TECHNICAL ASSISTANCE

TO

PAPUA NEW GUINEA

FOR THE

ESTABLISHMENT OF PILOT HIV/AIDS CARE CENTERS

October 2003
CURRENCY EQUIVALENTS
(as of 28 August 2003)

Currency Unit – kina (K)
K1.00 = $0.2925
$1.00 = K3.418

ABBREVIATIONS

ADB – Asian Development Bank
ARV – anti-retroviral
AusAID – Australian Agency for International Development
CBO – community-based organization
GF – Global Fund
HIV/AIDS – human immunodeficiency virus/acquired immune deficiency syndrome
MDG – Millenium Development Goal
MTP – medium-term plan
NAC – National AIDS Council
NDOH – National Department of Health
NGO – nongovernment organization
PHA – people living with HIV/AIDS
PMGH – Port Moresby General Hospital
PNG – Papua New Guinea
STI – sexually transmitted infection
TA – technical assistance
UN – United Nations
USAID – United States Agency for International Development
VCT – voluntary counseling and testing
WHO – World Health Organization
WPRO – WHO Regional Office for the Western Pacific

NOTES

(i) The fiscal year (FY) of the Government ends on 31 December.

(ii) In this report, "$" refers to US dollars.

This report was prepared by M. Dugue.
I. INTRODUCTION

1. In Papua New Guinea (PNG), progress in achieving the Millennium Development Goals (MDGs) will require increased and sustained public investment in education and health. Levels of social indicators remain extremely poor, especially for women. Low life expectancy, high infant mortality, poor adult literacy, and low enrolment at all levels of education combine with low per capita income to make PNG’s human development level the lowest of the Asian Development Bank (ADB) Pacific Developing Member Countries. The poor achievement to date reflects lack of spending on essential services and inadequate development management under difficult physical and social conditions. The minimal progress achieved in life expectancy is now jeopardized by a large-scale HIV/AIDS \(^1\) epidemic. In the country strategy and program update and forthcoming Country Strategy Program (CSP), ADB’s strategy for PNG highlights HIV/AIDS as a critical issue, and ADB, together with other development partners, is raising the profile of HIV care and prevention.

2. A joint United Nations/United States Agency for International Development (UN-USAID) review of the PNG National HIV Medium Term-Plan 1998-2002 (MTP) conducted in December 2002 confirmed that the HIV/AIDS epidemic is generalized and severe, and identified serious gaps in the national response to it. The Government has requested ADB assistance in this sector, to be undertaken in conjunction with parallel assistance from the World Health Organization (WHO). The Technical Assistance (TA)\(^2\) objectives, scope, financing, and implementation arrangements were reconfirmed during the Fact-Finding Mission of 13–21 August 2003. The TA framework is in Appendix 1.

II. ISSUES

3. The first HIV infections in PNG were reported in 1987; since then, HIV prevalence has been increasing at an alarming rate. In mid-2002 PNG became the fourth country in the Asia-Pacific region, after Thailand, Cambodia, and Myanmar, to have a generalized HIV epidemic.\(^3\) The prevalence of HIV among antenatal women in Port Moresby General Hospital (PMGH) and Goroka Hospital reached 1% in the first half of 2002.\(^4\) The situation in the rural areas is unknown, but the pattern of population movements between urban and rural areas suggests that the virus is now largely present in the country. AIDS is now the major cause of death in PMGH, and one in six sex workers is infected. Many people are diagnosed with HIV when their immune system is already severely weakened. In some hospitals, HIV and tuberculosis patients are housed in the same ward. The public health system cannot cope with the increased burden of illness. The main mode of transmission is heterosexual intercourse,\(^5\) and the male-female ratio of HIV infection is almost equal, with 51% found in males. However, a much higher HIV prevalence is found in 13–22-year-old females compared to males of the same age. Increasing urban and rural poverty has led to rising levels of crime and growth of the sex trade. Prevalence of sexually transmitted infections (STIs) is among the highest in the world, even among supposedly “low-risk” rural populations. These figures are attributed to high levels of risky behavior, sexual violence, and failure of the public health system to provide accessible clinical

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\(^1\) Human immunodeficiency virus/acquired immune deficiency syndrome.

