Validation Report
December 2017

Papua New Guinea: HIV/AIDS Prevention and Control in Rural Development Enclaves

Reference Number: PVR-539
Project Number: 39033
Grant Number: 0042

Independent Evaluation ADB

Raising development impact through evaluation

ABBREVIATIONS

ADB	–	Asian Development Bank
ARV	–	antiretroviral
CCM	–	country coordinating mechanism (Global Fund)
CSM	–	condom social marketing
HSIP	–	Health Sector Improvement Program
MOA	–	memorandum of agreement
NACS	–	National AIDS Council Secretariat
NDOH	–	National Department of Health
PCR	–	project completion report
PHC	–	primary health care
PNG	–	Papua New Guinea
PPP	–	public-private partnerships

NOTE

In this report, "$" refers to US dollars.

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PROJECT BASIC DATA

Project Number	39033-022	**PCR Circulation Date**	25 Apr 2017	
Grant Number	0042	**PCR Validation Date**	Dec 2017	
Project Name	HIV/AIDS Prevention and Control in Rural Development Enclaves			
Sector and Subsector	Health	Disease control of communicable disease - Health sector development and reform - Health system development		
Strategic Agenda	**Inclusive economic growth**			
Safeguard Categories	Environment		C	
	Involuntary Resettlement		C	
	Indigenous Peoples		B	
Country	Papua New Guinea		**Approved** ($ million)	**Actual** ($ million)
ADB Financing ($ million)	**ADF:** 15.00	**Total Project Costs**	25.00	24.16
	OCR: 0.00	**Grant**	15.00	14.08
		Borrower	3.00	3.09
		Beneficiaries	0.00	0.00
		Others	0.00	0.00
Cofinancier	Australia/ New Zealand	**Total Cofinancing**	7.00	7.00
Approval Date	25 Apr 2006	**Effectiveness Date**	3 Sep 2006	31 Aug 2006
Signing Date	05 Jun 2006	**Closing Date**	31 Jul 2010	17 Feb 2016
Project Officers		**Location**	**From**	**To**
	I. Mikkelsen-Lopez	ADB headquarters	Jul 2016	Feb 2016
	N. Carandang	ADB headquarters	Mar 2013	Jul 2016
	S. Tanaka	ADB headquarters	Jan 2011	Feb 2013
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ADB = Asian Development Bank, ADF = Asian Development Fund, IED = Independent Evaluation Department, IETC = Thematic and Country Division, OCR = ordinary capital resources, PCR = project completion report.
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I. PROJECT DESCRIPTION

A. Rationale

1. In the early 2000s, available data suggested that the HIV/AIDS epidemic in Papua New Guinea (PNG) was growing rapidly. During a 2004 national consensus workshop, it was estimated that the prevalence of people living with HIV was between 0.9% and 2.5% of the population. If these estimates were correct, the epidemic in PNG, affecting more than 1% of the general population, was probably generalized[1] and threatened the country's social fabric and economic development, as it had in African countries. The spread of HIV epidemic in PNG was worrying, and aid partners had started pouring money to help PNG, but in a fragmented and uncoordinated

[1] World Health Organization (WHO) definition of "generalized HIV epidemic" is HIV being firmly established in the general population. In numerical proxy, it is HIV prevalence consistently exceeding 1% among pregnant women. Most generalized HIV epidemics are mixed in nature, in which certain (key) subpopulations are disproportionately affected. http://www.who.int/hiv/pub/guidelines/arv2013/intro/keyterms/en/ (accessed on 2 September 2017).

way. Australia, New Zealand, the United States, the European Union, the United Nations agencies, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) were all supporting HIV/AIDS projects, realized that there was a need to better coordinate their support.

2. Available HIV/AIDS data were mainly for Port Moresby and urban centers while the situation in the rural areas was unknown. With successive attempts at decentralization, the quality of basic services in rural areas, including health services, had been declining dramatically as provincial and district governments lacked capacity and resources. Weak governance, high levels of diseases associated with HIV/AIDS, growing at-risk groups, gender and cultural issues, and major challenges in the delivery of basic health services were also identified as major constraints to implementing an effective HIV/AIDS program.

