ADB

Completion Report

Project Number: 39033
Grant Number: 0042
April 2017

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

Asian Development Bank

CURRENCY EQUIVALENTS

Currency Unit – kina (K)

		At Appraisal	At Project Completion
		25 April 2006	30 June 2012
K1.00	=	$0.33	$0.45
$1.00	=	K3	K2.21

ABBREVIATIONS

ADB	–	Asian Development Bank
BSS	–	behavioral surveillance study
CCM	–	Country Coordinating Mechanism (Global Fund)
CHAI	–	Clinton Health Access Initiative
CPS	–	country partnership strategy
CSM	–	condom social marketing
DFAT	–	Department of Foreign Affairs and Trade (Australia)
HSIP	–	Health Services Improvement Program
MOA	–	memorandum of agreement
NACS	–	National Aids Council Secretariat
NDOH	–	National Department of Health
NRI	–	National Research Institute
NSP	–	National Strategic Plan on HIV/AIDS
PNG	–	Papua New Guinea
PPP	–	public–private partnership
PSI	–	Population Services International
SOE	–	statement of expenditure
STI	–	sexually transmitted infection
TNT	–	*Tokaut na Tokstret* (PSI's Sexual Health & Relationships Program)
UNAIDS	–	Joint United Nations Programme on HIV/AIDS
UNDP	–	United Nations Development Programme
WHO	–	World Health Organization

NOTE

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

Vice-President	S. Groff, Operations 2
Director General	X. Yao, Pacific Department (PARD)
Director	E. Veve, Urban, Social Development and Public Management Division, PARD
Team leader	I. Mikkelsen-Lopez, Health Specialist, PARD
Team members	N. Carandang, Safeguards Specialist, PARD
	A. Salvador, Operations Officer, PARD

CONTENTS

BASIC DATA

A. Grant Identification

1.	Country	Papua New Guinea
2.	Grant Number	0042
3.	Project Title	HIV/AIDS Prevention and Control in Rural Development Enclaves
4.	Receiver	PNG Department of Treasury
5.	Executing Agency	PNG National Department of Health
6.	Amount of Grant	$25.0 million
7.	Project Completion Report Number	1611

B. Grant Data

1.	Appraisal/Fact-finding	
	– Date Started	28 August 2005
	– Date Completed	7 September 2005
2.	Grant Negotiations	
	– Date Started	21 November 2005
	– Date Completed	24 November 2005
3.	Date of Board Approval	25 April 2006
4.	Date of Grant Agreement	5 June 2006
5.	Date of Grant Effectiveness	
	– In Grant Agreement	3 September 2006
	– Actual	31 August 2006
	– Number of Extensions	0
6.	Closing Date	
	– In Grant Agreement	31 July 2010
	– Actual	17 February 2016
	– Number of Extensions	4
7.	Terms of Loan	NA
	– Interest Rate	
	– Maturity (number of years)	
	– Grace Period (number of years)	
8.	Terms of Re-lending (if any)	NA
	– Interest Rate	
	– Maturity (number of years)	
	– Grace Period (number of years)	
	– Second-Step Borrower	

9. Disbursements

a. Dates

Initial Disbursement	Final Disbursement	Time Interval
18 October 2006	22 January 2016	111.20 months
Effective Date	**Original Closing Date**	**Time Interval**
31 August 2006	31 July 2010	47.03 months

b. Amount ($)

Category No.		Category Name	Original Allocation	Last Revised Allocation	Amount Disbursed	Undisbursed Balance	Amount Cancelled
3201	01	Civil Works	2,592,000	4,442,000	4,187,997	254,003	254,003
3601	02A	Computers & Medical Equipment	1,380,000	1,220,000	1,481,583	(261,583)	(261,583)
3602	02B	Vehicles	742,000	452,000	449,927	2,073	2,073
1100	03	Consultants-ADB	10,000,000	8,110,789	9,476,358	(1,365,569)	(1,365,569)
1400	04A	Studies, Surveys & Reports	2,490,000	2,819,796	3,219,918	(400,122)	(400,122)
3101	04B	Other Consulting Services	1,545,000	165,041	2,393	162,648	162,648
3801	05	Training, Seminars & Workshops	1,035,000	1,527,000	1,117,320	409,680	409,680
3901	06	Project Management	1,494,000	491,960	549,188	(57,228)	(57,228)
1900	07	Unallocated	722,000	1,593,786	0	1,593,786	1,593,786
1200		Equipment		197,571	168,716	28,855	28,855
1300		Training		980,057	422,949	557,108	557,108
		Total	**22,000,000**	**22,000,000**	**21,076,349**	**923,651**	**923,651**

( ) = negative, ADB =Asian Development Bank, NA = not applicable, PNG = Papua New Guinea.

10. Local Costs (Financed)

- Amount ($) 4.19 million
- Percent of Local Costs 58%
- Percent of Total Cost 17%

C. Project Data

1. Project Cost ($ million)

Cost	Appraisal Estimate	Actual
Foreign Exchange Cost	10.52	16.89
Local Currency Cost	14.48	7.28
Total	25.00	24.16

2. Financing Plan ($)

Cost	Appraisal Estimate	Actual
Implementation Costs		
Government of PNG Financed	3.00 million	3.09 million
ADB Financed	15.00 million	14.08 million
Grant from Government of Australia	3.50 million	3.50 million
Grant from Government of New Zealand	3.50 million	3.50 million
Total	**25.00 million**	**24.16 million**
IDC Costs		
Borrower Financed	0	0
ADB Financed		
Other External Financing	0	0
Total	**25.00 million**	**24.16 million**

ADB = Asian Development Bank, IDC = interest during construction, PNG = Papua New Guinea.

3. Cost Breakdown by Project Component

Component	Appraisal Estimate	Actual
Component 1 Public–Private Partnerships (PPPs)	7.10 million	8.97 million
Component 2 CSM & Behavior Change (PSI)	12.48 million	14.28 million
Component 3 HIV Surveillance (NDOH & NRI)	3.75 million	0.30 million
Component 4 Project Management	1.67 million	0.61 million
Total	25.00 million	24.16 million

CSM = Condom Social Marketing, NDOH = National Department of Health, NRI = National Research Institute, PPP = public-private partnership, PSI = Population Services International.

4. Project Schedule

Item	Appraisal Estimate	Actual
Date of Contract with Consultants		
Neil Brenden – Project Coordinator	Q2 2006	26 September 2006
Jeremy Syme – Project Manager	Replacement	30 March 2009
Stephen Charteris – PPP Specialist	Q2 2006	5 September 2006
John Gugumi – Deputy Project Manager (Operations)	Replacement	19 September 2007
Dorothy Memti – Operations & Finance	Replacement	4 December 2010
Holly Buchanan – Behavioral Surveillance	Q2 2006	1 March 2007
Fumihiko Yokota – Epidemiologist	Q2 2006	20 October 2007
Andia Kenneth – Procurement Officer	Q2 2006	29 January 2007
Donald Wari – Accountant	Replacement	14 April 2009
Stanley Mando – Building Field Supervisor	Q2 2006	7 July 2008
Kel Browne – Deputy Project Manager (Health)	Q2 2006	1 April 2007
Midterm Review		
Lea Shaw	Q3 2008	14 August 2008
Civil Works Contracts Phase 1		
WR Carpenters & Co Estates	**Date of Award**	**Completion of Work**
Kudjip Tea Esate Aid Post (Company)	October 2007	September 2008
Kigibah Estate Aid Post (Company)	November 2007	November 2008
Bunumwo Aid Post (Company)	October 2007	November 2008

Sigri Coffee Aid Post (Company)	October 2007	September 2008
Kimel Health Center (Government)	October 2007	November 2008
Aviamp Health Sub-Center (Government)	October 2007	July 2008
St Anzalem Aid Post (Church)	October 2007	November 2008
Shalom Care Center (Church)	October 2007	November 2008
Mt. Hagen Hospital Counselling Rooms (Government)	October 2007	October 2008
Aviamp Tea Estate Aid Post (Company)	January 2010	February 2010
Kindeng Tea Estate Aid Post (Company)	November 2009	February 2010
Kindeng Coffee Estate Aid Post (Company)	November 2009	February 2010
Kindeng Health Center (Government)	November 2009	February 2010
Nunga Health Sub-Center (Government)	November 2009	February 2010
Kawi Aid Post (Government)	November 2009	February 2010
Usnang Aid Post (Church)	November 2009	February 2010
Nazarene White House Clinic (Church)	November 2009	March 2010

Ramu Agri Industries	**Date of Award**	**Completion of Work**
Ranara Aid Post (Government)	October 2008	June 2009
Gusap Health Center (Government)	September 2007	April 2008
Walium Health Center (Government)	December 2007	July 2008
Bibuai Aid Post (Church)	October 2007	July 2008
Dumpu Aid Post (Government)	October 2008	June 2009
Kesewai Aid Post (Government)	October 2008	October 2009
Rai Clinic (Company)	December 2007	June 2009

Barrick Kainantu	**Date of Award**	**Completion of Work**
Apinenga Day Clinic (Government)	July 2007	March 2009
Apinenga CHW House (Government)	July 2007	March 2009
Musuam Aid Post (Government)	July 2007	June 2009
Marawasa Aid Post (Government)	July 2007	March 2009
Onamunga Health Center (Church)	July 2007	March 2009
Urante Famo Aid Post (Church)	July 2007	August 2009
Sonofi Aid Post (Government)	July 2007	August 2009
Fomu 1 Aid Post (Government)	July 2007	August 2009
Kainantu Hospital (Government)	July 2007	April 2010

Pogera Joint Venture	**Date of Award**	**Completion of Work**
Pogera Urban Clinic (Government)	July 2007	June 2009
Mulitaka Health Center (Government)	July 2007	June 2009

Oil Search	**Date of Award**	**Completion of Work**
Bagaule Health Sub-Center (Government)	October 2007	April 2009
Inu Health Sub-Center (Government)	October 2007	January 2009
Sisibiah Aid Post (Government)	October 2007	January 2009
Tugiri Aid Post (Government)	October 2007	January 2009
Kaipu Health Sub-Center (Government)	October 2007	May 2009
Pimaga Rural Hospital (Government)	October 2007	March 2009

Higaturu Oil Palms	**Date of Award**	**Completion of Work**
Siroga Clinic (Company)	September 2008	July 2009
Sangara Health Center (Government)	September 2008	July 2009
Saiho Health Center (Government)	March 2007	January 2010
Isivini Aid Post (Government)	March 2007	January 2010
Igora Aid Post (Government)	March 2007	January 2010
Embi Clinic (Company)	March 2007	April 2010

Civil Works Contracts Phase 2

WR Carpenters & Co Estates	Date of Award	Completion of Work
Minj Health Center (Government)	February 2010	August 2010
Norba Health Sub-Center (Church)	February 2010	August 2010
Nazarene White House (Church)	February 2010	August 2010
Dona Health Sub-Center (Church)	February 2010	July 2010
Banz 1 Mitimongum Health Sub-Center (Church)	February 2010	July 2010
Bukapena Aid Post (Government)	February 2010	June 2011
Minj Health Center (Government, defect rectification)	February 2012	April 2012

Higaturu Oil Palms	Date of Award	Completion of Work
Tingim Laip Resource Center (Company)	March 2009	April 2010
Gona Health Sub-Center (Church)	March 2007	August 2010
Oro Bay Health Center (Church)	March 2010	October 2010
Irigi Clinic (Company)	September 2010	February 2011
Sorovi Aid Post (Government)	September 2010	February 2011
Bareji Aid Post (Government)	September 2010	December 2010
Moale Aid Post (Company)	September 2010	December 2010

Ramu Agri Industries	Date of Award	Completion of Work
Mutzing Health Center (Government)	October 2008	July 2010
Modilon Hospital Pathology Laboratory (Government)	October 2008	July 2010
Ragiampun Aid Post (Government)	October 2009	November 2010
Ragiampun Aid Post - 1 x staff house	October 2009	November 2010
Tsuia Health Sub-Center (Government)	October 2009	December 2010

Pogera Joint Venture	Date of Award	Completion of Work
Pogera Urban Clinic - Staff House No. 1	June 2010	December 2010
Pogera Urban Clinic - Staff House No. 2	June 2010	December 2010
Pogera Urban Clinic - Staff House No. 3	June 2010	December 2010
Pogera Urban Clinic - Staff House No. 4	June 2010	December 2010
Pogera Urban Clinic - Staff House No. 5	June 2010	December 2010
Pogera Urban Clinic - Staff House No. 6	June 2010	December 2010
Mulitaka Health Center - Staff House No. 1	June 2010	December 2010
Mulitaka Health Center - Staff House No. 2	June 2010	December 2010
Mulitaka Health Center - Staff House No. 3	June 2010	December 2010
Mulitaka Health Center - Staff House No. 4	June 2010	December 2010
Mulitaka Health Center - Staff House No. 5	June 2010	December 2010
Paiam–Pogera Hospital - HIV Clinic	January 2011	December 2011

Oil Search	Date of Award	Completion of Work
Waro Health Sub-Center (Government)	December 2008	January 2010
Kantobo Aid Post (Government)	December 2008	January 2010
Juni Health Sub-Center (Government)	September 2010	May 2011
Malanda Health Center (Church)	September 2010	July 2011
Idauwi Health Sub-Center (Government)	September 2010	June 2011
Hiwanda Health Sub-Center (Church)	September 2010	July 2011
Kikori Hospital (Church)	September 2010	May 2011

Barrick Kainantu	Date of Award	Completion of Work
Tuta Aid Post & Staff House (Church)	July 2007	February 2012
Famo Ston Aid Post and Staff House (Church)	July 2007	February 2012
Bilimoa Aid Post (Government)	July 2007	February 2012
Pomasi Aid Post (Church)	July 2007	February 2012
Kainantu Hospital Laboratory (Government)	July 2007	May 2012

Equipment and Supplies	Appraisal Estimate	Actual
Health Radios		Q4 2007
Medical Equipment Kits hase 1	Q3 2006	Q2 2008
Medical Equipment Kits Phase 1	Q3 2006	Q2 2008
AT Projects Incinerators		Q2 2010
Vaginal Speculums Boucher & Muir		Q2 2010
Computers & Equipment for Surveillance Phase 1	Q2 2006	Q3 2009
Computers for Equipment Surveillance Phase 2		Q3 2011
Medical Equipment Kits Meddent Phase 2		Q2 2012
FHI360 for the IBBS		Q2 2012
Motor Vehicles Enclave Companies	Q3 2006	Q3 2007
Motor Vehicles NDOH, NRI, PSU	Q2 2006	Q3 2009
CD4 Machines (Laboratory)		Q4 2010
Laboratory Renovation & Equipment CPHL PMGH		Q4 2007

Project Milestones

1.	**For Establishing Public–Private Partnerships in Rural Enclaves**		
1.1	Design template MOA for public-private partnerships	Q1 2006	Q1 2007
1.2	Initially establish at least two public-private sector partnerships in rural development enclaves to expand PHC, including maternal and child health, and HIV/AIDS prevention and treatment	Q4 2006	Q2 2007
1.3	Rehabilitate rural health facilities for primary health care and upgrade and equip enclave health facilities for HIV prevention and care activities within 6 months of signed MOA	Q3 2006	Q3 2008
1.4	Support WHO, NDOH, NACS, and their partners to train health care providers in rural development enclaves for VCT, HIV-related laboratory activities, and treatment; assess quarterly	Q3 2006	Q4 2007
1.5	Support UNAIDS and UNDP to undertake HIV/AIDS advocacy skills for members of the Special Parliamentary Committee on HIV/AIDS Advocacy and other targeted leaders at all levels of government; assess on quarterly basis	Q2 2006	
2.	**For Community Behavior Change and Social Marketing of Condoms**		
2.1	Contract one international NGO or firm to work with each development enclave and local community-based NGOs, CBOs and/or FBOs to develop and implement the targeted behavioral change program strategies	Q2 2006	Q1 2007
2.2	Conduct baseline surveys within 2 months of signed MOA	Q2 2007	Q3 2008
2.3	Initiate development of skills and techniques of NGOs, CBOs and/or FBOs to conduct long-term BCC and monitoring of behavioral change in targeted districts	Q3 2006	Q3 2007
2.4	Contract one international social marketing organization	Q2 2006	Q1 2007

3.	**For Strengthening and Expanding National HIV/AIDS Surveillance System**		
3.1	Contracts for consultants executed by March 2006	Q1 2006	Q1 2007 Q4 2007
3.2	Complete transitional plan for moving system to NDOH and begin implementation	Q2 2006	Q2 2008
3.3	Establish HIV/AIDS surveillance unit in NDOH, and behavioral surveillance unit in NRI	Q2 2006	Q4 2007 Q1 2007
3.4	Complete expanded system design and begin implementation of surveillance system in phased manner	Q2 2006	Q4 2007
3.5	Training of staff in facilities included in national HIV/AIDS surveillance system as facilities come online	Q3 2006	Q2 2008
3.6	Equip facilities included in surveillance system and prepare protocols and reference manuals	Q4 2006	Q2 2008
4.	**Project Management**		
4.1	Contract for project coordinator executed by March 2006	1 Mar 2006 31 Dec 2008 30 Nov 2011	29 Sep 2006 30 Mar 2009 01 Dec 2012
4.2	CCM review meetings	Q2 2006	Q2 2007
4.3	Manage and coordinate Project activities	Q1 2006	Q3 2006
4.4	Manage relationships with co-financiers	Q1 2006	Q3 2006
4.5	Monitor and evaluate project progress and outputs, quarterly	Q3 2006	Q1 2008
4.6	Submission of reports	Q3 2006	Q4 2006

BCC = behavior change communication, CBO = community-based organization, CPHL = Central Public Health Laboratory, FBO = faith-based organization, MOA = memorandum of agreement, NACS = National Aids Council Secretariat , NDOH = National Department of Health, NGO = nongovernment organization, NRI = National Research Institute, PHC = primary health care, PMGH = Port Moresby General Hospital, PPP = public-private partnership, PSU = project support unit, Q = quarter, UNAIDS = Joint United Nations Programme on HIV/AIDS, UNDP = United Nations Development Programme, VCT = Voluntary Counseling and Testing, WHO = World Health Organization.

