



Mid Term Review
of the Pacific Regional Strategy on HIV (2004–2008)
and its implementation

Final Report

David Fowler
Bill O’Loughlin
Sister Vika Tikinatabua

© Copyright Secretariat of the Pacific Community 2007

All rights for commercial / for profit reproduction or translation, in any form, reserved. SPC authorises the partial reproduction or translation of this material for scientific, educational or research purposes, provided that SPC and the source document are properly acknowledged. Permission to reproduce the document and/or translate in whole, in any form, whether for commercial/for profit or non-profit purposes, must be requested in writing. Original SPC artwork may not be altered or separately published without permission.

Original text: English

Secretariat of the Pacific Community Cataloguing-in-publication data

Fowler, David.

Mid Term Review of the Pacific Regional HIV Strategy (2004-2008) and its implementation

: final draft report / David Fowler; Bill O'Loughlin; Sister Vika Tikinatabua.

1. HIV infections — Prevention & control — Oceania. 2. AIDS (Disease) — Prevention & control — Oceania.

I. Fowler, David II. O'Loughlin, Bill III. Tikinatabua, Sister Vika IV. Secretariat of the Pacific Community

614.599392095

AACR2

ISBN 978-982-00-0192-3

TABLE OF CONTENTS

Executive summary	7
Acronyms	5
Acknowledgments	6
1.0 Background	13
2.0 Context	14
3.0 Leadership and Governance	15
3.1 Key Findings.....	15
3.1.1 Leadership.....	15
3.1.2 Planning and Coordination Capacity	16
3.1.3 Involvement of HIV Positive People	18
4.0 Access to Quality Services	20
4.1 Key Findings.....	20
4.1.1 HIV Treatment	21
4.1.2 Care and Support.....	21
4.1.3 Voluntary Confidential Counselling and Testing	22
4.1.4 HIV Prevention	22
4.1.5 Sexually Transmitted Infection Services	24
4.1.6 Procurement of ARVs and Essential Commodities	25
4.1.7 Laboratory Capacity.....	25
5.0 Regional Coordination	26
5.1 Key Findings.....	26
5.1.1 Harmonisation	26
5.1.2 Strategy Gaps	27
5.1.3 Regional/PICT Linkages and Utilisation of Existing Knowledge and Capacity	27
5.1.4 Development Planning Linkages	29
6.0 Program Management	30
6.1 Key Findings.....	30
6.1.1 Regional Strategy Reporting, Monitoring, Evaluation and Implementation	30
6.1.2 Strategy Revisions.....	31
6.1.3 Adequacy of Funding	32
6.1.4 Resource Pooling	33
6.1.5 Integration with National Development Planning.....	34
7.0 General	35
7.1 Key Findings.....	35
7.1.1 Gender	35
7.1.2 Improved Coordination and Management of the Regional Strategy.....	37
7.1.3 National HIV Plans and Mainstreaming	38
7.1.4 Papua New Guinea.....	39
7.1.5 The Way Forward and Recommendations	40
Recommendations	44
Leadership and Governance	44
Access to Quality Services.....	44
Regional Coordination	45
Program Management	45

General	46
Appendix One: Persons Consulted in the course of Conducting the Mid Term Review of the Pacific Regional Strategy on HIV and AIDS.....	48
Appendix Two: Methodology.....	54
Appendix Three: Implementation of Mid Term Review Recommendations	56
References.....	69

ACRONYMS

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
APLF	Asia Pacific Leadership Forum on HIV and AIDS and Development
ANC	Ante Natal Clinic
ARH	Adolescent Reproductive Health
ART	Anti Retroviral Therapy
ARVs	Anti Retroviral drugs
AusAID	Australian Agency for International Development
CCM	Country Coordinating Mechanism
CDO	Capacity Development Organisation
FJN+	Fiji Network of People Living with HIV and AIDS
FSM	Federated States of Micronesia
GFATM	Global Fund to fight AIDS Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAC	National AIDS Council/Commission
NGO	Non Government Organisation
NZAID	New Zealand Agency for International Development
PIAF	Pacific Islands AIDS Foundation
PICASO	Pacific Islands Council of AIDS Service Organisations
PICT	Pacific Island Countries and Territories
PLWHA	People Living With HIV and AIDS
PNG	Papua New Guinea
POLHN	Pacific Open Learning Health Network
PRHP	Pacific Regional HIV and AIDS Project
PRSIP	Pacific Regional Strategy Implementation Plan
RRRT	Regional Rights Resource Team
SPC	Secretariat of the Pacific Community
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USP	University of the South Pacific
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organization

ACKNOWLEDGEMENTS

The independent “mid-term review of the Pacific Regional Strategy on HIV (2004–2008) and its implementation” was conducted by a three member team. The review team visited 11 countries and conducted approximately 230 interviews in more than 100 organisations.

The Secretariat of the Pacific Community (SPC) gratefully acknowledges the contributions made by governments, faith-based organisations, individuals, non-governmental organisations and regional and international organisations to this review.

SPC also wishes to acknowledge the financial support received from the governments of Australia and New Zealand for activities relating to the review.

EXECUTIVE SUMMARY

The adoption of the Pacific Regional Strategy on HIV and AIDS in 2004 demonstrated the commitment of Pacific Island leaders to avoiding the devastating impact that HIV AND AIDS has had on all other regions of the world. Although HIV and AIDS had already become a generalised epidemic in Papua New Guinea, HIV prevalence in the rest of the Pacific region was still believed to be low. However, failure to act would not only decimate the health status of Pacific communities but also would place at risk the social and economic gains of recent decades.

In the relatively short period since its adoption, the strategy has already facilitated a significantly enhanced response to HIV and AIDS. Leadership has been shown at all levels of society in promoting an environment supportive of HIV and AIDS programs. Partnerships have been strengthened between government and civil society organisations to work collaboratively in addressing HIV and AIDS. Regional organisations and donor agencies are increasingly coordinating their efforts.

There has also been progress in scaling up service provision. Examples include:

- many people with HIV are on anti retroviral therapy (ART)
- universal access to ART is an achievable goal in the near future
- a systematic approach to procurement of ART and other essential commodities is being established
- care and support arrangements are being implemented for people living with HIV
- second generation surveillance (mapping of risk and infection) has been undertaken in some countries and is being planned in others
- there is evidence of some reduction in risk behaviour in a small number of countries, possibly resulting from prevention programs

However, minimising the threat of HIV and AIDS to the Pacific region will require sustaining and building on the supportive environment established and further scaling up access to quality services. HIV risk behaviours remain high. Other sexually transmitted infections (STIs) are at endemic levels in many Pacific Island countries and territories (PICT). The infrastructure necessary for a comprehensive response is still not strong in the Pacific.

Among the regions of the world, the Pacific is in the unique position of potentially being able to provide universal access to HIV prevention, treatment, care and support in the relatively near future. The Pacific Regional Strategy has established the building blocks for that to occur. The challenge now is to build the operational response necessary for universal access to prevention, treatment and care services.

Background

The Pacific Regional Strategy on HIV and AIDS was adopted at the 34th Meeting of Pacific Islands Forum leaders in 2004. The goal of the strategy is to reduce the spread and impact of HIV and AIDS, while embracing people infected and affected by the virus.

The strategy has three main purposes:

- to increase the capacity of PICT to achieve and sustain an effective and sustainable response to HIV and AIDS
- to strengthen coordination of the regional-level response and to mobilise resources and expertise to help PICT to achieve their targets
- to assist PICT to achieve and report on their national and international targets in response to HIV and AIDS

An implementation plan for the strategy was adopted in mid 2005. Implementation of the strategy is conceived as a collaborative exercise between all governments, civil society organisations (including groups of people living with and affected by HIV and AIDS, faith based organisations, community based organisations, non government organisations and media), regional agencies, and development partners.

The Secretariat of the Pacific Community (SPC) has lead responsibility for coordinating implementation of the strategy. Coordination occurs through the HIV and STI Section within the Public Health Programme. Technical staff are employed with expertise in the areas of program management, clinical service provision, behaviour change communication, monitoring/evaluation and strategic information (e.g. epidemiology/surveillance, data management, vulnerability mapping).

The Pacific Regional Strategy Implementation Plan (PRSIP) provides a framework in which objectives, outputs and activities are grouped according to the following components:

Component 1: Leadership and Governance

Component 2: Access to Quality Services

Component 3: Regional Coordination

Component 4: Program Management

In mid 2006 SPC commissioned a mid term review of the Pacific Regional Strategy. The review was intended to assess the impact of the strategy in each of the component areas of PRSIP as well as provide findings and make recommendations to support and contribute to an expanded and sustainable multi-sectoral response to HIV and AIDS across the region and in each of the PICT. The methodology proposed and implemented comprised a review of documentation and consultations with regional and national partners.

Leadership and Governance

At a regional level HIV is recognised as a major issue facing PICT. Key implementing agencies and donors have recognised that developing leadership across different levels of society and sectors is essential if the development challenges of HIV are to be effectively addressed. This includes political leadership, faith based and traditional leaders, institutional leaders (e.g. government ministries) and civil society.

The adoption of the regional strategy by PICT leaders through the Pacific Islands Forum reflects political leadership at the highest level. There is also evidence of strong political leadership in many of the PICT. This includes the personal engagement of key political leaders (e.g. the involvement of the former Fiji Parliamentary Speaker as a Special Representative of the Joint United Nations Programme on HIV and AIDS (UNAIDS), and the Prime Minister of Samoa as patron of the Samoa AIDS Foundation) as well as specific budget allocations in some PICT (e.g. Solomon Islands, Tuvalu, Marshall Islands, Samoa, Fiji).

Examples of leadership in other sectors of society include:

- the adoption of the Nadi Declaration by the World Council of Churches Pacific members, which commits supporters to embrace people with HIV and combat discrimination; it also supports prevention efforts by recognising “the freedom for individuals to make informed choices and to have access to condom use”
- the adoption of the Declaration of Commitment and Partnership with UNAIDS by the Pacific Islands Chiefs of Police Forum
- the inclusion of HIV and STIs in the school-based Adolescent Health and Development Program

Because of limited capacity at the PICT level, efforts to build leadership should be focused on consolidating broad political awareness of the potential threat of HIV to national development. Specific interventions should be prioritised on those themes (e.g. gender, human rights) and sectors (e.g. education, uniformed services) where action or preparedness is most important.

Most PICT have established multi-sectoral National AIDS Councils/Commissions (NACs) to coordinate strategy implementation. Generally NACs are not functioning well in regard to strategy direction and coordination. Attendance is poor, participation by sectors outside of health is erratic and there is general confusion regarding roles and responsibilities. Given the diversity of PICT, there needs to be greater flexibility in determining governance structures.

Access to Quality Services

Minimising the risk of HIV transmission and enhancing the health of those already infected are dependent on access to quality services. A comprehensive service response covers the areas of prevention, treatment, care and support. In a low prevalence environment, efforts to build leadership and governance and to improve coordination and management should be primarily aimed at building a supportive environment for the provision of quality services.

In a low prevalence setting, and particularly in the Pacific region where HIV is primarily sexually transmitted, HIV and STI services need to be closely aligned. Risk behaviours for HIV and other STIs overlap and require a coordinated approach to prevention programming. STIs are also a cofactor in HIV transmission risk. STI diagnosis and

treatment are also therefore an important HIV prevention strategy. Because STIs are an indicator of HIV risk behaviour, service delivery outlets where high numbers of STIs are diagnosed should be considered in placing voluntary confidential counselling and testing (VCCT) services.

Currently there is variable access to quality services across PICT.

In most PICT there is evidence of increasing awareness of HIV. Awareness in the form of accurate information will be sufficient for some people to adopt safer behaviours. However, many people require more intensive behaviour change interventions. Continuing high rates of sexual risk behaviour even among those with accurate information demonstrate the need to achieve greater reach in behaviour change strategies.