3. In pursuing an export-driven economic growth, the Government of PNG had established "development enclaves", such as mines, plantations, and logging sites, in rural areas. These discrete centers of economic activity generated jobs and a cash economy contrasting with the subsistence farming of the surrounding rural populations. Such conditions were unfortunately ideal to foster the exchange of goods and cash-for-sex between workers in the development enclaves and the surrounding populations, transforming the enclaves into potential HIV/AIDS "hotspots." Poverty, lack of information, and stigma were the major risk factors that could facilitate the spread of HIV. In communities, HIV/AIDS projects were implemented through civil society organizations most of which were small and lacked capacity, except for a few faith-based ones. Private economic operators in provinces were willing to help but required assistance.

4. At the request of the government, ADB approved a $15.0 million grant to help develop public-private partnerships (PPP) to prevent the spread of HIV around the rural enclaves.[2] The project was implemented from 2006 until 2016, and a project completion report (PCR)[3] was prepared in April 2017.

B. Expected Impacts, Outcomes, and Outputs

5. The expected impact of the project was to control and stabilize the spread of HIV infection by 2015 and by 2020, respectively. To achieve these, the expected outcomes were: (i) strengthening the government response to the HIV epidemic; and (ii) changing community behavior away from high numbers of concurrent partners and toward an increased use of condoms.

6. Four components were developed with expected outputs from each. These were: (i) functioning public-private sector partnerships in rural development enclaves improving and extending health services; (ii) national social marketing of condoms program implemented and behavior change programs established in the partnership enclaves; (iii) strengthened and expanded national sentinel surveillance system for HIV; and (iv) an appropriate project management established within the National Department of Health (NDOH).

[2] ADB. 2006. *Report and Recommendation of the President to the Board of Directors: Proposed Asian Development Fund Grant to Papua New Guinea for the HIV/AIDS Prevention and Control in Rural Development Enclaves Project*. Manila.

[3] ADB. 2017. *Completion Report: HIV/AIDS Prevention and Control in Rural Development Enclaves in Papua New Guinea.* Manila.

C. Provision of Inputs

7. The grant, approved on 25 April 2006, became effective on 31 August 2006. The project was to be completed over a 4-year period, i.e., by July 2010. It was, however, extended four times and closed on 17 February 2016. Extensions were required mainly due to delays in starting project activities and challenges in the implementation arrangements for disbursing the grant proceeds. Discussions around the memorandums of agreement (MOA) with the enclave operators, involving NDOH as the executing agency (para. 12) and the local governments, took time to finalize. Likewise, the disbursement of funds through the Health Sector Improvement Program (HSIP) under the NDOH consolidated donors' assistance to the health sector in one joint account to strengthen government's ownership and coordination; however, this created unusual challenges for ADB. There were also delays in finalizing the scope of work, architecture and costs of civil works; in resolving land disputes; and during implementation due to poor supervision by some enclave operators. The National AIDS Council Secretariat (NACS) was not only slow to approve research activities, but the social marketing of condoms took some time to generate demand and was later disrupted by changes in the national HIV/AIDS strategy.

8. The project cost was estimated at $25.0 million at appraisal, to be financed by ADB ($15.0 million), the Government of Australia ($3.5 million), the Government of New Zealand ($3.5 million) and the Government of PNG ($3.0 million).[4] The actual project cost at closing date was $24.2 million. The grants from Australia and New Zealand, allocated to the social marketing of condoms and the behavior change programs (component 2), were fully disbursed. Funds allocated to the surveillance system (component 3) and to project management (component 4) were not fully utilized due to delays in implementation and were reallocated to civil works, e.g., additional health facilities and staff houses.

9. At appraisal, the project proposed to engage individual international consultants (200 person-months) and individual local consultants (549 person-months) (footnote 2). NDOH engaged as planned international consultants (project coordinator, epidemiologist, behavioral surveillance specialist, and procurement specialist) and local consultants (accountant, building field supervisor, operation and finance officer, trainers supervisors for surveillance, statistician, data entry clerks, as well as interviewers). Other key experts, e.g., deputy project manager, PPP specialist, were also engaged. The recruitment of individual consultants likewise added to implementation delays. ADB was to engage two international companies for the behavior change program and the social marketing of condoms. Eventually, only one firm took over and implemented both programs, reducing the total cost of the programs.