5. Project Performance Report Ratings

	Ratings	
Implementation Period	**Development Objectives**	**Implementation Progress**
From 25 April 2006 to 31 December 2006	Satisfactory	Satisfactory
From 1 January 2007 to 31 December 2007	Satisfactory	Highly Satisfactory
From 1 January 2008 to 31 December 2008	Satisfactory	Highly Satisfactory
From 1 January 2009 to 31 December 2009	Satisfactory	Satisfactory
From 1 January 2010 to 31 December 2010	Satisfactory	Satisfactory
From 1 January 2011 to 31 December 2011		On Track
From 1 January 2012 to 31 December 2012		On Track
From 1 January 2013 to 31 December 2013		Potential Problem
From 1 January 2014 to 31 December 2014		Potential Problem
From 1 January 2015 to 31 December 2015		Potential Problem

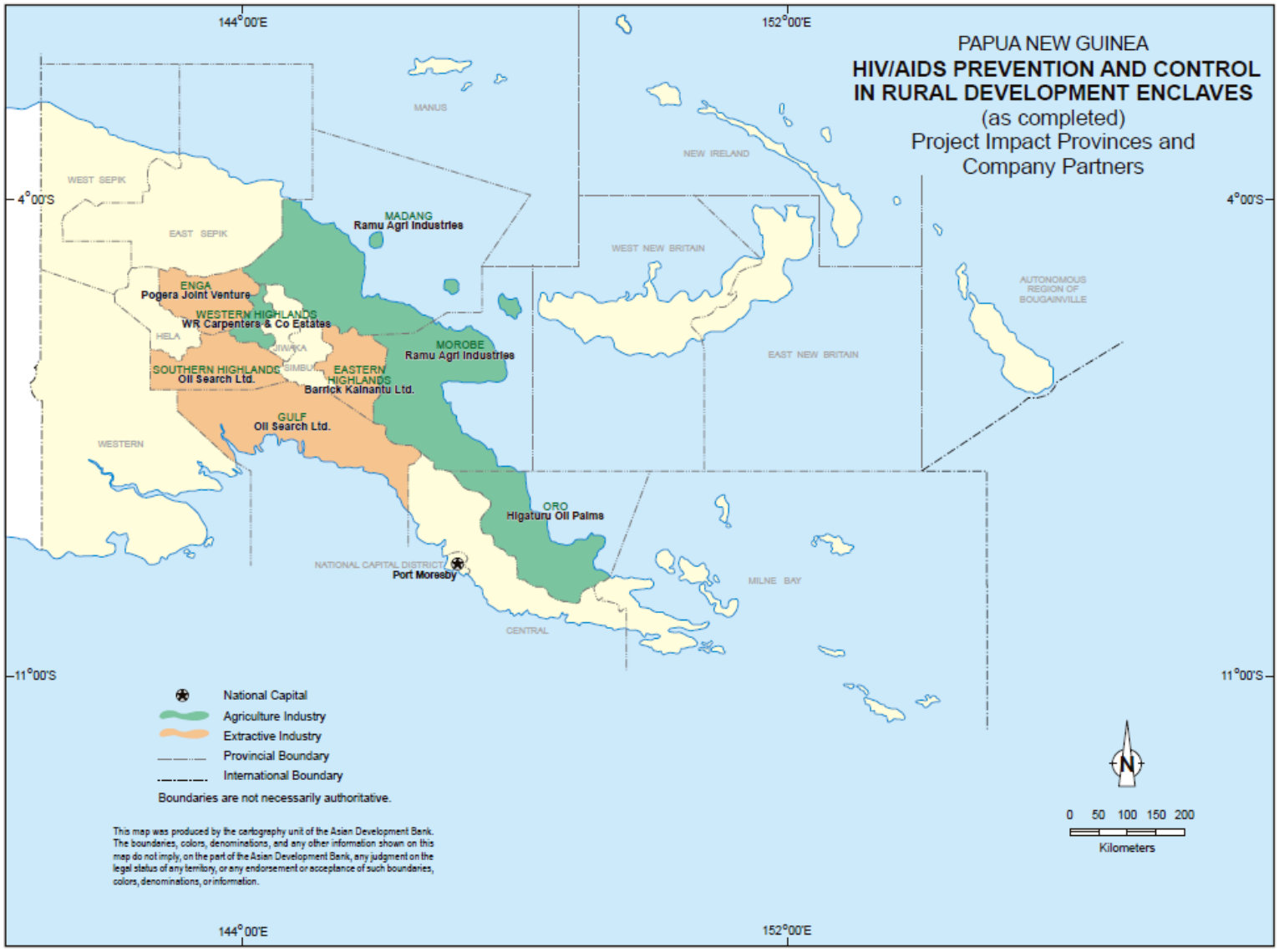
D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members[a]
Inception Mission	21 September 2006	2	21	a
				b
Special Project Administration	24 November 2006	1	1	a
Special Project Administration	16 March 2007	1	2	a
Review Mission	19 March 2007	1	5	a
Review Mission	21 May 2007	1	5	a
Review Mission	30 July 2007	2	23	a,b
Review Mission	19 November 2007	2	20	a,b
Review Mission	22 February 2008	1	3	a
Review Mission	12 May 2008	1	4	a
Midterm Review Mission	25 August 2008	2	36	c,b
Review Mission	26 October 2008	2	26	c,b
Review Mission	27 May 2009	2	15	c, b
Review Mission	03 June 2009	2	10	c,b
Review Mission	22 April 2010	2	30	c.b
	12 April 2010			c
	16 June 2010	1	4	c
	29 August 2010	1	5	d
	01 October 2010	1	8	c
Review Mission	23 March 2011	1	11	c
	30 May 2011	1	5	c
Review Mission	09 February 2012	2	14	c
SOE Audit	13 February 2012	2	4	e,f
Review Mission	16 April 2012	2	1	b,c
Project Completion Review	12 June 2012	2	10	b,c,d,g

SOE = state-owned enterprise.

[a] a = project specialist, b = national officer c = social development specialist, d = economist, e = disbursement specialist, f = disbursement officer, g = health evaluation specialist consultant.

MAP 1


PAPUA NEW GUINEA
HIV/AIDS PREVENTION AND CONTROL IN RURAL DEVELOPMENT ENCLAVES
(as completed)
Project Impact Provinces and Company Partners
144°00'E
152°00'E
4°00'S
11°00'S
MANUS
NEW IRELAND
WEST SEPIK
EAST SEPIK
MADANG
Ramu Agri Industries
WEST NEW BRITAIN
AUTONOMOUS REGION OF BOUGAINVILLE
ENGA
Pogera Joint Venture
WESTERN HIGHLANDS
WR Carpenters & Co Estates
HELA
JIWAKA
SIMBU
MOROBE
Ramu Agri Industries
EAST NEW BRITAIN
SOUTHERN HIGHLANDS
Oil Search Ltd.
EASTERN HIGHLANDS
Barrick Kainantu Ltd.
GULF
Oil Search Ltd.
WESTERN
ORO
Higaturu Oil Palms
NATIONAL CAPITAL DISTRICT
Port Moresby
MILNE BAY
CENTRAL
National Capital
Agriculture Industry
Extractive Industry
Provincial Boundary
International Boundary
Boundaries are not necessarily authoritative.
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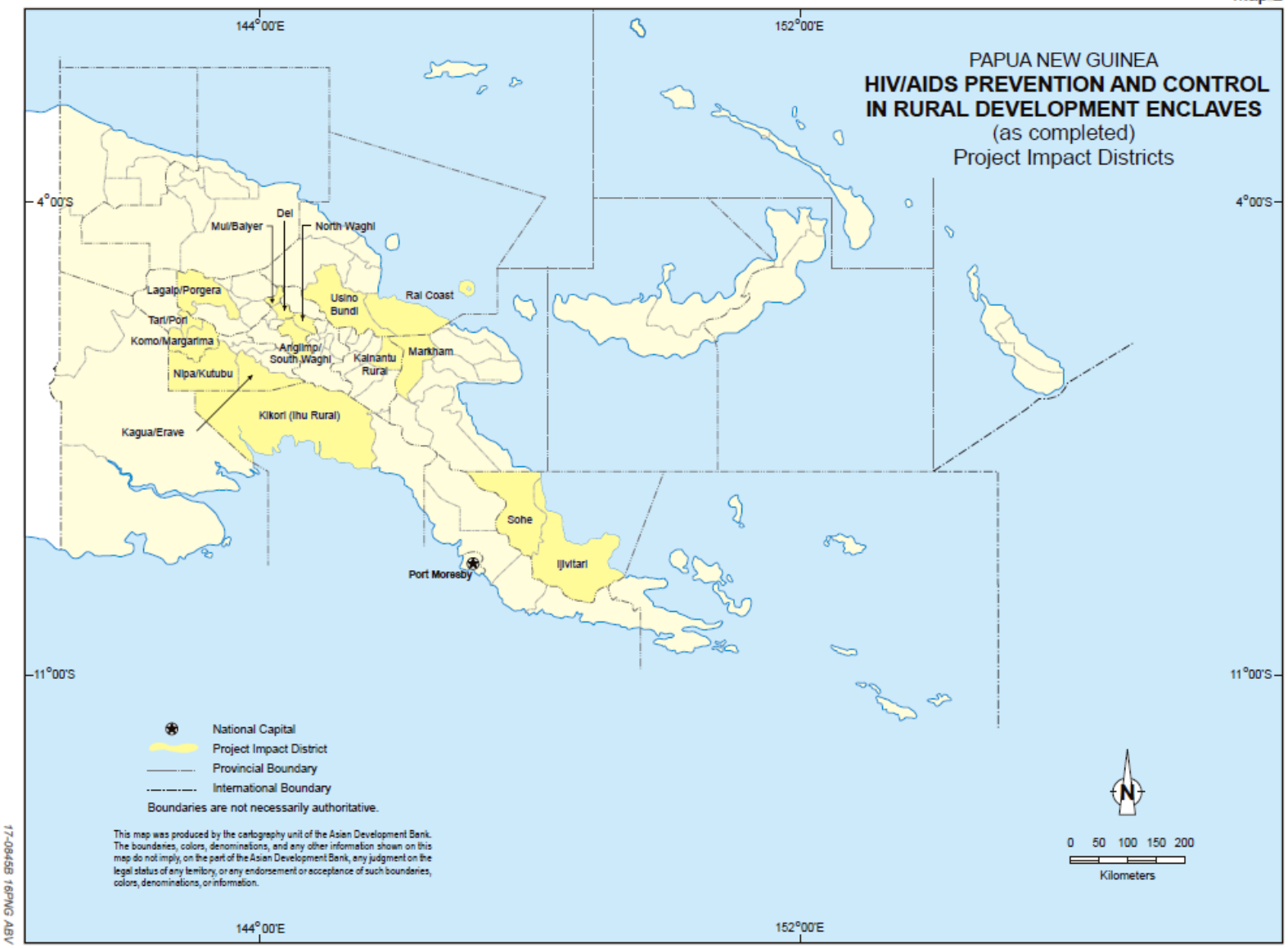
0 50 100 150 200
Kilometers
17-0845A 16PNG ABV

Map 2


144°00'E
152°00'E
4°00'S
11°00'S
PAPUA NEW GUINEA
HIV/AIDS PREVENTION AND CONTROL
IN RURAL DEVELOPMENT ENCLAVES
(as completed)
Project Impact Districts
Mul/Baiyer
Del
North Waghi
Lagaip/Porgera
Usino
Bundi
Rai Coast
Tari/Pori
Komo/Margarima
Angiimp/
South Waghi
Kainantu
Rural
Markham
Nipa/Kutubu
Kagua/Erave
Kikori (Ihu Rural)
Sohe
Ijivitari
Port Moresby
National Capital
Project Impact District
Provincial Boundary
International Boundary
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Kilometers
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I. PROJECT DESCRIPTION

1. The HIV/AIDS Prevention and Control in Rural Development Enclaves project was designed to strengthen the response of the Government of Papua New Guinea (PNG) to HIV and to implement strategies to control the epidemic among rural populations.[1] This project was designed when the HIV epidemic was estimated to be at a critical stage, and the government identified HIV/AIDS prevention and control as one of its top development priorities under the Medium Term Development Strategy 2005–2010.[2] Health indicators in PNG were deteriorating and there were widespread problems in maintaining effective rural health services due to the lack of funding and supplies; weak management; and limited capacity and fragmented infrastructure. With 85% of PNG's population living in rural areas, and many communities surrounding economic enclave developments, there was a concern that communities surrounding these developments had a higher HIV risk as they engaged in sex with those working in the economic enclaves.

2. The project objective was to control by 2015, and stabilize by 2020, the spread of HIV infection. The project's four components sought to: (i) establish public–private partnerships (PPPs) in rural development enclaves, and interagency partnerships; (ii) implement community behavior change and condom social marketing (CSM); (iii) strengthen and expand the surveillance system for HIV; and (iv) undertake project management.

3. The project was designed in close coordination with HIV/AIDS initiatives under the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) through the National Department of Health (NDOH), National AIDS Council Secretariat (NACS), and PNG's main development partners.

II. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

4. The project design proved relevant. The components supported the outcome of strengthening the government's response to addressing the spread of HIV. Engaging with the private sector in health service delivery and improving the rural health infrastructure remain important priorities for PNG.

5. In 2005, a number of development partners, including the Australian Department of Foreign Affairs and Trade (DFAT), scaled up their support to control HIV/AIDS, and PNG was successful in its application for Global Fund Round 4 funding. The NACS was established and finalized PNG's second national strategy for HIV, the PNG National Strategic Plan on HIV/AIDS 2006–2010.[3] The objective of the project was in line with the goal of this strategic plan. The project was relevant to the Asian Development Bank (ADB) country strategy and program (CSP), 2006–2010 for PNG, which outlined ADB assistance to address the burden of communicable diseases.[4] It was also aligned with the Pacific Strategy 2005–2009, which

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

[2] Government of Papua New Guinea. 2004. *The Medium Term Development Plan 2005–2010.* Port Moresby.

[3] National Department of Health and National AIDS Council Secretariat. 2005. *PNG National Strategic Plan on HIV/AIDS 2006–2010*. Port Moresby.

[4] ADB. 2006. *Country Strategy and Program: Papua New Guinea, 2006–2010*. Manila.

prioritized enhancing the supply of and demand for quality social services through more coordinated donor support, and mobilizing private sector service delivery.[5]

6. The project was timely—PNG was seeking partners to support primary care delivery, because the health system was unable to meet community needs for health care despite increased health financing.[6] The project offered the opportunity to collaborate with new partners on district health service improvement, and the NDOH developed a strong sense of project ownership from its active engagement during implementation.

B. Project Outputs

7. The project outputs are detailed in Appendix 1 and were updated at the initial stage of project implementation following the development of a project monitoring and evaluation plan. The design and monitoring framework was streamlined to include 2–3 indicators per component that were periodically monitored. All four outputs were achieved (although project management was partially achieved), and most of the covenants were complied with (Appendix 2). Selected project activities were adjusted based on recommendations from the midterm review and to reflect initiatives undertaken by other development partners, including the DFAT-funded *Tingim Laip*. Detailed discussions of each component are provided below.

1. Component 1: Establish public–private partnerships in rural development enclaves and interagency partnerships

8. **Promotion of public–private partnerships with rural development enclaves to improve and extend health services to the surrounding communities**. Six memorandums of agreement (MOAs) were signed among NDOH, provincial governments, and enclave operators in selected rural areas by the end of 2007.[7] The NDOH signed MOAs with three agricultural and three extractive industry companies (Appendix 3). The MOAs covered most project components, but implementation by enclave operators focused on civil works with less emphasis on other components, particularly prevention activities.

9. **Rehabilitation of rural health infrastructure for primary health care and upgrading of facilities required for HIV prevention, testing, and care.** A total of 154 buildings were renovated at 78 health sites in project provinces (more than the planned 81 facilities) to improve their utilization and functionality, and provide private space within the facilities for consultations, testing, and counseling (Appendix 3). In addition, 57 staff houses were renovated to improve staff retention at these facilities. The total rehabilitation cost was $11.7 million.