The availability of condoms is inadequate in many PICT. This is the result of poor forecasting and/or barriers to distribution at a local level.

Voluntary confidential counselling and testing is not widely available in most PICT. However, there is evidence of effective scaling up in Papua New Guinea.

Provision of STI services is of variable quality in most PICT. In some cases the provision of service delivery points is inadequate. In many cases staff are inadequately trained. Laboratory-based diagnosis is generally not available.

Care and support for people with HIV are a priority in most PICT. While much remains to be done, Papua New Guinea and Fiji are making significant effort to scale up this area of service provision. The Pacific Islands AIDS Foundation (PIAF) is playing a significant role in supporting PICT efforts.

Intensive effort is being made to ensure access to HIV anti retroviral therapy in most PICT. The work of SPC staff and the World Health Organization (WHO) as well as other regional partners has contributed to this.

Universal access to ART needs to be at the cornerstone of the Pacific response to HIV. In principle, access to necessary treatment is a basic human right. HIV testing is a strategic priority primarily because of its potential prevention benefit (reducing sexual transmission between partners, reducing mother-to-child transmission, reducing infectivity through reduced viral load). It also provides essential surveillance information for mapping disease transmission and target interventions effectively. However, without access to ART, any benefit from treatment is outweighed for most people by stigma and discrimination.

Access to quality services (prevention, care/support and treatment) has been adversely affected by inadequate planning. Policy frameworks are often unclear regarding the mix of services (e.g. laboratory-based and syndromic diagnosis of STIs) to be provided and service delivery points, prioritisation of target populations, human and financial capacity needs. Limitations in systems to provide strategic information including surveillance, social research and service quality improvement measures have contributed to inadequate planning.

Implementation of the regional strategy needs to be more focused on assisting PICT in developing effective programs to improve access to quality services. This includes:

- a more operational approach in planning
- integrating capacity development into ongoing assistance and program/project implementation
- closer alignment between HIV, STIs and reproductive health programs
- strengthening systems to provide strategic information

Regional Coordination

Since the adoption of the regional strategy there have been improvements in coordination of activity between regional agencies. This is most evident in the adoption of a regional strategy implementation plan across agencies. The plan describes all activities being implemented by agencies relevant to the regional strategy.

The PRSIP, while likely to reduce duplication in activity, does not facilitate a coordinated approach to planning. Currently it is a combination of separately developed plans by different regional agencies. Also the framework is of little use to PICT in aligning their work with the regional plan and identifying linkages. Recommendations are made in this report for coordinated planning in the context of an operational program framework.

Program Management

At the regional level there is broad agreement around role delineation between agencies (even though there are overlaps in functions between agencies). This is a significant achievement given different policy mandates, funding sources, PICT coverage and different project timeframes. However, a coordinated approach to planning, development of cross-agency teams and better communication could improve management. Initiatives in these areas would also improve support for PICT program implementation.

Gender

Gender inequality is a fundamental cause of vulnerability to HIV. Its most profound impact is on women and is compounded by biological factors. However, it also contributes to vulnerability among men by reinforcing stereotypical roles associated with higher risk-taking. Those who adopt a transgender role also suffer specific forms of vulnerability.

During the conduct of this review, there was strong support for addressing gender issues and specific interventions were reported on. Projects targeting women are the third largest group (after youth and sex workers) in competitive grants administered through the Pacific Regional HIV and AIDS Project (PRHP). The relationship between human rights and gender equality is a focus of the Regional Rights Resource Team (RRRT) hosted by the United Nations Development Programme (UNDP). Men as partners projects were reported to be very effective in those countries where they were implemented. Papua New Guinea has developed a draft HIV and gender strategy to complement its National HIV Strategic Plan.

Ensuring that the gender dimension of HIV is effectively addressed requires an approach that integrates HIV with a broader approach to sexual and reproductive health, including interventions that focus on underlying causes of gender inequality. The Revised Pacific Platform for Action on Advancement of Women and Gender Equality 2005 to 2015 provides the policy context for addressing the causes of gender inequality.

Immediate actions that should be undertaken to more specifically address gender in the context of the regional strategy are:

- employ a gender specialist focusing on HIV and STIs in one of the Pacific Regional Strategy implementing agencies
- establish a gender team across regional agencies
- undertake a situational review/assessment of gender in the context of HIV in the Pacific
- integrate a specific consideration of gender in developing the next strategy implementation plan (program implementation framework)
- assist PICT in integrating gender into program planning

The Way Forward

Key directions in revising the regional strategy over the next two years are:

- mobilisation of resources to sustain the response to HIV and STIs in the period after 2008
- an increased focus on scaling up access to quality services (particularly prevention and STI services) at the PICT level
- adoption of more systematic and coordinated planning focused on operational objectives
- an integrated approach to HIV and STIs through closer alignment between the HIV strategy implementation plan and programs addressing adolescent health and development
- integration of capacity development into ongoing collaboration/support arrangements
- a more focused approach on key sectors and cross-cutting issues in mainstreaming
- more flexibility in interpretation of the concept of one national AIDS authority
- mainstreaming gender into the strategic and program response
- provision of sufficient funding to ensure at least one NGO in each of the PICT has capacity to implement high quality prevention programs

Detailed recommendations to implement these directions are outlined in this report.

1.0 BACKGROUND

The Pacific Regional Strategy on HIV and AIDS was adopted at the 34th Meeting of Pacific Islands Forum leaders in 2004. The goal of the strategy is to reduce the spread and impact of HIV and AIDS, while embracing people infected and affected by the virus.

The strategy has three main purposes:

- to increase the capacity of Pacific Island countries and territories (PICT) to achieve and sustain an effective and sustainable response to HIV and AIDS
- to strengthen coordination of the regional-level response and to mobilise resources and expertise to help PICT to achieve their targets
- to assist PICT to achieve and report on their national and international targets in response to HIV and AIDS

An implementation plan for the strategy was adopted in mid 2005. Implementation of the strategy is conceived as a collaborative exercise between all governments, civil society organisations (including groups of people living with and affected by HIV and AIDS, faith based organisations, community based organisations, non government organisations (NGOs)), regional agencies, and development partners.

At the regional level, funding provided by the Australian Agency for International Development (AusAID) to the Secretariat of the Pacific Community (SPC) for strategy implementation covers 22 PICT. However, funding provided through other mechanisms covers a subset of these (e.g. the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) covers 11 PICT). The period for which different projects are funded also varies.

SPC has lead responsibility for coordinating implementation of the strategy. Coordination occurs through the HIV and STI Section within the Public Health Programme. Technical staff are employed with expertise in the areas of program management, clinical service provision, behaviour change communication, monitoring/evaluation and strategic information (e.g. epidemiology/surveillance, data management, vulnerability mapping). Most staff had only commenced employment in the six months prior to the commissioning of the mid term review.

The Pacific Regional Strategy Implementation Plan (PRSIP) provides a framework in which objectives, outputs and activities are grouped according to the following components:

- Component 1: Leadership and Governance
- Component 2: Access to Quality Services
- Component 3: Regional Coordination
- Component 4: Program Management

In mid 2006 SPC commissioned a mid term review of the Pacific Regional Strategy. The review was intended to assess the impact of the strategy in each of the component areas of PRSIP as well as provide findings and make recommendations to support and contribute to an expanded and sustainable multi-sectoral response to HIV and AIDS across the region and in each of the PICT. The methodology proposed and implemented was a review of documentation and consultations with regional and national partners.

2.0 CONTEXT

HIV and AIDS has had a devastating impact on individuals, families, communities and nations world wide. Almost 30 million have died and an estimated 40 million are currently living with HIV AIDS, mostly in developing countries. HIV AIDS is not only a health crisis but also one that fundamentally threatens the development aspirations of those nations most affected. Economies have been devastated and basic social service sectors such as health and education are collapsing.

With the exception of Papua New Guinea, PICT have been largely spared the worst consequences of HIV and AIDS. Infection levels are still believed to be generally low and consequently the broader impact on society has not been great. However, the conditions that have led to high levels of HIV infection elsewhere also exist in the Pacific. Unless effective action is taken now, PICT may face the same impact from HIV as that endured elsewhere as well as in one of its own members – Papua New Guinea.

Many of the factors that have contributed to high levels of HIV transmission elsewhere also are present in the Pacific. They include: the high proportion of young people in the population; significant movement of people into, through and out of the region; and, in particular, high rates of other sexually transmitted infections (STIs) and teenage pregnancies. Limited economic opportunities and weak economies compound the vulnerability of PICT to HIV transmission.¹

3.0 LEADERSHIP AND GOVERNANCE

Terms of Reference

- Assess the level of PICT national leadership and capacity for planning and coordinating a response to HIV and AIDS, and if relevant identify possible ways of strengthening national capacity.
- Assess the level and status of involvement of HIV positive people in both regional and national level and recommend ways of strengthening the involvement of HIV positive people.

3.1 Key Findings

3.1.1 Leadership

At a regional level, HIV is recognised as a major issue facing PICT. Key implementing agencies and donors have recognised that developing leadership across different levels of society and sectors is essential if the development challenges of HIV are to be effectively addressed. This includes political leadership, faith based and traditional leaders, institutional leaders (e.g. government ministries) and civil society.

The adoption of the regional strategy by PICT leaders through the Pacific Islands Forum reflects political leadership at the highest level. This political leadership is given organisational form through the strategy organisational structures established in SPC.

There is also evidence of strong political leadership in many of the PICT. This includes the personal engagement of key political leaders (e.g. the involvement of the former Fiji Parliamentary Speaker as a Special Representative of the Joint United Nations Programme on HIV and AIDS (UNAIDS), and the Prime Minister of Samoa as patron of the Samoa AIDS Foundation) as well as specific budget allocations in some PICT (e.g. Solomon Islands, Tuvalu, Marshall Islands, Samoa, Fiji).

Faith based organisations, which are a major social force in the Pacific region, are playing a leadership role. The adoption of the Nadi Declaration by the World Council of Churches' Pacific members in 2004 is helping to establish a supportive environment in which HIV programs can be implemented. In particular, the Nadi Declaration commits supporters to embrace people living with HIV and AIDS (PLWHA) and combat discrimination. It also supports prevention efforts by recognising "the freedom for individuals to make informed choices and to have access to condom use".²

Despite the sensitivity and often conservative attitudes within faith based organisations regarding issues of sex and sexuality, many leaders in PICT are contributing to more open discussion and supporting the adoption of necessary HIV interventions. At a very practical level, faith based organisations in some PICT (e.g. Tonga, Fiji and Solomon Islands) have provided refuge for HIV positive people who have been rejected from their communities.

Successful interventions have also occurred in engaging other influential forces in society. They include traditional leaders, uniformed services and the media.

Leadership capacity is being developed more broadly in civil society through the establishment of HIV-focused NGOs and inclusion of HIV in the programs of other NGOs. At the level of program/project implementation in PICT, the performance of many NGOs is highly effective.

The performance of NGOs addressing HIV as advocates for civil society or specific constituencies is limited at the regional level and variable at the PICT level. At the regional level there is little coordination between NGOs and no unified voice. In some countries NGOs are closely involved in HIV policy formulation and have strong partnerships with government. In others there are strong divisions between NGOs and poor relationships with government.

Funding has been allocated regionally to enhance the role of NGOs in policy advocacy and develop better linkages between NGOs working at PICT level. Despite some achievements (e.g. developing a common position on scaling up towards achieving universal access), progress in achieving these outcomes has been limited.

