Completion Report

Project Number: 38599
Grant Number: 0021
December 2011

HIV/AIDS Prevention and Capacity Development in the Pacific

Asian Development Bank

ABBREVIATIONS

ADB	–	Asian Development Bank
BCC	–	behavior change communication
CSM	–	condom social marketing
DMC	–	developing member country
FSM	–	Federated States of Micronesia
GFATM	–	Global Fund to Fight AIDS, Tuberculosis, and Malaria
IEC	–	information, education, and communication
M&E	–	monitoring and evaluation
MDG	–	Millennium Development Goal
MOH	–	Ministry of Health
MSIA	–	Marie Stopes International Australia
MSIP	–	Marie Stopes International Pacific
MSM	–	males who have sex with males
MTR	–	midterm review
NGO	–	nongovernment organization
PPMES	–	project performance monitoring and evaluation system
PRSIP	–	Pacific Regional Strategic Implementation Plan
RMI	–	Republic of the Marshall Islands
SGS	–	second-generation surveillance
SPC	–	Secretariat of the Pacific Community
STI	–	sexually transmitted infection
TA	–	technical assistance
UNAIDS	–	Joint United Nations Program on HIV/AIDS
UNGASS	–	United Nations General Assembly Special Session on HIV
WHO	–	World Health Organization

NOTE

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

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BASIC DATA

A. Grant Identification

1.	Country	Regional
2.	Grant Number	0021
3.	Project Title	HIV/AIDS Prevention and Capacity Development in the Pacific
4.	Grantee	Secretariat of the Pacific Community
5.	Executing Agency	Secretariat of the Pacific Community
6.	Amount of Grant	$8.0 million
7.	Project Completion Report Number	PCR:REG 1293

B. Project Data

1.	Appraisal	Waived during management review meeting
2.	Grant Negotiations	
	– Date Started	27 September 2005
	– Date Completed	29 September 2005
3.	Date of Board Approval	8 November 2005
4.	Date of Grant Agreement	18 November 2005
5.	Date of Grant Effectiveness	
	– In Grant Agreement	15 February 2006
	– Actual	18 April 2006
	– Number of Extensions	None
6.	Closing Date	
	– In Grant Agreement	30 September 2010
	– Actual	30 June 2011
	– Number of Extensions	1

7. Disbursements

a. Dates

Initial Disbursement	Final Disbursement	Time Interval
31 August 2006	11 July 2011	58
Effective Date	**Original Closing Date**	**Time Interval**
15 February 2006	30 September 2010	55

b. Amount ($ million)

Category	Original Allocation	Last Revised Allocation	Partial Cancellations	Amount Disbursed	Undisbursed Balance
Research & studies	0.49	0.08	0.41	0.07	0.02
Equipment	0.24	0.33	0.00	0.29	0.03
Materials & supplies	2.05	2.03	0.19	1.83	0.20
Training & workshops	0.66	0.78	(0.04)	0.63	0.16
Consulting services	2.36	2.27	0.09	2.14	0.13
Project management	1.67	2.32	(0.65)	2.09	0.23
Unallocated	0.53	0.19	0.32	0.00	0.19
Total	8.00	8.00		7.04	0.96

C. Project Data

1. Project Cost ($ million)

Cost	Original Estimate	Actual
Foreign Exchange Cost	8.00	7.04
Total		

2. Financing Plan ($ million)

Cost	Original Estimate	Actual
Implementation Costs		
ADB Financed	8.00	7.04
Total		

ADB = Asian Development Bank,

3. Cost Breakdown by Project Component ($ million)

Component	Original Estimate	Last Allocation	Actual
A. Base Cost			
1. Surveillance and surveys	1.82	1.35	1.34
2. Community response	2.92	3.72	3.24
3. Targeted interventions	1.09	0.42	0.37
4. Project management	1.64	2.32	2.09
Subtotal (A)	**7.47**	**7.81**	**7.04**
B. Duties and taxes	**0.00**	**0.00**	**0.00**
Subtotal (B)	**0.00**	**0.00**	**0.00**
C. Contingencies			
Subtotal (C)	**0.53**	**0.19**	**0.00**
Total	**8.00**	**8.00**	**7.04**

4. Project Schedule

Item	Original Estimate	Actual
Date of contract with consultant	Apr 2006	Apr 2006
First procurement	Jun 2006	May 2006
Last procurement	Jun 2007	Jul 2009
Establish committee	Sep 2006	Jul 2008
Establish and implement reporting systems	Aug 2006	Jul 2008
Extension of grant closing date		Jul 2008
Closing of grant accounts		Jul 2011

5. Project Performance Report Ratings

Implementation Period	Ratings	
	Development Objectives	Implementation Progress
From 30 Nov 2006 to 30 Nov 2007	S	S
From 1 Dec 2007 to 30 Nov 2007	S	S
From 1 Dec 2007 to 30 Nov 2008	S	S
From 1 Dec 2008 to 30 Nov 2009	S	S
From 1 Dec 2009 to 30 Nov 2010	S	S
From 1 Dec 2010 to 30 Jun 2011	S	S

S = satisfactory.

D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members
Inception	1–16 Jun 2006	2	16	a, b
Review 1	30 Jul–4 Aug 2007	2	12	a, c
Review 2	17–27 Nov 2007	2	22	a, d
Midterm Review	25 Jun–1 Jul 2008	1	7	a
Review 3	18–19 Sep 2008	1	2	a, c
Review 4[a]	23–30 Aug 2009	8	16	a, e, f, g, h, i, j, k
Review 5	22 Feb 2010	1	1	a
Project completion review	Aug 2011	2		c , h

a = project implementation specialist, b = operations assistant, c = consultant, d = young professional, e = procurement specialist, f = counsel, g = financial control specialist, h = project analyst, i = director, j = disbursement analyst, k = Project Administration Unit head.

[a] Review was held at the Asian Development Bank headquarters, where Secretariat of the Pacific Community representatives met with staff from the Central Operations Services Office, Loan Administration Division, Office of the General Counsel, and Pacific Department.

I. PROJECT DESCRIPTION

1. The HIV/AIDS Prevention and Capacity Development in the Pacific Project was formulated as the Asian Development Bank's (ADB) first HIV/AIDS[1] project for the Pacific and the first grant to a regional organization, the Secretariat of the Pacific Community (SPC). The project was financed through an Asian Development Fund grant of $8 million. It was approved by ADB on 8 November 2005 and became effective on 15 February 2006.

2. The project complemented the Pacific region's own efforts on HIV/AIDS prevention. It formed part of the Pacific Regional Strategic Implementation Plan[2] (PRSIP) which supports implementation of the Pacific Regional Strategy on HIV/AIDS.[3] The PRSIP is funded by multiple development partners, implemented by Pacific developing member countries (DMCs) with assistance from multiple technical agencies, and coordinated and monitored by SPC.

II. EVALUATION OF DESIGN AND IMPLEMENTATION

3. The goal of the project was to reduce the spread and impact of HIV/AIDS in the Pacific. The purpose was to contribute to improving the management and delivery of HIV/AIDS prevention in the Pacific by targeting vulnerable populations in 10 countries.[4] The project had four components aligned to project outputs: (i) strengthening surveillance, (ii) supporting prevention activities in communities, (iii) targeting vulnerable groups, and (iv) project management. The executing agency was the SPC. The HIV/STI section of SPC coordinated project implementation under the guidance of a public health director. The design and monitoring framework is in Appendix 1.

A. Relevance of Design and Formulation

4. The design of the project was relevant and aligned with ADB and regional strategies. Project objectives were in line with the ADB Pacific Strategy for the New Millennium, 2000–2004; Pacific Strategy, 2005–2009; and ADB's Poverty Reduction Strategy in the Pacific.[5] It was aligned with the Pacific Regional Strategy on HIV/AIDS, which was developed through consultation with key stakeholders to ensure that it reflected the unique situation in the Pacific region. The design took advantage of consultative mechanisms used to develop the submission for assistance from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). GFATM stakeholders had links with representatives from vulnerable and high-risk groups and represented their interests through regional GFATM activities and mechanisms.[6]

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[1] The term HIV/AIDS used in project references is sometimes referred to as HIV/STI (for sexually transmitted infections) in the context of Pacific developing member country operational planning.

[2] The PRSIP is the Pacific Islands Forum framework for guiding the implementation of activities concerned with HIV and other sexually transmitted infections in the Pacific. It encourages development partner coordination and harmonization and takes into account member countries' differing absorptive capacity. The PRSIP has had two phases, Phase I from 2004-2008 and Phase II from 2009-21013, which are referred to collectively as the PRSIP.

[3] SPC. 2005. *The Pacific Regional Strategy on HIV/AIDS 2004-2008*. Noumea, New Caledonia.

[4] Cook Islands, Federated States of Micronesia, Kiribati, Republic of Marshall Islands, Nauru, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

[5] ADB. 2003. *Millennium Development Goals in the Pacific: Relevance and Progress.* Manila; ADB. 2004. *Responding to the Priorities of the Poor: A Pacific Strategy for the Asian Development Bank, 2005–2009*. Manila; ADB. 2004. *Enhancing the Fight Against Poverty in Asia and the Pacific: The Poverty Reduction Strategy of the Asian Development Bank.* Manila.

[6] The Pacific islands Regional Multi-Country Coordinated HIV/AIDS Project was approved for $5.12 million by GFATM Round 2 for implementation in 2003–2008. The proposal for Round 5 was approved for malaria only. The next GFATM proposal was adopted for Round 7, 2008–2013.

5. Pacific health systems face the double burden of preventing and treating persistent traditional infections along with a rising tide of new lifestyle diseases, but have limited resources for dealing with HIV/AIDS. To ensure flexibility, the project design was broad in its description of each component, not specifying the various health systems, priorities, and capacities of each recipient country. Informal country capacity assessments were undertaken to finalize project design.

6. The project midterm review (MTR) conducted in July 2008 incorporated lessons from the first 2 years of implementation that were intended to improve the effectiveness of each activity in the face of varying country capacity, but did not change the intended goal or purpose. At project completion, the objectives remained relevant regionally under the PRSIP and nationally as reflected in most countries' strategic plans.

B. Project Outputs

7. The project had four outputs: (i) developing national HIV/AIDS surveillance capacity in Pacific DMCs to better understand HIV infection risk factors, (ii) reducing the burden of HIV/AIDS among participating DMCs through pilot interventions, (iii) supporting targeted interventions for vulnerable populations in participating DMCs, and (iv) project management. The outputs were delivered though four components and 17 subcomponents. The project met most of its original targets and accomplished 90% of its outputs. The coverage of countries under each subcomponent varied depending on readiness and alignment with other plans and activities. The project's outputs and performance against the original targets are in Appendix 1.

8. The MTR resulted in a change of scope for some activities, as described under each subcomponent (paras. 10–23). One activity was reduced in scope in light of limited national capacity. Several activities were expanded or extended over a longer period due to higher than expected demand. Several activities were discontinued, as they were either being undertaken by other development partners or were otherwise no longer required. After the MTR, SPC staffing was increased and revised activities were implemented.