\(^2\) The TA was first listed in ADB Business Opportunities on 28 August 2003.

\(^3\) The severity of the epidemic is reflected in the fact that the Joint United Nations Programme on HIV/AIDS (UNAIDS) has recently scaled up its presence, with the appointment a permanent country coordinator in PNG.


\(^5\) Comprising 89% of cases.
WHO estimates that PNG generates over 1 million new cases of curable STIs annually, and that the STI services are not seeing more than 1% of all cases. STIs are major cofactors in the transmission of HIV. The evidence is clearly pointing to a southern African-type social-epidemiological pattern in HIV transmission, and HIV is a serious threat to PNG’s future.

4. PNG was not able to submit a proposal at the first round of the Global Fund\(^7\) and the proposal (for $6.4 million) presented at the second round was rejected. The latter proposal was for an HIV prevention program to change behavior among sex workers, their clients, and 14–19-year old youths. Some comments reported by the Global Fund technical review panel were that "there was no mention of HIV treatment in the proposal" and that "much of the budget was allocated for government spending." This proposal was not recommended for funding in its present form but strongly encouraged to be resubmitted after revision following the recommendations of the panel. A new proposal was submitted in May 2003, but whether it will be accepted or not is unknown.

5. The Government’s capacity to respond strongly and rapidly is scant. The MTP was a broad-based multisectoral approach to a national response. The MTP did not set priorities or present an implementation plan or costing, and served more as a guide than a strategic plan. Few of the MTP’s aims have been accomplished. The MTP makes no commitment to improve medical care of HIV-positive people, and provides for no mechanisms to provide home care, support groups, or community care centers. The Australian Agency for International Development (AusAID) is reviewing its prevention strategy,\(^8\) but care for people with HIV remains almost nonexistent, except where church health services have attempted to build programs of home-based and day care. Their capacity is limited compared to the magnitude of the problem. Voluntary testing is nonexistent, and most people still do not receive pre- and posttest counseling, despite large investment in counselor training. Experience in Asia and Africa shows that, provided they have strong support from peers and/or families, HIV-positive people who are involved in awareness raising and care delivery can demonstrate that they can still live long, productive lives. However, people newly diagnosed in PNG are rarely referred on to other HIV-positive people or organizations that offer counseling. Although overall discrimination may be subsiding in Port Moresby, stigma and discrimination remain strong. Uninformed health workers are reluctant to care for people infected with HIV. Children orphaned by AIDS are reportedly rejected by families and live on the streets of Port Moresby, trying to support themselves.\(^9\) A radically new approach is required to meet the increasingly desperate needs of those affected by HIV/AIDS.

### III. THE TECHNICAL ASSISTANCE

6. The rapid increase in HIV/AIDS cases urgently requires treatment strategies, including anti-retroviral medication (ARV). When the MTP was drafted, access to ARV was financially impossible for PNG. Today, these drugs are becoming available in the region for approximately $1 per day. However, facilities are lacking to manage the impact of treatments, including

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\(^6\) The massive decrease in aid posts has severely cut the number of facilities available for primary health care. Churches provide approximately 51% of all health services, but concerns about morality and Christian values among staff tend to limit access of many patients to user-friendly STI services.

\(^7\) The purpose of the fund is to attract, manage, and disburse additional resources through a new public-private partnership that will reduce, significantly and in a sustainable manner, infections, illness, and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis, and malaria, and helping reduce poverty.

\(^8\) AusAID is supporting the national and provincial AIDS council secretariats implement the MTP through the National HIV/AIDS Support Project, 2000-2005 ($33 million).

\(^9\) Around 3,000 children, many AIDS orphans, are estimated to be living on the streets of Port Moresby.
toxicity, side effects, and adherence, and unsupervised treatment could increase resistance and iatrogenic\textsuperscript{10} accidents.