10. Though there were some land ownership disputes which were subsequently resolved[5], the project did not request for any resettlement. It was classified category C for environment and resettlement. In the PNG cultural and geographical context, no special arrangements were planned for indigenous people.

D. Implementation Arrangements

11. The project was prepared in close coordination with the NDOH, the NACS, and PNG's main development partners. The Global Fund had signed an agreement with PNG in 2005 with the country coordinating mechanism (CCM) of the Global Fund working with NACS to fight the HIV/AIDS epidemic in PNG. Development partners in the health sector were trying to improve

[4] Footnote 3, Appendix 1.
[5] Footnote 3, para. 34.

coordination. In 1998 to 2001, the ADB Health Sector Development Program (HSDP)[6] helped strengthen NDOH leadership and improve cooperation among development partners with the establishment of the HSIP. The HSIP supported a sector-wide approach for health under the NDOH leadership and management, pooling resources from various partners. The project was also to be implemented through the HSIP, in close collaboration with the Global Fund and other development partners.

12. NDOH was the executing agency. A project management team, composed of consultants, was established within the NDOH and reported to the Secretary of Health. The project manager had regular meetings with the Secretary and other senior NDOH staff. The team worked closely with the HIV Program of the Disease Control Branch of the NDOH.[7] In the provinces where enclave operators were located, provincial coordinating committees were established to develop a MOA with the participation of the NDOH, provincial governments and enclave companies. These committees, though supposed to meet quarterly, did not meet regularly as enclave operators and provincial health officers had limited commitment to do so. The CCM was proposed as the project steering committee but found itself overburdened with its responsibility as oversight to the Global Fund grants. Subsequently, a technical working group was created within the CCM to improve coordination and effectively monitor the project activities.

13. The project financial management and procurement procedures followed the NDOH systems under the HSIP. Despite the additional project-funded staff, however, the HSIP was unable to ensure timely and smooth project implementation due to limited management capacity and cumbersome procedures. After the 2008 mid-term review, the implementation arrangements were revised requiring all consultants from then on to report to the project manager. This improved work coordination and strengthened consultants' accountability.[8]

14. The conditions for grant effectiveness were met on schedule and most of the grant covenants were complied with. The following covenants were considered partially complied with: (i) compliance with auditing requirements (there was a misunderstanding on the audit requirements of the HSIP), and (ii) the role of the CCM (heavy workload). Although a separate account was created for the project under the HSIP, auditing was performed on the consolidated account of all funds under the HSIP. The overburdened CCM (para. 12) or the technical working group on HIV/AIDS did not provide the expected supervision and advisory functions.[9] The project manager and the team of consultants were eventually made fully responsible for the technical quality of the project activities.

II. EVALUATION OF PERFORMANCE AND RATINGS

A. Relevance of Design and Formulation

15. The PCR considered the project highly relevant. The project was aligned with the government's expenditure priorities in the 2005–2010 Medium-term Development Strategy (MTDS)[10] as well as with improving rural health services delivery, as reflected in the National

[6] ADB. 1997. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Technical Assistance Grant to the Papua New Guinea for the Health Sector Development Program.* Manila (Program Loans 1516/1517-PNG (SF) and associated investment loan L1518-PNG (SF)).

[7] The World Health Organization and the Clinton Health Access Initiative were also located in the HIV unit of the NDOH Disease Control Branch.

[8] Footnote 3, para. 36.

[9] Footnote 3, para. 12.

[10] Government of Papua New Guinea. 2004. *The Medium-Term Development Strategy 2005–2010.* Port Moresby.

Health Plan 2011–2020.[11] The ADB country strategy and program (CSP) 2006–2010 identified health and HIV/AIDS as one of its four areas of strategic focus.[12] The project aimed to strengthen government leadership and improve coordination with development partners, which had been the problem with the existing national HIV/AIDS program. Important gaps in the national HIV/AIDS program were identified and which the project decided to address were the need to: (i) mobilize the private sector, (ii) strengthen surveillance, (iii) explore behavior risk factors, and (iv) better target high-risk groups.