9. **Output 1: strengthening surveillance.** This component improved national HIV/AIDS surveillance capacity through three subcomponents that developed methodologies and skills for conducting second-generation surveillance (SGS) on risk factors for HIV infection and prevention among high-risk subpopulations.

10. **Regional data warehouse.** This subcomponent was partly achieved. Significant progress was made on data collection, an important purpose underlying this subcomponent. However, the development of a regional data warehouse as originally conceived during project design was not completed. Case definitions and minimum data sets to be collected by participating DMCs were developed. At MTR, the activity was reduced in scope to a stand-alone data store to house data from STI testing and treatment pilot sites, SGS surveys, and routine surveillance. By project completion, most participating DMCs were routinely reporting STI and HIV surveillance data to the SPC, though not disaggregated by gender or other categories as envisaged at project design. Routine surveillance data continues to be collected every 6 months, and there is a significant repository of country data accessible at the SPC, which is used to modify approaches to HIV and other STIs.

11. **Expanded second-generation surveillance.** This subcomponent was partly completed. Technical assistance (TA) was provided to 8 of the 10 countries under the project[7] to expand the SGS survey program.[8] It included country visits, needs assessments, survey tool preparation, training package development, and assistance in analyzing data and writing reports. The first round of SGS reports was published for the Cook Islands, Federated States of Micronesia (FSM), Republic of the Marshall Islands (RMI), and Tuvalu. Repeat SGS reports were released for Kiribati, Solomon Islands, Tonga, and Vanuatu, improving the data for review of national HIV strategic plans. Tuvalu received TA from the World Health Organization (WHO), and Nauru completed the demographic health survey in 2007 and published it in 2009, with support from the SPC, which included an HIV and other STI knowledge and attitude component. This provided valuable assistance to targeted behavior change communication (BCC) campaigns, national planning, and STI strategies. With 10 Pacific countries now having at least one SGS report published from 2007 to 2010, the target was substantially met.

12. **Expanded routine surveillance and improved country laboratory capacity.** This subcomponent was completed. It supported training laboratory staff and equipping national laboratories, which built capacity to collect and analyze data and improve the surveillance and treatment of HIV and other STIs. Nauru, Cook Islands, and Solomon Islands participated in the STI testing pilot program. Country databases were established and training was given on data entry. A training package to cover routine surveillance and laboratory skills was delivered in six countries in 2009–2010.[9] Improved laboratory capacity from the beginning of 2009 to June 2011 allowed 14,946 people to be counseled and tested for HIV and to learn their test results, which is a significant improvement on counseling and testing before 2007. Diagnosis of chlamydia, the most common STI in participating countries, is now available in most of the countries.

13. **Output 2: community interventions for HIV/AIDS prevention.** This component provided support for a regional condom social marketing (CSM) program to promote condom supply and use to males and females; the development of BCC materials and delivery of BCC programs; and STI treatment and care programs, including training for local health care workers and the provision of equipment and materials to STI treatment facilities.

14. **Condom social marketing.** This subcomponent was partly completed. Kiribati, Solomon Islands, and Vanuatu were selected for CSM. The program was initially implemented by Marie Stopes International Pacific (MSIP) in partnership with local nongovernment organizations (NGOs). The CSM program promoted male condom use; provided related information, education, and communication (IEC) materials; and established community condom sales distribution networks. The pace of implementation was slower than planned mainly because of human resource capacity constraints in MSIP and in-country partner agencies. Implementation faced challenges arising from negative attitudes to female condoms and the ongoing distribution of free condoms through the United Nations Population Fund. The Kiribati program was dropped due to difficulty in identifying a strong in-country partner. Despite these constraints, a locally branded male condom was developed along with IEC materials. The CSM program was launched in Solomon Islands and Vanuatu with the establishment of formal and informal distribution networks, mainly in urban centers, and community education and promotion.

[7] Nauru and Tuvalu received similar assistance provided from other sources, as agreed by development partner coordination mechanisms during project implementation.

[8] The first round of SGS surveys was undertaken in 2004–2005 by the University of New South Wales with support from the World Health Organization and the SPC for Kiribati, Samoa, Solomon Islands, Tonga, and Vanuatu.

[9] Training was organized by the WHO and the SPC and did not include Tonga at that time.

15. Although at project completion sales figures were below the targets in the grant agreement, the CSM program was sustained in Vanuatu through formal distribution networks and run by Save the Children (Australia) and a local supermarket chain. In Solomon Islands, the CSM program continues as a sustainable model through informal distribution channels.

16. **Behavior change and communication**. This subcomponent was partly completed. All participating DMCs received BCC training in a phased approach. Regional training took place to support events such as the Melanesia Arts Festival, South Pacific Games, and Pacific Youth Festival. Trainees were mainly from ministries of health (MOHs), NGOs, and church groups. BCC campaigns targeted a variety of groups including pregnant women, youths, taxi drivers, males who have sex with males (MSM), sex workers, and seafarers. At MTR, peer education and support program mapping were added to this subcomponent. Consultants reviewed programs and organizations using peer education with vulnerable population groups. They identified gaps and capacity-building needs across the 10 participating DMCs, which included an unclear definition of peer education, national HIV/AIDS and other STI strategies weak in targeting and linking vulnerable groups to effective activities, and the lack of effective monitoring and evaluation (M&E) and coordination. BCC is now recognized as a legitimate and valued activity in the Pacific, and development partners are willing to consider continued funding for it. Project activities were effective, but BCC changes in Pacific countries will need support beyond the project period.

17. **Development of information, education, and communication materials**. This subcomponent was partly completed. The BCC team used results from SGS and local mapping exercises to build the capacity of MOHs and NGOs to develop BCC plans and materials. This subcomponent also produced and distributed seafarer and maritime diaries in 2008, 2009, and 2010 that provided information essential to safeguarding the health of seafarers, with a focus on reducing risk and vulnerability to HIV/AIDS and other STIs. The diaries were distributed with safe sex packs and posters. Positive feedback was received from users and distributors of the diaries.

18. The *Love Patrol* series, a television drama that promotes safe sex, proved an effective BCC activity under the project. Variable literacy rates in the Pacific and the geographic isolation of many Pacific island countries demanded a medium with reach. The *Love Patrol* series was produced by Wan Smolbag, a Vanuatu NGO.[10] An evaluation of the television series showed that it was effective at reaching youths and young women in particular, groups that were identified as vulnerable. The project funded the production of a third series, *Love Patrol Three*, which focused on safe sex and HIV/AIDS. By July 2011, *Love Patrol Three* had been broadcast on primetime television in five countries: Cook Islands, Fiji, New Guinea, Palau, Papua New Guinea, and Vanuatu.[11] Kiribati, the FSM, the RMI, Solomon Islands, and Tonga have scheduled *Love Patrol* to air. Data from the Cook Islands and Vanuatu suggested that *Love Patrol Three* was seen by 55%–86% of the urban population. The *Love Patrol Three* DVD and accompanying resource guide has been distributed to MOHs, NGOs, schools, health clinics, community groups, universities, media, and regional organizations. *Love Patrol*'s reach is extended by the internet, where it has its own Facebook page.

19. At project design, the SPC and the Pacific Regional HIV/AIDS Program identified a program that trains community representatives on gender-equality issues, Stepping Stones, as a

[10] *Love Patrol One* and *Love Patrol Two* were funded by the Australian Agency for International Development, New Zealand Aid, GFATM, and the SPC.

[11] Television viewership reports from Fiji and Papua New Guinea and data collected in street surveys in Vanuatu and Solomon Islands concerning *Love Patrol Two* indicated that it was seen by 311,600 people, not including viewers from other countries. *Love Patrol Three* can be assumed to have similar or better coverage.

potentially useful communication channel. The Stepping Stones program proactively addressed gender inequality in the context of HIV/AIDS and other STIs, undertaking gender assessments and dividing the community into peer groups by age and sex to facilitate the discussion of sensitive issues.[12] Support included a regional training workshop and TA for Kiribati, Solomon Islands, and Vanuatu. The project catalyzed the launch of the Stepping Stones program in Kiribati and Solomon Islands, where civil society and local authorities demonstrated strong commitment and ownership. It was then supported by other development partners through the Pacific Response Fund in these two countries and in the FSM.

20. **Sexually transmitted infection services.** This subcomponent was partly completed. A pilot program for testing and treating chlamydia and gonorrhea was developed for implementation in the Cook Islands, Nauru, and Solomon Islands. TA was provided to participating DMCs on how to use laboratory diagnostic machines and conduct routine surveillance, and health workers were trained to diagnose and manage STIs. Equipment was procured for clinics and a comprehensive case management training package was developed in consultation with regional partners. As part of the strategy to control and prevent STIs, counseling and testing services were scaled up during the first few months of 2011, providing services that met minimum standards in eight participating DMCs.

21. At project completion, most participating DMCs were able, for the first time, to offer chlamydia testing and treatment services in urban centers, and the screening and treatment of pregnant women have improved. Cumulatively to the end of the project, more than 31,000 people were tested for chlamydia. Of 933 pregnant women who tested positive for chlamydia during 2010, 782 (84%) were provided a course of treatment. As surveillance in most participating DMCs shows high prevalence rates among asymptomatic women, this is a significant achievement.

22. **Output 3: targeted interventions for vulnerable groups.** This component (i) established five drop-in centers with information for seafarers, (ii) developed and distributed IEC materials for vulnerable groups, (iii) trained nongovernment organizations working with vulnerable groups, (iv) supported training in regional maritime schools, (v) trained people infected with HIV to enhanced their livelihood skills, and (vi) provided antiretroviral drugs for people with HIV.

23. **Seafarers drop-in centers.** This subcomponent was partly completed. Two centers, in Tuvalu and Kiribati, received long-term support from port authorities and local NGOs in targeting seafarers and related communities, and continue to operate beyond project closure. In the RMI, the drop-in center was to be established at a fisheries and nautical training center but failed to operate as the RMI had no seafarers working on international ships. In Solomon Islands and Vanuatu, centers could not be established as the project was unable to secure accommodation for them. However the Council of Churches in Vanuatu is now negotiating to establish an NGO to operate these two drop-in centers. At project completion, two centers were operational, in Kiribati and Tuvalu; two had potential to become operational, in Solomon Islands and Vanuatu; and one, in the RMI, was not established.

24. **Maritime schools.** This subcomponent was partly completed. SPC worked with the Regional Maritime Program to revise the HIV/STI safe sex sections of the occupational health and safety standard course and to update and expand the standard social responsibility course. The revised curricula were presented to maritime organizations during a regional meeting in Fiji in 2007, where 7 of the 10 participating DMCs were represented, 6 of which—Kiribati, Samoa,

[12] Marion Quinn. 2011. *PRSIP II Gender and Human Rights Audit.*

Solomon Islands, Tonga, Tuvalu, and Vanuatu—now provide at least some education on preventing HIV and other STIs in their course work. The other country was Nauru, which does not have a maritime training college. At project completion, most maritime schools were providing varying amounts of information on HIV and other STIs.