A. Purpose and Output

7. The TA will support, on a pilot basis, the development of a model for HIV/AIDS care, based on private-public networks and partnerships to expand care and treatment facilities. Possible funding from the Global Fund is expected to enable replication and sustainability of this scheme. To increase the access of HIV-infected people to comprehensive care, treatment, and support, a small number of pilot facilities within the existing health system will be established. One center will be initially established in PMGH, and, later, one in a church health facility in a high-prevalence area. The Catholic HIV/AIDS Program has already expressed interest in selecting one of the Catholic hospitals as a pilot HIV treatment center. The introduction of a selected number of ARVs will greatly improve the quality of life of people infected by the virus, allowing them to stay economically and socially active. Priority will be given to reducing mother-to-child transmission. WHO has recommended that PNG be placed in the group of countries given priority in increasing access to ARV medication through the International Treatment Access Coalition (ITAC). By involving people living with HIV/AIDS (PHA) in the support of newly infected people, the Project is also expected to reduce the stigma and discrimination suffered by people infected by the virus.

8. The outputs of the TA are the following:

(i) By the end of 2004 the following should be accomplished:

(a) at least one clinic established in PMGH, with trained staff and outreach network of community-based organizations;
(b) 100 patients receiving comprehensive clinical care, counseling, and support, including access to, and monitoring of, ARV treatment; and
(c) strengthened capacity for community support for care and counseling of HIV/AIDS patients.

(ii) By October 2005 the following should be accomplished:

(a) 3,000 patients treated; and
(b) a pilot center established in a church hospital.

9. HIV-infected people will be involved in the pilot center design; the PMGH center will work with nongovernment organizations (NGOs) and churches to identify the cases and guarantee compliance with treatment. The preliminary feasibility study has been prepared by the National Department of Health (NDOH) and PMGH.

B. Methodology and Key Activities

10. Considering international experience and best practices, HIV/AIDS care and support will be based on the following principles:

(i) voluntary counseling and testing network to serve as an entry point to the comprehensive care system;

\textsuperscript{10} Accidents resulting from toxicity of the treatment.
(ii) access to HIV/AIDS drugs, including ARV drugs, as well as treatment of opportunistic infections;
(iii) continuum of care from home to health facility; and
(iv) involvement of PHA in counseling and support.

11. The TA will be organized around (i) establishment of pilot centers in the public health system (PMGH) and in a church facility; and (ii) development of national treatment guidelines and protocols, and review and revision of national drug policies and procedures.

1. Establishment of Pilot Centers

12. The first center will be the PMGH HIV Clinic and Day-Care Center (public health system). Existing facilities (STI clinic) on the grounds of PMGH will be used to provide an expanded system of care for PHA. Initially, the focus will be on building the capacity of staff to provide services to PHA, equip the center, and build referral systems and partnerships necessary for the functioning of the Center. Discussions will be held with a number of NGOs (Salvation Army, etc.) that can conduct home visits and care and thus provide the foundation for a center outreach network. NDOH will procure ARV with the support of WHO country and regional offices. The second center will be a pilot in a church hospital in a high-prevalence area. The Catholic HIV/AIDS Program has already expressed interest in selecting one Catholic hospital as a pilot HIV treatment center. Experience in establishing and running these pilot centers will be used in the design and planning of more HIV clinics in the provinces.

2. Development of National Treatment Guidelines and Protocols

13. WHO guidelines for a public-health approach to ARV treatment, *Scaling Up Antiretroviral Therapy in Resource-Limited Settings*” (June 2002), will provide the over-riding policy framework. National treatment guidelines will be formulated within this framework. Priority will be placed on clinical guidelines, selection criteria of ARV enrollment, and a protocol to ensure adherence to the treatment. The TA will help NDOH establish and monitor a national program of comprehensive HIV care, treatment, and support. This program will be within the framework of the new national MTP for HIV/AIDS. NDOH will work collaboratively with the National HIV/AIDS Council and its secretariat. The chief physician of PNG and consultant physician at PMGH will implement the national strategy to increase access to HIV treatment in PNG under the secretary of health and in collaboration with the National AIDS Council (NAC).