16. This validation acknowledges the project's alignment with both the government and ADB's strategies at the time of approval (para. 15) and at completion.[13] The project's approach to integrate its HIV/AIDS activities into primary health care (PHC) by mobilizing the private sector—both the economic operators[14] and civil society organizations, including faith-based organizations—to control HIV in rural communities, shows an innovative partnership with the private sector to control HIV infection in rural communities and this innovative approach is recognized in the Country Assistance Program Evaluation of 2015.

17. Nevertheless, this validation also noted a few shortcomings. The project consisted of largely independent project components, resulting in lack of coherence in delivering results. This was acknowledged and improved after the mid-term review, when the role of the project manager in coordinating project components was reinforced.[15] The condom social marketing (CSM) was supposed to be another innovative approach and was also supported by the government when the project was designed. However, following the changes in the government, it was discontinued due to some concerns related to religious convictions.[16] A better design would have been to aim to reconcile the different views of various political parties.

18. The project design and monitoring framework also had a few weaknesses. For instance, one indicator for outcome (iii) had no baseline (para. 6). It required all health staff in participating enclaves to pass the accreditation for voluntary counseling and treatment and antiretroviral (ARV) service including outreach. It did not, however, indicate how many already passed the accreditation at the beginning of the project. Some output indicators, especially on CSM, did not meet the SMART[17] criteria: (i) increase in adequate access to basic health services (indicator 3) was not specific or properly defined; (ii) behavioral change programming activities in participating enclaves established, supervised, and monitored (indicator 4) was not properly defined, and (iii) selected sentinel sites reporting to national sentinel (indicator 6) were not measurable making these difficult to monitor. Despite these weaknesses, the validation still considers the project relevant.

B. Effectiveness in Achieving Project Outcomes and Outputs

19. The PCR rated the project effective. The project expected outcomes—strengthened PNG Government's response to the HIV epidemic and community behavior changes in HIV-related risky behaviors—were achieved. Health facilities in rural areas were renovated and the

[11] Government of Papua New Guinea. 2010. *National Health Plan 2011–2020*. Port Moresby.
[12] ADB. 2006. *Country Strategy and Program: Papua New Guinea, 2006–2010.* Manila.
[13] Government of Papua New Guinea. 2010. *The Medium-Term Development Plan 2011–2015*. Port Moresby; and ADB. 2010. *Country Partnership Strategy: Papua New Guinea, 2011–2015.* Manila.
[14] Economic operators are the enterprises working in the development enclaves, i.e., one enterprise for one development enclave (footnote 2).
[15] Footnote 3, para. 36.
[16] Footnote 3, para. 19.
[17] Specific, measurable, achievable, relevant, and time-bound.

number of HIV-related visits increased despite the renovated facilities not being "fully functional" because other structural components of the PHC service delivery had not been addressed by the project. These included medicine supplies, staff incentives and qualification, management. Ongoing supervision of public facilities by health staff from the enclaves was not sustained, except where there were strongly committed individuals. In addition, an extensive network for condom distribution was developed and risky behavior changed around the enclaves. The HIV surveillance system was successfully expanded and a behavior surveillance research was implemented.

20. Gender aspects were likewise incorporated in the project. For example, it focused on gender-based violence and communication between couples. Such workshops and training courses for men were held in six participating enclaves for 5,600 people, including volunteers from church groups and care centers. The workshops enabled the participants to be comfortable in discussing sexual relations with their clients. The project was environment and resettlement category C and the covenant that rehabilitation and operation of all health facilities involved in the project comply with all applicable laws and regulation of PNG and ADB was complied with.[18] Although at approval, the project was classified as category B for indigenous people, an ethnic minority plan was not needed since PNG is predominantly comprised of indigenous peoples.[19]

21. Four out of the six outcome indicators were met. The government's budget allocation for HIV/AIDS prevention has increased; almost all clinical staff from participating health facilities have attended training; and participation in HIV and genital infection tests increased. The PCR reports that more than half of sexually active men surveyed in the participating enclaves consistently uses condoms with their partners (footnote 5). However, without baseline information, it is difficult to assess this information as an achievement. Although the PCR did not specify the actual count, one outcome target was not achieved as only "few" health facilities have met the criteria of "fully functional".