25. **Livelihood skills and antiretroviral drugs.** This subcomponent was not completed. It was intended to provide livelihood skills training for people with HIV. However at MTR it was agreed to discontinue this activity because few people in participating countries other than Fiji had HIV and the GFATM ended up providing antiretroviral drugs to all participating DMCs. Therefore no funds were provided through the project for this activity. Instead, at MTR it was agreed to include a financial contribution to the United Nations Population Fund for procuring safe sex kits for distribution to men and women in participating DMCs.

26. **Output 4: project management.** This subcomponent was completed. The project was implemented within the management structure of SPC's public health and HIV/AIDS section, which served as the project management unit (PMU) with an additional project coordinator, a project assistant, and an M&E officer provided by the project. Procurement and disbursement were managed and coordinated by the PMU. Semiannual progress reports were shared with development partners. Project work plans were integrated into PRSIP, as were country operational plans. The project produced five external independent audit reports, for each of the fiscal years from 2006 to 2010. ADB agreed to an SPC proposal to use a local audit firm that complies with international auditing standards, after the SPC submitted the first auditor's report 5.4 months late.

27. The first 2 years of project implementation experienced start-up delays, an understaffed PMU, lack of SPC management oversight of implementation, and late notice from SPC of modifications to project implementation arrangements. PMU experienced difficulty attracting staff and suffered high turnover, a problem common to many projects in the Pacific because of brain drain of qualified candidates. However, MTR resolved key management issues, after which project implementation proceeded smoothly. There was also an increase in the number of SPC monitoring missions in response to low country capacity and a request from countries without capacity for an extension to ensure full project implementation, which increased project administrative costs.

28. **Monitoring and evaluation.** This subcomponent was partly completed. SPC did not submit the required project performance monitoring and evaluation system (PPMES) to ADB within 6 months of grant effectiveness, as required. There were ongoing delays in finalizing the PPMES because SPC prioritized the PRSIP M&E framework. The PPMES was finalized only late in 2008, so a parallel method of collecting project data for reporting was developed in which the M&E project officer undertook some evaluation, notably of the CSM and seafarer drop-in centers, and SPC technical staff undertook other evaluations of project-funded activities.

C. Project Costs

29. The project cost was originally estimated at $8.0 million. At completion, the project had disbursed $7.04 million (88%) and $0.96 million (12%) was unspent. The main reason for reduced costs was the partial achievement of subcomponents as described in Section B (paras. 10–23), particularly those for surveillance and STI services. The main categories of reduced expenditure were research and studies, materials and supplies, consulting services, and contingencies. Appendix 2 shows the original project allocation and actual expenditures by cost category, as well as final project costs and fund utilization during implementation.

D. Disbursements

30. During the first 2 years of implementation, disbursements were significantly delayed, in large part because the submission of withdrawal applications was delayed by SPC due to inexperience with ADB procedures. After MTR, SPC established an executive oversight committee to address implementation bottlenecks. This was effective in improving implementation performance. A number of financial management issues regarding increasing the imprest account, the frequency of submissions for withdrawal reimbursement, and converting the undrawn balance to euros to minimize exchange rate losses were resolved. From 11% actual disbursement in early 2008, disbursement increased to 70% through project imprest account withdrawals by the end of 2009. At closing, the project had disbursed 88% of project funds. Annual disbursements are in Appendix 3.

E. Project Schedule

31. The original completion date was 31 March 2010 and the closing date was September 2010. Following the initial 2 years of implementation, project activities were significantly behind schedule, and a comprehensive MTR was conducted in July 2008 to review and revise activities based on implementation experience. The completion was extended to 30 December 2010 and the closing date to 30 June 2011 to allow the completion of the CSM subcomponent, continue and evaluate the STI surveillance and BCC programs, and submit the final report and payment claims. Project implementation was carried out largely according to the revised implementation schedule agreed following MTR. The original and actual project implementation schedules are compared in Appendix 4.

F. Implementation Arrangements

32. SPC was the executing agency. SPC's public health and HIV/AIDS section served as PMU, based in Noumea, New Caledonia. A full-time project coordinator and project assistant were recruited in 2006, and an M&E project officer was recruited in 2007. At the end of 2008, the HIV/AIDS section moved to Suva, Fiji, in accordance with SPC's decentralization policy, but project staff remained in Noumea. An executive oversight group was established at SPC in mid-2008 to ensure coordination between the two locations.

33. This was SPC's first experience as the executing agency of an ADB-funded project. Difficulties with recruiting qualified staff and unfamiliarity with ADB's procurement procedures caused a slow start to project implementation. However, three factors improved project implementation after the MTR: (i) additional staff for PMU, (ii) SPC's strengthened management oversight, and (iii) ADB's prompt assistance in response to implementation bottlenecks.

34. At design, it was agreed that the project would be coordinated by a steering committee of representatives of stakeholder organizations with expertise in HIV/AIDS, including participating DMCs, civil society, development partners, SPC, and ADB. However, to avoid duplication, it was decided at inception that a separate steering committee for the project would not be established, but rather an existing regional coordination mechanism would be utilized. The GFATM's Pacific Island Regional Monitoring and Country Coordinating Mechanism and, later, the Pacific Island HIV & STI Response Fund were used. While both mechanisms complied with criteria for a project steering committee, they focused on development partner coordination rather than on detailed project implementation. However, the efforts of PMU and ADB to coordinate project activities closely with stakeholders helped to ensure that this did not impede the project.

G. Conditions and Covenants

35. Eighteen of the 21 grant covenants were complied with. SPC partly complied with three covenants: (i) furnishing the audit report for 2006, (ii) establishing the steering committee, and (iii) developing the PPMES. Appendix 5 shows the status of compliance with grant covenants at project completion.

H. Consultant Recruitment and Procurement

36. Consultants were recruited in accordance with ADB's Guidelines on the Use of Consultants (2010, as amended from time to time), most of them as individuals. Consultants provided services in HIV and other STI surveillance, information and communications technology (including data management), CSM, BCC, HIV prevention, peer education, STI case management, laboratory diagnostics, project management, seafarer support, and monitoring and evaluation. An NGO, MSIP, was recruited to assist implementing CSM. ADB and the SPC established a productive and close relationship early during the recruitment of staff and contractors for the project. Some adjustments were required to consulting services, including the creation of two international BCC positions (rather than one national), replacement of the HIV support specialist with an STI specialist, and inclusion of a project assistant and project specialist. These changes were agreed between ADB and the SPC. Consulting services are summarized in Appendix 6.

37. Procurement for drop-in centers, laboratory and diagnostic equipment, and routine and second-generation surveillance and BCC activities (communication materials, diaries, etc.) complied with ADB Procurement Guidelines (2010, as amended from time to time). A list of equipment procured is in Appendix 7.

I. Performance of Consultants, Contractors, and Suppliers

38. The project funded 20 long-term staff, 5 short-term consultants, and 4 subcontractors for a total of 752 person-months. PMU staff were managed by the manager of the Public Health Division and head of the HIV/AIDS section of SPC. Technical staff were managed by technical cluster coordinators of SPC. SPC staff performance review procedures were followed to plan work and assess performance. All project-funded staff, with one exception, performed well and achieved their objectives, taking into account dependence on participating DMCs and their capacity constraints. The exception was the M&E officer, whose contract ended in May 2009 and was not renewed because of underperformance. The poor performance impeded the laboratory capacity-building component, but this problem was resolved by hiring a laboratory consultant, who produced high-quality outputs and generated positive feedback from participating DMCs.[13]

39. The subcontractor MSIP, a field office of Marie Stopes International Australia (MSIA), was engaged to implement the CSM program. MSIP demonstrated limited technical and management capacity for implementation. Eventually, MSIP's capacity limitations and underperformance were untenable, so MSIA closed the MSIP office in early 2010 and continued implementation under MSIA. The assessment of MSIA and MSIP was *unsatisfactory*. Aside from this particular case, the performance of contractors, suppliers of basic laboratory and office equipment, and domestic and international consultants was *satisfactory*.

[13] SPC. 2009. Grant Progress Report (July–December 2009), Annex A. Unpublished (Grant 0021-REG).

J. Performance of the Borrower and the Executing Agency

40. At design, SPC had the most updated knowledge of public health and HIV/AIDS status in participating DMCs. SPC's lack of detailed knowledge of country capacity gaps, which was required for effective project implementation, prompted agreement to prepare country capacity assessments. A risk identified at design was that SPC might not be able to effectively manage the project in addition to its other responsibilities nor retain its human resource capability and expertise. These risks did eventuate and are reflected in project implementation delays in the first 2 years and discrepancies between SPC and country data. However, following MTR and associated project revisions, SPC provided additional staff resources and executive oversight, which proved effective in resolving bottlenecks and improving performance. Financial management issues were resolved, staffing stabilized, and revised activities implemented. Given the improvement in project implementation in the second half of the implementation period and overall project results, the performance of SPC is rated *satisfactory*.

K. Performance of the Asian Development Bank

41. ADB was responsive and allocated considerable staff time and resources to address issues arising during implementation. These included negotiations on the recruitment of project staff and consultants, contract formats, and the recoding of travel expenses of SPC staff. ADB's efforts to ensure the proper implementation of the M&E program were less successful because of SPC's late design and submission of a PPMES and weaknesses in securing STI data exchange with participating DMCs and project monitoring at project sites. Further, ADB oversight was less frequent than it could have been during the first 2 years of project implementation and additional review missions could have been sent. However, additional reviews held following MTR, including a major review conducted with SPC at ADB headquarters, put implementation back on track. Good communication was maintained throughout implementation, despite changes in SPC and ADB project officers. Overall, ADB's performance was *satisfactory*.

III. EVALUATION OF PERFORMANCE

A. Relevance

42. The project was *highly relevant*. It was fully aligned with ADB's strategy in the Pacific, participating DMCs' national strategies, WHO and Joint United Nations Program on HIV/AIDS (UNAIDS) strategy,[14] and health sector development priorities. It constituted a core part of the PRSIP. The design took advantage of the consultative processes and mechanisms used to develop the GFATM Round 5 submission in 2005.[15] Changes made at MTR built on lessons learned during the first 2 years of implementation and better reflected SPC and participating DMC capacities. These changes brought minor changes in project scope and implementation arrangements and required reallocating project proceeds and extending the closing date. The environment for the project was favorable, featuring political stability and strong political support in participating DMCs for health policy reforms.[16] The project provided crucial support to the governments' health and youth policies, including the design and implementation of national strategic plans on HIV/AIDS.

[14] WHO. 2010. *A Strategy to Halt and Reverse the HIV Epidemic Among People Who Inject Drugs in Asia and the Pacific, 2010–2015*. http://www.who.int/entity/hiv/pub/idu/searo_harm_reduction_strategy2010-2015.pdf.

[15] ADB was a member of the GFATM country consultative mechanism.

[16] Participating DMCs reaffirmed the continuing importance of health as a regional priority, especially action to mitigate HIV/AIDS and other STIs, at Pacific ministers of health regional meetings in 2007 and 2009 and annual Pacific Islands Forum leaders meetings in 2007 and 2008.