10. The project provided supervision, equipment and training for service improvement to 111 facilities, including facilities that were not included under the civil works component. Medical equipment were provided to all renovated health facilities, following the NDOH Health Facilities Branch standards. In addition, 115 equipment kits were supplied to health facilities, including facilities in enclaves that did not require renovation.

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[5] ADB. 2004. *Responding to the Priorities of the Poor: A Pacific Strategy for the Asian Development Bank 2005–2009.* Manila.

[6] World Bank, Australian Agency for International Development, National Economic and Fiscal Commission. 2013. *Below the Glass Floor: Analytical Review of Expenditure by Provincial Administrations on Rural Health from Health Function Grants & Provincial Internal Revenue*. Washington DC: World Bank.

[7] Companies and their locations are noted in the maps.

11. The project procured six "CD4" machines for the enclave companies to improve clinical management of people living with HIV from the surrounding areas.[8] Two CD4 machines were placed in nongovernment district hospitals at Porgera-Paiam and Kudjip, where patient fees were charged. Concerns were raised during project implementation about the suitability of these machines for the PNG environment, and the need for low technology equipment.

12. **Collaboration with World Health Organization, National Department of Health, National Aids Council Secretariat, and partners' training and protocols.** The project organized four courses as part of professional development for clinicians in the enclaves. These courses covered (i) HIV testing in health facilities; (ii) improved management of sexually transmitted infections (STIs); (iii) Integrated Management of Adult Illness, which is the Antiretroviral Therapy prescriber course; and (iv) refresher courses for CD4 operators. STI Syndromic Management training was provided to a total of 464 clinicians and provincial disease control officers. The Integrated Management of Adult Illness course was delivered to 78 senior clinicians. The NDOH added the Provider Initiated Counseling and Testing to the Voluntary Counseling and Testing strategy for HIV testing to improve access to HIV testing. This enabled clinicians to conduct HIV testing as a more routine aspect of clinical care. The project was able to arrange funding for the International Education Agency and the NDOH HIV Counseling and Testing unit to deliver Provider Initiated Counseling and Testing courses for 347 (92%) clinicians in the enclaves. In collaboration with the Clinton Health Access Initiative (CHAI), the Central Public Health Laboratory, and Becton Dickinson, the project supported the professional development of laboratory technicians operating CD4 machines.

13. **Development of leadership for HIV/AIDS advocacy.** The project envisaged collaboration with the United Nations Development Programme (UNDP) in strengthening the involvement of the Provincial Health Offices and Provincial AIDS Committees in the enclaves. UNDP received an initial ADB grant of $100,000 for the Joint United Nations Programme on HIV/AIDS (UNAIDS) for advocacy with PNG parliamentarians through a Special Parliamentary Committee for HIV and AIDS, but the committee was unable to function effectively within the Parliament.[9] Consequently, NDOH agreed that UNDP should use the funds for "Community Conversations", which involved advocacy within communities in enclave areas, but this shift did not take place. Following the midterm review, NDOH and UNAIDS agreed to redirect the funds into initiatives for Greater Involvement with People Living with HIV, and funded specific activities in the enclaves through Igat Hope, the National Association for People Living with HIV. These activities included organizational capacity building for 15 groups of people living with HIV. The project also worked with Igat Hope to strengthen its capacity to establish a national network with provincial groups, and support a national conference in 2010. This output deviated significantly from appraisal, but received positive feedback from NACS, DFAT, and UNAIDS, and from the independent organizational audit review of Igat Hope.

2. Component 2: Community behavior change, and condom social marketing

14. This component entailed strengthening the capacity of civil society partners to implement behavior change strategies, and implement a national program for social marketing of condoms.

[8] These machines are used to count the CD4 T lymphocytes in a patient's blood in order to determine the stage of HIV infection, which assists clinicians in knowing when to start HIV patients on life-saving therapy.

[9] This group had been re-established following the 2007 elections when key HIV advocates within the PNG Parliament had lost their seats.

15. **Developing the competency of community and civil society organizations to address issues related to the HIV epidemic leading to sustainable behavior change.** This output was revised during implementation after startup delays and changes with the sub-contracting arrangement. It was originally designed as two sub-components: Community Behavior Change Intervention and CSM. Population Services International (PSI) was to implement the CSM in association with Alternate Visions, which was subcontracted to implement the Community Behavior Change Intervention. The subcontract was terminated due to subcontractor's illness, and PSI subsequently assumed direct responsibility for both subcomponents. In 2009, these subcomponents were merged into "Promoting Healthy Sexual Behaviors" under one contract with PSI to expand its well-received behavior change activities on sexual health.

16. Sexual health workshops and training courses for men—focusing on gender-based violence and communication between couples—were held with more than 5,600 people in all six enclaves. Volunteers from churches and care centers participated in the training courses, which enabled them to feel more comfortable addressing issues of sexual relations within marriages and sexuality within families.

17. **Social marketing of condoms throughout the country.** The CSM component output was achieved, despite some early setbacks associated with changes in branding of the socially marketed condom from *Karamap* to *Seif Raida* (male condom) and *Stap Seif* (female condom).[10] PSI established 1,225 outlets nationwide (85 within enclave areas), doubled the target of 600 outlets, and developed a distribution network using private sector logistics expertise. Sales of condoms to eight distributors and wholesalers for resale through retail outlets amounted to 296,790. Distribution of branded condoms totaled 615,396; while distribution of all condoms (including generic) amounted to 4.3 million by 2010. The ADB report and recommendation of the President (footnote 1) suggested that other sexual health products be socially marketed and lubricants be promoted through organizations working with vulnerable populations, but PSI ceased the supply of lubricants following research that showed people were not using lubricants for sex, and packaged condoms already contained sufficient lubricant.

18. PSI undertook several key activities for condom promotion: (i) a healthy baby campaign (*Malolo Liklik*); (ii) condom promotions (*Seif Raida*); and (iii) support activities on men's sexuality and sexual health called *Tokaut na Tokstret* (TNT). Mass media (selected TV spots, radio and print media), mobile technology, and community events were used for *Malolo Liklik* and *Seif Raida* campaigns, while TNT was conducted through workshops. A total of 2,445 people participated in the TNT workshops. The reach of the campaigns for *Malolo Liklik* and *Seif Raida* was greater through mass media. Exposure to *Malolo Liklik* and *Seif Raida* was high (70% and 74% of enclave population respectively), while that of TNT was low (12%) due to the limited number of people it reached in a 4-day workshop.

19. The CSM was not granted an extension because of concerns raised by the Department of National Planning & Monitoring about national promotion of condoms as a government strategy. Funds for this subcomponent were redirected into promoting healthy sexual behaviors.

[10] The *Karamap* brand was introduced by the DFAT National HIV/AIDS Support Project in 2004. The project undertook a review of this brand and following extensive consultations decided to develop a new brand of condoms (*Seif Raida* and *Stap Seif)* in order to increase its reach and acceptability.

3. Component 3: Strengthen and expand surveillance system for HIV

20. This component aimed to support NDOH to build and operationalize a national HIV surveillance system, including behavioral surveillance.

21. **Facilitate transfer of the surveillance system to the National Department of Health.** This was to include establishment of an HIV/AIDS surveillance unit within the Disease Control Branch of NDOH to focus on sero-surveillance. NACS transferred the responsibility for surveillance to NDOH in 2006. The project contracted a consultant to assist NDOH with surveillance in late 2007 and procured a computer server for the surveillance unit. The unit was fully staffed by the end of 2007 and finalized the first surveillance plan (2007–2010) in 2008 together with the 2007 estimation report. This report was the first comprehensive assessment on HIV epidemic in PNG. From 2007 to 2010, the surveillance unit systematically collected and collated data from all the testing and treatment sites and generated quarterly and annual reports.

22. **Operationalize the surveillance system at the facility level.** This was to be done by providing training and equipment to hospitals, health centers, blood banks, and enclaves to conduct HIV/AIDS surveillance. Passive surveillance was established across the country with blood banks, STI clinics, antenatal clinics, other health facilities, and HIV testing sites. The surveillance unit worked closely with the NACS Monitoring and Evaluation team through the Surveillance Technical Working Group composed of experts in HIV surveillance and epidemiology with representation from WHO, UNAIDS, NDOH and CHAI. This group established provincial monitoring, evaluation and surveillance teams to assist with collection of data on testing and treatment. The reporting system was parallel to the national health information system. A total of 84 computers and other equipment were procured between 2009 and 2011 to support clinics nationwide to collect and collate data for surveillance. By 2010, 266 HIV testing sites were reporting data, and sentinel surveillance had been established at 35 sites in 16 provinces. Enclaves were unable to function as sentinel surveillance sites because the patients seen at company clinics were not representative of the population. HIV testing at enclave company clinics was included in the NDOH passive surveillance system.

23. A Behavioral Surveillance Unit became operational at the National Research Institute (NRI) in 2007 with funding from the Health Services Improvement Program (HSIP), although the memorandum of understanding between NDOH and NRI was not formalized until 2008.[11] Eighteen staff were engaged by the unit by end of 2008. By the end of 2010, seven behavioral surveillance studies (BSS) had been conducted on most at-risk populations, including three undertaken in enclave sites. Behavioral surveillance reports were produced for truck drivers, women in the sex trade, youth, workers in plantations, and workers in mining companies, which provided data on risk behaviors and populations at risk; these were criticized, however, as being delayed and not directly complementing sero-surveillance activities.

24. There was a focus on capacity building of research staff, but the Behavioral Surveillance Unit was unable to continue at NRI due to lack of funding, despite the endorsement of BSSs as part of NDOH's 3-year surveillance plan.

[11] The HSIP trust account is under the umbrella of PNG's NDOH sector-wide approach, which pools various contributions from a number of donors, including ADB.

4. Component 4: Project Management

25. This component provided support to institutionalize NRI's capacity to conduct behavioral surveillance, and enable effective and efficient project management and implementation, including monitoring and evaluation, and partner coordination.

26. A project management team was established within NDOH and provided oversight of the project, including monitoring and financial management. The team was responsible for liaising with NDOH, enclave companies and other partners. The Country Coordinating Mechanism (CCM) of the Global Fund was assigned as the project steering committee.

27. The project undertook regular monitoring of activities at the enclave sites to ensure standards were met, to appraise clinical work and provide professional development. By the end of 2010, 99 visits have been made, about 25% of which involved provincial government staff. A comprehensive monitoring and evaluation framework was developed and implemented covering all four components (Appendix 4). This was updated regularly during review missions.

C. Project Costs

28. The project cost (calculations based on actual disbursements and cost of taxes charged for project expenditures), inclusive of physical and price contingencies, was estimated at $25.0 million at appraisal.[12] The actual project cost at grant closing was $24.16 million.

29. Component 1 experienced cost overruns resulting from increased civil works costs. The development and execution of civil works agreements were delayed because of delays in identifying health facilities for renovation; the lack of supervision by the project office also led to increases in civil works costs. The delay in processing of payments from the HSIP was a major issue and affected the reimbursement of funds to the enclave companies, resulting in a large amount of unspent funds at the original project end date, thus necessitating a no-cost extension. Natural disasters—including the 2007 Cyclone Oro, landslides in the Eastern Highlands, and floods in the Western Highlands—also contributed to suspension of civil works. Component 2 experienced a cost overrun due to late startup, problems with a subcontractor, and the decision not to extend the CSM component. Funds were reallocated to building additional health facilities and staff houses. Spending on components 3 and 4 were below the budgeted amounts because of project implementation delays, which led to activities not being completed.

30. The grants from DFAT and New Zealand Ministry of Foreign Affairs and Trade were allocated for Component 2 and administered by ADB, and were fully disbursed.

31. The project experienced temporary closure of the HSIP trust account from December to April each year due to the year-end rollover and uploading of the annual activity plan by NDOH, which suspended all project activities under the HSIP, including civil works and training. To overcome funding issues, project consultants self-funded activities during the first quarter of each year, and were then reimbursed in the second quarter.

[12] Funding was estimated at $7.10 million for component 1; $12.48 million for component 2; $3.75 million for component 3; and $1.67 million for component 4 (Project Data, section 3c). ADB provided a grant of $15.0 million from the Asian Development Fund and government cost sharing, including cofinancing from other development partners such as DFAT and MFAT, covered the remaining $10.0 million.

D. Disbursements

32. A total of $21.08 million was disbursed, which is 16% below the appraisal amount. The project used the HSIP trust account during implementation, but in order to comply with the grant requirements of maintaining a separate project account and submitting an annual audit, a dedicated project accountant was assigned to monitor and prepare withdrawal applications submitted to ADB. On 8 November 2006 the project received an initial advance of $1.0 million. The imprest account procedure was used to reimburse eligible project expenditures and SOE procedure was used to liquidate advances from the HSIP trust account, which proved efficient. However, the SOE procedure was not suitable based on audit findings (detailed receipts were difficult to locate), and therefore liquidation of the advance towards the end of the project took longer and delayed implementation. The use of the SOE procedure was suspended as of March 2012 due to absence of an annual independent external audit.

33. Prior to closing of the grant account, an SOE review was conducted by ADB in February 2012. Subsequently, an audit was required as an assurance that the imprest account and SOE procedures were used for eligible project expenditures. An accounting firm was engaged in July 2014 to examine the use of SOE procedures from 2006 to 2012. The grant account was financially closed on 17 February 2016 after the substantiation of expenditure claims and NDOH certification of the validity of project expenses. The disbursement schedule as estimated at appraisal was unrealistic, as it failed to take into account possible delays during implementation. Two project extensions were approved to complete the remaining project activities, process final payments, and liquidate the imprest account.

E. Project Schedule

34. The grant was approved on 25 April 2006 and became effective on 31 August 2006. The project was originally scheduled to be implemented over a 4-year period (August 2006 to July 2010). However, following four extensions (totaling 5 years and 7 months), the project was closed on 17 February 2016. Factors contributing to the extended implementation period were:

(i) **Process delays.** Slow initial signing of the MOAs with the enclave operators; HSIP was slow to process checks and provide funds to the enclave operators, affecting the civil works schedule and a number of training and surveillance monitoring activities; processing of ADB funds to replenish the HSIP trust account was also slow.

(ii) **Limited information.** Poor communication between ADB's Operations Services and Financial Management Department made it difficult for the project management unit to take remedial actions to correct issues with HSIP in a timely way. The progress of civil works was affected by agreements that were not always straightforward, and delays in finalizing the scope of work, architectural plans and costing. Research approval by NACS was slow, resulting in data delays.

(iii) **Limited supervision.** Poor supervision of building contractors by some enclave operators resulted in delays in completing building construction.

(iv) **Demand generation.** Increasing the demand for branded condoms took longer than expected. By mid-2010, concerns regarding the alignment of condom distribution to the national strategy disrupted PSI's condom distribution through a large number of outlets.

(v) **Geographic and local context.** Difficulty in accessing sites affected the progress of civil works, especially during wet season. In some areas, disputes arose among interested parties, especially landowners, and it took time to resolve minor issues emerging from the new developments.

F. Implementation Arrangements

35. The NDOH was the executing agency for the project and the CCM was proposed as the steering committee to oversee and guide the activities. Provincial coordinating committees were established in each province where an enclave operator was located, with the committees expected to meet quarterly. MOAs were the key vehicles for partnership between NDOH, provincial governments and enclave companies. The implementation of the behavior change component and social marketing of condoms was contracted to PSI. The surveillance was implemented through NDOH, while behavioral surveillance was implemented by NRI.

36. The project management team was established within NDOH and reported to the Secretary of Health. The team worked closely with the HIV Program Unit within the Disease Control Branch and with other development partners (CHAI and WHO) located within the unit. There were a number of challenges associated with managing the project. The CCM was overburdened with its role of managing the workload for Global Fund grants, and could not function as an effective steering committee. Consequently, a working group within the CCM was established to improve coordination and effectively monitor the project activities. The provincial coordinating committees did not meet regularly, and enclave operators and provincial health officers had limited commitment to do so. The project used NDOH systems for finance and procurement but this became increasingly problematic as the project progressed. Despite having additional project-funded staff, HSIP was unable to ensure smooth project implementation, due to limited management capabilities, and cumbersome processes for obtaining check signatures. The project management arrangements were revised following the midterm review, with all consultants across the various components reporting to the project manager. This improved work coordination and coherence, and strengthened the accountability of consultants. The project manager and NDOH liaised effectively via regular meetings with the Secretary and other senior staff.

G. Conditions and Covenants

37. Grant effectiveness conditions were met on schedule. Most of the grant covenants were relevant and complied with. Section 4.02 (concerning an independent audit of ADB-managed funds) was not complied with because of a misunderstanding in audit requirements. An independent audit of ADB funds in the HSIP was deemed incompatible with the working of the HSIP system, and resulted in non-compliance with ADB's financial reporting and auditing covenants. Schedule 5 Para.3 (concerning the use of the established CCM as project steering committee) was not complied with due to the heavy workload of the CCM, which was also managing the Global Fund grants, and non-functioning of the technical working group. The project was designed using the primary health care model as a platform for providing HIV care, while the technical working group was organized vertically, with an exclusive focus on HIV, which made it challenging to view HIV service delivery as an integral part of a primary health care model. Nevertheless, NDOH provided technical oversight and the project team supported NDOH with project supervision.