At a regional level, HIV is being increasingly recognised as an issue that impacts more broadly on development aspirations and therefore needs to be addressed in sectors additional to health. Examples of how this has occurred include a Partnership Declaration signed by the 21 Chiefs of Police in the Pacific with UNAIDS, a tripartite partnership Agreement between UNAIDS, the Fiji Defence Force and the Ministry of Home Affairs, and the inclusion of HIV and STIs in school-based Adolescent Health and Development programs. The Partnership Declaration and the Tripartite Agreement call for the establishment of workplace policies and programs.

The extent to which high-level leadership has been established is impressive. However, these achievements need to be consolidated through institutional and organisational development at a PICT level. The need to do so is recognised in the Pacific Regional HIV and AIDS Project (PRHP) action plan for 2007.

Despite initiatives being implemented in other sectors, at a PICT level HIV is still primarily addressed as a health issue. Given the relatively low prevalence of HIV currently in most PICT and the range of other development challenges, this may be inevitable. In pursuing a multi-sectoral response, it may be appropriate to focus on consolidating broad political awareness of the potential development threat of HIV and prioritise interventions in those sectors where action is of most immediate relevance and/or preparedness is most important.

3.1.2 Planning and Coordination Capacity

Overall, efforts to develop strong policy leadership for responding to HIV at regional and PICT levels have been very effective. However, institutional arrangements for providing leadership in planning and coordination have been less effective, particularly at the PICT level.

At the regional level, key implementing agencies – United Nations (UN) agencies, SPC and PRHP – are committed to the “three ones” principles. This is evident in the endorsement of the regional strategy and adoption of PRSIP. Discussions are occurring to build on the Global Fund Country Coordinating Mechanism (CCM) to establish one

governing body for implementation of the strategy. The development of a common monitoring and evaluation framework is also being discussed.

While the above measures indicate progress towards a coordinated response, they do not reflect a shared approach to planning. PRSIP is a combination of separately developed implementation plans by different agencies. While this will assist in reducing duplication, it is unlikely to contribute significantly to a strategic programmatic approach. This is discussed further in section 4.1 of this report.

Coverage of different PICT through each of the projects included in the strategy and variable conditions of funding are a significant barrier to coordination of planning. This is particularly the case in relation to those PICT that relate to French or US jurisdiction.

The regional strategy identifies National AIDS Councils/Committees (NACs) as the key organisational structure at the PICT level for leadership in planning and coordination. In most, if not all PICT, stakeholders have expressed concerns regarding the capacity of NACs in undertaking this role. Common problems identified included poor attendance, lack of commitment from those not directly involved in program implementation, content not linked to program implementation, lack of role definition, and inadequate/no preparation of agenda papers. Major contributing factors have been competing demands on the time of senior decision makers – particularly in government – and limited capacity to provide the secretariat functions necessary for the operation of a multi-tasked, high-level committee.

While several Capacity Development Organisations (CDOs) have undertaken a significant role in supporting the functioning of NACs, this is sometimes problematic. Some CDOs lack the organisational experience required. In some cases CDOs have problematic relationships with governments, which further frustrate their capacity to support the functioning of NACs.

The concept of partnership between government and civil society that underlies the concept of National AIDS Councils/Committees requires a significant organisational cultural shift in how most government instrumentalities operate. To some extent, institutional arrangements for governance of the GFATM at the regional level serve as a model for partnership. Strengthening the role of the Pacific Islands Council of AIDS Service Organisations (PICASO) in advocacy and as a peak body at the regional level for PICT NGOs, could also contribute to partnership at the PICT level. In regional forums, PICT NGOs would work with PICASO in advocating on behalf of their constituencies, thereby gaining experience that can be applied at a national level.

The principle of one national AIDS authority should not be interpreted as centralising all planning and coordination functions in one national committee. Differences between PICT, particularly in regard to population and institutional capacity, require flexibility in governance arrangements for HIV strategy. Governance structures should be focused on achieving operational objectives and guided by principles of accountability, transparency and partnership. A realistic assessment needs to be made of the resources required and available for different governance structures.

In PICT, the concept of one national AIDS authority should be interpreted as agreement to institutional arrangements for governance based on the principles of accountability, transparency and partnership. The functions of those arrangements are:

- to facilitate partnership between government and civil society agencies in planning and coordination
- to ensure the best available expertise and experience are utilised in decision making
- to enhance multi-sectoral involvement
- to enhance collaboration between and within sectors
- to strengthen high-level leadership support for addressing HIV

There are different mechanisms that can be adopted to achieve the above functions. In larger countries it may be feasible to provide the secretariat support necessary for NAC members to give informed input across a range of relevant issues. This might include structures that include technical support committees which will also require secretariat support. However, the resources required for these functions to be implemented effectively should not be underestimated. It is unlikely that they can be maintained without the support of at least one full-time staff officer. For members to provide informed input, agendas and background papers on matters being discussed need to be available prior to meetings.

In countries where support capacity and technical expertise may be limited, alternative organisational arrangements will need to be considered. This might include an annual congress, where additional technical expertise can be bought from outside to assist in planning, coordination and review. This might be supplemented by more regular meetings during the year between key implementing agencies.

3.1.3 Involvement of HIV Positive People

The involvement of HIV positive people at the regional and national levels is limited. At the regional level, the Pacific Islands AIDS Foundation (PIAF) has been established as the organisational peak for HIV positive people. Through the foundation's AIDS Ambassador Program, support is being given to positive people in the region to be public spokespersons. This is helping build a supportive environment for HIV programs, including the reduction of stigma and discrimination.

At a PICT level, a positive support group only exists in PNG and Fiji. However, a small number of positive people in other countries are playing an active public role as well as initiating the development of peer-based positive support groups (e.g. Vanuatu).

There are a number of barriers to strengthening the involvement of HIV positive people. There are also barriers to HIV testing and, consequently, the number of people who are HIV positive but unaware of their status is probably higher than the number diagnosed. This alone reduces the involvement of HIV positive people.

At the Pan Pacific Conference, the Declaration of the Positive People of the Pacific identified four key areas for improving quality of living for PLWHA: Stigma and discrimination; HIV in the workplace; Treatments; and Advocacy. The Pacific Islands Positive Network (PIN+) was also launched.

Major barriers to testing, and hence involvement of HIV positive people, include:

- poor protection of HIV confidentiality in HIV testing
- inadequate provision of pre and post test counselling
- high levels of stigma and discrimination regarding HIV
- lack of legal protection against discrimination for people who are HIV positive

- lack of ongoing counselling for people with HIV
- inadequate provision of care and support facilities for people with HIV
- inadequate access to ART

There are initiatives being implemented to address legal issues related to HIV. PIAF and the University of the South Pacific (USP) Law School have established the PIAF Legal Task Force, which is addressing the dangers of criminalising HIV transmissions. PIAF has produced brochures informing PLWHA of their legal rights. The Regional Rights Resource Team (RRRT) is being funded in 11 PICT to provide technical support to reform legislation in relation to HIV and other STIs. SPC has been tasked in PRSIP to assist in this process. RRRT is also training Community Paralegals, located in most PICT, in HIV and AIDS human rights and the law.

In PNG the HIV and AIDS Management and Prevention Act 2003 provides legal protection against discrimination or stigmatisation. It also provides legal protection for privacy and confidentiality. Areas covered by the act include employment, contractual arrangements, accommodation and school attendance, among others. Legal action can be taken by complaints to bodies such as the Ombudsman Commission, civil action or criminal prosecution.

Initiatives are also being implemented to address stigma and discrimination. In addition to the role of faith based organisations discussed earlier, the UNAIDS Asia Pacific Leadership Forum on HIV and AIDS and Development (APLF) is engaging political and civil society leaders in launching the Declaration of Partnership and Commitment to Overcoming Stigma and Discrimination.

During consultations it was clear that people with HIV are currently experiencing high levels of stigma and discrimination and generally lack legal recourse. However, initiatives in addressing such issues have only recently commenced. It is too early to comment on their effectiveness and therefore it is premature to make recommendations on how measures can be strengthened. Existing measures need to be closely monitored and remedial action taken if they are not effective.

4.0 ACCESS TO QUALITY SERVICES

Terms of Reference

- Identify and comment on issues affecting PICT service delivery for HIV prevention, testing and counselling, treatment and care – particularly in the context of providing Universal Access to treatment care, including upskilling and training of VCCT services providers.

4.1 Key Findings

Activities undertaken by regional partners involved in the Pacific Regional Strategy on HIV and AIDS have contributed to HIV being given significant priority by governments and civil society in PICT. In turn, this is creating a supportive environment necessary for implementation of an effective HIV response at the PICT level. However, the emphasis given to developing broad, overarching strategic plans has not extended to planning more focused programmatic interventions that address the core service response required to achieve universal access.

There are gaps in service provision in most PICT across the spectrum, from prevention to treatment and care, that will prevent the achievement of universal access. A programmatic approach is required in service planning if these gaps are to be filled. Such an approach is one that includes:

- setting operational objectives
- establishing quantifiable targets necessary to achieve operational objectives
- identifying mechanisms to achieve targets
- assessing the costs and benefits of different mechanisms
- determining the human and financial capacity needs to develop/strengthen selected mechanisms
- establishing policies, protocols and guidelines to implement programs
- developing monitoring and reporting systems, including quality management and improvement processes
- adopting implementation plans specifying inputs, outputs, timelines, roles and responsibilities, and costings

At regional and PICT levels, the overlap of HIV, STIs and reproductive health is becoming recognised and a shared programmatic response in some areas is being implemented. Examples include:

- procurement of condoms is based on forecasting need across programs
- in Vanuatu, Ministry of Health Adolescent Health and Development programs and HIV are jointly managed

However, service delivery in these areas is not well integrated into PRSIP. This creates risk of duplication of effort and failure to maximise synergies.

4.1.1 HIV Treatment

With the possible exception of Papua New Guinea, the Pacific region is in the unique position internationally of potentially being able to offer universal access to anti retroviral therapy (ART) in the relatively near future. The number of people infected is still low, adequate funds are available and technical expertise is available.

Universal access to ART needs to be at the cornerstone of the Pacific response to HIV. In principle, access to necessary treatment is a basic human right. HIV testing is a strategic priority primarily because of its potential prevention benefit (reducing sexual transmission between partners, reducing mother-to-child transmission, reducing infectivity through reduced viral load). It also provides essential surveillance information for mapping disease transmission and target interventions effectively. However, without access to ART, any benefit from treatment is outweighed for most people by stigma and discrimination.

Barriers to HIV testing and treatment are both systemic and social. At the social level, despite significant progress, discrimination and stigma associated with HIV infection remain high. Efforts to engage leaders at all levels of society and broadly targeted communication to improve community knowledge regarding HIV must continue, care and support structures must be established, and legal protection must be provided.

While prerequisites for providing universal access exist, various challenges must be addressed to achieve this objective. They include:

- variation in health system infrastructures between PICT and different levels of need (i.e. number of people who are HIV positive) will require responses to be tailored to specific PICT
- small numbers of people with HIV in some PICT may require shared care arrangements (e.g. anti retroviral drugs (ARVs) assessment and prescribing at regional/external level and monitoring, primary health care in each of the PICT)
- staff turnover is a factor mitigating against sustainability of highly specialised treatment, particularly in smaller PICT; flexibility in protocols and systems is required to allow for this

Scaling up access to ART requires clearly defined roles, responsibilities and tasks, which are determined and monitored within an operational planning framework (the programmatic approach is described in section 4.1).

4.1.2 Care and Support

Access to ART is the one measure that will provide the greatest health benefit for people with HIV. However, maximising access to testing, maintaining adherence to complex treatments and ensuring quality of life also require care and support services. Ideally this should include access to peer support and professional services such as quality counselling as well as systemic approaches to dealing with wider welfare needs.