B. Effectiveness in Achieving Outcome

43. The project was *effective*. It significantly contributed to establishing testing and counseling for HIV and other STIs in participating DMCs through the provision of laboratory equipment and training of medical personnel. The project contributed to improved HIV and STI surveillance though SGS and routine surveillance by providing laboratory equipment and training for participating DMC health personnel. The project catalyzed the establishment and expansion of BCC, which was followed by other development agencies and improved access to IEC materials on HIV and other STIs, especially for youths and other high-risk groups. Data on regional and national prevention and capacity development are in Appendix 8.

44. For outcome 1, strengthening surveillance, the project contributed significantly to strengthening the capacity of participating DMCs in data analysis. Surveillance systems, including national and provincial laboratories, were established in all participating countries. The SPC continues to collect data every 6 months and contributes to HIV/AIDS and STI surveillance and prevention approaches regionally and nationally.

45. The dissemination of surveillance data to participating DMCs and regional stakeholders improved, informing policy and program development. The proactive approach of project surveillance staff to providing epidemiological updates at regional meetings and reviewing the SGS process with participating DMCs has improved surveillance in participating DMCs. In May 2008 regional partners agreed on STI case definitions and minimum data sets and produced a consensus document.[17] Based on the consensus document, which incorporated lessons from the pilot evaluations, the system of collecting laboratory data was redesigned and established in participating DMCs in 2009 and 2010. Rates for STIs were established for each country only during the project, as most previously lacked the capacity to test and report prevalence rates. At the end of the project, 9 of the 10 participating DMCs were able to report chlamydia, gonorrhea, and syphilis rates for 2009. Participating DMCs use the survey information as baseline data in their M&E frameworks for their HIV and STI national strategic plans and UNGASS reports.

46. The target of reducing the prevalence of STIs was partly achieved. The purpose of the project has been successfully addressed through improved national laboratories' capacity in STI diagnostics. Laboratory capacity was improved and 14,946 people were counseled and tested for HIV/AIDS by project completion. This significantly improved counseling and testing, as these services were unavailable before the project. In the first 6 months of 2011, 12,806 people were tested for chlamydia. However, the results from STI testing, SGS, and pilot surveys showed high prevalence, as, on average, one sexually active young person in four has an STI. It was too ambitious to reduce such prevalence during the project, as this will require sustained effort.

47. Through outcome 2, a community response to HIV and other STIs, the project successfully introduced BCC programs in participating DMCs. The coverage and scale of prevention improved, funding to the region increased, and relationships were built with other regional partners. At project completion, pilot CSM programs had been implemented in Solomon Islands and Vanuatu. The program had expanded access to affordable male condoms in the capital and some provincial urban areas. An evaluation of the television serial *Love Patrol Three*[18] showed that the program had broad reach, especially with youths and young women, groups identified as vulnerable. The *Love Patrol Three* DVD and accompanying resource guide were distributed in participating DMCs and other territories to MOHs and NGOs. The Stepping

[17] SPC, et al. 2008. *Improving National STI Surveillance in Pacific Island countries and territories.* http://www.spc.int/hiv/index2.php?option=com_docman&task=doc_view&gid=129&Itemid=148.
[18] 2011. *Love Patrol Series 4. Final Report.* Port Vila, Vanuatu.

Stones program successfully and proactively addressed gender inequality in the context of HIV and other STIs, undertaking gender assessments and dividing the community into peer groups by age and sex to facilitate discussion of sensitive issues.[19]

48. Outcome 3, targeted interventions for vulnerable groups, was partly completed, as the project established two drop-in centers for seafarers and made progress toward establishing two more. Another achievement under this component was the production and distribution of seafarer and maritime diaries in 2008, 2009, and 2010 in participating DMCs to maritime training schools, seafarers' unions, shipping companies and agents, and maritime administrations.

C. Efficiency in Achieving Outcome and Outputs

49. The project was *less efficient* in achieving its outcomes and outputs. High disbursements were achieved only after MTR in mid-2008. Contributions to SGS and STI routine surveillance capacity in participating DMCs fell short of expectations regarding data collection and reporting. The introduction of BCC programs was adequate in two of three pilot countries. Two underachieving project activities were incomplete at project closing: CSM and seafarer drop-in centers. However, most project milestones were delivered by project completion, and project disbursement reached 88%.

50. The project contributed to improving the socioeconomic status of target beneficiaries through (i) cost savings owing to increased health awareness and reduced disease prevalence and (ii) enhanced incomes for those who care for the sick. No socioeconomic surveys were carried out during the project to support estimates of the project's direct and indirect economic benefits. However recent literature indicates that targeted interventions such as youth education, seafarer training materials, and enhanced capacity in NGOs that work with MSM and commercial sex workers are central to helping these vulnerable groups benefit from HIV prevention and care interventions.[20]

D. Preliminary Assessment of Sustainability

51. The project is rated *likely sustainable.* All participating DMCs have established national AIDS committees and designed and approved national HIV/AIDS and STI plans. National health policies address STI concerns, although there is still underestimation of the potential HIV/AIDS threat. While there is now considerable evidence from SGS and routine surveillance that can be used to gain commitment from participating DMCs and inform programming, there is an ongoing need to help participating DMCs' collect routine surveillance data; improve access to testing and treatment, especially among vulnerable groups; develop strategies to tackle high STI rates; and develop and implement BCC. The project contributed to improving capacity in STI services in some of these areas, but the evidence of improved access for people with HIV to treatment, care, and support indicates that gains may be vulnerable to staff turnover and the limited capacity of national health service infrastructure.

[19] Marion Quinn. 2011. *PRSIP II Gender and Human Rights Audit*.

[20] United Nations Children's Fund. 2001. *The State of Health Behavior and Lifestyle of Pacific Youth*, Port Vila.; United Nations Children's Fund. 2007. *Young People's livelihoods in Vanuatu: Using What You've Got to Get What You Need*, Port Vila; World Bank. 2006. *At Home and Away*. Washington, DC; World Bank. 2008. *Opportunities to Improve Social Services. Human Development in the Pacific Islands*. Washington, DC; WHO. 2010. *Priority HIV and Sexual Health Interventions in the Health Sector for Men Who Have Sex with Men and Transgender People in the Asia–Pacific Region*. Manila.

52. The capacity of participating DMCs to deliver the full range of care services for HIV/AIDS and other STIs has been strengthened, though some gaps in service areas remain.[21] Access to quality services has improved with increased TA and funding and improvements in communication, networking, and partnerships, resulting in better coordination and cooperation to support resource mobilization. BCC programs are in place and continue to receive development partner support. The CSM program continues in Solomon Islands and Vanuatu, demonstrating a shift in people's attitudes. There were significant achievements in BCC; improved access to treatment, care, and support; increased access to antiretroviral therapy and HIV testing and counseling; and better STI detection and management.

E. Impact

53. The goal of the project was to reduce the spread and impact of HIV/AIDS in the Pacific. A number of STIs facilitate HIV transmission, and their high prevalence in the region indicates high potential for HIV transmission. The project had a significant impact on national capacity building in surveillance. A body of evidence is now available to garner support from participating DMCs and drive the development of new regional strategies to tackle STIs.[22] Baseline data are now available for participating DMCs to improve the monitoring, reporting, and evaluation of their national responses. Available data indicate that progress in surveillance has been slowly building since 2007–2008, with some evidence of substantial change in the health sector. The project expanded access to IEC materials and condoms though the CSM program and support to the United Nations Population Fund. Dialogue in communities has been promoted through BCC and the Stepping Stones program.

54. By design, the project constituted a core part of PRSIP, ensured the efficient use of resources, and augmented DMC activities. Participating DMC governments reaffirmed the continuing importance of health as a regional priority, especially action to mitigate HIV/AIDS and other STIs, at regional meetings and in national and regional strategic plans. This is expected to improve public health, increase the efficiency of public health expenditures, expand diagnosis and treatment, strengthen prevention, and increase acceptance of people living with HIV.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

55. Project performance is rated *successful*, based on the preceding assessment of its being *highly relevant*, *effective*, *less efficient*, and *likely sustainable* (Appendix 9). The project built capacity in targeted areas of the health sector in participating DMCs, improved surveillance and laboratory capacity, and initiated the BCC necessary for long-term sector development. The project's focus on improving access and affordability of laboratory testing and counseling, while improving the quality of data collection and reporting, was highly relevant to regional needs. The project met most of the targets set at design for the four components.

B. Lessons

56. There are several lessons from the project. First, even if a project is aligned with regional strategies, designs need to incorporate sufficient national consultation and consider country

[21] UNGASS country progress reports on the Federated States of Micronesia for 2008 and 2010, the RMI for 2008 and 2010, Nauru for 2010, Samoa for 2010, Solomon Islands for 2010, Tonga for 2010, Tuvalu for 2008 and 2010, and Vanuatu for 2010.

[22] UNAIDS. 2009. *Second Independent Evaluation, 2002–2008. Pacific Region Summary Report.* http://data.unaids.org/pub/BaseDocument/2009/20090622_sie_countrysummaryreport_pacific_en.pdf.

absorptive and technical capacity and commitment. Second, efforts to strengthen routine surveillance and laboratory capacity will achieve only limited success where health information systems and laboratory services are weak. Third, an executing agency's ability to implement project activities within set timeframes is diluted where there is limited PMU capacity, a lack of experience with ADB procedures, and inadequate executive oversight. Fourth, establishing a project steering committee is challenging where separate development partner committees already exist to oversee arrangements for Pacific countries. Fifth, national M&E remains a challenge due to lack of capacity and minimal regional support to assist participating DMCs. While regional evaluations of some activities have taken place, they need to focus on impact or outcome indicators rather than on the process of implementation.

C. Recommendations

57. **Project-related.** There are seven project-related recommendations. First, development partners should consider helping MOHs to focus on national capacity building and planning within the PRSIP framework. This may take considerable time and resources, but is most likely to produce results. Second, participating DMCs should work to implement regionally endorsed strategies within the PRSIP framework over the next five years by utilizing the considerable technical and financial assistance available from development partners in the region. Third, participating DMCs should continue to strengthen data collection for evidence-based responses over the next two years, including routine surveillance, the development of health information systems, formative assessments, and monitoring and evaluation. Fourth, participating DMCs should continue to strengthen laboratory support for HIV/AIDS and other STI screening to ensure adequate prevention planning and implementation. Fifth, MOHs should prioritize and support evidence-based strategies to implement targeted approaches and work with populations most at risk. Sixth, participating DMCs should work with the PRSIP review team and NGO networks to reduce stigma and discrimination through advocacy and amendments to legislation, enforce human rights, and enhance the environment for preventative care services. Seventh, the PRSIP review team and NGO networks should assist the SPC with reporting to ADB, UNAIDS, WHO, GFATM and AusAID and other donors involved in HIV/AIDs prevention capacity building, and associated compliance monitoring.