H. Consultant Recruitment and Procurement

38. Consultant recruitment was undertaken in accordance with ADB's *Guidelines on the Use of Consultants* (2013, as amended from time to time). NDOH was involved in the selection of all international and national consultants. The PSI, NRI, and the NDOH Surveillance Unit recruited their own team members following the government's recruitment guidelines.

39. NDOH engaged individual international consultants (project manager, epidemiologist, behavioral surveillance specialist, and procurement officer) and national consultants (building field supervisor, operations and finance officer, and accountant). Other key experts were added, including deputy project manager (health), PPP specialist, and a project coordinator. A total of 200 person-months of international consultant services and 549 person-months of national consultant services were proposed at appraisal. This involved a substantial number of individual consultant contracts that had to be procured, adding implementation delays.

40. Component 2 was designed to be implemented by two international companies, but PSI eventually took over all the activities under component 2 (para.14). One PSI consultant had to be replaced as they were from a non-ADB member country.

41. Civil works, goods, and services were procured in accordance with ADB's Procurement Guidelines (2010, as amended from time to time). A total of 96 contracts were awarded for civil works. Equipment and supplies such as health radios, medical equipment kits, beds, laboratory machines, incinerators and other health facility equipment were purchased. Motor vehicles for enclave companies and the executing agency, NRI and the project support unit were procured for use during project implementation. The substantial number of procurement packages resulted in significant inefficiencies and administrative costs.

42. Procurement of equipment for health facilities took more than 12 months because of slow government processes. Contracting of a consulting firm (PSI) for component 2 was delayed by up to 1 year because of the delayed establishment of PSI in PNG, while several changes in personnel within the first 2 years affected implementation of some activities. Recruitment of surveillance consultants was slow, particularly identification of a suitable epidemiologist. The MOA between NDOH and NRI was not signed until early 2008 due to disagreements over roles and responsibilities

I. Performance of Consultants, Contractors, and Suppliers

43. The overall performance of consultants was satisfactory, although there was staff turnover within the project management team. The team was able to maintain a good working relationship with the executing agency and enclave operators.

44. PSI, as the contracted company for component 2, brought international experience to the project and established the organization as a viable and respected nongovernmental entity in PNG. While there were some personnel changes in the first phase of the project, it did not substantially affect their overall performance, and ability to deliver the behavior change outputs.

45. The international consultants contracted for surveillance worked closely with their national counterparts. Both NDOH and NRI reported positively on their ability to build the capacity of team members and establish surveillance systems.

J. Performance of the Borrower and the Executing Agency

46. The performance of the executing agency, NDOH, is rated satisfactory. NDOH was enthusiastic about the PPP approach and actively engaged in project design and implementation. However, there were delays in approving the scope of and tenders for facility rehabilitation, which disrupted a number of the civil works activities. Disbursement of funds from

the HSIP trust account was inefficient, and there were challenges in supplying drugs to the facilities upgraded by the project.

47. NDOH provided adequate support for surveillance and the training of healthcare workers but monitoring of enclave activities, especially at the provincial and district level, was lacking. The executing agency was constrained during implementation because of changes in staff within the counterpart Disease Control Branch towards the end of the project.

K. Performance of the Asian Development Bank

48. The performance of ADB was satisfactory. ADB was responsible for approvals, disbursements and monitoring, and communicated well with national and provincial agencies. It demonstrated a collaborative approach with other partners through the HSIP. It was responsive to government and to enclave operator demands, especially with regard to civil works activities.

III. EVALUATION OF PERFORMANCE

A. Relevance

49. The project is rated *highly relevant*. It addressed the priorities of the government with respect to strengthening primary health care and improving rural service delivery pursuant to the National Health Plan 2011–2020.[13] The project facilitated partnerships in delivering health services, which are the key result areas envisaged to achieve the Millennium Development Goals. The project was consistent with the ADB CSP, 2006–2010.[14] The CSP review noted that ADB had successfully demonstrated innovative partnerships with the private sector to control HIV in rural communities.[15] This proved significant in the midst of declining health services and weak health sector indicators. The Independent Review Group 2010 report stated that the ADB project "continues to produce good results to support health systems strengthening in rural areas as well as a specific HIV/STI response."[16]

50. The project's components were designed to address areas not covered by other development partners, but the components were implemented largely in isolation from each other. The midterm review noted that the design lacked logical links, but was improved with the realignment of components under the project manager (para. 36).

B. Effectiveness in Achieving Outcomes

51. The project is assessed *effective* in meeting the two outcomes. It made a substantial contribution in strengthening the government's response to the HIV epidemic, as well as to community behavior change.

52. Under component 1 the project exceeded the target for facility renovations (154 buildings at 78 health facilities), but few of the health facilities meet the outcome target of being "fully functional", because of structural determinants that were not addressed by the project (i.e., medication supply, staffing, and management). The target of a 10% annual increase in use of Voluntary Counseling and Testing services by rural populations was exceeded. The targets for

[13] Government of Papua New Guinea. 2010. National Health Plan 2011–2020. Port Moresby.
[14] Footnote 4.
[15] ADB. 2010. Papua New Guinea: *Country Strategy and Program: (2006–2010).* Final Review. Manila.
[16] NACS. 2010. *Independent Review Group on HIV/AIDS*. Port Moresby. Report from an assessment visit on 22 April–5 May 2010. p.6

HIV and STI testing were exceeded, contributing to the outcome targets for accessing treatment for STI. An estimated 250,000 people around the enclaves were reached.

53. The number of people tested at enclave health facilities increased by 65% from 2005 to 2010, meeting the outcome indicator for Voluntary Counseling and Testing services (details are in Appendix 4). A total of 56,056 HIV tests were recorded by the end of 2010. Only 50 out of 111 (< 50%) supported health facilities were able to provide HIV testing by the end of 2011, due to inadequate supervision and management at the enclave level, and by district health officers.

54. There was a 10% increase in the number of supervised births in health facilities from 2007 to 2010, and a small increase in the number of women attending at least one antenatal visit, relative to the project target of 10% increase by 2009.

55. Supervision visits declined over the project period despite professional staff development. Of the 47 facilities in the enclave project areas that could provide HIV care, only 10 were found to be providing antiretroviral services. Constraints include difficulties obtaining a regular supply of antiretroviral drugs (and other medications) from NDOH (supported by the Global Fund), and a lack of ongoing supervision. The facilities within company boundaries offered a good standard of service to their workforces and immediate communities. The expected level of partnership between the private operators and government at the provincial level did not eventuate at most sites because the MOAs were not legally binding. Enclave operators were expected to restructure their health services to provide ongoing services to surrounding communities, and expand HIV preventative services along with other primary care services. This did not occur, except in the case of Oil Search, which had a pre-existing policy to do so, and Barrick Kainantu; in both cases strongly committed individuals at the company level were instrumental in ensuring the project outcomes were achieved.

56. Under component 2, the project was able to demonstrate a shift in behavior in communities surrounding the enclaves. Exposure to campaigns conducted by PSI had some influence on decisions to use condoms with casual partners, but performance vs. the outcome indicator of a 50% increase in use was not confirmed. Qualitative assessment of Marital Relationship Training showed improvement in perception of HIV risk and communication between couples, but not in condom acceptability and use.

57. The total sale of condoms was lower than anticipated due to initial delays in startup and in promoting the *Seif Raida* brand. Nevertheless, the distribution of condoms (branded and non-branded) reached a total of 4.2 million. There was also an extensive distribution network, with more than 1,200 outlets established to sell condoms across the country.

58. Component 3 was effective in achieving a viable HIV surveillance system and expanding the number of HIV reporting sites. The project successfully established the HIV sero-surveillance unit within NDOH and the behavioral surveillance unit at NRI. The improvements in data collection and in the consistency of reporting led to a revision in the HIV prevalence rate in PNG in 2009. PNG's epidemic was not progressing rapidly as expected and the epidemic was unevenly spread across the country. The behavioral surveillance component provided useful information for HIV programming, especially in relation to populations that were most at risk. It took time for the findings to be released and used by PSI because the surveillance component was structured as behavioral research, rather than a surveillance exercise.

C. Efficiency in Achieving Outcomes and Outputs

59. The project is rated *less efficient*. Startup implementation was delayed by recruitment, and changes took place in key personnel in the middle of implementation. The procurement of equipment was delayed by 12 months (the use of government procurement processes was not adequately accounted for during planning). There were significant unspent funds at the original project closing date due to delays in the civil works component and PSI activities, which necessitated a no-cost project extension. Unutilized funds were reallocated to civil works to enable expansion of health facility rehabilitation. The slow disbursement of funds from the HSIP trust account delayed reimbursement to enclave operators, and separate accounts and alternative procurement processes were established as a result.

60. The project's PPP approach with enclave operators was seen as a cost-effective option for expanding rural health services because the enclave companies were already providing HIV services and could support nearby health facilities to strengthen service delivery. Although the approach was not adopted by all enclave operators, it provided insight on how to engage with the private sector, and built relationships with government and churches. The behavior change and CSM activities demonstrated efficient approaches to using existing networks within communities for training and condom distribution.

D. Preliminary Assessment of Sustainability

61. The project is assessed *likely to be sustained*. The government's funding for HIV increased from K6.6 million in 2006 to K26.0 million in 2011. In 2011, the government funded the entire budget for antiretroviral therapy (K15.0 million) following the end of the Global Fund Round 4 grant. Additional funding (K6 million) was also secured by NACS to support counselling and testing and continue the enrollment of new patients on antiretroviral therapy. Nearly 70 health facilities are confirmed to be open at the end of the project, but with limited capacity due to budget constraints. Furthermore, the HIV data collected is currently not integrated into the national health information system.

62. The project was aligned with the National Health Plan 2011–2015, which prioritized rural health service delivery and PPPs as part of its platform for service delivery. The challenge is how the government can create additional partnerships and sustain those that have been established. At the provincial level, selected Provincial Health Authorities are including private sector operators in the development of their provincial plans to strengthen service delivery.

63. Oil Search Limited has extended its services beyond the facilities covered by the project in the Southern Highlands Province to provide regular in-service clinical training. The company expanded its operations nationwide through the Oil Search Foundation following its success as principal recipient of the Global Fund grants for Rounds 8 and 10. The Oil Search Health Foundation took on larger contracts for the health sector management, training and procurement, illustrating how the private sector can further assist government in delivering its priorities. The involvement of private companies such as Ramu Agri Industries can be further sustained through the use of tax credits to continue their services to local communities; they recruited a community engagement manager to continue liaising with provincial health and local communities. Similarly, WR Carpenters & Co Estates funded a community relations program that could be expanded to include liaison with provincial health authorities.

64. The branded condoms, *Seif Raida* and *Stap Seif,* complement the supply of generic condoms distributed nationwide by the Business Coalition Against AIDS on behalf of NACS. PSI continues to operate in PNG with funding from Australia, Exxon Mobil and the Global Fund.

65. Surveillance is firmly embedded into NDOH and the NDOH is assessing how to integrate HIV surveillance into a broader digital health information system.

E. Impact

66. In general, the project positively impacted delivery of HIV prevention and rural health services. The expansion and improvement of HIV prevention services, especially testing and treatment services, during the project may have contributed to the stabilization of HIV in PNG. Nationwide, the number of people tested for HIV increased from 16,691 in 2006 to 138,581 in 2010. Testing facilities increased from 60 in 2006 to 266 in 2010. Treatment had been provided to almost 8,000 people at the end of 2010 (83.7% of those eligible), and sites providing antiretroviral increased from 38 in 2006 to 78 in 2010. The expansion cannot be attributed to the project alone but to combined efforts with Global Fund, DFAT and an increased number of civil society partners implementing HIV prevention services.

67. The project demonstrated increased knowledge of HIV. The demand for condoms increased, and the availability of condoms in rural sites increased.

68. The quality of care at health facilities improved, and 89% of health facilities supported through the project were operational. The capacity building component increased knowledge and confidence among clinicians. The project completion review noted the stakeholders' observations on the behavioral change in the population, such as reduction of domestic violence following sexual health promotion courses.

69. The improvement in surveillance and data collection and collation resulted in more reliable information. The commitment of PNG to HIV prevention increased as demonstrated by increased funding for HIV prevention and care programs. The project contributed to this change through its support for an annual planning process with NACS, which brought all stakeholder activities under one budget and increased government funding for HIV prevention.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

70. Overall, the project is rated successful. It contributed significantly to expansion of services for HIV prevention and care in rural areas through the PPP approach. The project achieved the majority of its target outputs, although there were a number of shortcomings, primarily on the participation of selected enclave operators and implementation delays. There were measurable improvements in outcomes across all components. The project improved the availability and quality of HIV and STI services at health facilities surrounding the enclaves and increased the uptake and use of condoms in communities. National-level surveillance was strengthened and a functional surveillance system put in place to provide HIV data. A national brand of socially marketed condoms was also established.

B. Lessons

71. The project demonstrated that the private sector can be a viable partner to deliver health services. The following key lessons were identified:

(i) Enclave operators with a focal point are more likely to effectively facilitate partnership agreements, monitor work progress and ensure availability of services for the local communities, but reliance on an individual may limit project ownership and isolate enclave staff from taking part in achieving improved service delivery.
(ii) The project would have benefited from bringing together all parties (enclave operators, government, and churches) at the outset to agree on services and identify roles. A provincial facilitator or focal point could be assigned to coordinate with stakeholders on a regular basis in lieu of the coordinating committees.
(iii) MOAs between NDOH and the enclave operators could have been tailored to the needs of provinces and specific enclaves rather than adopting a generic approach, which could have increased ownership and commitment to achieving target outputs.
(iv) Effective supervision of health facilities is an integral part of improving health service delivery. Health managers need to be more active in providing oversight of service delivery and allocation of appropriate resources in their districts and provinces.
(v) Behavior change programs for HIV prevention were more acceptable when the focus was on human sexual relationships, communication between couples and sexual health. Sexual health promotion needs to include gender power relations and violence, as these are areas related to vulnerability for HIV transmission in PNG.
(vi) Stigma remains a major barrier to condom uptake and use. Programming that focuses on the use of condoms for family planning can help reduce this stigma.
(vii) Condom distribution became more efficient, and enabled greater coverage in rural areas when the project negotiated directly with wholesalers for distribution to retailers. Establishing harmonious relationships with other existing HIV projects in rural areas helped promote condoms to rural communities.
(viii) The use of the HSIP trust account was not appropriate for a project investment and was a significant obstacle to timely disbursement. The project would have benefited from having a separate imprest account to manage payments more efficiently.

C. Recommendations

1. Project Related

72. **Future monitoring**. HIV surveillance should be incorporated in routine national information systems under NDOH to ensure continuity of data collection and timely reporting. There should be stronger advocacy by the government for sustainability of surveillance systems, ensuring that staffing and operational costs to maintain the systems are built into recurrent budgets.

73. **Covenants.** The majority of the covenants remain valid.

74. **Further action or follow-up.** The following recommendations address the potential to implement project activities more broadly, and sustainably:

(i) The future development of MOAs for service provision needs to be based on a realistic assessment of capacity and service assessment in both the public and private sectors. These agreements should be tailored to specific needs and requirements of the

enclaves and provinces, should be reflected in provincial plans, and should incorporate mechanisms for accountability. Clear roles and responsibilities and agreed annual targets and performance assessments should also be included.

(ii) There should be a facilitator in each province to help liaise between NDOH and the enclaves, and build relationships between the private sector and public agencies. This should ideally be the provincial or district health manager.

(iii) The enclave operators should explore the feasibility of using the government's tax credit scheme to fund activities to continue work started by this project.

(iv) There should be a strong commitment to maintain service improvements at district level. ADB and the government need to build on lessons from this project to create an enabling environment for effective service provision, by maintaining investments in health facility infrastructure, providing regular supervision, training and retraining staff, and maintaining equipment and supplies.

(v) Equipment procurement assessment should be improved to ensure that the health facilities' equipment are suitable and regularly maintained and repaired.

75. **Timing of the project performance evaluation report.** Given the delay in project closing, which was long after completion of most of the physical works, a project performance evaluation report should be prepared as soon as possible.

2. General

76. At project appraisal and during implementation, the capacity of the executing and implementing agencies to carry out monitoring and supervision of activities and financial planning and reporting should be assessed and capacity enhancing measures implemented.

77. The use of SOE procedures will not work in PNG without rigorous monitoring. The systems for procurement and distribution under NDOH need to be strengthened to ensure timely and transparent procurement of goods and supplies.

PROJECT FRAMEWORK

Impact the Project is Aligned with
To control by 2015 and stabilize by 2020 the spread of HIV infection.