Currently the small numbers of people with HIV in some PICT may make HIV positive peer support groups unviable and, consequently, alternatives to peer support structures need to be considered. Already in some countries where numbers are small, NGOs and faith based organisations have prioritised the meaningful involvement of people with HIV in their organisations. At the regional level, PIAF provides a mechanism for

communication, solidarity and support for some people with HIV who are isolated because of small numbers in their own country or territory.

In consultations undertaken in preparing this report, the quality of counselling available to people with HIV (with some exceptions) was generally reported to be poor. In some PICT there is no capacity to provide post test counselling for those receiving a positive diagnosis (and sometimes when there is, the quality is poor). In many PICT, ongoing access to counselling for people with HIV either doesn't exist or is of poor quality.

To some extent in the Pacific, counselling is seen in a pastoral and faith-based context. Used wrongly, this can reinforce feelings of guilt rather than empowering clients to deal with the psychological and social dimensions of their situation.

Systemic approaches to protecting the human rights (e.g. freedom from discrimination in regard to issues such as housing and employment) and addressing the welfare needs of positive people need to be developed. Already in Fiji, access to housing grants and support allowances for people with HIV who are unemployed is occurring and may provide an example for other PICT. Faith based organisations in Tonga, Solomon Islands and Fiji and the Samoa AIDS Foundation have provided more immediate assistance in the form of housing and employment for people with HIV who have been disadvantaged because of their HIV status.

Organisations such as Fiji Network of People Living with HIV and AIDS (FJN+), which has been jointly funded through PRHP grants and the Government of Fiji for salaries and operational costs, provide practical examples of empowering positive people. This core funding has facilitated FJN+ in mobilising other resources to support HIV positive people and engage in advocacy and community education.

4.1.3 Voluntary Confidential Counselling and Testing

Despite some efforts in capacity development the availability and quality of voluntary confidential counselling and testing (VCCT) services across PICT is generally reported to be poor (although there is evidence of significant scaling up in PNG). Common themes raised during the consultation phase of this review that have contributed to poor availability and quality included:

- poor definition of minimum requirements for VCCT; opportunities for professional accreditation lacking; protocols lacking
- no clear planning regarding capacity development
- ethical issues regarding testing and access to ARV not widely considered
- values, beliefs and attitudes of health care workers that hinder VCCT are not adequately addressed
- lack of strategic consideration regarding targeting of VCCT service provision
- linkage between HIV and STI testing, including referral systems, not clear
- respective roles of STI syndromic diagnosis, control and treatment and laboratory-based testing not clearly defined

4.1.4 HIV Prevention

Overall, the quality of prevention strategies in the Pacific is not high. Specific interventions are often developed in isolation from broader program frameworks. Awareness-raising interventions are often equated with behaviour change. Evaluation is

usually at best superficial and more often absent and therefore does not contribute to quality improvement.

Promoting accurate information about HIV is an essential component of an overall prevention strategy. For some people it will be sufficient to enable behaviour change. It also helps establish an environment in which more sustained behaviour programs can be implemented. However, ongoing risk behaviour among those who have accurate knowledge demonstrates the need for more intensive and sustained behaviour change interventions.

There is some evidence that training provided by PRHP and SPC is contributing to better understanding of behaviour change. In round two of the PRHP competitive Grants Program, the number of agencies that proposed behaviour change activities increased significantly.

At the regional level, efforts to support prevention services are not well integrated. Different agencies develop and support a range of intervention types (e.g. condom availability, behaviour change communication, social marketing and peer support) with little consideration of how they fit into a broader prevention planning framework (e.g. health promotion; health outcomes) or how they are linked to other strategy components such as VCCT, treatment, care and support.

PRSIP, by describing what different agencies are doing, is making a significant contribution to reducing duplication in effort and clarifying respective roles between agencies. However, rather than being the result of a strategic planning process, it is more akin to an agreement to combine separately planned projects/programs.

Strategic information is necessary, particularly for prevention planning but also more broadly for program planning. Strategic information needs cover traditional public health domains such as epidemiology/surveillance as well as behavioural monitoring, social research, service utilisation data and monitoring/evaluation. With the notable exception of second generation surveillance efforts and to some extent monitoring/evaluation, efforts have been piecemeal at the regional level in defining and meeting strategic information needs.

At the PICT level, there are what appear to be some well-planned and well-implemented prevention activities. However, broader program planning approaches largely replicate those at the regional level. Priority appears to be given to achieving consensus in planning in order to develop a sense of shared commitment. However, the same outcome can be achieved through participatory processes where criteria for decision making are agreed to beforehand and planning processes are well facilitated.

Understanding and prioritisation of target populations at the PICT level is variable. Among larger population groups such as youth and women, some projects are based on a clear assessment of different levels of risk among population segments, contributing factors, analysis of opportunities and barriers, identification of critical intermediaries and adoption of a range of interventions to achieve objectives. However, most are not thereby reducing their effectiveness.

There are examples of well-planned approaches to targeting groups at higher risk who are also bridging populations to the wider community in some countries. They include men

who have sex with men (MSM) in Samoa, sex workers in Solomon Islands and seafarers in Kiribati. However, in general, marginalised and other groups at higher risk are not sufficiently prioritised in most PICT. This particularly applies to sex workers.

Peer education appears to be a catch-all phrase used to describe any type of interpersonal communication at an individual or small-group level (except for counselling). The quality of peer education is reported by stakeholders to be highly variable. Several have attributed this to inadequate training both in regard to time allocated and quality.

The tasks required of peer educators need to be more clearly addressed in training and ongoing mentoring. Training must cover a complexity of information, communication and presentation skills, and provide practice in conducting activities. Peer education programs need to be monitored on an ongoing basis to ensure the knowledge and skills of providers is kept up to date.

There would be significant benefits in improving collaboration between the Adolescent Reproductive Health Program and PRSIP partners. The program, which is auspiced by SPC, is funded by two of the PRSIP partners – the United Nations Population Fund (UNFPA) and United Nations Children’s Fund (UNICEF). Both the Adolescent Health and Development Program and PRSIP target youth and have overlapping objectives. The Adolescent Health and Development Program aims to ensure young people are knowledgeable about HIV and STIs and, in the context of life skills education, to ensure young people are empowered to make life decisions including those around sex and sexuality.

While young people (aged 10–25 years) are the primary target population, the program also aims to develop a supportive environment by targeting parents, teachers, and faith based organisations. In each of the 10 countries in which the program operates, there is a focal point in government and non government sectors.

4.1.5 Sexually Transmitted Infection Services

High rates of STIs are common in most PICT. STIs are a significant cause of morbidity as well as a co-factor in HIV transmission. Scaling up the provision and quality of STI services is an immediate priority in order to prevent the escalation of HIV transmission in the Pacific region. A comprehensive service response to STIs includes behaviour change programs, diagnosis and treatment services as well as partner notification and surveillance.

Policy options need to be assessed at the PICT level. They include the possible role of presumptive treatment (given existing high rates of some STIs), the role of syndromic management and treatment based on laboratory-based diagnosis and the possible use of newly developing technologies and vaccines.

Significant challenges exist in improving access to STI services. People at risk need accurate information and encouragement to access services. Service provider skills need to be enhanced. Among some service providers, attitudes (e.g. negative judgements of client’s sexual behaviour) and practices (e.g. lack of confidentiality) that may be a barrier to clients accessing services need to change.

In many PICT, service delivery points need to be expanded and management systems improved.

Regional agencies can make a significant contribution to PICT in scaling up STI services. That contribution includes:

- mobilising additional funding required
- technical assistance in provision of training
- facilitating discussion around policy options
- assistance in operational planning including costing

The availability of funding through a potential round seven of GFATM provides an opportunity to address the above issues. It is recommended that a key priority of the 2007 PRSIP be the provision of assistance to PICT in developing a fully costed proposal to scale up STI services to be submitted for round seven GFATM funding. Should round seven not occur or the submission be unsuccessful, funding should be sought from other donors.

4.1.6 Procurement of ARVs and Essential Commodities

There is reported to be significant progress in the procurement of ARVs in the region. The Fiji national pharmacy is acting as regional hub for procurement for several countries and has good distribution channels to those countries. ARVs are being purchased from pre-qualified agents in Australia and supply lead time is three weeks compared to 4–6 months if sourced through World Health Organization (WHO) systems.

Procurement of condoms is a significant problem in the region. UNFPA is responsible for the procurement of all reproductive health commodities. There have been repeated stock-outs of condoms at the Fiji warehouse as a result of under-forecasting of needs by some countries. High turnover of pharmacists at a country level may be contributing to poor forecasting. A significant increase in demand over the past two years may also make forecasting more difficult. (For example, the number of condoms ordered regionally has more than doubled in the past two years.)

Within PICT, supply chains do not always operate well. Anecdotally, condoms are not always available at district- or village-level health services.

There is a range of other commodities necessary for a comprehensive response to HIV. They include treatments for opportunistic infections and ARV paediatric formulations. While the number of HIV infections remains low, it is feasible to use time-limited funding grants to address these needs. However, options such as the proposed Pacific Fund need to be considered for a more sustainable response.

4.1.7 Laboratory Capacity

Laboratory capacity for HIV confirmatory testing and diagnosis of bacterial STIs and antimicrobial susceptibility is limited in the region. Consideration needs to be given as to whether these services are needed more widely.

5.0 REGIONAL COORDINATION

Terms of Reference

- Assess inputs of key partners including AusAID (PRHP), GFATM, UN agencies, ADB and NZAID under the regional strategy's framework and identify gaps/overlaps and the extent of harmonisation of regional initiatives.
- Identify ways to develop better linkages across countries' national strategic planning and implementation processes; this should include the level of strategic connection between the Regional Strategy and the National Plans (HIV and broader overarching National Strategic Development Plans where they exist).
- Assess the coordination of peer education activities at both the regional and national levels, and recommend ways of strengthening peer education activities.
- Assess the extent to which existing knowledge and capacity in the region are being utilised (in terms of duplication and reinventing processes).

5.1 Key Findings

5.1.1 Harmonisation

The adoption of the Pacific Regional Strategy on HIV and AIDS and the development of PRSIP reflect a strong commitment by key partners to harmonisation of regional initiatives to address HIV. During consultations undertaken in preparing this report, key partners indicated a willingness to engage in further harmonisation such as agreement on common reporting and monitoring/evaluation systems as well as adopting program-based funding.

AusAID, the New Zealand Agency for International Development (NZAID) and the Asian Development Bank (ADB) have adopted a pragmatic approach in harmonising the allocation of funding in light of the respective mandates of UN agencies, less flexible funding frameworks of GFATM and different PICT coverage by respective agencies. AusAID, as the initial and largest funder of the regional strategy, allocated funds on the basis of identifiable gaps in the work of the UN agencies and activities funded through GFATM. Allocations by NZAID and ADB have addressed remaining gaps and helped compensate for funding shortfalls resulting from unsuccessful GFATM bids for further HIV and AIDS funding.

Recognising the complexity inherent in having a diversity of technical agencies working on HIV and AIDS, UN agencies have adopted a joint programming approach to better coordinate their activities. UNAIDS is committed to adopting this approach in working with other multilateral agencies and donors. "The UN is committed to a rational division of labour and well-balanced use of resources, identifying lead agencies for specific activities and achieving harmonisation through inter-agency collaboration and joint programming."³

Given the number of PICT covered by the regional strategy, different country coverage through different funding agencies, different timelines for different funding programs, and different mandates among agencies, goodwill and pragmatism will continue to underpin harmonisation. This approach has meant that while there are overlaps in the

mandates of different agencies, there is a relatively low level of duplication in activities funded.