22. Assessing the output achievements is more difficult because not all indicators met the SMART criteria (para. 18) and some reported achievements were different from the output indicators. The PCR reported a 25% increase in supervised deliveries, which may or may not explain the achievement of output indicator 3 (i.e., 10% annual increase in adequate access to basic health services). The PCR also reported 1,225 condom outlets established, three behavioral surveillance sites conducted, and 30 antenatal clinics sites conducted surveillance in 2010. It is not clear which corresponding output indicators were being referred to. Nevertheless, this validation views that majority of outcomes and outputs were met and rates the project effective.

C. Efficiency of Resource Use

23. The PCR considers the project less efficient. Delays at start-up, in finalizing the MOAs with the economic operators, recruiting individual consultants, implementing the behavior change, and in condom distribution programs required extensions of the grant closing date. A reallocation of the unused funds to civil works was undertaken to cover cost increase and requirement for staff housing. The use of project funds for staff housing in the rural areas, however, was deemed appropriate as it is a useful incentive to retain qualified staff in isolated areas. Civil works and other project activities were also delayed by the slow disbursement of funds from the HSIP's trust account, requiring alternative procurement processes.

[18] Footnote 3, Appendix 2.
[19] Footnote 2, Appendix 11.

24. This validation reviewed the draft economic analysis presented in September 2005 for the Management Review Meeting.[20] The analysis concluded that the project economic internal rate of return would be 32% with an economic net present value of $98 million. These figures assumed that at least 200,000 HIV infections would be avoided over the following 20 years and an important reduction of sexually transmitted infections. The PCR did not examine the validity of these assumptions and only provided qualitative remarks on the project cost-efficiency. Attributing partly to the project, the surveillance system is now providing more accurate data showing that the 2005 estimates of HIV infections were too high. A more comprehensive economic analysis of the project at completion, including improvement of PHC services in the concerned communities, might have been useful. Considering important start-up delays, the need for project extension, and reallocation of funds, this validation assesses the project less than efficient.

D. Preliminary Assessment of Sustainability

25. The PCR assesses the project likely to be sustained. The government has increased HIV/AIDS funding,[21] and in 2011 the entire budget for ARV therapy following the end of the round 4 grant of the Global Fund. The HIV surveillance is well established, providing more accurate, timely, and useful data to mobilize donors' assistance and determine a more efficient allocation of resources. The HIV/AIDS data is not yet incorporated in the national health information system, but the NDOH is working on integrating the HIV surveillance system into a broader digital health information system. The branded condoms distributed under the project complement the nationwide supply of generic condoms by the Business Coalition Against AIDS on behalf of the NACS. The consulting firm engaged under the project for the CSM and behavior change activities is continuously working in PNG.

26. In 2010, a separate study by the NACS Independent Review Group on HIV/AIDS assessed that the ADB project "continues to produce good results to support health system strengthening in the rural areas as well as a specific HIV/sexually transmitted infections response."[22] By strengthening PHC and by incorporating HIV/AIDS activities in the communities into PHC services, the project has significantly increased the chances of sustaining these activities. The follow-up project approved by ADB in 2011[23] will also complement and strengthen the sustainability of this project for example, by human resource development, community health facility upgrading, and health promotion in local communities. Given the information in this section, the validation considers the project likely sustainable.

III. OTHER PERFORMANCE ASSESSMENTS

A. Preliminary Assessment of Development Impact

27. The PCR assessed that the project had a positive impact on the delivery of HIV prevention and rural health services where it was implemented. It was also a good example of strengthening rural PHC services, integrating HIV/AIDS programs into PHC with the technical support and supervision of the NACS, and collaborating with the private sector. The combined efforts of the project, development partners and the Global Fund to support the government HIV/AIDS program, have produced important results. As presented in the PCR: (i) nationwide, the number of people

[20] Footnote 3, para. 59.
[21] Governments funding for HIV increased nearly fourfold from 2006 to 2011 (footnote 3, para. 61).
[22] National AIDS Council Secretariat. 2010. *Independent Review Group on HIV/AIDS: Report from an Assessment Visit on 22 April-5 May*. Port Moresby (p. 6).
[23] ADB. 2011. *Report and Recommendation of the President to the Board of Directors: Proposed Administration of Grant and Loan to Papua New Guinea for the Rural Primary Health Services Delivery Project*. Manila.

tested for HIV infection increased from 16,691 in 2006 to 138,581 in 2010; (ii) testing facilities increased from 60 in 2006 to 266 in 2010; (iii) treatment had been provided to almost 8,000 people at the end of 2010 (83.7% of those eligible); and (iv) the number of sites providing ARV service increased from 38 in 2006 to 78 in 2010.[24] With project activities to be likely sustainable and the continuing support of development partners, the HIV/AIDS epidemic in PNG is likely to have been more controlled by 2015 and stabilized by 2020. Based on the above discussion, this validation assesses the preliminary project impact as satisfactory.