58. **General.** There are five general recommendations derived from project experience. First, despite varying capacity, government ministries may be more suitable executing agencies for HIV/AIDS prevention and capacity-development projects than an international organization. MOHs can work in tandem with SPC as implementing agencies, which is a role that is perhaps more appropriate to SPC's mandate. Second, ADB needs to strengthen oversight through additional missions and reviews when a new executing agency is unfamiliar with ADB rules and procedures. Third, better development partner coordination is required for HIV/AIDS prevention and capacity building, as these activities are currently hampered by multiple funding streams and fragmented oversight committees. Fourth, more policy dialogue is needed on the relative priorities of HIV/AIDS relative to other health concerns in Pacific DMCs. Fifth, prevention activities should continue to incorporate gender considerations into their design because the low status of women is a challenge to providing access on prevention methods, information, testing, care, support, and treatment.[23]

[23] ADB, 2007. *Cultures and Contexts Matter. Understanding and Preventing HIV in the Pacific*. Manila; World Bank. 2009. *HIV and AIDS in South Asia: An Economic Development Risk.* Washington DC; See footnotes 14 and 22.

PERFORMANCE SUMMARY AGAINST THE DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Indicators/Targets	Revised Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Project Achievements
Impact Reduced spread and impact of HIV/AIDS in the Pacific	A trend of decreased incidence of HIV by 2012 Reduced economic and social impact from the HIV/AIDS epidemic Reduced mortality and morbidity attributed to AIDS in the region	A trend of decreased incidence of HIV by 2012 Reduced economic and social impact from the HIV/AIDS epidemic Reduced mortality and morbidity attributed to AIDS in the region	Regional MDG reports produced by the UNDP Regional reports of UNAIDS Monitoring and evaluation reports of the Pacific Regional Strategy on HIV/AIDS, 2004–2008 UNGASS reports SGS reports[a]	**Assumptions** The base-line prevalence of HIV/AIDS is as low as currently believed to be or at least within a range of 10%. Regional programs such as the Global Fund continue to support HIV/AIDS efforts in the Pacific. **Risks** The economic situation in participating DMCs worsens and distracts governments from HIV/AIDS efforts Other health issues assume greater urgency in participating DMCs and distract health authorities.	New HIV infections in the region declined from an average of 4,700 (range: 3,800–5,600) in 2001 to an average of 4,500 (range: 3,400–6,000) in 2009. Excluding Papua New Guinea, the number of new HIV diagnoses reported annually in all participating DMCs was 85 in 2008 and 82 in 2009.
Outcomes Contribution to the improved management and delivery of HIV/AIDS prevention in the Pacific through the targeting of vulnerable populations as part of PRSIP I and II	By 2009, HIV infection rates in vulnerable populations no more than 1%	By 2010, HIV infection rates in targeted vulnerable populations no more than 1%	Regional reports of UNAIDS and WHO Monitoring and evaluation reports of the Pacific Regional Strategy on HIV/AIDS UNGASS reports	**Assumptions** The SPC is able to retain its HIV/AIDS staff and expertise. Country commitment to HIV /AIDS and other STI prevention is maintained during implementation[b]	While the number of people living with HIV in Oceania nearly doubled from 2001 to 2009, from an average of 28,000 (range: 23,000–35,000) to an average of 57,000 (range: 50,000–64,000), HIV prevalence remains relatively low at an average of 0.9% (range: 0.8%–1.0%).[b]

Design Summary	Performance Indicators/Targets	Revised Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Project Achievements
					HIV prevalence in Pacific island countries and territories remains low at 0.015%, compared with 3.100% in Papua New Guinea.
Outputs 1. Strengthened surveillance of HIV and other STIs	National strategies and responses in all participating DMCs are modified based on the results of surveillance programs	All participating DMCs with completed and updated SGS data	Regional reports of UNAIDS and WHO UNGASS reports SGS reports[a] Regional reports by UNAIDS Monitoring and evaluation reports of the Pacific regional Strategy on HIV/AIDS, 2004–2008	**Assumption** National capacity to undertake activities is sufficient with the support provided.	SGS reports in the 1st Round: Tuvalu in 2007, Cook Islands in 2009, and FSM and RMI in 2010 SGS reports in the 2nd Round: Tonga in 2008; Solomon Islands, Vanuatu, and Samoa (under Ministry of Health endorsement) in 2009; and Kiribati in 2010
2. Community response to HIV and other STIs	By 2009, a CSM program fully implemented in all participating DMCs By 2009, 80% of all respondents reporting having used a condom during their last sexual encounter with a non-cohabiting partner By 2009, the prevalence of STIs is reduced to less than 10% in the prenatal population	By project completion, CSM programs fully implemented in Kiribati, Solomon Islands, and Vanuatu By project completion, 80% of targeted respondents report having used a condom during their last sexual encounter By project completion, the prevalence of the STIs chlamydia and gonorrhea in participating DMCs is reduced by 10% among ANC women.	MSIP program reports[a] Regional reports of UNAIDS Monitoring and evaluation reports of the Pacific Regional Strategy on HIV/AIDS, 2004–2008. UNGASS reports SGS reports[a]	**Assumptions** National capacity to undertake activities is sufficient with the support provided. Determinants of sexual behavior outside the control of the project remain neutral or favorable. Other development partners continue financial support for CSM and BCC. The SPC has can maintain its focus on HIV/AIDS activities.	CSM is established in Solomon Islands and Vanuatu. Progress in sexual behavior change is slow, from 61.7% on average in Vanuatu to 7.4% in Nauru, but Kiribati demonstrated visible achievements with seafarers, up to 70.7% in 2009 against 38.2% in 2006.

Design Summary	Performance Indicators/Targets	Revised Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Project Achievements
				There is a general policy of screening for STIs in Pacific DMCs and providing treatment.[b]	
3. Targeted interventions for vulnerable groups	By 2009, 80% of vulnerable populations have access to HIV education to reduce their vulnerability to HIV infection	By project completion, 80% of targeted vulnerable populations can correctly identify measures to prevent the transmission of HIV & other STIs.	Regional reports of UNAIDS Monitoring and evaluation reports of the Pacific Regional Strategy on HIV/AIDS, 2004–2008 UNGASS reports Global Fund for AIDS, Tuberculosis, and Malaria reports	**Assumption** National capacity to undertake activities is sufficient with the support provided.	Proportion reporting correct knowledge of HIV/AIDS prevention methods: FSM youths aged 15–24 51.7%,Tuvalu seafarers 27.8% Proportion reporting no incorrect beliefs about HIV/AIDS transmission: FSM youths aged 15–24 41.7%, Tuvalu seafarers 63.6% Proportion who both report correct knowledge of HIV/AIDS prevention and no incorrect beliefs about HIV transmission: Cook Islands youths aged 15–24 male 46.4%, female 40.9%; and transgender people and men who have sex with men 51.8%; Kiribati youths aged 15–24 male 48.4%, female 38.8%; RMI youths aged 15–24 male 8.4%, female 3.8%; Nauru youths aged 15–24 male 9.6%, female 13.3%; Solomon Islands youths aged 15–24 male 66.0%, female 54.1%; and Tonga youths aged 15–24 male 3.6%, female 1.8%
4. Project management	Project milestones achieved	Project milestones achieved	Project reports	**Assumption** The SPC can maintain	Project milestones were achieved.

Design Summary	Performance Indicators/Targets	Revised Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Project Achievements
			Monthly updates and minutes of SPC executive oversight group for grant 21[a]	focus on HIV/AIDS activities.	

ANC = antenatal care, BCC = behavior change communication, CSM = condom social marketing, DMC = developing member country, FSM = Federated States of Micronesia, MDG = Millennium Development Goal, MSIP = Marie Stopes International Pacific, SGS = second-generation surveillance, UNAIDS = Joint United Nations Program on HIV/AIDS, RMI = Republic of the Marshall Islands, UNGASS = United Nations General Assembly Special Session on HIV.

[a] Additional monitoring mechanism after the midterm review.

[b] Additional assumption after the midterm review.

Sources: Joint United Nations Programme on HIV/AIDS (UNAIDS). 2010. Global report: *UNAIDS Report on the Global Aids Epidemic;* SPC. 2009. *HIV Epidemiological Update for Pacific Island Countries*, 2009. SPC, Nuomea, 2009; UNGASS Country Progress Reports, 2008 and 2010; SPC Estimates and Reports, 2006-2010; Tuvalu SGS Survey Report 2007; UNGASS Country Progress Report: Federated States of Micronesia, 2010; Cook Islands SGS Report 2005-2006, 2009; SPC Estimates and Reports, 2006-2010; UNGASS Country Progress Report: Republic of Marshall Islands, 2010; UNGASS Country Progress Report: Nauru, 2010; Solomon Islands SGS Survey Report 2008; Tonga SGS Survey Report 2008.

ACTUAL AGAINST PROJECTED COSTS

Table 2.1: Grant Allocation and Actual Expenditures
($ million)

Category	Original Allocation	Revised Allocation	Actual
Research and studies	0.49	0.08	0.07
Equipment	0.24	0.33	0.29
Materials and supplies	2.05	2.03	1.83
Training and workshops	0.66	0.78	0.63
Consulting services	2.36	2.27	2.13
Project management	1.67	2.32	2.09
Contingency	0.53	0.19	0.00
TOTAL	**8.00**	**8.00**	**7.04**

Source: Asian Development Bank.

Table 2.2: Actual Costs Versus Original Estimates by Grant Component
($ million)

Component	Original Estimate	Last Allocation	Actual
A. Base Cost			
1. Surveillance and surveys	1.82	1.35	1.34
2. Community response	2.92	3.72	3.24
3. Targeted interventions	1.09	0.42	0.37
4. Project management	1.64	2.32	2.09
Subtotal (A)	**7.47**	**7.81**	**7.04**
B. Duties and Taxes	**0.00**	**0.00**	**0.00**
Subtotal (B)	**0.00**	**0.00**	**0.00**
C. Contingencies			
Subtotal (C)	**0.53**	**0.19**	**0.00**
Total	**8.00**	**8.00**	**7.04**

Source: Asian Development Bank.

ANNUAL DISBURSEMENTS
($ million)

Year	Quarter	Amount Disbursed	Cumulative
2006	4	0.03	0.03
2007	2	0.12	0.15
2008	1	0.61	0.75
	2	0.54	1.28
	3	1.75	3.04
	4	0.41	3.45
2009	1	0.42	3.87
	2	1.19	5.06
	3	0.09	5.15
	4	0.49	5.64
2010	2	0.71	6.35
	3	0.18	6.53
	4	0.24	6.77
2011	1	0.17	6.93
	2	0.07	7.01
	3	0.03	7.04

Source: Asian Development Bank.
Note: Numbers may not seem precise because of rounding.

PROJECT IMPLEMENTATION SCHEDULE

Figure 5.1: Strengthened Surveillance

Description	Item	Planned versus Actual Timeline																			
		2006				2007				2008				2009				2010			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Establish regional surveillance data store	RRP																				
	Actual																				
Expand second-generation surveillance program, including for identified groups	RRP																				
	Actual																				
Expand routine surveillance capacity	RRP																				
	Actual																				
Improve national laboratory capacity	RRP																				
	Actual																				

RRP = report and recommendation of the President.
Source: Secretariat of the Pacific Community final report.