5.1.2 Strategy Gaps

In July 2005 a review of programmatic and funding gaps in PRSIP was produced.⁴ That review correctly identified the following intervention areas as priorities to avoid early escalation of the HIV epidemic in the Pacific:

- a stronger focus on targeted outreach to vulnerable and higher-risk individuals*
- condom advocacy, targeted distribution and social marketing
- scaling up voluntary confidential counselling and testing services including at ante natal clinics (ANCs)
- an aggressive approach to strengthening STI diagnosis and treatment
- enhancing targeted prevention of mother-to-child transmission programs

While agreeing with the findings of the 2005 review, we also believe prevention programs more broadly need to be strengthened. High levels of STIs in many PICT indicate widespread risk behaviour.

Additional funding provided by ADB and NZAID since the 2005 review will be used to fund the gaps identified in the 2005 review. However, current funding through GFATM and for PRHP and SPC-administered projects is due to end in 2008. If, as anticipated, there is a round seven for GFATM covering the period from 2008, we recommend that the above priorities form the basis of a funding submission.

5.1.3 Regional/PICT Linkages and Utilisation of Existing Knowledge and Capacity

Currently linkages between strategies and implementation plans at the regional and PICT level are not strong. Different implementation frameworks make it difficult to efficiently link technical expertise and financial support to country needs. Different frameworks also make it difficult for PICT to utilise existing knowledge and capacity in the region and thus avoid duplication and reinventing processes.

We recommend the adoption of a common program framework for implementation plans at regional and PICT levels. Operational planning processes as described in section 4.1 would be used in PICT to develop implementation plans for each of the components outlined below. This will facilitate planning at the regional level based on the identified needs of PICT. This includes seeking donor funds that will be allocated by regional agencies to PICT as well as aligning technical assistance to PICT needs. Any HIV/STI implementation framework should include the following components:

- prevention
- clinical services (ART, STIs, VCCT, procurement, laboratory)

* The analysis identified the following groups as vulnerable to and at increased risk of HIV transmission:

- commercial seafarers and their partners
- individuals with sexually transmitted infections
- internationally and internally mobile populations
- individuals who engage in “transactional” sexual practices with multiple sexual partners
- men who have sex with men

Priority interventions required were noted as: behaviour change communication, HIV and STI related counselling and support, and reliable access to simple and rapid diagnostic testing and condoms.

- care and support
- governance (organisational structures, including coordination, and funding arrangements, including resource mobilisation)
- enabling environment (leadership projects, community development, gender, national development)
- capacity development (human resources, institutional strengthening)
- strategic information (surveillance, monitoring/evaluation, behavioural/social research, operational research)

Operational components will be guided by principled underlying strategies. For example, governance arrangements will be informed by principles such as transparency and partnership, among others.

During the consultations undertaken in the review process, agencies in PICT expressed great interest in accessing information about similar activities in other PICT and collaborating on joint projects. Examples ranged from targeting socially marginalised groups (e.g. sex workers, MSM) to developing shared protocols around treatment issues (e.g. commencement of ART).

The potential to better leverage regional initiatives was also identified. For example, in most PICT efforts are being made to involve the faith based organisations in creating a more supportive environment for implementing HIV strategies. However, many were unaware of the Nadi Declaration of church leaders. When they were informed, it was considered a useful mechanism to help build faith based organisation support in their own country.

The adoption of a common program framework allows PICT to more easily identify and access relevant linkages at a regional level. It also allows PICT to benchmark performance against each other. Benchmarking is a basic tool for quality assurance and improvement. A common program framework would assist monitoring/evaluation at both regional and PICT levels as well.

The adoption of a common program framework is also consistent with the concept of regional cooperation articulated in the Pacific Plan.⁵ In addition, it contributes to the objective under good governance in the Pacific Plan of “Improved transparency, accountability, equity and efficiency in the management and use of resources in the Pacific”.⁶

There is an inherent complexity in the diversity of technical agencies working on HIV and AIDS in the Pacific. A common program framework and joint planning will reduce duplication of effort. Formation of teams across agencies where staff are working on common program areas could further contribute to an integrated approach in implementation.

While the adoption of a common program framework would greatly enhance linkages, it is acknowledged that other initiatives are being made regionally to improve communication. They include the PRHP website and the publication of an HIV newsletter by SPC. Shared approaches are also being adopted in capacity planning between PICT. Cooperative mechanisms are being established in the purchase of ARVs too. This also meets the criteria for regional provision of public goods/services outlined in the Pacific Plan.⁷

5.1.4 Development Planning Linkages

In most PICT, HIV planning occurs in isolation from either other health sector planning processes or broader development planning.

Some key donor agencies in the Pacific are adopting sector-wide approaches in health funding. To ensure HIV is accorded high priority, consideration should be given to scheduling of HIV planning in relation to broader health sector planning. Issues related to human resources, monitoring, surveillance and evaluation, health service facilities and health service delivery considered in broader health planning impact upon the capacity to deliver HIV-related services. More specifically, building a comprehensive health service response to HIV should occur in the context of building capacity to address communicable diseases overall.

Broader development planning also has implications for HIV strategies. Issues such as gender and human rights are of fundamental importance in ensuring an effective HIV response and are key considerations in national development planning. More generally, most areas of national development planning will have implications for HIV risk and vulnerability.

Advocacy for measures to mitigate any adverse consequences for HIV risk and vulnerability resulting from national development policies should occur in national development planning. However, most PICT do not have the policy capacity within their own HIV sectors to effectively undertake this alone. Regional organisations, particularly the United Nations Development Programme (UNDP), have a key role to play in assisting PICT in this regard. Mainstreaming within regional agencies (e.g. SPC) will also enhance capacity to inform PICT-level mainstreaming.

6.0 PROGRAM MANAGEMENT

Terms of Reference

- Identify issues to improve reporting, monitoring and implementation of the regional strategy and recommend ways to improve its M/E framework.
- Recommend any revisions needed to the regional strategy, and include references to any necessary budget, personnel and/or management implications of the recommendations.
- Assess the adequacy of funding for the regional strategy, in the context of the extent to which available funding is matched to (a) PRSIP, and (b) current estimated needs in the Pacific, including analytical assessment of proportion of funds that are directly related to management compared to implementation of activities.
- Assess and recommend ways of pooling of resources to effectively manage and report on the PRSIP – i.e. programming approach with one reporting format to all funding agencies and partners.
- Assess the integration of national strategic planning processes at country level and how these might be better integrated into national development planning processes (if not already).

6.1 Key Findings

6.1.1 Regional Strategy Reporting, Monitoring, Evaluation and Implementation

The regional partners have established a Monitoring and Evaluation Reference Group to improve activity in this area. In 2005 this group modified a monitoring and evaluation framework agreed to earlier in the year. The modified framework provides an effective structure for monitoring and reporting against the three purposes stated in the regional strategy:

- to increase the capacity of PICT to achieve and sustain an effective response to HIV and AIDS
- to strengthen coordination of the regional-level response and mobilise resources and expertise to assist countries to achieve their targets
- to help PICT to achieve and report on their national and international targets in response to HIV and AIDS

The revised framework includes a standardised core set of tools to collect and analyse data and to report against other requirements (e.g. United Nations General Assembly Special Session on HIV and AIDS, Millennium Development Goals). For the purpose of data management, it utilises the Country Response Information System (CRIS).

The framework also provides an effective mechanism for evaluating the overall achievement of the strategy purposes. However, its utility in analysing strategy failure is more limited. The underlying assumption is that the activities outlined in PRSIP will, if implemented, result in the purposes being achieved. The extent to which they are achieved can be simply attributed to quality and timeliness in the implementation of activities.

As discussed earlier in this report, the current approach to planning (in effect an amalgamation of plans developed separately by partner agencies) is inadequate for an effective strategic response. The adoption of a health outcomes approach to planning, mapping of externally mandated actions (e.g. by UN agencies) against the resulting plan, and identification of key gaps and possible inconsistencies would add capacity to analyse strategy failures.

6.1.2 Strategy Revisions

We recommend that increased priority be given to the following matters in the remaining years of the Pacific Regional Strategy on HIV and AIDS:

- a stronger focus on operational planning to support PICT programmatic and funding priorities
- strengthening prevention and STI programs
- closer alignment between HIV-funded projects and Adolescent Health and Development programs
- mobilisation of resources for sustaining an effective programmatic response to HIV and STIs in the period post 2008

The eight themes that frame the regional strategy provide an appropriate basis for an effective response to HIV and AIDS in the Pacific. However, PRSIP does not provide a clear operational framework for developing an effective programmatic response.

The implementation plan should group core services, infrastructure and governance requirements for an effective response (i.e. a program) to achieving the overall goal of the strategy. Ideally this framework for the implementation plan would also be adopted by PICT. In so doing, PRSIP will address two immediate challenges noted in an independent review of programmatic and funding gaps conducted in 2005.⁸ They were:

- the regional strategy and its implementation plan must provide a very clear framework for future investment by bilateral and multilateral partners in the fight against HIV and AIDS in the Pacific
- the implementation plan must be closely linked to the immediate programmatic and funding priorities at the national level

As proposed in section 5.1 of this report, the framework would consist of:

- prevention
- clinical services (ART, STIs, VCCT, procurement, laboratory)
- care and support
- governance (organisational structures, including coordination, and funding arrangements, including resource mobilisation)
- enabling environment (leadership projects, community development, gender, national development)
- capacity development (human resources, institutional strengthening)
- strategic information (surveillance, monitoring/evaluation, behavioural/social research, operational research)

Program planning principles discussed in section 4.1 of this report would guide the development of implementation plans.

Within the proposed framework, greater emphasis should be given to supporting service delivery. Of immediate priority are the high priority activities and interventions identified in the 2005 review:

- a stronger focus on targeted outreach to vulnerable and higher-risk individuals
- condom advocacy, targeted distribution and social marketing
- scaling up voluntary confidential counselling and testing services including at ANCs
- an aggressive approach to strengthening STI diagnosis and treatment
- enhancing targeted prevention of mother-to-child transmission programs

As discussed in section 5.1.2, we recommend that prevention programs more generally be strengthened, given evidence of widespread risk behaviour.

During consultations undertaken in conducting this review, significant gaps in each of these areas were identified in PICT. Funding sourced through ADB and NZAID since the review is intended to address these gaps. Improved program planning will also contribute to better coordination between prevention projects.

The Adolescent Health and Development Program and the HIV and STI Section of SPC should develop a joint program to address HIV and STI prevention, targeting youth. There are potential synergies between the two projects and possible duplication in activity can be avoided.

Funding provided by AusAID and NZAID for the Pacific Regional Strategy and PRHP, as well as GFATM-funded activities cease at the end of 2008. Mobilising resources to sustain the response to HIV and AIDS in PICT is a key action outlined in the current strategy.⁹

We recommend that scaling up STI services and HIV/STI prevention programs is a key focus of a funding proposal for round seven of GFATM. The proposal should be based on detailed operational planning and costing in those countries intended to be included in the proposal. Assistance to PICT in developing the proposal should be a key priority in the first half of the 2007 PRSIP.

We also recommend that a fully costed strategy and program implementation plan (utilising the program framework and planning principles recommended in this report) should be developed for the five-year period post 2008. This would include identification of those functions that can be best done regionally in line with the principles of the Pacific Plan and those that should be implemented at PICT level.

6.1.3 Adequacy of Funding

There is a lack of clarity regarding funding roles at regional and PICT levels for HIV strategies. This includes the respective roles of donor agencies and PICT governments.

There is limited collaboration and clarity regarding funding roles within agencies working at both regional and country levels.

Until implementation planning is done that includes identification of the minimum service requirements necessary to implement a comprehensive response at a PICT level (the program framework described in section 5.1), utilising the principles of program planning described in section 4.1, it is not possible to develop a detailed costing and

hence assess the adequacy of existing funding. This planning would include identifying what tasks can be done most effectively at the regional level (in line with the principles outlined in the Pacific Plan). It would then be possible to more appropriately determine allocations to be made at regional and PICT levels.