B. Performance of the Borrower and Executing Agency

28. The PCR rates the performance of the NDOH, as executing agency, satisfactory. The NDOH was actively engaged in project design and implementation. It also fully supported the PPP approach with the economic operators in the development enclave. There were delays, however, in approving civil works and the disbursement of funds through the HSIP trust account was inefficient. In other parts of the country, the regular supply of medicines to the project rehabilitated facilities was problematic. At the provincial and district levels, the monitoring and support of project activities were often inadequate. The NDOH provided adequate support for surveillance and training of healthcare workers. This validation rates the performance of the borrower and executing agency satisfactory based on the discussion above.

C. Performance of the Asian Development Bank and Cofinanciers

29. The PCR rated the ADB performance satisfactory. Despite some difficulty in communication between ADB operations and financial departments staff, particularly on the use of the HSIP for the disbursement of funds, ADB was responsive to the government's and enclave operators' requests. Approvals, disbursements, and monitoring of project activities were generally timely and adequate. ADB further demonstrated its ability to collaborate with other development partners for both project design and during implementation. Similarly, the governments of Australia and New Zealand, cofinanciers for the CSM and the behavior change programs were fully supportive and responsive to ADB and the NDOH requests during project implementation. This validation rates the ADB and cofinanciers' performance satisfactory.

D. Others

30. In view of PNG's geographical and cultural context, the delivery of quality health services in the rural areas remains a major challenge for the government. Decentralization also implies ownership and commitment of the provincial and district authorities. In the health sector, regular supplies of medicines, equipment maintenance, and staffing of health facilities in the rural areas have always been major issues. ADB's experience with the HIV/AIDS Prevention and Control in the Rural Development Enclaves Project was useful in designing and implementing the Rural Primary Health Services Delivery Project in PNG, which was approved in 2011 (footnote 23).

IV. OVERALL ASSESSMENT, LESSONS, AND RECOMMENDATIONS

A. Overall Assessment and Ratings

31. The PCR rated the project successful. This validation also assesses the project successful, given the core criteria ratings of relevant, effective, less than efficient, and likely sustainable.

[24] Footnote 3, para. 66.

Overall Ratings

Validation Criteria	PCR	IED Review	Reason for Disagreement and/or Comments
Relevance	Highly relevant	Relevant	Innovative design; weak coherence of activities improved after midterm review. The government discontinued the CSM component; and some output and outcome indicators do not meet the SMART criteria (paras. 17–18).
Effectiveness	Effective	Effective	
Efficiency	Less efficient	Less than efficient	
Sustainability	Likely to be sustained	Likely sustainable	
Overall Assessment	**Successful**	**Successful**	
Preliminary Assessment of Impact	Positive	Satisfactory	
Borrower and Executing Agency	Satisfactory	Satisfactory	
Performance of ADB	Satisfactory	Satisfactory	
Quality of PCR		Satisfactory	Para. 42.

ADB = Asian Development Bank, IED = Independent Evaluation Department, PCR = project completion report.
Note: From May 2012, IED views the PCR's rating terminology of "partly" or "less" as equivalent to "less than" and uses this terminology for its own rating categories to improve clarity.

B. Lessons

32. This validation agrees with the lessons identified in the PCR on the need for regular supervision of local health staff, the effectiveness a focal point for the enclave, the need to bring together all parties at the outset, and in addressing the social stigma issues in the behavioral change component and tailoring of the MOAs to the local needs. This validation has also identified additional lessons as follows.

33. **Project level lessons.** Regular supervision with coaching is essential for maintaining and improving the quality of health services delivery. Especially in rural areas, supervision is also required to support often isolated local staff and helps to retain health-workers. Civil works successfully rehabilitated health facilities under the project, but regular supervision of public health facilities by health staff of the economic operators, as agreed in the MOAs, were not sufficiently sustained.