C. Cost and Financing

14. The total TA cost is estimated at $655,000 equivalent, comprising $422,000 equivalent in foreign exchange costs and $233,000 equivalent in local currency costs. ADB’s TA funding program will finance $360,000 of foreign exchange cost and $90,000 equivalent of local currency cost on a grant basis. ADB financing will cover consulting services, procurement of equipment, laboratory reagents and drugs, organization of workshops, transport costs, and production of reports. WHO will contribute $72,000 equivalent on a parallel basis for consulting services, procurement of drugs, and organization of workshops. The balance of $133,000 equivalent will be provided by the Government in the form of counterpart staff, support services, and office facilities. Detailed cost estimates and financing plan are in Appendix 3.
D. Implementation Arrangements

15. NDOH will be the Executing Agency, and will provide office space and full-time counterpart staff (one physician and three nurses) of the STI clinic in PMGH. WHO will initially hire a consultant for 3 person-months to start preparing for implementation, focusing mainly on establishing the network between community based organizations (CBOs) supporting PHAs, and the health system. The TA will last about 30 months beginning in October 2003. The TA will require 11 person-months of international consulting services. The consultant will be recruited on an individual basis, in accordance with ADB’s Guidelines on the Use of Consultants. Terms of reference are in Appendix 4. The consultant will submit (i) an inception report one month after fielding; (ii) a progress report at the end of the 12th month of TA implementation; (iii) a draft final report at the end of the 24th month of TA implementation; and (iv) a final report within one month of receiving ADB’s comments, if any, on the draft final report.

16. The training and workshops will be organized by NDOH with technical support from WHO. NDOH will procure drugs and reagent in accordance with ADB’s Guidelines for Procurement, with technical support from WHO and WPRO.11 WHO will provide technical support through an HIV/AIDS care adviser based in the PNG WHO office, supported by regular missions of the WPRO team (epidemiologist and care adviser), and will coordinate all the inputs.

17. Information on treatment and protocols will be disseminated to other health services throughout PNG. Building on the lessons learned, similar clinics will be established in other rural and urban centers in high-prevalence areas. It is expected that financing obtained under the GF will ensure the sustainability of this scheme.

IV. THE PRESIDENT’S DECISION

18. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of $450,000 on a grant basis to the Government of Papua New Guinea for the Establishment of Pilot HIV/AIDS Care Centers, and hereby reports this action to the Board.

11 WHO Regional Office for the Western Pacific.
## TECHNICAL ASSISTANCE FRAMEWORK

<table>
<thead>
<tr>
<th>Design Summary</th>
<th>Performance Indicators/Targets</th>
<th>Monitoring Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td>Develop a more supportive environment for PHA, and expand access to care and treatment</td>
<td>HIV/AIDS treatment and protocols available in the country</td>
<td>UNAIDS country assessment of HIV/AIDS programs</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>- Develop an HIV/AIDS care model that is sustainable over the long-term (Global Fund) - Strengthen capacity for clinical management of HIV/AIDS patients - Strengthen capacity for community support for care and counseling of HIV/AIDS patients</td>
<td>- Number of HIV/AIDS cases enrolled for treatment and care - Number of community-based organizations and support groups involved in care and management of HIV/AIDS patients</td>
<td>Reports by NDOH and WHO</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td>- A day-care center at PMGH and in a church-based facility - Staff trained to provide services to PHA - Referral systems and partnerships to establish a center outreach network - Formulation and implementation of national treatment guidelines</td>
<td>By the end of 2004: - Clinic in PMGH established, with staff trained and outreach network established - 100 patients receiving comprehensive clinical care, counseling, and support, including access to and monitoring of ARV treatment - National treatment guidelines implemented</td>
<td>Data and reports of NDOH and WHO, and ADB missions</td>
</tr>
</tbody>
</table>
### Design Summary

<table>
<thead>
<tr>
<th>Performance Indicators/Targets</th>
<th>Monitoring Mechanisms</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>By October 2005:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- One pilot center established in a church hospital</td>
<td>WHO reports and feedback from ADB missions</td>
<td>Staff have the capacity to understand and implement the clinical guidelines and protocols.</td>
</tr>
<tr>
<td>- 3,000 patients receiving comprehensive treatment and counseling</td>
<td></td>
<td>Procurement and distribution of ARV are reliable.</td>
</tr>
</tbody>
</table>

