 2). 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 the population now lives on less than \$1 a day, up from 25% in 1996.³ Prospects for formal employment are minimal, and it 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. Rising poverty 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 remain unstable, and security in urban areas appears to have worsened. In response, 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 1995-2003.⁴

Communicable diseases are the main cause of morbidity and mortality in PNG, and they account for approximately 50% of the country's mortality.⁵ 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 (footnote 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.

Socioeconomic 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 15 years. All sectors of society need to work together by taking positive steps in addressing the epidemic in the next 5–10 years.

The goal of the grant is to assist the Government in its fight against HIV/AIDS and its effort to meet the MTDS target for HIV/AIDS control. The grant will help the Government 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 ensure that the investments proportionally benefit the poor and disadvantaged. The Project reduces vulnerability risks of the poor and disadvantaged 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 UNDP. 2004. *Human Development Report*. New York, USA.

³ ADB. 2004. *Country Strategy and Program Update (2004–2006): Papua New Guinea*. Manila.

⁴ UNICEF. Available: http://www.unicef.org/infobycountry/papuang_statistics.html

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, which released the first tranche for HIV/AIDS in August 2005. ADB was recently included as a member of the Global Fund 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

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. Promoting condom use and making condoms available in rural areas will further protect women from the risk of HIV. The Project will provide women with STI treatment. Greater accessibility to STI treatment 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 nonoperational public health clinics in rural areas, far more women will receive primary health care, STI treatment, and HIV care.

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 limited. The churches have played a significant role in social change, 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. Sex workers are stigmatized and their social capital is reduced with families and communities. When these women develop AIDS, they are often abandoned by their families. Many other women are 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 tries to reduce the stigma associated with HIV/AIDS, it has little impact, particularly in rural areas.

Has an output been prepared?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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E. Social Safeguards and Other Social Risks

Item	Significant/ Not Significant/ None	Strategy to Address Issues	Plan Required
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 are 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	Affordability is not expected to be an issue. 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 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 into 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