Figure 5.2: Strengthening Prevention at Community Level

Description	Item	Planned versus Actual Timeline																			
		2006				2007				2008				2009				2010			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Condom social marketing program	RRP																				
	Actual																				
Behavior change communication	RRP																				
	Actual																				
Sexually transmitted infection services	RRP																				
	Actual																				

RRP = report and recommendation of the President.
Source: Secretariat of the Pacific Community final report.

Figure 5.3: Targeted Interventions

Description	Item	Planned versus Actual Timeline																			
		2006				2007				2008				2009				2010			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Establishment of seafarer & community drop-in centers	RRP																				
	Actual																				
Develop targeted information, education, and communication materials for vulnerable groups	RRP																				
	Actual																				
Training for maritime schools	RRP																				
	Actual																				

RRP = report and recommendation of the President.
Source: Secretariat of the Pacific Community final report.

Figure 5.4: Project Management and M&E

Description	Item	Planned versus Actual Timeline																			
		2006				2007				2008				2009				2010			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Manage the project	RRP																				
	Actual																				
Conduct baseline monitoring	RRP																				
	Actual																				
Monitor and evaluate project progress and outputs	RRP																				
	Actual																				

RRP = report and recommendation of the President.
Source: Secretariat of the Pacific Community final report.

STATUS OF COMPLIANCE WITH PROJECT COVENANTS

Covenant	Reference to Grant Agreement	Status of Compliance
The Recipient shall cause the proceeds of the Grant to be applied to the financing of expenditures on the Project in accordance with the provisions of the Grant Agreement.	Article III, Section 3.01	Complied with.
The goods and services and other items of expenditure to be financed out of the proceeds of the Grant and the allocation of amounts of the Grant among different categories of such goods and services and other items of expenditure shall be in accordance with the provisions of Schedule 2 to this Grant Agreement, as such Schedule shall may be amended from time to time by agreement between the Recipient and ADB.	Article III, Section 3.02	Complied with.
Percentages of ADB financing Except as ADB may otherwise agree, the items of the Categories and Subcategories listed in the Table shall be financed out of the proceeds of the Grant on the basis of the percentages set forth in the Table.	Schedule 2, para. 3	Complied with.
Reallocation Notwithstanding the allocation of Grant proceeds set forth in the Table, (a) if the amount of the Grant allocated to any Category appears to be insufficient to finance all agreed expenditures in that Category, ADB may, by notice to the Recipient, (i) reallocate to such Category, to the extent required to meet the estimated shortfall, amounts of the Grant which have been allocated to another Category, but, in the opinion of ADB, are not needed to meet other expenditures; and (ii) if such reallocation cannot fully meet the estimated shortfall, reduce the withdrawal percentage applicable to such expenditures in order that further withdrawals under such Category may continue until all expenditures there under shall have been made; and	Schedule 2, para. 4	Complied with. On November 2007 and July 2008, the Grant funds were reallocated among Grant categories.
Imprest account; Statement of Expenditures (a) Except as ADB may otherwise agree, the Recipient shall establish immediately after the Effective Date, an imprest account at Banque de Nouvelle Caledonie. The imprest account shall be established, managed, replenished and liquidated in accordance with ADB's Loan Disbursement Handbook dated January 2001, as amended from time to time, and detailed arrangements agreed upon between the Recipient and ADB. The initial amount to be deposited into the impress account shall not exceed $500,000. (b) The SOE procedure may be used for reimbursement of eligible expenditures and to liquidate advances provided into the imprest account, in accordance with ADB's Loan Disbursement Handbook dated January 2001, as amended from time to time, and detailed arrangements agreed upon between the Recipient and ADB. Any individual payment to be reimbursed or liquidated under the SOE procedure shall not exceed $50,000.	Schedule 2, para. 5	Complied with. A second generation imprest account in Euros was established to enable easier reporting in USD by clearly establishing exchange rates.
Condition of Withdrawals from Grant Account Notwithstanding any other provision of this Grant Agreement, (a) no withdrawals shall be made from the	Schedule 2, para. 6	Complied with. Letters of no objection were received from each PDMC.

Covenant	Reference to Grant Agreement	Status of Compliance
Grant Account and (b) no Grant proceeds may be applied for the financing of any Project activities to take place in any Project PDMC until such time as ADB shall have received evidence, satisfactory to ADB, that such Project PDMC supports the Project activities to take place in its territory.		
Except as ADB may otherwise agree, all goods and services to be financed out of the proceeds of the Grant shall be procured in accordance with the provisions of Schedule 3 (Procurement) and Schedule 4 (Consultants) to this Grant Agreement	Article III, Section 3.03	Complied with.
Withdrawals from the Grant Account in respect of goods and services shall be made only on account of expenditures relating to: (a) goods that are produced in and supplied from, and services that are supplied from, such member countries of ADB as shall have been specified by ADB from time to time as eligible sources for procurement, and (b) goods and services that meet such other eligibility requirements as shall have been specified by ADB from time to time.	Article III, Section 3.04	Complied with.
The Grant Closing Date for the purposes of Section 8.02 of the Grant Regulations shall be 30 September 2010 or such other date as may from time to time be agreed between the Recipient and ADB	Article III, Section 3.05	Complied with. ADB approved the extension of Grant closing date to 30 June 2011.
In carrying out of the Project and operation of the Project facilities, the Recipient shall perform, or cause to be performed, all obligations set forth in Schedule 5 (Execution of the Project) to this Grant Agreement.	Article IV, Section 4.01	Complied with.
(a) The Recipient shall (i) maintain, or cause to be maintained, separate accounts and financial statements for the Project; (ii) have such accounts and related financial statements audited annually, in accordance with appropriate auditing standards consistently applied, by independent auditors whose qualifications, experience and terms of reference are acceptable to ADB; (iii) furnish to ADB as soon as available but in any event not later than 6 months after the end of each related fiscal year, certified copies of such audited accounts and financial statements and the report of the auditors relating thereto (including the auditors' opinion on the use of the Grant proceeds and compliance with the financial covenants of this Grant Agreement as well as on the use of the procedures for the imprest account and statement of expenditures), all in the English language; and (iv) furnish to ADB such other information concerning such accounts and financial statements and the audit thereof as ADB shall from time to time reasonably request. (b) The Recipient shall enable ADB, upon ADB's request, to discuss the Recipient's financial statements for the Project and its financial affairs related to the Project from time to time with the auditors appointed by the Recipient pursuant to Section 4.02(a) above, and shall authorize and require any representative of such auditors to participate in any such discussions requested by ADB, provided that any discussion shall be conducted only in the presence of an authorized officer of	Article IV, Section 4.02	Partially complied with. Separate bank account and financial statements were in place. Accounts have been audited annually, with findings that accounts are in line with standards. SPC failed to conduct its 2006 audit no later than 6 months after end of FY2006 (or 20 June 2007). SPC provided formal written request to ADB in August 2007 to complete audit using a local auditing firm complying with international auditing standards. Audit was completed on 16 November 2007 and audit report received on 11 December 2007, 5.4 months late. SPC contracted to have the 2007-2008 audits undertaken in February 2008 and provided the report to ADB before 30 June 2008 as per Grant Agreement deadline.

Covenant	Reference to Grant Agreement	Status of Compliance
the Recipient unless the Recipient shall otherwise agree.		SPC provided the 2008 audit report to ADB before the 30 June 2009 deadline. Audit Report was received on 14 May 2009. Accounts were found in line with standards. SPC provided the 2009 audit report to ADB in July 2010. Accounts were found in line with standards. The 2010 audit report was received on 17 August 2011, when ADB fielded the project completion review mission.
The Recipient shall enable ADB's representatives to inspect the Project, the goods financed out of the proceeds of the Grant, and any relevant records and documents.	Article IV, Section 4.03	Complied with.
The following are specified as additional conditions to the effectiveness of this Grant Agreement for the purposes of Section 9.01(e) of the Grant Regulations: (a) the Project Management Unit shall have been established and become operational in a manner satisfactory to ADB; and (b) the Project Manager shall have been appointed. Such Project Manager shall possess experience and qualifications acceptable to ADB.	Article V, Section 5.01	Complied with.
A date ninety (90) days after the date of this Grant Agreement is specified for the effectiveness of the Grant Agreement for the purposes of Section 9.04 of the Grant Regulations.	Article V, Section 5.02	Complied with.
Status and Organization of the Recipient The recipient shall maintain its existence as a regional inter-governmental organization. The recipient shall notify ADB immediately upon receipt of any Project PDMC's intention to withdraw its membership from the Recipient.	Schedule 5, para. 1	Complied with.
Project Management The Recipient shall be the Project Executing Agency for the Project. The Recipient shall be responsible for providing overall Project guidance and coordinating implementation of the Project. To ensure coordination and integration of the Project, the Project Executing Agency will be assisted by a Steering Committee. The Steering Committee shall include representatives from key stakeholder organizations with expertise in HIV/AIDS in the Pacific, including Project PDMC governments, civil society organizations, people living with HIV/AIDS, development partners, the Recipient and ADB. The Steering Committee shall operate within the framework of the coordinating and oversight vehicle established for the PRSIP and shall be responsible for: (a) the policy and strategic direction of the Project; (b) monitoring and reviewing Project implementation; and (c) providing necessary guidance as appropriate. The	Schedule 5, paras. 2-3	Partially complied with. At the inception meeting of the Response Fund Steering Committee in October 2008, the proposal to take responsibility for the Grant was rejected. The HIV Section Head then proposed that the PRSIP Coordinating and Coordinating and Strategic Reference Group (CSRG) take overall responsibility. Unfortunately, the group was not formed. The Executive Oversight Group (EOG) was established to provide close monitoring of implementation activities.

Covenant	Reference to Grant Agreement	Status of Compliance
Steering committee shall (a) meet as often as necessary to implement the Project and, at a minimum, no less than twice a year and (b) be maintained until Project completion.		
Donor and Strategy Coordination The Recipient shall ensure that the Project is implemented in accordance with the PRS and PRSIP, and that all Project activities complement the HIV/AIDS activities funded by the GFATM.	Schedule 5, para. 4	Being complied with. The ADB Project constitutes part of the PRSIP 2004-2008 and its successor PRSIP II (2009-2013), which are funded by multiple donors and coordinated by SPC.
Environmental Standards The Recipient shall monitor the Project activities resulting in medical waste. Through its LabNet initiative, the Recipient shall assist Project participating DMCs in complying with their respective national medical waste disposal laws, regulations and standards.	Schedule 5, para. 5	Complied with.
Project Performance Monitoring, Evaluation and Review The Recipient shall develop a comprehensive Project Performance Monitoring and Evaluation System (PPMES) based on the monitoring and evaluation framework adopted under the PRSIP. The PPMES shall systematically generate data on inputs and outputs of all Project components utilizing the PPM Indicators to measure Project impacts. No later than six months after Grant effectiveness, the Recipient shall refine the PPMES framework and attendant monitoring and recording arrangements and establish concrete systems and procedures for utilizing the PPMES framework to measure Project impacts. The PPMES shall be in a form and substance satisfactory to ADB.	Schedule 5, para. 6	Delayed compliance. The PPMES was submitted during Mid Term Review (2008).
Progress reports The Recipient, through the PMU, shall submit to ADB semi-annual progress reports and, within three months of Project completion, a Project completion report, each in form and substance satisfactory to ADB.	Schedule 5, para. 7	Complied with. Quarterly progress reports provided between Six Monthly Progress reports
Project Review Within 18 months of Grant effectiveness, the Recipient and ADB shall jointly undertake a mid-term review of the Project to assess the progress in implementing the Project objectives and identify any necessary changes in Project design, the Project implementation schedule and/or implementation arrangements as appropriate.	Schedule 5, para. 8	Complied with but delayed to 24 June–1 July 2008.