### Activities

- Staff training in the two centers
- Equipping of the centers
- Procurement of drugs
- Elaboration of national treatment guidelines

<table>
<thead>
<tr>
<th>Activities</th>
<th>Number and qualification of staff trained</th>
<th>Centers equipped and functional ARV available</th>
<th>Guidelines available and disseminated</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO Inputs</td>
<td>WHO reports and feedback from ADB missions</td>
<td>Staff have the capacity to understand and implement the clinical guidelines and protocols.</td>
<td></td>
</tr>
<tr>
<td>ADB Inputs</td>
<td>Procurement and distribution of ARV are reliable.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ADB Inputs

- International consultant (11 person-months), $157,000
- Training and workshops, $60,000
- Drugs and laboratory reagents, $153,000
- Equipment, $10,000

### WHO Inputs

- International consultant for 3 person-months, $39,000
- Drugs and laboratory reagents, $23,000
- Training and workshops, $8,000

### Government Inputs

- Office accommodation and transport, $20,000 equivalent
- Counterpart staff, $100,000 equivalent (one physician and three full-time nurses)

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**Note:**

- **ADB**=Asian Development Bank, **ARV**= anti-retroviral, **NDOH**=National Department of Health, **PHA**=people living with HIV/AIDS, **WHO**=World Health Organization.
SUMMARY INITIAL POVERTY AND SOCIAL ANALYSIS REPORT FORM

A. Linkages to the Country Poverty Analysis

| Sector identified as a national priority in country poverty analysis? | Yes |
| Sector identified as a national priority in country poverty partnership agreement? | No country poverty partnership agreement signed yet, but HIV is included in the NPRS and MTDS, prepared with ADB support. |

Contribution of the sector/subsector to reduce poverty in PNG: Achieving MDGs will require increased and sustained public investment in education and health. Levels of social indicators remain extremely poor, especially for women. Low life expectancy, high infant mortality, poor adult literacy, and low enrolment at all levels of education combine with low per capita income to make PNG’s human development level the lowest of the ADB’s Pacific member countries. The poor achievement to date reflects past lack of spending on essential services and inadequate development management under difficult physical and social conditions. The little progress achieved so far in life expectancy is now jeopardized by a large-scale HIV/AIDS epidemic.

B. Poverty Analysis Proposed Classification

| What type of poverty analysis is needed? | |

C. Participation Process

Stakeholder analysis? Yes. The preparation of the Project involved an analysis of the community-based organizations involved in community care, and the establishment of formal links with these organizations, to ensure a proper follow-up of patients treated.

Participation strategy? Yes. The TA explicitly aims to ensure the participation of community-based organizations (churches and NGOs) and people living with HIV (peer support groups).

D. Gender and Development

Strategy to maximize impacts on women: Many women are diagnosed with HIV at antenatal clinics, but no posttest counseling is available. In making such service available, the Project will improve the capacity of women to cope with the disease. In the absence of medical or home-based care other that that provided by some church organizations, care is provided exclusively by the family, mainly women. The Project will alleviate this load and support women.

Gender plan prepared? No

E. Social Safeguards and other Social Risks

<table>
<thead>
<tr>
<th>Significant/ Not Significant/ None</th>
<th>Strategy to Address Issues</th>
<th>Plan Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resettlement</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Indigenous Peoples</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Labor</td>
<td>The establishment of treatment guidelines and importation of ARV will allow the medical staff to access prophylaxis, which is not available in</td>
<td>No</td>
</tr>
</tbody>
</table>
The Project will improve access to ARV of the poor, women, and vulnerable groups. (ARV is only accessible to wealthy patients.)