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting	Risks	Status at Project Completion
Outcome 1. Strengthened government of PNG in responding to the HIV epidemic 2. Community behavior change away from high numbers of concurrent partners and toward increased use of condoms	By 2011: a. Increased government financial allocation to HIV/AIDS prevention by 20% year on year b. Condom use in the participating enclaves increases 50% over baseline (to be established) by end of project c. All health staff in participating enclaves pass accreditation for VCT and ART services, including outreach d. 70% of rural health facilities in participating enclaves that were not functioning in 2005 now fully functional and providing comprehensive PHC e. 10% increase year on year in use of VCT services by rural populations in participating enclaves (compared to baseline year) f. The number of people appearing for sexually transmitted diseases at clinical facilities increased by 10% over previous year	a. Government expenditures and budget data b. Project reports and field assessments c. Development partners' reports on HIV/AIDS d. Global Fund progress reports submitted by government or CCM e. Qualitative surveys in rural communities f. NACS M&E reports g. Final project evaluation	2007 elections distract attention from fighting HIV/AIDS Poverty continues to increase	a. Government of Papua New Guinea allocation to HIV was K26.0 million in 2011 (53% increase from 2010) b. 50.7% of sexually active men used condoms consistently with their partners c. 92% of clinical staff from participating health facilities have attended the HIV Counselling and Testing courses d. Few health facilities meet the criteria of "fully functional" due to structural determinants not addressed by the project (i.e., medication supply, staffing, and management) e. 14,471 HIV tests in 2011 (171% increase from 2005 baseline) f. 7,367 persons appearing for genital infections test compared to 6,864 at baseline
Outputs 1. Functioning public–private sector partnerships in rural development enclaves improving and extending health services. 2. National social marketing	At least six public private partnerships entered into At least two partnerships fully functioning within first year of Project Annual increase, by at least 10%, of surrounding community populations with adequate access to basic health services	Project reports and field assessments Baseline surveys Community health surveys Behavioral change surveys National HIV/AIDS surveillance system	Government unwilling to allow private sector supervision and management of local public health facilities Government unable to provide adequate staff,	1. Six Memorandums of Agreement signed by end of 2007. Five addendums signed by end of 2009 for Phase 2. Six economic operators signed up and commenced the project by end 2007. 25% increase in

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting	Risks	Status at Project Completion
of condoms program established, and behavior change programs established in partnership enclaves. 3. Strengthened and expanded national sentinel surveillance system for HIV. 4. Project management established within NDOH	Behavior change programming activities in participating enclaves are established, supervised, and monitored within 6 months of signed MOA All enclaves are included in national social marketing scheme Selected sentinel sites reporting to national sentinel surveillance system within 2 years of Project start Other 3 regional STI/HIV/AIDS clinics reporting to NACS' monitoring system within 3 months of their startup	records	medicines and supplies, and equipment to local public health facilities and provincial hospitals Global Fund ARTs and rapid HIV test kits do not reach enclaves and surrounding communities HSIP unable to disburse funds efficiently	supervised deliveries compared to baseline of 4,974 in 2006. 2. Commercial condom outlets established in and around all 6 enclaves, 1225 outlets throughout Papua New Guinea by end July 2011. Three behavioral surveillance sites conducted at three rural development enclave sites. Commercial condom outlets established in and around all 6 enclaves, 1225 outlets throughout Papua New Guinea by end July 2011. 3. 30 Antenatal clinics sites (15 Urban and 15 rural sites) in 16 provinces conducted HIV and STI sentinel surveillance in 2010. Remaining 4 provinces did not conduct the periodic sentinel surveillance, but they routinely reported the HIV data 4. Project management unit established in NDOH (1 x Project Manager 1 x Deputy Project Manager 2 x Project Accountants 1 x Civil Works Supervisor 1 x Administrative Officer)

Key Activities with Milestones

1. For Establishing Public–Private Partnerships in Rural Enclaves

1.1 Design template MOA for public–private partnerships by March 2006

1.2 Initially establish at least two public-private sector partnerships in rural development enclaves to expand PHC, including maternal and child health, and HIV/AIDS prevention and treatment by December 2006

1.3 Rehabilitate rural health facilities for primary health care and upgrade and equip enclave health facilities for HIV prevention and care activities within 6 months of signed MOA
1.4 Support WHO, NDOH, NACS, and their partners to train health care providers in rural development enclaves for VCT, HIV-related laboratory activities, and treatment; assess quarterly
1.5 Support UNAIDS or UNDP to undertake HIV/AIDS advocacy skills for members of the Special Parliamentary Committee on HIV/AIDS Advocacy and other targeted leaders at all levels of government; assess on quarterly basis

2. For Community Behavior Change and Social Marketing of Condoms

2.1 Contract one international NGO or firm to work with each development enclave and local community-based NGOs, CBOs, or FBOs to develop and implement the targeted behavioral change program strategies by April 2006
2.2 Conduct baseline surveys within 2 months of signed MOA
2.3 Initiate development of skills and techniques of NGOs, CBOs, or FBOs to conduct longterm BCC and monitoring of behavioral change in targeted districts by September 2006
2.4 Contract one international social marketing organization by March 2006

3. For Strengthening and Expanding National HIV/AIDS Surveillance System

3.1 Contracts for consultants executed by March 2006
3.2 Complete transitional plan for moving system to NDOH and begin implementation
3.3 Establish HIV/AIDS surveillance unit in NDOH, and behavioral surveillance unit in NRI by June 2006
3.4 Complete expanded system design and begin implementation of surveillance system in phased manner
3.5 Training of staff in facilities included in national HIV/AIDS surveillance system as facilities come online
3.6 Equip facilities included in surveillance system and prepare protocols and reference manuals by December 2006

4. Project Management

4.1 Contract for project coordinator executed by March 2006
4.2 CCM review meetings, ongoing
4.3 Manage and coordinate project activities, ongoing
4.4 Manage relationships with cofinanciers, ongoing
4.5 Monitor and evaluate project progress and outputs, quarterly
4.6 Submission of reports

Inputs

ADB: $15.0 million
Government of PNG: $3.0 million
Government of Australia: $3.5 million
Government of New Zealand: $3.5 million

ADB = Asian Development Bank, ART = antiretroviral, BCC = behavior change communication, CBO = community-based organization, CCM = Country Coordinating Mechanism of the Global Fund, FBO = faith-based organization, HSIP = Health Services Improvement Program, M&E = monitoring and evaluation, MOA = memorandum of agreement, NACS = National Aids Council Secretariat, NDOH = National Department of Health, NGO = nongovernment organization, PHC = primary health care, PNG = Papua New Guinea, STI = sexually transmitted infection, UNAIDS = Joint United Nations Programme on HIV/AIDS, UNDP = United Nations Development Programme, VCT = voluntary counselling and testing, WHO = World Health Organization.
Source: Asian Development Bank.

STATUS OF COMPLIANCE WITH GRANT COVENANTS

Covenant	Reference in Grant Agreement	Status of Compliance
In the 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 to this Grant Agreement.	Art. IV Section 4.01	Complied
(a) The Recipient shall (i) maintain, or cause to be maintained, separate accounts 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 imprest account/ statement of expenditures under the HSIP Trust Account), 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.	Art. IV Section 4.02	Partially complied. The project did not comply with the project reporting and auditing requirements. This also applied to co-financiers fund of $7.0 million to finance component 2 activities. Funds were provided to the ADB for administration, and consultants were recruited by ADB Although a separate account was created under the HSIP, the audit performed was on the consolidated account of all funds under the HSIP.
(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) hereabove, and shall authorize and require any representative of such auditors to participate in any such discussions requested by ADB, provided that any such discussion shall be conducted only in the presence of an authorized officer of the Recipient unless the Recipient shall otherwise agree.	Art. IV Section 4.02	Complied
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.	Art. IV Section 4.03	Complied
<u>General</u> The Project shall be implemented under the umbrella of the HSIP, the national sector-wide approach (SWAP) program for health	Schedule 5 Para. 1 Project Implementation	Complied

Covenant	Reference in Grant Agreement	Status of Compliance
sector development in Papua New Guinea.		
Project Executing Agency 2. NDOH shall be the Project Executing Agency, and as such shall have overall responsibility for the carrying out of the Project. The Project coordinator, to be based within NDOH, shall work in close association with the HSIP in all matters of Project administration, as well as with the CCM.	Schedule 5 Para. 2 Project Implementation	Complied
Country Coordinating Mechanism/Project Steering Committee The CCM established to administer the Global Fund in Papua New Guinea shall serve as the steering committee for the Project. The Recipient shall ensure that the CCM at regular intervals reviews progress and guides implementation under the Project, thus ensuring management and resource efficiencies are achieved with the Global Fund. The CCM shall continue to be chaired by the Secretary of NDOH and shall meet on a quarterly basis, or more regularly if required. The CCM shall grant ADB a seat on the CCM and the Project shall contribute to the support of the CCM Secretariat. ADB shall be provided with a copy of the minutes of all CCM meetings. The CCM technical working group for HIV/AIDS shall review and advise on the technical aspects of the Project.	Schedule 5 Para. 3 Project Implementation	Partially complied. The heavy workload of the CCM together with the non-function of the technical working group prevented the CCM from effectively delivering its supervision responsibilities.
Economic Operators NDOH shall assume primary responsibility for undertaking negotiations with participating economic operators to establish individual public-private partnerships. In this connection, NDOH shall develop a template memorandum of agreement to define the respective roles and responsibilities, and inputs and expected outputs of the Recipient and the economic operator. Subsidiary public-private relationships may also be included wherever necessary to capture the network of participants involved in the response to HIV/AIDS. The Recipient shall cause the CCM to review and endorse each such memorandum of agreement.	Schedule 5 Para. 4 Memoranda of Agreement	Complied
Economic Operators Under the terms of each memorandum of agreement to be entered into with	Schedule 5 Para. 5 Memoranda of Agreement	Complied

Covenant	Reference in Grant Agreement	Status of Compliance
the economic operators, rural health facilities in the surrounding communities of the rural development enclaves shall be rehabilitated to provide primary health care services, including HIV prevention, VCT, and the care of people with HIV/AIDS. The economic operators shall provide oversight and manage the partnerships with the public health facilities in their communities and provide health services to their employees and the surrounding communities.		
Civil Society Organizations and Others NDOH shall be responsible for entering into memoranda of agreement with civil society organizations and other parties on an as-needed basis covering the respective responsibilities of the Recipient and such organizations and/or parties in relation to Project objectives or Project activities. The Recipient shall cause the CCM to review and endorse each such memorandum of agreement.	Schedule 5 Para. 6 Memoranda of Agreement	Complied
Collaboration among Implementing Agencies In addition to NDOH and the economic operators, the Project shall be implemented by the NACS, provincial and district health offices, hospitals, health facilities, WHO, UNAIDS, provincial AIDS committees, and various local NGOs. NDOH shall be responsible for the implementation of a comprehensive, nationwide HIV/AIDS surveillance system. Promptly after the Effective Date, the NACS shall facilitate a transfer of existing data and files of the current HIV/AIDS surveillance system to NDOH. NDOH and the NACS shall cooperate in the production and distribution of data and analytical information on the evolution of, and response to, the HIV/AIDS epidemic in Papua New Guinea. The NACS shall continue to monitor and evaluate the national response to HIV/AIDS. The Project shall support and contribute to the implementation of the monitoring and evaluation (M&E) system.	Schedule 5 Para. 7 Inter-Agency Collaboration	Complied
Support for NGOs/CBOs/FBOs NDOH and the CCM shall support and/or contract selected NGOs/CBOs/FBOs working in HIV prevention, behavior change and communication, VCT, treatment and care, including home-based care. The Recipient shall ensure that evidence based	Schedule 5 Para. 8 Inter-Agency Collaboration	Complied

Covenant	Reference in Grant Agreement	Status of Compliance
performance is used to guide the selection process of NGOs/CBOs/FBOs engaged to assist NDOH and the CCM.		
Support for UNAIDS To strengthen the leadership of the Recipient's response to HIV/AIDS, NDOH shall support the in-country UNAIDS office in its efforts to build greater advocacy for HIV/AIDS at all levels of government and to promote the "Three Ones" among central, provincial, and district government agencies, and among all stakeholders.	Schedule 5 Para. 9 Inter-Agency Collaboration	Complied
Collaboration with World Health Organization In matters related to the development of counseling, testing, treatment and care protocols, and adaptation for implementation in one or more PNG contexts, NDOH shall seek the assistance of WHO in establishing standards to be applied under the Project. Similarly, in-service training programs of the above functions will be facilitated by WHO and other partners under the responsibility of NDOH. The Recipient, through NDOH, shall support and make use of NDOH-WHO-NACS competencies in VCT, treatment, and care training, including home-based care.	Schedule 5 Para. 10 Inter-Agency Collaboration	Complied
Support for HIV/AIDS Referral Centers The Recipient shall encourage NDOH, WHO and provincial hospitals to work together under the Project to develop hospital referral centers patterned on the model established by the Heduru Clinic at Port Moresby General Hospital. The Recipient, through NDOH, shall also assist in the development of public-private partnerships between provincial hospitals and the economic operators.	Schedule 5 Para. 11 Inter-Agency Collaboration	Complied
Annual National Budgets The Recipient, through the Department of Treasury and DNPRD, shall ensure that $3.9 million (in Kina equivalent), including its own counterpart funds, is allocated in the national budget for fiscal year (FY) 2006 for the Project. The Recipient shall take the required measures at the appropriate times to ensure that the Project's budget is taken into account in the government's annual planning and budgeting process, and included in all national budgets through to and including FY2010.	Schedule 5 Para. 12 Financial Matters	Complied

Covenant	Reference in Grant Agreement	Status of Compliance
Waiver of Import Duties and Taxes The Recipient, through the Internal Revenue Commission, shall ensure that all health hardware items, such as condoms and personal lubricants, for Component 2(ii) of the Project, are imported into PNG free of all taxes and duties, and released promptly to the consultants engaged by ADB to administer this subcomponent.	Schedule 5 Para. 13 Financial Matters	Complied
Recurrent Budget for HIV/AIDS Prevention The Recipient shall ensure that its recurrent allocation for HIV/AIDS prevention in its annual budget increases by 20 percent per year throughout the life of the Project beginning in FY2006.	Schedule 5 Para. 14 Financial Matters	Complied
HIV Surveillance System and Surveillance Personnel The Recipient, through NDOH, shall support and maintain at least the same number of surveillance sites and surveillance personnel as exist at the completion of the Project for a minimum of four years after the Project's completion.	Schedule 5 Para. 15 Other Matters	Complied
Hospital Referral Centers The Recipient shall roll out three regional referral centers for STIs and HIV at Mt. Hagen Hospital, Angau Memorial Hospital, and Nonga Base Hospital, in addition to Heduru Clinic at Port Moresby General Hospital.	Schedule 5 Para. 16 Other Matters	Complied
Local Health Facilities and the Private Sector The Recipient shall take all necessary steps to ensure the smooth and timely delivery of all management and supervisory assistance pledged to local health facilities by the economic operators in participating rural development enclaves pursuant to their respective memoranda of agreement with the Recipient.	Schedule 5 Para. 17 Other Matters	Complied
Environmental Considerations The Recipient, through NDOH, shall ensure that the rehabilitation and operation of all health facilities involved in the Project comply with all applicable laws and	Schedule 5 Para. 18 Other Matters	Complied

Covenant	Reference in Grant Agreement	Status of Compliance
regulations of Papua New Guinea and ADB's *Environment Policy (2002)*.		
Anticorruption Measures During Project implementation, NDOH shall follow ADB's *Anticorruption Policy,* it being understood that ADB reserves the right to investigate, directly or through its agents, any alleged corrupt, fraudulent, collusive or coercive practices relating to the Project. NDOH shall ensure that (a) periodic inspections of the contractors' activities related to fund withdrawals and settlements are carried out, (b) relevant provisions of ADB's *Anticorruption Policy* are included in all bidding documents for the Project, and (c) all contracts financed by ADB in connection with the Project include provisions specifying the right of ADB to audit and examine the records and accounts of NDOH and all contractors, suppliers, consultants and other service providers as they relate to the Project.	Schedule 5 Para. 19 Other Matters	Complied
Project Performance Monitoring and Evaluation Data collection shall be undertaken to monitor progress in achieving the Project objectives. Specifically, NDOH and the Project coordinator shall jointly develop a project performance monitoring and evaluation system (PPMES) that will provide the Recipient, ADB, and the Cofinanciers with information on: (i) the technical performance of the Project; (ii) measures of Project impact, including social and economic benefits; and (iii) progress towards targets and goals identified in the Project design and monitoring framework and the Recipient's medium term development strategy. All baseline data existing as at the date of this Grant Agreement, such as the quarterly routine case reporting and periodic sentinel surveillance activities, the Report of the 2004 National Consensus Workshop, AIDS Indicator Surveys, the planned 2006 Demographic and Health Survey, NHASP surveys and reports, and reports from the four STI clinics (Mt. Hagen, Port Moresby, Goroka, and Lae), shall be taken into account when assembling the data. Whenever necessary, particularly within the individual rural development enclaves and their surrounding communities, the Recipient shall cause NDOH to conduct baseline surveys within the first year of operations. The Recipient shall also cooperate with the consultants responsible for the social marketing of	Schedule 5 Para. 20 Other Matters	Complied

Covenant	Reference in Grant Agreement	Status of Compliance
condoms so as to enable them to conduct their own research to establish baselines and subsequent measures throughout the Project. All reports shall be submitted by NDOH to the CCM, ADB, the Cofinanciers, and other key development partners throughout Project implementation; these reports shall include indicators of Project completion, delivery and benefits.		
Project Review The CCM shall include the Project in its own quarterly reviews. In addition, ADB and the CCM will jointly carry out Project supervisory missions every 6 months. Before each visit, an updated progress report shall be prepared by NDOH. Two years after the commencement of the Project, the CCM shall undertake a comprehensive mid-term review of the Project to (i) examine the scope, design, implementation arrangements, and other relevant issues in light of the Recipient's development of HIV/AIDS strategies and policies; (ii) assess the Project's progress and achievement of its objectives; (iii) identify problems and constraints; and (iv) recommend any required modifications, restructuring, and reallocations. The Recipient shall issue invitations to ADB and the Cofinanciers to participate in the mid-term review.	Schedule 5 Para. 21 Other Matters	Partially complied. The CCM was not able to fully carry out its functions as it was overloaded with responsibilities to the Global Fund and the provincial coordinating committees did not meet regularly due to limited resources and accountability. This was improved following the mid-term review where consultants were recruited to support regular meetings and reviews.