CONSULTING SERVICES

Consultants and Contractors Required	Actual Consultants and Contractors Recruited	Planned Input (person-months)	Actual Input (person-months)
Chief advisor	Grant coordinator	46.0	40.0
	Grant specialist & deputy coordinator[a]	0.0	33.0
Project officer	Project officer for M&E	46.0	24.0
	Project assistant	0.0	54.5
Lead surveillance specialist	HIV and STI surveillance officer	42.0	46.0
Epidemiologist	Epidemiologist	16.0	8.0
Database developer and information technology systems specialist	HIV & other STI data management officer	24.0	24.0
Laboratory specialist	HIV & other STI laboratory specialist	18.0	18.0
Mapping coordination specialist	Peer education mapping consultant	6.0	1.6
Condom social marketing specialist, international and national	Condom social marketing program under Marie Stopes International[b]	31.0	39.5
BCC specialist	BCC officer 1	35.0	32.5
Peer education and BCC specialist	BCC officer 2		48.5
	Peer education officer	84.0	9.0
STI specialist	STI specialist	10.0	11.0
	STI officer	0.0	12.0
Seafarer support officer	Seafarer support officer	6.0	14.0
HIV support specialist	HIV and STI laboratory consultant	9.0	6.5
	Second-generation survey specialist		14.5
	Social research desk review consultant		1.4
	Grant project design consultant		1.0
	Wan Smolbag[c]		27.0

BCC = behavior change communication, M&E = monitoring and evaluation, STI = sexually transmitted infection.

[a] New position approved through a minor change in scope memo dated January 2008.

[b] Marie Stopes International was hired to implement the community response to HIV/AIDS prevention component of the Grant.

[c] Wan Smolbag is a Vanuatu nongovernment organization that produced *Love Patrol*, a BCC capacity-building output.

Source: Asian Development Bank estimates.

LIST OF EQUIPMENT

Table 7.1: List of Equipment Procured under the Grant

Equipment Description	Location	Year Procured
1 desktop computer 1 laser color printer 1 laptop computer	SPC Suva laboratory specialist	2006
Computer & accessories Laser printer Computer table Phone & fax machine Office chairs (high and low back) Table with folding legs 12 stackable plastic chairs 2-drawer filing cabinet Electric jug and water filter Refrigerator, television, & DVD player Table tennis table and accessories Dartboard, board games, and pool table Board games Pool table Stationeries and office supplies Air conditioner Container with awning	Equipment for seafarers' drop-in center. One set of equipment each was provided to Kiribati; Majuro, Republic of the Marshall Islands; Honiara and Noro, Solomon Islands; Santo and Port Vila, Vanuatu; and Tuvalu.	2006
STI pilot testing equipment: Probetec Instrument	Cook Islands	2007
STI pilot test equipment: Probetec Instrument	Solomon Islands	2008
STI pilot test equipment: Probetec Instrument	Vanuatu	2009
Desktop computers (including UPS and software) for laboratory data management and routine surveillance	Nauru, Solomon Islands and Tonga	2008
STI equipment including disinfector, vaginal speculum, and sponge forceps	Cook Islands, Federated States of Micronesia, Kiribati, Nauru, Republic of the Marshall Islands, Solomon Islands, Tonga	2009
PIMA™ 4 Machine	Solomon Islands	2010

SPC = Secretariat of Pacific Community, STI = sexually transmitted infection, UPS = uninterrupted power supply

Sources: Asian Development Bank and Secretariat of the Pacific Community progress reports.

Table 7.2: Distribution of Laboratory Equipment Procured under the Grant

Country	Diagnostic equipment sets		Routine laboratory equipment				Office Equipment
	Probetec Instrument	Dynal CD4 Testing	Microscopes	Speculums	Boiling Instrument Sterilizers	Sponge Forceps	Computers (Including UPS and Software) for Data Management
Cook Islands	1 (2007)			12			
Federated States of Micronesia		1 (2008) [a]	1	170			
Kiribati		1 (2010) [a]	3	20	1	10	
Republic of the Marshall Islands		1 (2010) [a]		72			
Nauru			1	40	1	5	1 (2008)
Samoa		1 (2010) [a]		20	1	10	
Solomon Islands	1 (2008)	1 (2010)	1	18	2		1 (2008)
Tonga		1 (2010) [a]		9	1		1 (2008)
Tuvalu		1 (2010) [a]					
Vanuatu	1 (2009)	1 (2010) [a]					
SPC		1 (2010) [a]					1 (2006)

( ) = year of acquisition, SPC = Secretariat of the Pacific Community, UPS = uninterrupted power supply.
[a] Provided by other development partners as part of coordination agreements.
Source: Secretariat of the Pacific Community progress reports, 2006–2010.

SELECTED DATA ON HIV/AIDS PREVENTION AND CAPACITY DEVELOPMENT IN THE PACIFIC

Table 8.1: Second-Generation Surveillance Reports and Rapid Reviews Dissemination

Country	First SGS Survey		Routine laboratory equipment		SGS Rapid Review
	Published (Year)	Results Disseminated	Published (Year)	Results Disseminated	Results Disseminated
Cook Islands	2009	Mar 2010			Mar 2010
FSM	2010	Oct 2009			Oct 2009
Kiribati	2006[a]	2007	2010	Jul 2009	Jul 2009
RMI	2010	Oct 2009			Oct 2009
Nauru	DHS 2007[b]	n/a			n/a
Samoa	2006[a]	2007	2009 (printed)	Limited [c]	Aug 2009
Solomon Islands	2006[a]	2007	2009	Oct 2009	Oct 2009
Tonga	2006[a]	2007	2008	Jun 2009	Jun 2009
Tuvalu	2007	Apr 2009			Apr 2009
Vanuatu	2006[a]	2007	2009	Jun 2009	Jun 2009

DHS = demographic health survey, FSM = Federated States of Micronesia, n/a = not applicable, RMI = Republic of the Marshall Islands, SGS = second-generation surveillance.

[a] SGS of HIV, other sexually transmitted infections, and risk behavior in six Pacific island countries was conducted by the University of New South Wales with support from the World Health Organization and the Secretariat of the Pacific Community.

[b] Demographic health survey with a special component on HIV/AIDS and other sexually transmitted infections provided by the Secretariat of the Pacific Community.

[c] The Ministry of Health endorsed the report but did not make it public.

Source: Secretariat of the Pacific Community progress reports, 2006–2010.

Table 8.2: New Cases of HIV and Deaths from HIV in Pacific Developing Member Countries, 2006–2009

Country	2006		2007		2008		2009	
	New Cases	Deaths	New Cases	Deaths	New Cases	Deaths	New Cases	Deaths
All Pacific Countries (excluding PNG)	89	21	87	10	85	8	82	17
Melanesia (excluding PNG)	62	4	48	4	48	0	57	7
Solomon Islands	2	0	2	1	2	0	1	1
Vanuatu	1	1	2	1	0	0	0	0
Micronesia	12	16	23	6	15	7	9	5
FSM	5	12	3	0	1	1	1	0
Kiribati			8		2	0	0	0
RMI	2	0	0	0	5	1	3	1
Nauru	0	0	0	0	0	0	0	0
Polynesia	15	1	16	0	22	1	16	5
Cook Islands	0	0	0	0	0	0	0	0
Samoa	0	0	4	0	3	0	3	1
Tonga	0	0	1	0	2	1	1	0
Tuvalu			0	0	1	0	0	0

FSM = Federated States of Micronesia, PNG = Papua New Guinea, RMI = Republic of the Marshall Islands.

Sources: HIV epidemiological update for Pacific island countries in 2006, 2007, 2008, and 2009; Secretariat of the Pacific Community estimates and reports for 2006–2010.

Table 8.3: Cumulative Reported HIV and AIDS Prevalence and deaths in Pacific Developing Member Countries, 2006–2009

Country	HIV (including AIDS)				AIDS (including deaths)				AIDS-related deaths				HIV Cumulative Incidence per 100,000			
	2006	2007	2008	2009	2006	2007	2008	2009	2006	2007	2008	2009	2006	2007	2008	2009
All Pacific Countries (excluding PNG)	**1,166**	**1,255**	**1,337**	**1,419**	**446**	**469**	**486**	**496**	**238**	**303**	**313**	**342**	**39**	**42**	**44**	**46**
Melanesia (excluding PNG)	**542**	**590**	**638**	**695**	**148**	**160**	**162**	**167**	**65**	**76**	**76**	**95**	**31**	**33**	**35**	**37**
Solomon Islands	8	10	12	13	3	4	5	5	3	4	4	5	2	2	2	2
Vanuatu	3	5	5	5	3	5	5	5	1	2	2	2	1	2	2	2
Micronesia	**307**	**331**	**343**	**352**	**174**	**181**	**193**	**196**	**92**	**145**	**154**	**159**	**57**	**63**	**64**	**65**
Federated States of Micronesia	32	35	36	37	27	27	28	28	27	27	28	28	29	32	33	33
Kiribati	46	54	52	52	28	28	28	28	23	23	23	23	49	57	54	53
Republic of the Marshall Islands	12	13	19	22	2	5	11	12	2	4	7	8	21	25	35	41
Nauru	2	2	2	2	1	1	1	1	1	1	1	1	20	20	21	21
Polynesia	**317**	**334**	**356**	**372**	**124**	**128**	**131**	**133**	**81**	**82**	**83**	**81**	**49**	**51**	**54**	**56**
Cook Islands	2	2	2	2									15	15	13	13
Samoa	12	16	19	22	8	8	8	9	8	8	8	9	7	9	10	12
Tonga	14	15	17	18	9	10	10	10	8	8	9	9	14	15	17	18
Tuvalu	9	10	11	11	2	3	4	4	2	3	3	3	93	103	100	99

PNG = Papua New Guinea.

Sources: HIV epidemiological update for Pacific island countries in 2006, 2007, 2008, and 2009; Secretariat for the Pacific Community estimates and reports for 2006–2010.