The delineation between regional agencies and PICT in program implementation will also assist in clarifying donor roles at multilateral and bilateral levels. At the regional level, funding should be allocated for implementation of those tasks that can best be undertaken regionally as well as the ongoing provision of high-level technical assistance. Given the urgency of the threat of HIV, funding should also be allocated regionally for enhancement of core program functions at a PICT level that are necessary to respond to it. Over time these functions should be funded at a PICT level, possibly with assistance from bilateral aid arrangements.

In section 6.1.2 we recommended that assistance be given to PICT in undertaking operational planning to inform a round seven GFATM submission and that a fully costed strategy and implementation plan be developed for the five-year period post 2008. Funding has already been provided in the NZAID grant for some activities relevant to providing assistance to PICT in undertaking this planning. Actions funded include:

- providing training and technical support to assist government, NGOs and CDOs to develop and implement national capacity building plans specifically related to HIV and AIDS (\$100,000)
- conducting a situational assessment of the capacity of national strategic plans to address HIV and AIDS in PICT not covered by existing regional programs (\$120,000)
- providing technical assistance to conduct rapid assessments of HIV vulnerability in PICT including identification, quantification and mapping of sub-population groups at risk of HIV infection (\$140,000)
- conducting a feasibility study for a Pacific Regional HIV and AIDS Fund, and preparing an implementation plan if appropriate (\$10,000)
- working on the development of phase 2 PRSIP (2009–2013) (\$30,000)

It may also be necessary to reallocate some staff resources currently identified for other activities in 2007.

6.1.4 Resource Pooling

In principle, most donor agencies in the Pacific are committed to the Paris Declaration on Aid Effectiveness. This includes:

- harmonisation and alignment of aid delivery between donor agencies
- alignment of aid with partner countries' priorities, systems and procedures
- reforming and simplifying donor policies and procedures
- providing reliable indicative commitments of aid over a multi-year framework and disbursing aid in a timely and predictable fashion according to agreed schedules

The Paris Declaration also commits partner countries to:

- developing prioritised results-oriented operational programs, as expressed in medium-term expenditure frameworks and annual budgets
- encouraging the participation of civil society and the private sector in coordinating aid

The adoption of a common program framework at regional and PICT levels, as described already in this report, would be consistent with the commitments made in the Paris Declaration. It would be operational and could be costed so as to provide medium-term expenditure frameworks and annual budgets. It would also provide greater clarity in aligning the commitments of different agencies as well as leveraging the comparative advantages of different donors.

The establishment of a common fund for receiving donor funds for the regional strategy should be considered by regional agencies and donors. Utilising the existing infrastructure established for GFATM could be considered. Such a fund would be consistent with the Paris Declaration in that countries would be able to participate in determining priorities.

The establishment of a resource pool is also consistent with the development of the Pacific Health Fund. The concept of the fund was endorsed by the Pacific Islands Forum Leaders in 2005 as a possible means for financing health priorities in the Pacific Islands region.

Conditions of funding should be standardised between donors as far as possible. The development of a single monitoring/evaluation framework should provide a common framework for performance reporting. The development of common financial reporting standards is also consistent with commitments made in the Paris Declaration.

6.1.5 Integration with National Development Planning

The development of operational programs at the PICT level will assist in better integration with national development planning frameworks. It will provide greater clarity regarding human and financial resource needs, which can be factored into national development planning. Operational programs will also identify program needs in other sectors.

HIV program operational planning should be timed to allow input to be made into national planning.

7.0 GENERAL

Terms of Reference

- Identify ways in which gender can be more specifically addressed to ensure that the gender dimensions of the epidemic are effectively addressed with a stronger focus by all implementing agencies and partners.
- Comment on and recommend ways to further streamline the coordination and management of the regional strategy, including a focal resource centre for HIV programs in the region.
- With a major focus on the way forward (both at the strategic policy level and concerning management/administration aspects – meetings, communications, etc.), recommend areas where the regional strategy needs to be revised.
- Assess whether the focus on stand-alone national HIV plans is impeding HIV mainstreaming efforts.

7.1 Key Findings

7.1.1 Gender

Gender inequality is a fundamental cause of vulnerability to HIV. Its most profound impact is on women and is compounded by biological factors for girls. However, it also contributes to vulnerability among men by reinforcing stereotypical roles associated with higher risk-taking. Those who adopt a transgender role also suffer specific forms of vulnerability.

In countries where heterosexual transmission is the major cause of HIV, women are increasingly affected. In sub-Saharan Africa the majority of new infections are in women. Reported new infections in Papua New Guinea are now higher among women than men.

Greater vulnerability among women is associated with lower social and economic status. Women are often disempowered in sexual relations and therefore unable to negotiate around sexual practices. In this situation their vulnerability to HIV risk is entirely dependent on their male partner's infection status and risk practices.

Economic insecurity can also result in women engaging in sex in exchange for money, goods and services. In most countries, rates of HIV are higher among women engaged in sex work.

During consultations, violence against women was reported to be high in many countries. This is also associated with increased vulnerability to HIV infection.

Ensuring that the gender dimension of HIV is effectively addressed requires an approach that integrates HIV with a broader approach to sexual and reproductive health including interventions that focus on underlying causes of gender inequality. The Revised Pacific Platform for Action on Advancement of Women and Gender Equality 2005 to 2015 provides the policy context for addressing the causes of gender inequality.¹⁰

The Pacific Platform, which was adopted at the second Pacific Ministers' Meeting on Women attended by 20 PICT in 2004, outlines commitments against four strategic themes: mechanisms to promote the advancement of women; women's legal and human rights; women's access to services; and the economic empowerment of women. Across each of these themes, eradication of poverty is a focus. HIV and AIDS is recognised in the Pacific Platform as a critical emerging issue affecting women.

There are a number of ways to more specifically and effectively address gender in the strategic response to HIV. Many of these were identified in preparing the Pacific Plan. They include:

- integrating HIV into sexual and reproductive health within strengthened primary health care services (including access to HIV/STI testing and treatment)
- developing legal safeguards that protect human rights in regard to sexual and reproductive health
- promoting reforms to laws and social policies that inhibit women's economic independence (e.g. property and inheritance laws)
- engaging political, religious and traditional leaders in challenging beliefs that reinforce gender inequality
- engaging men as partners in addressing gender inequality
- ensuring women are effectively targeted in prevention campaigns
- ensuring surveillance and data collection reflects gender aspects
- the development of a gender audit tool by the United Nations Development Fund for Women (UNIFEM)

During the conduct of this review, there was strong support for addressing gender issues and specific interventions were reported on. Projects targeting women are the third largest group (after youth and sex workers) in competitive grants administered through PRHP. The relationship between human rights and gender equality is a focus of the UNDP-funded RRRT. Men as partners projects were reported to be very effective in those countries where they were implemented.

Papua New Guinea, compared to other PICT, has in recent years more fully investigated the implications of gender for developing a comprehensive, effective approach to addressing HIV.* Numerous research and evaluation studies have been undertaken, existing policies and strategies have been reviewed, and a draft national policy and a draft strategic plan on gender and HIV have been developed.

The strategic approach adopted is underpinned by mainstreaming and integration of gender in a programmatic approach. As described in a report on strengthening a gendered approach, "Mainstreaming for gender and HIV and AIDS itself involves two strands: mainstreaming gender into specific HIV and AIDS programming and mainstreaming 'gender and HIV and AIDS' across sectors as part of a multi-sectoral approach".¹¹

The above report also notes that mainstreaming "must be teamed with targeted programmes for women and girls (or men and boys, in aspects where they are disadvantaged)".¹² This is consistent with findings from consultations undertaken in this

* Although PNG has developed a national strategic plan to address gender and HIV AND AIDS, it is reported that the level of gender expertise in PNG is low, and that the gender capacity of the Women's Division, Department of Community Development and of the National Council of Women has declined over the past two years.

review. Many of those consulted expressed a strong commitment to (though sometimes limited understanding of) addressing gender but uncertainty as to how this could be translated to action.

To promote a programmatic approach to gender, the PNG gender strategy includes a situational analysis of each of the key focus areas of the broader national strategic plan and identifies actions (gender strategies).

Some of the priorities, both organisational and issue-based, in the PNG gender strategy are likely to be identified as such more generally in the Pacific context (e.g. developing a gender mainstreaming framework, leadership and gender-based violence). However, a more detailed situational analysis and review of existing strategies at regional and PICT levels are required in order to identify priorities.

Immediate actions that should be undertaken to more specifically address gender in the context of the regional strategy are:

- employ a gender specialist focusing on HIV and STIs in one of the Pacific Regional Strategy implementing agencies
- establish a gender team across regional agencies
- undertake a situational review/assessment of gender in the context of HIV in the Pacific
- integrate a specific consideration of gender in developing the next strategy implementation plan (program implementation framework)
- assist PICT in integrating gender into program planning

In developing the next regional strategy, gender should be included as a key planning issue.

7.1.2 Improved Coordination and Management of the Regional Strategy

Despite the number of coordinating, implementing and donor agencies at the regional level, coordination between most is relatively good. There is strong commitment from most to work cooperatively and, in so doing, minimise duplication of effort. PRSIP, while not necessarily an effective planning tool, has provided a framework to coordinate activities. The major gap in coordination is the limited involvement by agencies responsible for US or French jurisdictions.

Theoretically, combining the management of activities carried out by SPC and PRHP would enhance coordination (a recommendation made for other reasons in this report). However, there is already good communication between the two.

There are some initiatives, raised during consultations, that could further enhance coordination. They include:

- circulating reports on PICT visits by different agencies in order to share information gained
- sharing schedules for PICT visits to reduce burden on key people at the country level
- considering joint missions to PICT when objectives overlap

There are many agencies at the regional level, often with overlapping functions, which creates confusion at a PICT level in determining the most appropriate points of

communication. Opportunities to access resources (information, financial, technical) or simply share information are consequently wasted.

The establishment of a focal resource centre at the regional level, which could be both a referral point to other agencies and a distribution point for information, could improve communication between regional and PICT agencies.

Adoption of a common program framework would also enhance communication. It would allow agencies at a PICT level to more easily identify entry points to source information and resources. This would occur through:

- using standard terminology
- identifying key contacts
- specifying technical and other resources available
- facilitating comparison of policies and programs in different PICT across the region

7.1.3 National HIV Plans and Mainstreaming

UNAIDS has defined mainstreaming in relation to HIV and AIDS as:

“.. a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within the workplace”.

Mainstreaming is important because policies and practices across different sectors:

- frame HIV risk and vulnerability (e.g. mobile populations are more likely to engage in sex with different partners because of physical separation from regular partners)
- impact on health seeking behaviours (e.g. discriminatory employment practices are a barrier to people testing for HIV)
- affect the care and support of people living with HIV (e.g. availability of income and housing assistance)
- contribute to underlying vulnerability (e.g. issues related to gender, culture, education)

At a fundamental level, HIV and AIDS is not only a health crisis but also a crisis that fundamentally threatens the development aspirations of those nations most affected. In many parts of the world, economies have been devastated and basic social service sectors such as health and education are collapsing. HIV and AIDS is a disease that disproportionately infects youth, particularly those of child-bearing age. The death of parents has left millions of children orphaned, with little hope of a supportive upbringing.

National HIV plans should facilitate mainstreaming efforts rather than impede them. Planning should engage actors from other sectors and identify key points of entry into other sector policies and programs as well as broader national development plans.

Initiatives at both regional and PICT levels in the Pacific have contributed to mainstreaming. At the regional level, activities described under leadership and governance in this report have helped establish a core group of advocates in other sectors for inclusion of HIV considerations. Funding provided for RRRT has contributed to consideration of HIV at a regional and PICT level in the context of human and associated legal rights. Examples at a PICT level also include the adoption of a strategic plan for responding to the impact of HIV and AIDS on women in Samoa.