PROVINCES AND DISTRICTS WITH PROJECT ACTIVITIES

1. The HIV/AIDS Prevention and Control in Rural Development Enclaves project implemented activities in the following provinces and districts.

2. **Component 1:**

(i)	Gulf Province:	Kikori District
(ii)	Morobe Province:	Markham District
(iii)	Madang Province:	Usino-Bundi and Rai Coast districts
(iv)	Enga Province:	Lagaip-Pogera District
(v)	Oro Province:	Ijivitari and Sohe districts
(vi)	Western Highlands Province:	Angalimp-South Waghi, North Waghi, Baiyer-Mul and Dei districts
(vii)	Eastern Highlands Province:	Kainantu District
(viii)	Southern Highlands Province	Nipa-Kutubu, Komo-Margarima, Tari, and Kagua-Erave districts

3. **Component 2:**

(i) for Sexual Health Promotion interventions: all provinces under component 1; and

(ii) For the Condom Social Marketing contract: all provinces (this activity had a nationwide focus).

4. **Component 3**: For the Behavioral Surveillance Surveys conducted through the National Research Institute: all provinces under component 1, plus Vanimo District (West Sepik Province) and the National Capital District (Central Province). The project also supported the National Department of Health to improve data collection nationwide for HIV and STI. In addition, Sentinel Surveillance was conducted in the provinces under component 1 plus the National Capital District and Central Province, Simbu, West Sepik and Manus provinces.

5**. Extractive and agricultural industries with signed MoAs:** (i) Barrick Kainantu. (operating in Eastern Highlands, with some overlap into the border areas with Morobe and Madang provinces); (ii) Higaturu Oil Palms (operating in Oro Province); (iii) Oil Search (operating in the Gulf, Southern Highlands and Hela provinces); (iv) Pogera Joint Venture (operating in Enga province); (v) Ramu Agri Industries (operating predominantly in Madang, and extending into Morobe province); and (vi) WR Carpenters & Co Estates (operating in Western Highlands and Jiwaka provinces).

5. **Summary of facilities implemented:**

Item	Enclave Operator	Health sites (no.)	Clinical Buildings (no.)	Staff Houses (no.)	Total ($)
1	WR Carpenters & Estates	25	31	0	2,165,468
2	Higaturu Oil Palms (Kula Oil Palms)	13	15	3	2,892,528
3	Ramu Agri Industries	12	14	3	1,660,390
4	Pogera Joint Venture (Barrick Niugini)	3	5	11	1,539,095
5	Oil Search	13	18	30	2,273,241
6	Barrick Kainantu	12	14	10	1,196,248
	TOTAL	**78**	**97**	**57**	**11,726,970**

Source: Project reports.

MONITORING AND EVALUATION FRAMEWORK

GOAL

Narrative Summary with Indicators	Report on Indicators December 2010
To contribute to the control of the spread of HIV infection by 2015 and stabilize by 2020 Prevalence rate no longer increasing by 2020	The 2009 NDOH HIV Epidemic Estimation Report as presented at the 2009 PNG Medical Symposium reported national HIV prevalence in 15–49 yr. olds as 0.95%. As of the end of December 2009, it was estimated to be 0.90%. Current data do not accurately measure prevalence. Listed below are the number of tests compared to the number of confirmed positive cases for each year. Surveillance data on antenatal populations is a recognized proxy for population level prevalence. ANC data is also listed below:

Table A4.1: Total Annual New HIV+ Tests in PNG (All Populations)

Year	No. Tested	No. Positive	% Increase	Trend
2006	16,691	3,673	22%	↓
2007	32,319	5,038	15.58%	↓
2008	120,607	5,084	4.21%	↓
2009	123,661	3,711	3.0%	↓
2010	138,581	4,208	3.0%	- ↓
2011	146,735	4,612	3.1%	- ↓

Note: January–August 2011 data only.
Source: Project documents.

Table A4.2: Annual New HIV+ Tests in PNG Among Pregnant Women

Year	No. Tests	No. Positive	% +	Trend
2006	18,268	221	1.2%	↓
2007	28,435	244	0.85%	↓
2008	46,316	337	0.74%	↓
2009	45,560	323	0.70%	↓
2010	49,062	246	0. 50%	↓
2011	No data			

PUBLIC–PRIVATE PARTNERSHIPS IN RURAL DEVELOPMENT ENCLAVES

OUTCOMES

Improved access to health and medical services, according to NDOH standards, for populations in the participating project areas, with a particular focus on	Phase 1 facilities = 49 for Civil Works Phase 2 facilities = 26 for Civil Works (16 completed at end of 2010 and 26 completed by end of July 2011)

STI and HIV prevention, diagnosis and treatment	Total facilities = 111 for service improvement (training, supervision, medical equipment)
All participating health facilities pass accreditation for HIV testing services[a]	Number where HIV testing was available: (i) December 2007: 8 (ii) December 2008: 28 (iii) December 2009: 32 (iv) December 2010: 37 (v) December 2011: 50 VCT accreditation of health facilities to conduct HIV testing is not required under NDOH policy. Health facilities with staff trained in HIV counseling and testing can provide the service (i.e., VCT or PICT). The project criteria for renovation of health facilities include a private consultation room with infection control utilities as per NDOH guidelines.
70% of rural health facilities in participating enclaves that were not functioning in 2005 now fully functional and providing comprehensive PHCb	Health facilities that were staffed and open were selected to participate in the project. Aid posts that were closed in 2005 remain closed due to land owner challenges, staffing availability or tribal violence. Few health facilities meet the criteria of "fully functional" due to structural determinants not addressed by the project (i.e., medication supply, staffing, and management).
Percentage of participating health facilities that are now functioning (Provincial hospitals are not included in the denominator.)	89% of participating health facilities are open; however several are not fully functional due to HRM capacity limitations. Several facilities have been removed from the project due to no staff or changed circumstances. Of the original 111 participating rural health facilities: 1 aid post is closed in Eastern Highlands (land dispute), 2 health sub-centers are closed in Eastern Highlands (no staff), 3 aid posts are closed in Southern Highlands (land dispute), 1 health center is closed in Southern Highlands due to staffing shortages, 1 aid post is closed in Western Highlands (land dispute), 2 aid posts are closed in Western Highlands due to lack of staff, and 2 aid posts are closed in Oro due to lack of staff. Aid posts all report chronic shortages of medication and other consumables. Many health centers also experience regular stock outs of medications and clinical consumables NDOH and DFAT-funded initiative in September 2011 will provide a standard medical kit to each health facility which may assist to ease the chronic undersupply in rural areas.

10% annual increase in use of HIV testing services by rural populations in participating enclaves compared to 2005
(Note: provincial hospital data not included.)

Table A4.3: Number of HIV Tests Conducted per Enclave per Year

Enclave	2005	2006	2007	2008	2009	2010
BKL	0	0	25	300	2,172	637
HOP	0	132	555	564	592	64
OSL	0	0	120	1,496	2,553	5,193
PJV	1,706	1,901	1,805	1,958	3,266	2,645
RAI	0	0	26	267	886	1,190
WRC	3,633	3,998	3,789	4,438	5,403	4,742
Total	**5,339**	**6,031**	**6,320**	**9,023**	**14,872**	**14,471**
% change		+13%	+5%	+43%	+65%	–2.7%

10% annual increase in use of STI services by rural populations in participating enclaves compared to 2005
Notes:
i. Provincial hospital data not included.
ii. Most aid post data not available.
iii. Most STI treatment delivered by aid posts staff is sub-therapeutic due to the absence of Syndromic STI protocol medications.
iv. STI treatment includes genital ulcers, abdominal pain in women, and genital discharges (the majority of female genital discharge is not STI related).

Table A4.4: Number of People Treated for Genital Infections per Enclave per Year

Enclave	2005	2006	2007	2008	2009	2010
BKL	796	537	682	757	550	402
HOP	126	103	206	199	176	236
OSL	739	688	547	661	498	803
PJV	1,912	1,456	1,316	1,610	1,797	1,177
RAI	370	485	385	557	996	599
WRC	2,921	2,823	2,869	3,221	4,737	4,150
Total	**6,864**	**6,092**	**6,005**	**7,005**	**8,754**	**7,367**
% change		–12%	–2%	+16%	+25%	–16%

Annual increase, by at least 10% of surrounding community populations with adequate access to comprehensive health services[c]

(Note: provincial hospital data not included.)

Table A4.5: Number of Patients Seen per Enclave per Year

Enclave	2005	2006	2007	2008	2009	2010
BKL	57,815	34,685	50,379	33,473	28,526	21,435
HOP	78,663	64,429	74,617	111,982	99,307	63,365
OSL	112,942	145,054	170,170	201,238	177,062	172,470
PJV	111,175	112,377	95,587	109,699	131,771	289,022
RAI	115,820	112,806	140,741	169,796	151,695	148,502
WRC	175,760	165,245	163,449	170,118	154,245	165,466
Total	**652,175**	**532,996**	**694,943**	**796,306**	**742,606**	**860,260**
% change		–18%	+30%	+14%	–7%	+16%

Notes:
1. Aid post data is not reported on by the NHIS.
2. Changes in patient number may represent fluctuations in enclave population and

	reporting, and not necessarily access to health services. PNG's estimated population growth rate is 2.5%. 3. In 2005 the numbers of patients reported across all enclaves and patient categories exceeded that in 2006; the reason is unclear.
OUTPUTS	
Functioning PPPs in rural development enclaves improving and extending health services At least six PPPs entered into	Six MOAs signed by end of 2007. Five addendum signed by end of 2009 for Phase 2. One enclave closed down operations so is unable to participate in phase 2. Project funding and time frames prohibit the addition of new enclaves.
At least two partnerships fully functioning within first year of project (2007)	Six economic operators signed up and commenced the project by end 2007. Initial partnership focused around civil works with a strong partnership between the private economic operators (companies) and the project office. Current initiatives are encouraging greater partnership with relevant provincial health officers.
Renovations on all identified health facilities are completed by end 2009 Percentage of planned renovations on all identified health facilities as per scope of work per participating enclave are completed by EOP (i.e., signed Civil Works Agreement)	Phase 1 renovations program closed at the end of the first quarter of 2010, with 49 facilities completed out of 49 facilities, with signed scopes of work (100%) Of the original 82 selected facilities; 11 did not progress and 22 were moved to phase 2 for completion in 2010–2011. 44 of 49 phase 1 renovations completed by the end of 2009 (90%) 22 phase 1 facilities were transferred to phase 2, plus 4 new facilities. A total of 26 facilities have signed Civil Works Agreements in place. 16 of 26 phase 2 renovations completed by the end of 2010 (62%) 26 out of 26 phase 2 renovations completed by the end of 2011 (100%) Note: 11 health facilities were not renovated using project funds at the request of the company. Some were completed with company funds and/or under the tax credit scheme, or were not undertaken due to various obstacles (road conditions, lack of staff, land dispute, tribal fights).
All equipment and fixtures provided to all identified health facilities as per standardized NDOH 'health facility kits' Percentage of participating health facilities that have received standard medical kits	100% of 44 health facilities have received standard medical equipment kits (Phase1). 100% of 26 health facilities have received standard medical equipment kits (Phase 2). An additional 36 health facilities received medical equipment kits (Phase 1 and 2).

Provincial health staff participate in supervision & support visits of health facilities Percentage of supervision visits per enclave that have a PHO staff member present	Limited provincial health officer or district health officer involvement in the supervision support visits. Percentage of supervision visits with PHO or DHO participation: (i) 2008: 16%; (ii) 2009, 2010 and 2011: <1%
All participating health facilities receive monthly supervision & support % of participating health facilities receiving supervision visits per month	The majority of supervision visits were not documented. 48% of participating health facilities received some supervision during 2008. No data are available for 2009, 2010 and 2011
Provincial health office staff participate in Project Management committee meetings % of committee meetings held per enclave that have PHO participation	Four enclaves held 16 coordination meetings during 2008 Three enclaves held eight coordination meetings during 2009 (four meetings from one enclave). Three enclaves held 10 coordination meetings during 2010. Three enclaves held a coordination meeting during 2011.
All health staff in participating enclaves pass accreditation for VCT (HIV testing) following attendance at 3 courses (Intro to HIV, RDT, and VCT) % of health staff allocated to work in each health facility in each enclave who complete NDOH accreditation for HIV testing	347/376 = 92% of clinical staff from participating health facilities have attended the HIV Counselling and Testing courses. Staffing numbers fluctuate (e.g., due to transfers, maternity leave, and study leave). Several people from outside the participating health facilities have attended the courses.
All health staff in participating health facilities attend STI Syndromic Management Course % of health staff allocated to work in each health facility in each enclave who attend STI Syndromic Management Course	464/376 = >100% Clinical staff from participating health facilities have participated in the STI Syndromic Management course. Staffing numbers fluctuate (e.g., due to transfers, maternity leave, and study leave). Several people from outside the participating health facilities have attended the courses.
All participating health facilities provide STI syndromic management as per the NDOH guidelines by 2010 % of participating health facilities providing STI care as per NDOH guidelines	37% (42/111) are providing STI care as per NDOH Guidelines. Health centers and health sub-centers mostly have access to the minimum medications required to treat STI (with the exception of Azithromycin which is frequently unavailable). Aid posts are rarely able to provide STI care as per NDOH guidelines as they do not receive the correct medications from the area medical stores or their supervising

<table>
<tr><td></td><td>health centers.</td></tr>
<tr><td>Total cases treated for genital ulcer, vaginal discharge, and urethral discharge syndromes per participating health facility per year.</td><td>See item number 5 for a table describing total number of genital conditions treated in the enclaves project.</td></tr>
<tr><td>Improvements in primary health care provision in participating health facilities as compared to baseline.

Total patient consults per participating health facility per year</td><td>Aid post data not included in the NHIS.
Aid post data is collected, but mostly unavailable due to collation limitations at provincial level.
Evidence of poor enumeration or miscalculation.
Daily tally sheets may not be coherent with monthly reports
See item number 6 for a proxy measure.</td></tr>
<tr><td>10% increase per year in the number of women having at least 1 antenatal visit by facility per enclave</td><td>Table A4.6: Antenatal Clinics Visits per Enclave per Year
<table>
<tr><th>Enclave</th><th>2006</th><th>2007</th><th>2008</th><th>2009</th><th>2010</th></tr>
<tr><td>BKL</td><td>430</td><td>534</td><td>670</td><td>627</td><td>556</td></tr>
<tr><td>HOP</td><td>1,080</td><td>1,305</td><td>1,350</td><td>902</td><td>1,086</td></tr>
<tr><td>OSL</td><td>1,697</td><td>1,794</td><td>1,877</td><td>1,875</td><td>2,301</td></tr>
<tr><td>PJV</td><td>1,914</td><td>1,824</td><td>1,840</td><td>1,794</td><td>1,393</td></tr>
<tr><td>RAI</td><td>1,613</td><td>1,640</td><td>1,911</td><td>2,101</td><td>1,977</td></tr>
<tr><td>WRC</td><td>3,945</td><td>3,322</td><td>3,509</td><td>2,842</td><td>3,128</td></tr>
<tr><td>Total</td><td>10,679</td><td>10,419</td><td>11,157</td><td>10,141</td><td>10,441</td></tr>
<tr><td>% Change</td><td></td><td>+2.49%</td><td>+6.61%</td><td>–10.01%</td><td>+2.87%</td></tr>
</table></td></tr>
</table>

% of births supervised in a health facility per enclave

True denominator of pregnancies difficult to calculate due to population movements & poor capacity of population enumeration at local level.

If ANC visit 1 attendance was used as a proxy denominator for numbers of pregnant women.

Year	ANC	Deliveries	%
2006	10,679	4,974	46
2007	10,419	5,181	49
2008	11,157	5,204	46
2009	10,141	5,561	54
2010	10,441	6,202	59

Project purchased 45 birthing couches for health center and sub-centers.

Birthing kits provided to health center and sub-centers with the standard equipment kits in 2009 and 2011 for Phase 2.