Table 8.4: Prevalence of Sexually Transmitted Infections among Adults Aged 15–49 in Pacific Developing Member Countries, 2009–2010

(%)

Country	Chlamydia Positive Tests		Gonorrhea Positive Tests		Syphilis Positive Tests	
	Male	Female	Male	Female	Male	Female
Melanesia						
Solomon Islands						
Vanuatu	9.3	20.0	8.7	5.9	1.3	3.0
Micronesia						
Federated States of Micronesia	15.1	16.9	5.0	2.7	2.3	1.5
Kiribati	6.3	10.2	1.3	2.6		
Republic of the Marshall Islands	24.2	18.7	32.7	4.2	0.7	1.6
Nauru	37.5	34.6	25.0	2.9	1.4	2.4
Polynesia						
Cook Islands	38.8	25.3	31.3	5.0	0.8	0.4
Samoa		26.9				
Tonga	29.2	20.0	56.7	6.6		
Tuvalu[a]	9.5	10.3		1.6	5.4	3.4

[a] Tuvalu HIV data is for 12 months.

Sources: Secretariat of the Pacific Community estimates and reports for 2006–2010; Cook Islands second-generation surveillance (SGS) report for 2005–2006, Pohnpei SGS report for 2008; SGS of HIV, other sexually transmitted infections, and risk behavior in six Pacific island countries and territories for 2004–2055; Republic of the Marshall Islands SGS report for 2006; Solomon Islands SGS report for 2008; Tonga SGS report for 2008; Tuvalu SGS report for 2007; Vanuatu SGS report for 2008.

Table 8.5: HIV Testing and Sexually Transmitted Infection Prevalence among Pregnant Women in Pacific Developing Member Countries, 2004–2010

(%)

Country	HIV testing			Chlamydia Positive Tests			Gonorrhea Positive Tests			Syphylis Positive Tests			Trichomonas Positive Tests		
	2004–2006	2007–2008	2009–2010	2004–2006	2007–2008	2009–2010	2004–2006	2007–2008	2009–2010	2004–2006	2007–2008	2009–2010	2004–2006	2007–2008	2009–2010
All Pacific Countries (excluding PNG)			**31.1**			**19.9**			**3.0**			**2.8**			
Melanesia			**16.1**			**18.6**			**3.1**			**-**			
Solomon Islands		1.2		6.4	10.8	n/a	0.4	1.3	n/a	10.0	3.4	n/a		17.9	
Vanuatu				13.2	25.1	18.6	2.4	3.0	3.1	0.8	5.0				
Micronesia			**47.6**			**18.2**			**3.8**			**3.2**			
Federated States of Micronesia		18.9			25.8	18.9		1.6	6.3		0.8	2.1			
Kiribati				13.0		17.5			4.4	2.1		8.5			
Republic of the Marshall Islands		4.8		25.1		23.1	2.5		3.8	12.4		3.5			
Nauru						49.3			4.2			-			
Polynesia			**65.9**			**23.0**			**1.7**			**1.1**			
Cook Islands	5.3			19.8		19.7	2.2		0.5	1.2		0.5	8.0		
Samoa		0.3		26.8		26.9	2.3		-						
Tonga		0.6		14.5	12.8	18.8	2.5	1.2	4.9	3.2		0.4			
Tuvalu[a]				17.5		13.2	0.9		3.8	1.7		4.9			

PNG = Papua New Guinea.

[a] Tuvalu HIV data is for 12 months.

Sources: Secretariat of the Pacific Community estimates and reports for 2006–2010; Cook Islands second-generation surveillance (SGS) report for 2005–2006, Pohnpei SGS report for 2008; SGS of HIV, other sexually transmitted infections, and risk behavior in six Pacific island countries and territories for 2004–2055; Republic of the Marshall Islands SGS report for 2006; Solomon Islands SGS report for 2008; Tonga SGS report for 2008; Tuvalu SGS report for 2007; Vanuatu SGS report for 2008.

Table 8.6: Laboratory Training of Medical Personnel in Pacific Developing Member Countries, 2007–2009

(trainees/country)

Country	Use of diagnostic equipment			STI Surveillance			
	Probetec instrument	Laboratory Updates for Technicians	PIMA CD4 Machine	STI Updates for Lab Specialist	Trichomonas Microscopy for Clinicians	Chlamydia Trainings	Comprehensive Case Management
Cook Islands				2		2	25
Federated States of Micronesia					2		35
Kiribati			5	5			26
Republic of Marshall Islands							25
Nauru				3	3		22
Samoa			3	12			18
Solomon Islands	2	24	3	18	2		79
Tonga			4	8			
Tuvalu			1	2			21
Vanuatu			3	6	4		16

STI = sexually transmitted infection.

Note: Training courses were conducted for 2–4 days. Comprehensive training on STIs was conducted in Pacific island countries and territories with joint support to the Secretariat of the Pacific Community from the Centers for Disease Control, World Health Organization, Oceania Society for Sexual Health and HIV Medicine, and United Nations Population Fund.

Table 8.7: Production and Distribution of Information, Education, and Communication Materials in Pacific Developing Member Countries, 2008–2010

Country	Seafarer's Diaries			Other IEC Materials		Safe Sex Kits	
	2008	2009	2010	STI Testing Brochure	STI Testing Comics	Male	Female
Pacific countries involved in grant implementation							
Cook Islands	400	400	50	3,000		2,000	1,000
Federated States of Micronesia	500	500	190			30,000	10,000
Kiribati	800	850	800			2,000	1,000
Republic of Marshall Islands	255	205	200			20,000	5,000
Nauru	50	50	20	2,000	1,000	500	500
Samoa	250	250	200			2,000	1,000
Solomon Islands	410	410	320	5,000		60,000	20,000
Tonga	350	350	200	1,000		2,000	1,000
Tuvalu	650	600	400			2,000	1,000
Vanuatu	350	275	220	20,000		60,000	20,000
Subtotal	**4,015**	**3,890**	**2,600**			**180,500**	**60,500**
Other Pacific countries							
Fiji	1,600	1,600	745				
Niue	40	40					
Palau	100	100	100				
Papua New Guinea	800	800	800				
Total	**6,555**	**6,430**	**4,245**				

IEC = information, education, and communication, STI = sexually transmitted infection.
Source: Secretariat of the Pacific Community progress reports for 2006–2010.

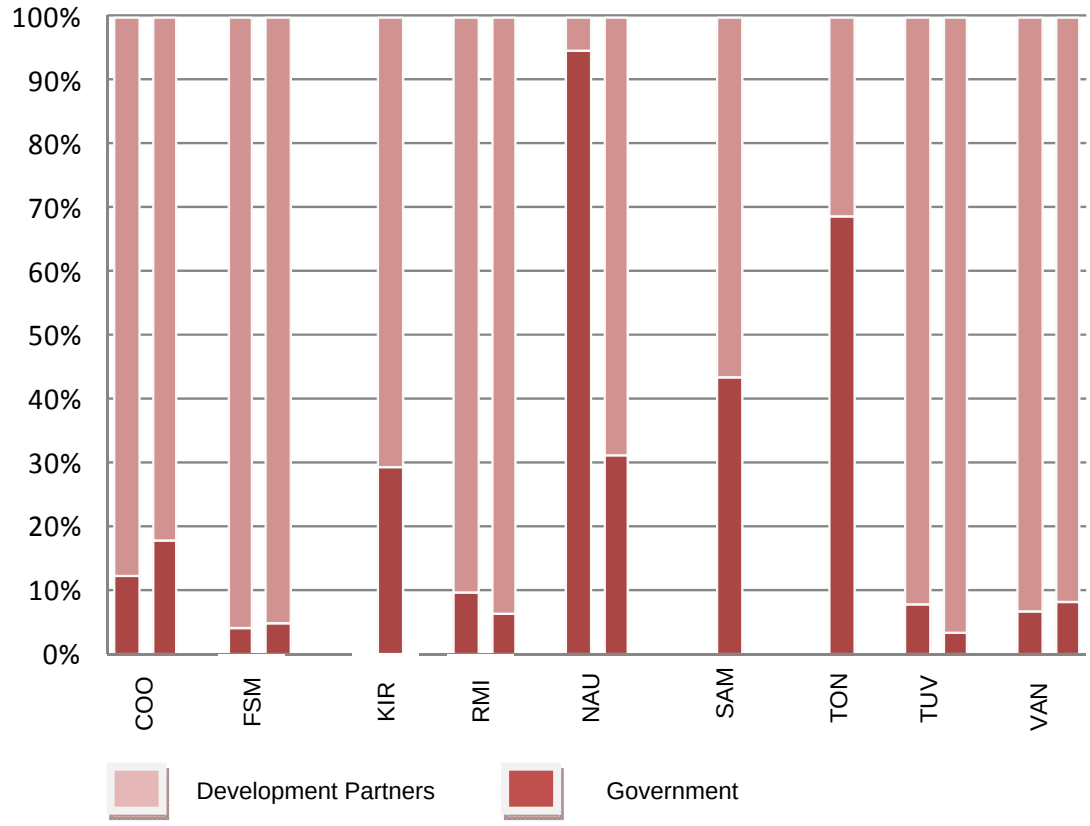
Table 8.8: Capacity Building for Community Response to HIV and Other Sexually Transmitted Infections in Participating Developing Member Countries, 2007–2009

(people/year)

Country	Developing BCC Materials / Planning and Management of HIV Response				Stepping Stones		
	2006	2007	2008	2009–2010[a]	2007	2008	2009[a]
Cook Islands	26			5			
Federated States of Micronesia	20	19		11			
Kiribati	23	10		33	18		33
Republic of Marshall Islands	12	49		61			
Nauru	19			31			
Samoa	16	22		22			
Solomon Islands	20	10			7	56	
Tonga		25	13	78			
Tuvalu	15			45	4		
Vanuatu				13	4	27	
SPC	20	8	5	4			

BCC = behavior change communication.
[a] Provided by other development partners as part of coordination agreements.
Source: Secretariat of the Pacific Community progress reports, 2006–2010.

Cofinancing of the HIV and Other Sexually Transmitted Disease Programs in Participating Developing Member Countries, 2009–2010
(%)



COO = Cook Islands, FSM = Federated States of Micronesia, KIR = Kiribati, RMI = Republic of the Marshall Islands, NAU = Nauru, SAM = Samoa, TON = Tonga, TUV= Tuvalu, VAN = Vanuatu.
Note: Data for Kiribati, Samoa, and Tonga available for 2010 only.
Source: Global Fund for AIDS, Tuberculosis, and Malaria national cofinancing reports, 2009–2010.

OVERALL ASSESSMENT SUMMARY

Criterion	Weight (%)	Assessment	Rating Value	Weighted Rating
Relevance	20	Highly relevant	3	0.6
Effectiveness	30	Effective	2	0.6
Efficiency	30	Less efficient	1	0.3
Sustainability	20	Likely sustainable	2	0.4
Overall Rating		**Successful**		**1.9**

Highly successful = overall weighted average is greater than 2.7.
Successful = overall weighted average is 1.6 or higher but less than 2.7.
Partly successful = overall weighted average is 0.8 or higher but less than 1.6.
Unsuccessful = overall weighted average is less than 0.8.
Source: Operations Evaluation Department. 2006. *Guidelines for Preparing Performance Evaluation Reports for Public Sector Operations*. Manila.