Mainstreaming needs to occur on the basis of a realistic assessment of capacity and priorities. Attempts to be very broadly inclusive of other sectors (despite HIV having potential impact in all sectors) have arguably had negative consequences in the Pacific. These include:

- National AIDS Councils/Commissions with membership from a very broad range of sectors being unfocused and suffering from lack of commitment, as reflected in poor attendance
- strategic plans being overly ambitious and too abstract to clearly identify priorities and provide operational direction

Focusing mainstreaming efforts on those sectors most relevant to current program priorities may have the greatest impact on the HIV response and reduce the risk of diluting effort given limited capacity. In addition to health, this would include cross-cutting themes such as gender, human rights, religion and culture, and sectors such as education and labour. Broader leadership initiatives such as the Asia–Pacific Leadership Forum, involvement in the Pacific Parliamentary Assembly on Population and Development and activities associated with the Pacific Islands Forum should be continued to maintain wider support.

Regional agencies that operate across sectors should play a leadership role in mainstreaming. They include SPC, UNAIDS and UNDP. Consideration should be given to identifying sector priorities for national development plans that can inform action in specific sectors. This would assist PICT identifying priorities for mainstreaming.

7.1.4 Papua New Guinea

In general, the key findings of this report do not relate to Papua New Guinea. The sheer scale of the epidemic in that country necessitates a response that would overwhelm consideration of other PICT. Significant resources are being allocated by aid donors to assist in that response.

There are, however, potential linkages in the Pacific regional strategy that can benefit PNG as well as providing opportunities for other PICT to learn from the PNG experience.

Regional strategies aimed at building an enabling environment to support the implementation of a multi-sectoral response to HIV are relevant to PNG. Common issues include:

- building high-level political support
- strengthening the role of faith based organisations
- undertaking NGO capacity development, particularly in regard to advocacy
- utilising regional sporting and cultural events to promote HIV awareness
- integrating gender into strategic responses
- addressing broader multi-sectoral and development dimensions of HIV

The impact of HIV in PNG is seen by many PICT as representing the threat that they themselves face. There is a keen interest in learning from the successes and failures of PNG.

Perhaps the greatest challenge PNG has faced in recent years has been scaling up the HIV response so as to have a significant impact at a population level. This challenge on a smaller scale at this stage confronts all PICT.

It is not possible on the basis of consultations undertaken over two days to make any realistic assessment of the successes and failures of PNG in scaling up its response. However, there is evidence that, over the past three years, the number of people on ART has increased significantly, a systematic approach is being implemented that will establish the infrastructure necessary to provide VCCT and care/support services accessible to the majority of PNG citizens, and widespread HIV awareness is being achieved. There is also some evidence of a reduction in risk behaviour (though largely anecdotal).

Regional strategies aimed at promoting an enabling environment should include PNG. Policies, protocols and systems adopted in scaling up access to services in PNG should be considered in program design in other PICT. Opportunities for staff from other PICT to undertake placements in PNG should be investigated in the context of capacity development.

7.1.5 The Way Forward and Recommendations

Key directions in revising the regional strategy over the next two years are:

- mobilisation of resources to sustain the response to HIV and STIs in the period after 2008
- an increased focus on scaling up access to quality services (particularly prevention and STI services) at the PICT level
- an integrated approach to HIV and STIs through closer alignment between the HIV strategy and the Adolescent Health and Development Program, focusing on HIV/STI education and sexuality/family life education for school-based and out-of-school youth
- adoption of more systematic and coordinated planning focused on operational objectives
- integration of capacity building into ongoing collaboration/support arrangements
- a more focused approach on key sectors and cross-cutting issues in mainstreaming
- more flexibility in interpretation of the concept of one national AIDS authority
- mainstreaming gender into the strategic and program response
- provision of sufficient funding to ensure at least one NGO in each PICT has capacity to implement high-quality prevention programs

Sustaining funding to support the response to HIV and AIDS in PICT is a key action outlined in the Pacific Regional Strategy. We have recommended that priority be given to assisting PICT in seeking funding through round seven of GFATM and in undertaking operational planning to form the basis of a Pacific strategy in the period after 2008 (see sections 6.1.2 and 6.1.3).

An increased focus on scaling up access to quality services (particularly prevention and STI services) at the PICT level is necessary to avoid early escalation of the HIV epidemic in the Pacific. Given the high rates of STIs in many PICT, broadly targeted prevention programs are required. However, additional priority needs to be given to population groups at higher risk of HIV prevention who act as bridging populations to the wider community. Health education and behaviour change strategies also need to be linked with strategies to maximise access to condoms, STI service delivery and VCCT as part of a comprehensive prevention response.

The extent to which HIV or other STIs need to be prioritised will vary between different strategy components. While other STIs are a significant cause of morbidity, they do not fundamentally threaten the development aspirations of PICT. HIV does and therefore should be the key focus of initiatives to develop strong national and multi-sectoral leadership.

The focus given to HIV or other STIs in prevention strategies will depend on the specific objectives of programs and projects. Risk of HIV **may** be a greater motivation for individual behaviour change. However, increased understanding of STIs may be necessary to promote access to STI diagnosis and treatment.

Both HIV treatment access, and access to STI diagnosis and treatment need to be prioritised. However, the high prevalence of STIs in many PICT may be a greater challenge for service delivery.

The objectives of the HIV strategy and the Adolescent Health and Development Program largely overlap in relation to youth. The Adolescent Health and Development Program includes coverage of HIV/STIs and family life/sexuality education for school-based and out-of-school youth. Priorities noted above for the remaining years of the HIV strategy have a strong focus on STI prevention, diagnosis and treatment. A joint programming approach should be adopted between the HIV strategy and the Adolescent Health and Development Program in areas of common coverage. Consideration should be given to providing additional funding to the Adolescent Health and Development Program to expand the PICT currently covered.

An effective response to HIV and STIs is primarily dependent on implementation at the PICT level. PRSIP is the framework for implementation of the regional strategy. If it is to be maintained in its current form, activities that support PICT implementation (e.g. support for monitoring/evaluation, availability of training) should be better grouped to allow PICT to identify possible resources.

The adoption of a common program framework at regional and PICT levels has been recommended in this report as a mechanism to address a range of issues that will also contribute to PICT implementation. They include improved planning, coordination and reporting, as well as better harmonisation of funding and technical assistance (including role delineation). By focusing on service delivery and related infrastructure/support requirements, it can also facilitate better linkages through clearer communication between regional and PICT levels.

It is not intended that one agency has centralised responsibility for implementing PRSIP. However, on the basis of joint planning, activities would be prioritised and agreement reached on implementation arrangements.

There is a discernible gap at PICT level between the broad policy settings (which are largely in place) necessary for an effective response to HIV and STIs, and the operational policies and guidelines necessary for scaling up access to services. Operational policies and guidelines identify minimum service levels, describe roles and responsibilities of different service providers, and linkages between different levels of the system (e.g. national pharmacy services and client service providers), and outline management systems for sustaining the system response.

Operational policies and guidelines facilitate a systematic approach to funding, training and monitoring/evaluation. Without operational policies and guidelines, any attempt to scale up access will be ad hoc.

While generic planning and specific health planning capacity exists in most PICT, assistance is required in translating the technical aspects of HIV and STIs into an operational response. This operational response needs to take account of existing service delivery systems and resources available. Opportunities to benchmark system responses across PICT can also contribute to ongoing quality improvement.

There is limited capacity in most PICT to adopt a broad multi-sectoral approach. Priority needs to be given to those sectors and issues that impact most on risk and vulnerability.

Most PICT have interpreted the principle of one national AIDS authority to mean a national AIDS committee with broad, high-level, multi-sectoral representation. In most if not all PICT, these national AIDS committees are dysfunctional. While there should be adherence to one governance structure, there should be flexibility in determining the most effective organisational arrangements.

Addressing the gender dimension of HIV is fundamental to addressing underlying causes of risk and vulnerability. It requires specific consideration in all aspects of planning, including strategy, programs and projects. It needs to be integrated through institutional frameworks and human resource capacity development.

Existing processes adopted at the regional level for capacity development in PICT need to be integrated into ongoing support arrangements. The current approach to capacity development is dominated by one-off skills development workshops and short-term assistance in planning exercises. Most stakeholders consulted in undertaking this review commented that this approach:

- is too generic and needs to be tailored to specific local contexts
- places too high a learning demand in too short a period of time and should be complemented by refresher training
- is too abstract and would benefit from being integrated into the design and delivery of actual projects
- is often delivered to the wrong people
- does not provide ongoing support for participants to resolve problems that arise when implementing projects based on learning from workshops

Solutions proposed during consultations included training delivered at service delivery sites, training integrated into project/service design and delivery, staff attachments with comparable services/projects, and other ongoing mentoring arrangements. Consideration also needs to be given to accreditation processes through institutions such as the Fiji School of Medicine or the WHO Pacific Open Learning Health Network (POLHN).

Support/mentoring relationships need to be established between individuals at regional and PICT levels around key components of program implementation. It was noted during consultation that this is already happening around ART and is contributing to greater preparedness and improvements in actual service provision. Development of teams across agencies at the regional level will strengthen capacity to establish such relationships.

The Mid Term Review was primarily based on consultations within PICT and with regional implementing agencies. There was limited time available for extensive desk research. Within these limitations, it was observed that PRHP, among other achievements, has been instrumental in the development of PICT strategies involving extensive participation by government and civil society organisations as well as building a sound basis for, and strengthening the involvement of civil society involvement in strategy implementation. However, maintaining separate management arrangements – with its associated costs for activities funded through PRHP and SPC – may no longer be required.

At the commencement of the current strategy, there was a quasi separation of functions between SPC and PRHP. PRHP was primarily focused on program delivery at the PICT level, while SPC was more focused on developing the regional strategy and associated linkages. In the period since then, SPC has become increasingly focused on supporting activity at a PICT level. If funding is to be made available for development of a new strategy and implementation plan post 2008, consideration should be given to amalgamating functions that are currently separately administered through PRHP and SPC. The role of SPC as an agency of PICT should be taken into account in determining the most appropriate auspice organisation.

The NGO sector has a special role in broad policy advocacy as well as delivery of prevention programs targeted at most at-risk populations. In regard to policy, unlike government ministries, NGOs are not limited by the mandates of elected governments. They also have direct access to population groups whose behaviour may place them in conflict with other aspects of government policy (e.g. sex workers, MSM).

During consultations it was observed that those NGOs that are most effective in advocacy and/or highly targeted prevention met one or more of the following criteria:*

- were highly focused on HIV as their core work (e.g. Samoa AIDS Foundation, AIDS Task Force of Fiji)
- had a lengthy history of extensive HIV involvement (e.g. Vanuatu One Small Bag)
- had extensive international experience working on HIV (e.g. Save the Children Fund and Oxfam in Solomon Islands)

To enhance quality of advocacy and prevention programming in the NGO sector, sufficient funding should be made available to at least one lead NGO to support a critical mass of staff and projects.

It was also observed that countries where these NGOs were also CDOs had a better partnership between government and non government sectors. It is recommended that these observations be considered in the upcoming review of CDOs to be conducted by PRHP.

The role of NGOs at regional and PICT levels would benefit from better coordination. Despite funding for a regional NGO network, coordination is currently weak. Investigation as to why this is the case should occur and if necessary consideration be given to alternative arrangements (e.g. biannual rotation of host organisation).

* Agencies listed often met more than one of the criteria.

RECOMMENDATIONS

Leadership and Governance

1. That a multi-sectoral response to HIV and AIDS focus on consolidating broad political awareness and capacity for advocacy regarding the potential development threat of HIV and prioritise interventions on those themes and sectors where action is of most immediate relevance and/or preparedness is most important. At the regional level and in all PICT, those themes will include gender, human rights, religion and culture. Sectors will include (in addition to health) education, justice, uniformed services, and transport (including maritime services).