Changes in number of births at health facilities may indicate changes in population numbers due to movements to enclaves and not improved access to supervised deliveries

Table A4.7: Supervised Deliveries per Enclave per Year

Enclave	2006	2007	2008	2009	2010
BKL	257	378	420	358	330
HOP	219	230	367	251	222
OSL	1,159	1,237	1,157	1,417	1,586
PJV	916	917	879	915	908
RAI	625	673	761	858	1,039
WRC	1,798	1,746	1,620	1,762	2,117
Total	**4,974**	**5,181**	**5,204**	**5,561**	**6,202**
% Change		+3.99%	+0.44%	+6.41%	+10.33%

% <1yr olds who have had X2 Measles Vaccine per enclave

Note: Due to population denominator estimation limitations at facility level, district-level data are used.

Table A4.8: Average % of children under Age 1 in Enclave Districts who had Two Measles Vaccines

Enclave	2005	2006	2007	2008	2009	2010
BKL	111	134	130	293	163	204
HOP	39	41	46	52	40	56
OSL	59	112	65	73	75	69
PJV	77	108	95	98	45	72
RAI	40	45	41	47	40	33
WRC	74	77	57	71	57	50
Total Av	**66%**	**86%**	**72%**	**105%**	**70%**	**89%**
Change		increase	decrease	increase	decrease	increase

Malaria incidence and mortality rate per enclave

Not currently measureable due to data difficulties.

CONDOM SOCIAL MARKETING AND STRENGHTHENING CIVIL SOCIETY ORGANIZATIONS TO ENGAGE IN COMMUNITY BEHAVIOR CHANGE	
Narrative Summary with Indicators	**Report on Indicators July 2011**
OUTCOMES	
Increased use of male and female condoms among target population Significant increase in % of men who used a condom (male or female) with last casual partner by end of project. Note: As of September 2010 indicators modified to the following. Significant increase in % of men who used a condom (male or female) consistently with casual partners in the past month by EOP from 66.6% to 76.6%.	2008 Baseline TRaC: Consistent condom use with non-regular partner: 66.6% Note: High baseline. In 2008, of sexually active men in rural economic enclaves aged 18–49, 64% used condoms consistently with casual partners in the past month. In 2011, 50.7% used condoms consistently with those partners. However, in that same time period, consistent condom use with regular partners increased from 8.5% in 2008 to 17.7% in 2011.
Sales of 5 million male condoms through commercial channels by EOP.	Cumulative since November 2008: 512,000 branded male condoms in 600 outlets by December 2009. Through September 2010 cumulative since November 2008: 615,396 branded male condoms in 700 outlets. Note: As of September 2010 no longer a valid indicator with the CSM component merging with BCC. Cumulative total distribution from CSM & non-branded = 4,273,307 condoms.
Sales of 1.2 million male condoms through NGOs working with the target group by EOP.	Cumulative since October 2007: 464,910 free generic male and 12,451 female condoms provided to NGOs and economic operators. Note: As of September 2010 no longer a valid indicator with the CSM component merging with BCC.
Sales of 200,000 female condoms by EOP.	Cumulative since September 2009: 22,478 branded Female Condoms sold. Note: As of September 2010 no longer a valid indicator with the CSM component merging with BCC.
Sale of 500,000 sachets of lubricants by EOP.	Cumulative since February 2010: 7,906 tubes. Note: It was decided not to bundle lubricants with condoms and only purchase 20,000 tubes as a trial with high-risk behavior groups. 12,833 total tubes of lubricant cumulative up to July 2011.

Community behavior change away from high numbers of concurrent partners and toward increased use of condoms By 2011: Condom use in the participating enclaves increases 30% over baseline (to be established) by end of project	TRaC baseline 2008: Ever used a male condom: 28.6% As of September 2010 indicators modified to the following: Among men who had more than one sexual partner, increase consistent condom use with non-marital, non-cohabiting partners in the last month from 75.6% to 85.6%. Among sexually active men aged 18–49 in rural economic enclaves, the proportion who had more than one partner in the past year who used condoms consistently with non-regular partners decreased from 75% in 2008 to 39.3% in 2011.
In participating economic enclaves and their surrounding populations, reduced proportion of people with concurrent partners by 10% over measured baseline by end of the project.	TRaC baseline: Having only one sexual partner in the past 12 months: 56.9% As of September 2010 indicators modified to the following: Decrease the percentage of men aged 15–49 who report they had more than one sexual partner in the past year from 43.1% to 33.1% in project sites. Among sexually active men aged 18–49 in rural economic enclaves, 54.1% reported more than one sexual partner in the past year in 2008 and 56.7% reported the same in 2011. The difference in these percentages are not statistically significant.
Behavior change programming activities in participating enclaves are established and supervised.	Cumulative since August 2008: 1,508 participants from all six enclaves in *Tokaut na Tokstret* Men's Sexual Health workshop by end 2009. Cumulative since August 2008: 1,681 participants from all six enclaves in *Tokaut na Tokstret* Men's Sexual Health workshop by end 2010. Cumulative since August 2008: 2,445 participants from all six enclaves in *Tokaut na Tokstret* Men's Sexual Health workshop by end 2011. Rapid PEER qualitative assessment show the TNT training is reducing concurrent partnerships, reducing gender-based violence, increasing couple communication, and improving relationship quality.
OUTPUTS	
National Social Marketing of condoms program established, and behavior change programs established in partnership enclaves All enclaves are included in national social marketing scheme	Commercial condom outlets established in and around all six enclaves, 600 outlets throughout PNG by end 2009. Commercial condom outlets established in and around all six enclaves, 700 outlets throughout PNG by end 2010. Commercial condom outlets established in and around all 6 enclaves, 1225 outlets throughout PNG by end July 2011. 85 of the 1,225 are within an enclave (7%)

Improved access to affordable condoms Regular supply of male condoms (free or social marketing) to the operators of the 6 selected economic enclaves.	All of the USAID-donated generic condom stock to PSI have been sent to the economic operators. Regular supply *Seif Raida* to commercial outlets is established. Economic operators are encouraged to order the generic condoms from the area medical stores and to facilitate Health Facilities to do the same. PSI supplied *Seif Raida* and *Stap Seif* condoms when required to the enclaves.
At least 2 wholesalers appointed in each province except Manus, which will have at least 1 wholesaler.	8 distributors, wholesalers and/or chain stores established; many have a network that cover multiple provinces psuch as Papindo, City Pharmacy and Chemcare. Others include Bintango, Price Rite and Alotau Enterprises Distributors act as wholesalers in the districts.
Significant increase in % of men in the six economic enclaves who report that condoms (male or female) are readily available. As of September 2010 indicators modified to: % of men who agree with the statement, "I know a place where I can obtain condoms within 15 minutes walk of where I live or work" increases from 82.9% to 92.9%.	(TRaC baseline monitoring scale values 1 to 4) "It is not difficult to find a place where condoms are sold": 2.22 % of men who agree with the statement, "I know a place where I can obtain condoms within 15 minutes' walk of where I live or work" increases from 82.9% to 92.9%. Among sexually active men aged 18–49 in rural, economic enclaves, the proportion of those who agreed decreased from 80.4% in 2008 to 69.0% in 2011. 1,225 outlets carrying condoms nationwide by EOP 20,000 lubricants distributed via NGOs or commercial sector by EOP 12,833 tubes of lubricant as of July 2011. 85 Condom Outlets established within a half mile of all enclaves by July 2011. 85 outlets within enclave Wholesalers appointed in each of the four regions. Momase 2; Southern 6; Highlands 5; Islands 7. 50% of established outlets are in rural areas. By July 2011, 30% of outlets are in Rural Areas.
Increased informed demand for condoms % of target population who say they know how to use a condom correctly by EOP. As of September 2010 indicators modified to: % of target population who say they know how to use a condom correctly increases from 84.3% to 94.3%.	TRaC baseline monitoring scale values 1 to 4: "I feel confident to use a male condom correctly": 3.10 Among sexually-active men aged 18–49 in rural, economic enclaves, the proportion of those who agreed decreased from 83.2% in 2008 to 76.1% in 2011.

Significant increase in % of target population who believe that a healthy-looking person can be infected with HIV. As of September 2010 indicators modified to: Increase the proportion of men aged 15-49 who believe that a healthy-looking person can be infected with HIV from 93.1% to 98.1%. % of target population who agree that, "I could easily find someone to talk to if I had concerns about HIV" increases from 78.5% to 88.5%.	TRaC baseline monitoring scale values 1 to 4: "A man cannot tell by looking if a woman has HIV": 3.17 Among sexually active men aged 18-49 in rural, economic enclaves, the proportion of men who agreed that a healthy-looking person can have HIV decreased from 99.4% to 82.4% in 2011. Among sexually active men aged 18–49 in rural, economic enclaves, the proportion of those who agreed decreased from 76.0% to 65.1% in 2011.
Decrease % of target population who believe people who use condoms have bad character. As of September 2010 indicators modified to: % of men who agree with the statement, "Using condoms will not imply to my partner that I have HIV" increases from 49.7% to 59.7%.	TRaC baseline monitoring scale values 1 to 4: My friends encourage me to carry condoms: 2.79 Among sexually-active men aged 18–49 in rural, economic enclaves, the proportion of those who agreed increased from 50.6% to 57.8% in 2011
% of target population who believe they can do what is necessary to protect themselves against HIV infection. As of September 2010 indicators modified to: % of men who agree with the statement, "My casual partner will approve of me using a condom" increases from 72.9% to 82.9%. % of men who agree with the statement, "I would be embarrassed to buy my own condoms" decreases from 39.5% to 29.5%. % of men who agree with the statement, "My casual partner will approve of me using a condom" increases from 72.9% to 82.9%.	TRaC baseline monitoring scale values 1 to 4: I find it easy to resist pressure from friends to have more than one sexual partner: 2.76 Among sexually active men aged 18–49 in rural, economic enclaves, the proportion of those who agreed decreased from 72.7% in 2008 to 58.3% in 2011. Among sexually active men aged 18–49 in rural, economic enclaves, the proportion of those who agreed decreased from 60.1% to 54.3% in 2011.
Significant % increase of men who used condoms consistently with their casual partners in the last 3 months As of September 2010 indicators modified to: % of target population who say they know how to use a condom correctly increases from 84.3% to 94.3%.	TRaC baseline 2008: Consistent condom use with a casual partner in the last month: 66.6% Among sexually active men aged 18–49 in rural, economic enclaves, the proportion of those who agreed decreased from 83.2% in 2008 to 76.1% in 2011.

% of men who say they have decreased the number of sexual partners in the last 2 years As of September 2010 indicators modified to: Decrease the percentage of men aged 15–49 who report they had more than 1 sexual partner in the past year from 43.1% to 33.1%.	TRaC 2008 baseline: Having only 1 sexual partner in the past 12 months: 56.9% TRaC 2008 baseline: Had sex with casual partner in the last month: 23% Among sexually-active men aged 18–49 in rural economic enclaves, 54.1% reported more than one sexual partner in the past year in 2008 and 56.7% reported the same in 2011. The difference in these percentages are not statistically significant.
Number of people trained in female condom use.	Cumulative : 1,720 people trained in the use of the female condom. Includes men from the sexual health workshop as well as training from PSI detailers as of end 2009. Cumulative : 2,230 people trained in the use of the female condom. Includes men from the sexual health workshop as well as training from PSI detailers as of end 2010. In 2011 media campaign events reached 17,682 men and women and PSI staff reached a further 5,015 men and women in an event in Lae.
Greater participation of the private sector and establishment of effective public-private partnerships at all levels for wider distribution of male and female condoms and lubricant. Collaboration with 5 private sector partners for nationwide distribution of male condoms and lubricant, and at least 1 private sector partner for female condoms	Eight distributors/wholesalers/chain retailers established; many have a network that cover multiple Provinces such as Papindo, City Pharmacy and Chemcare. Others include Bintango, Price Rite and Alotau Enterprises. Distributors act as wholesalers in the Districts. Female condoms were distributed commercially via City Pharmacy and Chemcare.
Five private sector partners trained in program goals and objectives, AIDS knowledge, social marketing, direct selling skills.	Eight distributors, wholesalers and/or chain retailers established; many have a network that cover multiple Provinces such as Papindo, City Pharmacy and Chemcare. Others include Bintango, Price Rite and Alotau Enterprises. Distributors act as wholesalers in the districts. Uplifting and in-house promos provides opportunity to train and inform partners.
STRENGTHEN AND EXPAND SURVEILLANCE SYSTEM FOR HIV	
Behavioral Surveillance	
Narrative Summary with Indicators	**Report on Indicators December 2010**
Strengthened and expanded national behavioral surveillance for HIV by the end of 2010. Number of BSS sites and X number of BSS research with targeted most at risk groups conducted annually	Round 2 = Five sites (July 2008–July 2009) with four research conducted with MARPS Round 3 = Three sites (August 2009–November 2010) with three research conducted with MARPS 2008: Three BSS sites with two research conducted and completed with MARPS: one site general population ANC + two sites MARPS —one STI clients and WRC

	workforce. 2009: Two BSS sites and two MARPS research conducted with OSL workforce and Vanimo High Risk Youth. 2010: Three BSS sites and three MARPS research conducted with women exchanging sex in Mt. Hagen (also drawing from rural areas of Western Highlands, Ramu Agri Industry workforce and Highlands Highway truck drivers. By end of 2010: Eight BSS sites and seven BSS research conducted with most at risk populations.
Repeat surveys conducted by targeted most-at-risk group by the end of 2010	Round 3 repeat trend data 2009–2010 from baseline done in Round 1 in 2006 with: Three repeat surveys conducted with workers at Ramu Agri Industries, Highlands highway truck drivers and women exchanging sex in Hagen.
Behavioral surveillance surveys conducted at rural development enclave sites annually.	By end of 2010: Three BSS conducted at three rural development enclave sites: Ramu Agri Industries (2010), WRC (2008) and OSL (2009). One BSS survey conducted at rural development enclave sites annually from 2008–2010.
% of rural economic enclaves that are included in national behavioral or bio-behavioral surveillance by end of project	At end of 2010, four rural economic enclave sites had been included as national surveillance BSS and IBBS priorities: 50% (3/6) of rural economic enclaves included in national behavioral surveillance by end of 2010 (Barrick Kainantu included as a site but closure caused cancellation of research).
Behavioral surveillance and bio-behavioral surveillance are integrated within the national surveillance plan and system, and conducted in synchronization between NDOH, NRI and other partners. Bio-behavioral surveys conducted collaboratively between sero and behavioral surveillance, nationally and in enclave areas by 2010	End 2010: Two bio-behavioral surveys and one RDS BSS conducted between national sero- and behavioral surveillance nationally and three in enclave areas.
Bio-behavioral surveillance protocol endorsed by the STWG	Bio-behavioral protocol endorsed by STWG for overall sentinel collection (2008) and done at two sites (ANC and STI)
NRI increases its profile in HIV behavioral research and develops technical capacities to plan and conduct annual behavioral surveillance research with targeted population groups. NRI HIV seminar series held annually with people and organizations attending	2007: 20 seminars (email list of >230) 2008: 16 seminars with 282 people attending from x different organizations (>301 on email list) . 2009: Eight seminars with 216 people attending from 54 different organizations (>450 on email list). 2010: Two seminars with 103 people attending from 27 different organizations (549 on email list at end 2010).

	2011: Upcoming seven seminars confirmed and scheduled for January to June 2011.
Number of annual behavioral surveillance reports produced, published and disseminated by NRI by the end of 2010	Two annual BSS surveillance reports produced, published electronically and disseminated by end 2009 (BSS at ANC and STI as part of sentinel surveillance IBBS). One annual BSS surveillance report for WRC printed for Jan 26th 2011 dissemination. One BSS surveillance report reviewed by STWG and formatted for printing awaiting comments from OSL for dissemination in March 2011. Four BSS reports in various stages of analysis and writing for dissemination in April, May and June 2011.
Number collaborative studies or affiliation agreements between NRI and other researchers and national and international research institutions or organizations involved in HIV related research and work	End of 2010: Five existing affiliation agreements (NDOH, ARCHSS LaTrobe, University of British Columbia, University of Sussex, University of Adelaide) and eight collaborative studies = two with NDOH, five with ARCHSS LaTrobe and one with both ARCSHS and NDOH.
Number of UNGASS indicators that had data reported by BSS unit at NRI at the end of 2010	Twenty-eight UNGASS indicators with data reported (from across four sites) by BSS unit at NRI at the end of 2009 and reported in UNGASS Report 2010. UNGASS indicators have been calculated for four additional sites and will be included in reports for end of 2011 UNGASS reporting by NACS.
OUTPUTS	
The NRI HIV behavioral surveillance unit is established, a full complement of staff is recruited and hired, and formal collaboration is established between NRI and NDOH MOU is signed between NRI and NDOH	MOU signed in April 2008 until end of 2010 and a variation made for an extension until the end of June 2011. Discussions in 2011 between NRI and NDOH for further MOA.
Number staff recruited as per surveillance plan budget	End of 2008: 5 full time BSS and 13 part time BSS casual staff recruited. End of 2009: 8 full time BSS staff and 6 part time BSS casual staff (10 overall casual staff throughout the year with four hired as fulltime staff by year end as one replacement research fellow and three new Project Officers) recruited as per surveillance plan budget. Note: staff hired July and August 2008 and all BSS team related indicators compiled from the third quarter 2008 to end 2009). End of 2010: 7 full and 5 part time BSS staff recruited as per surveillance plan with two positions presently vacant and to be filled short term contract for 6 months in 2011.
% of staff with desk, computer and access to communication	100% of staff with desk, computer and access to communication.