34. Under the project, a template was developed for the MOAs between NDOH, local health authorities, and the economic operators. While the objective of this standardization was to accelerate the signing of MOAs, it had, in fact, an opposite result, i.e., with the MOA not considering the local conditions, constraints and needs at the onset, the MOAs were not always satisfactory, causing delays in signing.

35. **Sector level lessons.** On the one hand, working with enclave operators and civil society organizations can, under some circumstances, be a cost-effective option to expand and improve health services delivery in rural areas. The project provided useful information on how to engage with the private sector (i.e., economic operators and not-for-profit civil society organizations,

especially the churches in PNG). On the other hand, while the NDOH enthusiastically supported a partnership with the economic operators in the rural development enclaves, there appeared to have been a lack of project ownership by the local provincial and district authorities, at least at the beginning of the project. With decentralization, it is important to confirm the local governments' representatives' involvement in project preparation and their commitment.

36. The project demonstrated that vertical programs such as HIV/AIDS can be efficiently integrated into PHC services. While specific technical support and management will remain necessary at the central level to guarantee quality and effectiveness of the program interventions, implementation at the local level would yield better results when integrated into PHC, whenever possible.

C. Recommendations for Follow-Up

37. HIV/AIDS data must be collected routinely nationwide and incorporated into the national health information system under the NDOH as quickly as possible.

38. Some economic operators have expressed interest in pursuing their collaboration with the public sector. Oil Search Limited, for example, has extended its operations nationwide through the Oil Search Foundation following its success as principal recipient of Global Fund grants.[25] Other companies may want to continue their collaboration with the local provincial authorities. The government or the provincial authorities may consider sustaining their involvement with tax credits or other business incentives. This is not only valid for HIV/AIDS prevention, testing and treatment, but also for PHC services.

39. When establishing MOA between the private sector partners (e.g., economic operators or NGOs) and the provincial governments for formal collaboration in health services delivery, the MOA templates should be provided highlighting the various aspects that need to be considered in the MOA. There should also be high flexibility to adapt the MOA to local needs.

40. The MOA should also describe the benefits for each party to ensure a clear win-win agreement. Duties and responsibilities of all the parties must be clarified in the MOA, and the appropriate mechanisms defined to ensure that accountability is established and agreed upon.

V. OTHER CONSIDERATIONS AND FOLLOW-UP

A. Monitoring and Reporting

41. Efforts must be taken to monitor the outcome indicators beyond the project life. Moreover, it is important to monitor the spread or containment of the HIV epidemic in PNG. This entails not only assessing the impact of the project, but also ensuring an efficient allocation of scarce resources in the health sector. Furthermore, it requires maintaining a surveillance system able to collect timely and accurate data, qualified staff for data analysis, and evidence-based allocation of resources.

B. Comments on Project Completion Report Quality

42. The PCR quality is rated satisfactory. It is technically strong, based on sound public health knowledge and practices. The project rational is clearly and logically described. Conclusion,

[25] Footnote 2, para. 63.

lessons and recommendations are appropriate and could be useful for similar health projects. One component of the PCR is missing, i.e., the review of the economic and financial analysis of the project realized at appraisal. Economic analyses of health projects are often based on general assumptions. In this case, however, the assumptions could not be confirmed.

C. Data Sources for Validation

43. This validation is based on the following documents: (i) the report and recommendation of the President and the PCR prepared by ADB; and (ii) minutes of the Management Review Meeting in September 2005 and the Staff Review Committee in November 2005. The validation also reviewed various back-to-office reports on the appraisal mission in 2005 and review missions from 2008 to 2015.

D. Recommendation for Independent Evaluation Department Follow-Up

44. This validation recommends that a performance evaluation report be prepared around 2020 as more accurate data on HIV should be available and the impact of the project could be better assessed by then. The quality of the rural health services and the integration of the HIV/AIDS program activities in PHC could be compared within and between the project development enclaves with the quality of rural health services in the areas supported by the ongoing ADB Rural Primary Health Services Delivery Project approved in 2011 (footnote 23), and in other rural areas of PNG.