<table>
<thead>
<tr>
<th>Affordability</th>
<th>Not significant</th>
<th>The Project will improve access to ARV of the poor, women, and vulnerable groups. (ARV is only accessible to wealthy patients.)</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Risks/ Vulnerabilities</td>
<td>None</td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

ADB=Asian Development Bank, ARV= anti-retroviral, MTDS=Medium Term Development Strategy.
## COST ESTIMATES AND FINANCING PLAN

($'000)

<table>
<thead>
<tr>
<th>Item</th>
<th>Foreign Exchange</th>
<th>Local Currency</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Asian Development Bank (ADB) Financing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. International Consultant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Remuneration and Per Diem</td>
<td>140</td>
<td>0</td>
<td>140</td>
</tr>
<tr>
<td>b. International and Local Travel</td>
<td>10</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>c. Reports and Communications</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. ARV and Laboratory Reagents</td>
<td>153</td>
<td>0</td>
<td>153</td>
</tr>
<tr>
<td>3. Training and Workshops</td>
<td>0</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>4. Equipment</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>5. Transport Costs for Drugs and Patients</td>
<td>0</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>6. Contingencies</td>
<td>47</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td><strong>Subtotal (A)</strong></td>
<td>360</td>
<td>90</td>
<td>450</td>
</tr>
<tr>
<td><strong>B. World Health Organization Financing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. International Consultants</td>
<td>39</td>
<td>0</td>
<td>39</td>
</tr>
<tr>
<td>2. ARV and Laboratory Reagents</td>
<td>23</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td>3. Training and Workshops</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>4. Miscellaneous Administration and Support Costs</td>
<td>0</td>
<td>2</td>
<td>2</td>
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<tr>
<td><strong>Subtotal (B)</strong></td>
<td>62</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td><strong>C. Government Financing</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. Office Accommodation and Transport</td>
<td>0</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>2. Remuneration and Per Diem of Counterpart Staff</td>
<td>0</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>3. Others</td>
<td>0</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td><strong>Subtotal (C)</strong></td>
<td>0</td>
<td>133</td>
<td>133</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>422</td>
<td>233</td>
<td>655</td>
</tr>
</tbody>
</table>

*Financed by ADB's TA funding program.

ARV=anti-retroviral.

Sources: Asian Development Bank and World Health Organization estimates.
OUTLINE TERMS OF REFERENCE FOR CONSULTANT

A. HIV/AIDS Expert (11 person-months)

1. The international consultant, in collaboration with the National Department of Health and working closely with the national HIV/AIDS focal point, the chief physician of Port Moresby General Hospital (PMGH) and the working group on care, treatment, counseling, and support for people living with HIV/AIDS (PHA) in Papua New Guinea (PNG) will provide technical support to the program on HIV/AIDS care treatment and counseling. The World Health Organization (WHO) will provide technical support through an HIV/AIDS care adviser based in the PNG WHO office and supported by regular missions of the team (epidemiologist and care adviser) from WHO Regional Office for the Western Pacific (WPRO), and will coordinate all the inputs. The specific terms of reference follow:

(i) Review the current status of the care, treatment, counseling, and support program on HIV/AIDS, especially focusing on programs available in Port Moresby and linked to PMGH.

(ii) Support the development of national guidelines on anti-retroviral (ARV) therapy based on WHO generic guidelines for resource-limited settings.

(iii) Support the development of protocol for access of PHA to treatment.

(iv) Promote and strengthen coordination between the public health service and partners (nongovernment organization, churches, public and private sectors) to improve referrals and compliance following treatment.

(v) Provide training to healthcare workers and community leaders in all aspects of care, treatment, counseling, and support for PHA.

(vi) Support the development of operational research related to the program.

(vii) Support the development of a monitoring and evaluation system for the program.

2. The consultant will submit the following:

(i) an inception report 1 month after fielding;

(ii) a progress report at the end of the 12th month of technical assistance (TA) implementation, drawing conclusions on lessons learned from establishing the first center, to prepare to establish a second center in a faith-based hospital;

(iii) a draft final report at the end of the 24th month of TA implementation; and

(iv) a final report, within two months of TA completion, which will recommend extension of the program to other provinces and centers.

B. Qualifications/Experience

3. The consultant must have the following:

(i) qualifications in HIV/AIDS medicine, with vast experience in developing countries in programs on treatment, care, counseling and support for PHA;
(ii) experience in HIV/AIDS clinical care program development and working with various social sectors, especially communities and community-based organizations; and

(iii) knowledge of WHO guidelines on scaling up of ARV treatment in resource-limited settings.