% increase in staff working in HIV socio-behavioral research with NRI from 2007 to 2010	400% increase in staff working in HIV socio-behavioral research with NRI from 2007 to end 2009. 2007: One seconded NRI Associate Research, one NRI Research Cadet and two UNPNG students on field placement = 4 End 2008: 5 ful time BSS and 12 part time BSS, three associate researchers, one visiting research fellow, one NRI research cadet = 23 End 2009: 8 full time BSS and 6 part time BSS, 3 associate researchers, 1 visiting research fellow, 1 NRI research cadet = 20 (1 UPNG student on field placement became a full time BSS and 1 associate became a full time BSS and are counted under their new position end year) = (20 – 4 = 16 or 4/1 for 400%) At end 2010: 7 full time BSS, five part time BSS, 4 associate researchers, 1 visiting fellow = 17 (17/4 = 400%).
Number of training sessions for BSS staff by training subject area	Overall by end of 2010 (2007–2010): 44 training sessions with 264 BSS staff in attendance 2010: 12 training sessions with 83 BSS staff on: use of PDA for data collection, BSS protocols, RDS refresher, work prioritization, alcohol and drug research, HIV research, RDS and data weighting and analysis, qualitative data verification and analysis, ProQuest and Chi square analysis 2009: 22 training sessions with 105 BSS staff on: Sexuality, GIS, SPSS, RDS, NVivo, indexes for stigma, writing, planning, legal issues for MARPS, size estimation MARPS, performance appraisals, data synthesis, integrating qualitative and qualitative research, data analysis, and the media and HIV. Mid-2008: 8 training sessions with 64 BSS staff on IBBS, SGS, BSS, qualitative data collection, NVivo, and fieldwork protocols and ethics. 2007: 2 training sessions for 12 NRI staff and research cadets and attached students UPNG on RDS and behavioral indicators
BSS team meetings annually	2010: Total = 41 BSS team meetings in 2010 with 16 staff meetings and 25 team technical meetings (and other daily meetings in the field during collection >50) 2009: Total 49 BSS meetings (with 12 of these with NDOH and other frequent meetings in the field) in 2009 2008: Total 14 BSS meetings (with 5 with of these with NDOH and other frequent meetings in the field) in 2008
Number staff attend national, regional and international conferences and forums	2010 Total = 12 BSS staff attend 7 national, regional and international conferences and forums 2009 Total = 57 BSS staff attend 26 national, regional and international conferences and forums 2008 Total = 21 BSS staff attend 16 national, regional and international conferences and forums NRI staff and attached UNPNG students

	2007 = 18 staff attend 16 national, regional and international conferences 2007 to 2010 = 108 staff (90 BSS staff and 18 NRI staff and student placements) attended 70 national, regional and international conferences.
Prioritized sites and groups at higher risk are selected for behavioral surveillance based on criteria and participate in BSS research at multiple levels[d] % of BSS targeted groups and sites, selected by criteria and endorsed by the STWG	100 % of BSS targeted groups and sites, selected by criteria and endorsed by the STWG.
Number members of sites who participate in BSS research	34 members of six sites who participate in BSS research (end of 2009, six petroleum, four plantation, four youth, seven for sex workers, six for Ramu, seven truck drivers).
BSS protocol developed and research ethics written and approval granted for each round of surveillance research. Behavioral Surveillance Protocol developed	One BBS protocol developed with NDoH for sentinel surveillance and approved by STWG (ANC and STI). One BSS Round 2 protocol developed 2008 (economic enclaves OSL and WRC). One BSS Round 2 (Vanimo High Risk Youth) and 1 BSS Round 3 protocol developed 2009. (Ramu, women exchanging sex and truck drivers). Three BSS protocols and research ethics approved for Round 2 and three BSS.
X BSS research ethics proposals submitted to and endorsed by the RAC and the MERC	Three BSS research ethics proposals submitted to the STWG and to the RAC; and three endorsed by STWG and three endorsed by RAC by end of 2010.
Behavioral surveillance monitoring reports are written by quarter, and BSS reports are written for each round of research and research findings disseminated annually. Number BSS reports written and number dissemination sessions held annually	End 2010: Four (2 final ANC & STI and 2 OSL & WRC) BSS reports written and 9 dissemination sessions held and eight quarterly BSS quarterly update reports written for NRI and ADB/NRI.
% of preliminary research findings disseminated to target populations and key stakeholders within 4–6 months of research data being gathered	25% of preliminary research findings are disseminated to target populations and key stakeholders within 4-6 months of research data being gathered.
Quarterly reports written	Two quarterly BSS reports written to NDOH/ADB and two quarterly BSS reports written to NRI 2007. Four quarterly BSS reports written to NDOH/ADB and four quarterly BSS reports written to NRI 2008. Four quarterly BSS reports written to NDOH/ADB four quarterly BSS reports written to NRI 2009. Four quarterly BSS reports written to NDOH/ADB and four quarterly BSS reports

	written to NRI in 2010. 14 quarterly reports written to NDOH/ADB and 14 quarterly BSS reports written to NRI by end of 2010.
Biological Surveillance	
Narrative Summary with Indicators	**Report on Indicators December 2010**
OUTCOMES	
Strengthened and expanded national sentinel surveillance system for HIV. 80% of all HIV testing sites in PNG will use the standard HIV case reporting form and regularly report to NDOH, HIV surveillance unit by the end of 2009.	In 2009, NDOH Surveillance Unit developed the data quality assurance tool to check whether or not HIV testing facilities are using the standard HIV case reporting form and other reporting forms. This tool was used in 2010. Of 287 HIV testing sites in PNG (as of the end of 2009), 250 sites (87%) reported to the NDOH surveillance unit using the standardized forms (2009 NACS. STI, HIV, and AIDS Annual Surveillance Report. Port Moresby, pp. 73–75).
At least one selected urban and rural ANC sentinel sites in all 20 provinces will conduct HIV and STI sentinel surveillance by the end of 2010.	Systematic national HIV/STI sentinel surveillance started in 2008 with 6 provinces. By the end of 2010, a total of 30 ANC sites (15 Urban and 15 rural sites) in 16 provinces conducted HIV and STI sentinel surveillance. Remaining 4 provinces did not conduct the periodic sentinel surveillance, but they routinely reported the HIV data through NDoH standardized routine reporting forms.
Improved routine and sentinel HIV and STI data in PNG Number and % of ANC, STI, TB, VCT, and Blood Bank sites that regularly report HIV and STI cases and their complete demographic data to NDOH.	219 VCT sites reported the monthly HIV testing summary to NDOH at least once during 2009 178 ANC sites reported the monthly HIV testing summary to NDOH at least once during 2009 118 STI sites reported the monthly HIV testing summary to NDOH at least once during 2009 85 TB sites reported the monthly HIV testing summary to NDOH at least once during 2009 28 Blood bank sites reported the monthly HIV testing summary to NDOH at least once during 2009. (2009 NACS. STI, HIV, and AIDS Annual Surveillance Report. Port Moresby).
• Numberand % of ANC, STI, and TB sentinel clinics which systematically collect data on HIV and STI infections, behavioral and demographic characteristics of sentinel surveillance participants	Among 178 ANC sites reported in 2009, 28 (16%) ANC sites conducted HIV/STI sentinel surveillance. Among 118 STI sites reported in 2009, seven (6%) STI sites conducted HIV/STI sentinel surveillance. Among 85 TB sites reported in 2009, five (6%) TB sites conducted HIV/STI sentinel surveillance.

OUTPUTS	
HIV routine and sentinel surveillance, and bio-behavioral surveillance protocols (including training and supervision manuals, and survey operation guideline) Completion of HIV routine and sentinel surveillance, and bio-behavioral surveillance protocols, training and supervision manuals, and survey operation guideline	Protocol for 2008 HIV and STI sentinel surveillance (including training and supervision manuals) was completed in 2008 June. Protocol for 2009 HIV and STI sentinel surveillance (including training and supervision manuals) was completed in 2009 May. Protocol for 2010 HIV and STI sentinel surveillance (including training and supervision manuals) was completed in 2010 June. * SOPs for routine HIV data reporting was completed in 2008 October and revised in 2010 September.
HIV routine case notification form, sentinel surveillance forms, and bio-behavioral surveillance questionnaires Completion of HIV routine case notification form, sentinel surveillance forms, and bio-behavioral surveillance questionnaires	HIV routine case notification form was completed in 2008. Sentinel surveillance forms were completed in 2008.
Trained surveillance staff Number and types of trained survey staff including: field recruiters, interviewers, phlebotomists, pre-post test counsellors, data entry officer, data managers, statisticians, and lab technicians.	In July 2009, 15 laboratory managers, 65 VCT/nurses, and 16 PDCOs were trained during the 5-day training workshops on national HIV/STI sentinel surveillance at the Hideaway Hotel (6–10 July 2009). In June 2010, 15 laboratory staff, 80 VCT/nurses, and 16 PDCOs/RMOs were trained during the regional HIV/STI sentinel surveillance training workshop in NCD and in Mt. Hagen.
Number of supervisory visits Number of supervisory visits using the checklists for quality assurance	Three supervisory visits were done at sentinel surveillance sites in highland region during 2009. Two supervisory visits were done at sentinel surveillance sites in Momase region during 2009. One supervisory visit were done at sentinel surveillance sites in Southern region during 2009. One supervisory visit were done at sentinel surveillance sites in NGI region during 2009. In 2010, due to the staffing issues at the NDoH surveillance unit, number of supervisory visits declined: Two supervisory visits were done in highland regions in 2010. No formal supervisory visits were done in Southern region in 2010. One supervisory visit was done in Momase region in 2010. One supervisory visit was done in NGI region in 2010.

3. **Project Management and Coordination**	
Narrative Summary	**Report on Indicators December 2010**
OUTCOMES	
Strengthened Government of PNG in responding to the HIV epidemic Increased government financial allocation to HIV prevention and care by 20% per year during 2008 and 2009 *Strengthened project synergies*	Government expenditure and budget data. Development partners reports on HIV/AIDS Global Fund progress reports submitted by government to CCM UNGASS 2008 UNGASS 2010 did not report on spending or financing sources for PNG. 2009 Government of PNG allocation to HIV was K25.7 million 2010 Government of PNG allocation to HIV was K31.9 million (23% increase) 2011 Government of PNG allocation to HIV was K49.0 million (53% increase)
Monthly coordination meeting held with all components of the project	Monthly in 2007, 2008 and 2009. Bi-monthly for 2010 (six meetings held).
Cross component participation in professional development	Participation Lists NRI seminar series notices 2007, 2008, 2009, 2010 Component 1 conducted 3 Sexual Health Sessions with BSS NRI Team. Component 1 conducted 2 Sexual Health Sessions for Data Collection NDOH Surveillance. Component 1 conducted 2 sessions with Component 2.
Each component contributes to the creation of the project M&E framework	M&E Report completed for end 2008. M&E Report completed for end 2009. M&E Report completed for end 2010. M&E Report completed for 2011.
OUTPUTS	
Project management established within NDOH Staff recruited and office space allocated for each (Shared office space)	1 x Project Manager 1 x Deputy Project Manager 2 x Project Accountants 1 x Civil Works Supervisor 1 x Administrative Officer Project Office Co-located on 2nd floor.
Project management systems developed and implemented Four project reports developed and disseminated	Quarterly reports received from each component 2007, 2008, 2009, and 2010. Quarterly score cards received from most enclaves 2008, 2009, 2010. Quarterly reports printed and disseminated to Stakeholders, Enclaves, Partners, and Donors for 2006, 2007, 2008.

per year	The 2009 year reports compiled and distributed via CD. The 2010 year reports compiled and distributed via CD.
Quarterly work plans submitted by each component to the coordinator	Quarterly work plans submitted by each Component for final quarter 2007 and for four quarters in 2008. Annual Work Plans were submitted for 2009 and 2010. 1st & 2nd Quarter work plans submitted for 2011
Support provided to the HSIP Management Branch Project office located within HSIP and is recognized as a resource by HSIPMB manager	Project Office is located with HSIP on the 2nd floor of the NDOH. Regular and as required meetings between E. Lionel (Manager of HSIPMB) and project office.
Project Participation in the Program and Finance Committees of HSIP	The project manager or one of the deputies have attended the schedule HSIP Program and finance committee meetings during 2007, 2008, 2009, 2010, 2011, and 2012.
Procurement follows HSIP procedures and according to approved plans	Project office procurement follows NDOH and HSIP procedures – ongoing.
Coordinator liaises effectively with the executing agency (NDOH) and development partners Participation and presentation to the TAG of the CCM of project progress	The project manager meets regularly informally and formally with the Secretary and or Deputy Secretaries, NDOH. Project Manager or Deputy Project Manager participate in the CCM meetings when scheduled. TAG not operational for the project. Project Office participates in the scheduled meetings with the Donor Partners Forum on HIV, and the Donor Partners Health Group.
The project is coordinated with other activities of the NDOH and development partners Project quarterly reports provided to NDOH, NACS, and development partners	Four quarterly reports provided to Stakeholders in 2007 Four quarterly reports provided to Stakeholders in 2008 Four quarterly reports provided to Manila in 2009. A CD containing all 2009 quarterly provided to stakeholders. Four quarterly reports provided to Manila in 2010 and a CD provided to stakeholders.
Monthly meeting with NDOH counterpart at Disease Control Branch	Project Manager and Deputy Project Manager meet regularly and as required with DCB counterparts. This includes Secretary of Health, Executive Director Public Health, Director Disease Control Branch, Specialist Medical Officers (HIV/STI), and the Planning and Monitoring divisions.
Monthly meetings in the development partners (SWAP, HSIP) meetings	Project Office participates in the SWAP scheduled meetings. Project Manager or deputy attended most Donor Partner Health meetings (WHO/DFAT chaired)
Six meetings of the Donor Forum on HIV	Project Office participated in all Donor Partner Forum meetings on HIV that had national significance (i.e., not the ones focused on PMGH)

ADB Manila is informed of project developments and issues Weekly updates sent to Manila	Project manager in weekly email and telephone communication with the ADB Manila Office and regular communication with the ADB PNG Country Office.

ADB = Asian Development Bank, ANC = antenatal care , BCC = behavioural change communication, BKL = Barrick Kainantu Limited, BSS = behavioral surveillance specialist, CCM = Country Coordinating Mechanism, CSM = condom social marketing , DFAT = Australian Government Department of Foreign Affairs and Trade, DHO = district health office , EOP = end of project, GIS = geographic information system, HSIP = Health Sector Improvement Program, HOP = Higaturu Oil Palms , HRM = human resource management , HSIPMB = Health Sector Improvement Program management branch, IBBS = integrated HIV bio-behavioral surveillance, M&E = monitoring and evaluation, MARPS = Most-At-Risk Populations, NACS = National AIDS Council Secretariat, NDOH = National Department of Health, NGO = nongovernment organization, NRI = National Research Institute, OSL = Oil Search Limited, PDA = personal digital assistant, PDCO = Provincial Disease Control Officer, PEER = Participatory Ethnographic Evaluation and Research , PHO = provincial health office, PICT = provider-initiated counselling and testing, PJV = Porgera Joint Venture , PNG = Papua New Guinea, RAI = Ramu Agri Industries , RDS = Respondent Driver Sampling, RDT = rapid diagnostic test, SPSS = Statistical Package for the Social Sciences, STI = sexually transmitted infection, STWG = Surveillence Technical Working Group, SWAP = sector-wide approach, TAG = technical advisory group , TB = tuberculosis, TNT = Tokaut na Tokstret, TRaC = Tracking Results Continuously, UNGASS = UN General Assembly Special Session on HIV/AIDS, USAID = U.S. Agency for International Development, UPNG = University of Papua New Guinea, VCT = volunteer counseling and testing, WHO = World Health Organization, WRC = Walter Randolph Carpenter .

[a] Participating health facilities are those in the enclaves with a scope of work signed for renovation and whose staff are participating in professional development. Accreditation includes: NDOH minimum standards for HIV testing; trained staff (Introduction to HIV, VCT, & RDT); and facility has running water, sink and a private room.

[b] "Fully Functional" are those with staff that are rostered to work in a facility, are paid, have accommodation, and receive regular supervision from the provincial health department; open at correct hours; have medications and consumables available in the health facility; and where staff do not charge patients for personal profit. "Participating Enclaves": six enclaves that have a signed MOA. "Comprehensive Primary Health Care" includes WHO and NDOH minimum standards for a health center or aid post, maternal child health, vaccinations, and STIs.

[c] "Surrounding community populations" are the "footprint" of the economic operator. Taken to mean the population surrounding participating health facilities in Phase 1. Adequate access includes WHO and/or NDOH minimum standards for health service access; number of doctors, nurses, CHW per population; and distance to primary health care facility, costs, transportation, cadre of staff available. Basic health services are NDOH minimum standards for the health center or aid post.

[d] Criteria include HIV and STI epidemiological and behavioral data, contextual factors, and projected BCC interventions.

Sources: Project Reports, 2009.