2. That in PICT, the principle of one national AIDS authority be interpreted as common agreement to institutional arrangements for governance. The objectives of those arrangements are:

- active participation in decision making
- facilitating partnership between government and civil society agencies in planning and coordination
- ensuring the best available expertise and experience are utilised in decision making
- enhancing multi-sectoral involvement
- enhancing collaboration between and within sectors
- strengthening high-level leadership support for addressing HIV

Mechanisms adopted to achieve these objectives should be guided by principles of accountability, transparency and partnership and based on a realistic assessment of the resources required and available for different governance structures.

3. That existing measures to strengthen the involvement of positive people be closely monitored and remedial action taken if they are not effective.

Access to Quality Services

4. That a common program framework for implementation plans be promoted at regional and PICT levels. The HIV/STI program framework will include the following components:

- prevention
- clinical services (ART, STIs, VCCT, procurement, laboratory)
- care and support
- governance (organisational structures including coordination and funding arrangements including resource mobilisation)
- enabling environment (leadership projects, community development, gender, national development)
- capacity development (human resources, institutional strengthening)
- strategic information (surveillance, monitoring/evaluation, behavioural/social research, operational research)

5. That the common program framework incorporate planning based on the following processes:

- setting operational objectives
- establishing quantifiable targets necessary to achieve operational objectives
- identifying mechanisms to achieve targets
- assessing the costs and benefits of different mechanisms
- determining the human and financial capacity needs to develop/strengthen selected mechanisms
- establishing policies, protocols and guidelines to implement programs
- developing monitoring and reporting systems, including quality management and improvement processes
- adopting implementation plans specifying inputs, outputs, timelines, roles and responsibilities, and costings

6. That universal access to ART for those who need it be adopted as an urgent and key objective of the Pacific Regional Strategy on HIV and AIDS.

7. That over the remaining years of the Pacific Regional Strategy, increased priority be given to scaling up access to quality services (particularly prevention and STI services) at the PICT level.

Regional Coordination

8. That regional agencies involved in PRSIP move beyond coordination of separately developed implementation plans to joint planning within a common program framework.

9. That regional agencies involved in PRSIP develop joint work teams on common function areas, e.g. monitoring and evaluation.

10. That the PRHP website and SPC HIV and AIDS website be amalgamated to become the website for the Pacific Regional Strategy. It should include the proposed program framework and implementation plan. Against each component, a mix of the following information should be included:

- model policies, procedures and protocols developed regionally and by PICT
- comparative data from PICT against performance indicators
- outline of technical, financial or other support available
- key contacts
- links to other relevant information

Resources currently used by SPC and PRHP should be combined to implement this recommendation.

11. That a team working across regional agencies be established and develop a joint work plan to better coordinate and strengthen assistance to PICT in mainstreaming efforts.

Program Management

12. That scaling up STI services and HIV/STI prevention programs be a key focus of a funding proposal for round seven of GFATM. Prevention programming will include the priorities identified in the 2005 review of the Pacific Regional Strategy (i.e. a stronger focus on targeted outreach to vulnerable and higher-risk individuals,* condom advocacy,

* The analysis identified the following groups as vulnerable to and at increased risk of HIV transmission:

targeted distribution and social marketing, scaling up of voluntary confidential counselling and testing services including at ANCs, an aggressive approach to strengthening STI diagnosis and treatment, enhancement of targeted prevention of mother-to-child transmission programs).

The proposal should be based on detailed operational planning and costing in those countries intended to be included in the proposal. Assistance to PICT in developing the proposal should be a key priority in the first half of the 2007 PRSIP.

13. That a fully costed strategy and program implementation plan (utilising the framework recommended in this report) be developed for the five-year period post 2008. This would include identification of those functions that can be best done regionally in line with the principles of the Pacific Plan and those that should be implemented at a PICT level. Over the five-year period 2008–2013, funds provided to the Pacific Regional Strategy to supplement PICT-level core functions should be allocated according to an agreed formula. Such a formula would include demographic factors, HIV risk and vulnerability, availability of bilateral donor funds and development need. Conditions of funding would include governance arrangements that provide for equitable participation by civil society organisations, including access to grants.

14. That the establishment of a common fund for receiving donor funds for the regional strategy be considered by regional agencies and donors. Utilising the existing infrastructure established for GFATM could be considered.

15. That, following the conclusion of existing funding arrangements, consideration be given to amalgamating functions currently separately administered for PRHP and the Pacific Regional Strategy. The role of SPC as an agency of PICT should be considered in determining the most appropriate auspice organisation.

16. That a joint programming approach be adopted between the HIV strategy and Adolescent Health and Development Program in areas of common coverage. These include HIV/STI and sexuality/family life education targeted at school-based and out-of-school youth. Consideration should be given to providing additional funding to the Adolescent Health and Development Program to expand the number of PICT currently covered.

General

17. That, in order to more specifically address gender in the context of the regional strategy, the following actions be adopted:

- employ a gender specialist focusing on HIV and STIs in one of the Pacific Regional Strategy implementing agencies
- establish a gender team across regional agencies
- arrange a situational review/assessment of gender in the context of HIV in the Pacific

-
- commercial seafarers and their partners
 - individuals with sexually transmitted infections
 - internationally and internally mobile populations
 - individuals who engage in “transactional” sexual practices with multiple sexual partners
 - men who have sex with men

Priority interventions required were noted as: behaviour change communication, HIV and STI related counselling and support, and reliable access to simple and rapid diagnostic testing and condoms.

- ensure specific consideration of gender occurs in developing the next strategy implementation plan (program implementation framework)
- assist PICT to integrate gender into program planning

In developing the next regional strategy, ensure the findings of the situational review/assessment of gender are considered.

18. That capacity development interventions, where possible, be specifically tailored to, and better integrated with PICT program interventions. This includes:

- training programs specifically tailored to PICT circumstances and needs
- more localised training provision
- integration of training into program/project implementation
- refresher training and follow-up assessment
- development of partnering and mentoring arrangements between PICT agencies and between regional and PICT agencies

Consideration also should be given to accreditation processes through institutions such as the Fiji School of Medicine or the WHO POLHN.

19. That, to enhance quality of advocacy and prevention programming in the NGO sector, sufficient funding be available to at least one lead NGO at a PICT level to establish a critical mass of staff and projects. This matter should be included in the upcoming review by PRHP of CDOs.

20. That NGOs review existing arrangements for the funding and functioning of a peak NGO organisation at the Pacific regional level.

APPENDIX ONE: PERSONS CONSULTED IN THE COURSE OF CONDUCTING THE MID TERM REVIEW OF THE PACIFIC REGIONAL STRATEGY ON HIV AND AIDS

Dr Dennie Iniakwala	Section Head, HIV and STI Section, SPC
Dr Gary Rodgers	Deputy Section Head, HIV and STI Section, SPC
Salli Davidson	Project Coordinator – HIV & STI Prevention and Capacity Development, HIV and STI Section, SPC
Kamma Blair	Monitoring and Evaluation Officer, HIV and STI Section, SPC
Robyn Drysdale	BCC Specialist, HIV and STI Section, SPC
Dr Janet Knox	STI Officer, HIV and STI Section, SPC
Nicole Gooch	HIV and STI Communications Officer, HIV and STI Section, SPC
Thierry Jubeau	Public Health Director, SPC
Linda Petersen	Women’s Development Adviser, SPC
Tom Kiedrzynski	Epidemiologist, SPC
Viliani Puloka	Physical Activity Adviser, SPC
Janet O’Conor	TB programme Adviser, SPC
Bill William Parr	Global Fund Coordinator, SPC
David Gowty	Planning Adviser, SPC
Richard Mann	Director, Corporate Planning, SPC
Dr Timaima Tuiketei	Director, Public Health, MOH (Fiji)
Dr Sulueti Duvaga	ARH Coordinator, MOH (Fiji)
Dr Joe Samuela	Asst Director Public Health, MOH (Fiji)
Dr Mosese Salusalu	HIV and AIDS Coordinator, MOH (Fiji)
Dr Tevita Marau	Fiji Family Health Association
Dr Jiko Luveni	FJN+
Tuberi Cati	FJN+
Emosi Ratini	FJN+
Jane Keith-Reid	AIDS Task Force Fiji
Luisa Tora	AIDS Task Force Fiji
Niraj Singh	AIDS Task Force Fiji
Robin Taylor	AIDS Task Force Fiji
S/N Serena	AIDS Task Force Fiji Clinic
Carlos Perera	Equal Ground Pacific
Apolosi Vosanibola	Fiji Pharmaceutical Services, MOH (Fiji)
Hasan Khan	Fiji Council of Social Services
Asiana Shah	Fiji Council of Social Services
Stuart Watson	Pacific Program Coordinator, UNAIDS
Jone Vakalalabure	UNAIDS
Steven Vete	APLF Sub Regional Coordinator, UNAIDS
Elizabeth Cox	Regional Program Director, UNIFEM

Laisa Bale-Tuinamoala	UNIFEM
Dr Manish Pant	Regional Director, International Federation Red Cross
Michael Sami	Mari Stopes International Pacific
Judith Leveille	Project Officer, UNICEF
Dr Helen Tavola	Social Policy Advisor, Pacific Islands Forum Secretariat
Monica Fong	Human Resource Development Policy Officer, Pacific Islands Forum Secretariat
Fe'iloakitau Kaho Tevi	Executive Secretary, World Council of Churches Office in the Pacific
Dr Seng Sopheap	HIV and AIDS/STI Focal Point, WHO
Dr Rufina Latu	Adolescent Sexual and Reproductive Health Pacific Coordinator, SPC
Larry Thomas	Coordinator, Regional Media Centre, SPC
Captain John P.B. Hogan	Maritime Program Coordinator, SPC
Virisila Raitamona	UNDP
Richelle Tickle	Pacific Projects Coordinator, AusAID

Ilisapeci Monovo	Pacific Program Manager Health Development, AusAID
Dr Setariki Vatucawaqa	Assistant Representative, UNFPA
Dr Wame Baravirala	UNFPA
Dimitri Geidelberg	NZAID
Tamara Aboagye-Kwarteng	Team Leader, PRHP
Jerry Cole	Grants Scheme Manager, PRHP
Salaseina Tupou	Project Officer, PRHP
Jocelyn Deo	Office Administrator, PRHP

Andrew Peteru	Director of Health Promotion, MOH (Samoa)
Ken Moala	Executive Director, Samoa AIDS Foundation
Siaosi Mulipola	Samoa AIDS Foundation
Fitu Fuimaono	Project Manager, Samoa AIDS Foundation
Peati Malaki	AIDS Ambassador, Samoa AIDS Foundation
Silipa	Samoa AIDS Foundation
Roina Faatauvaava-Vavatuva	Chief Executive Officer, Samoa Umbrella for Non Government Organisations
Dr Asawa Fousino	WHO
Stephan Terras	WHO
Mr Kamu	Division of Women
Jason Malietoa	Division of Women
Uales Heaps	Health Promotion, MOH (Samoa)
Dr Sineva Sinclare	HIV and AIDS Officer, MOH (Samoa)
Apineru Peniamina	Samoa Family Health Association

Sue Kelly	Director, Pacific Health, Education and Environment Section, AusAID
Paula Henrikson	Program Manager, Health & HIV AND AIDS, Education and Environment Section, AusAID
Ursula Carolyn	Health Team, Education and Environment Section, AusAID
Corinne Tarnawsky	Health Team, Education and Environment Section, AusAID
Bernard Pearce	Assistant Director, HIV Task Force, AusAID
Alexandra Robinson	Aid Expert, Health, Population and Gender Section, International Branch, AusAID
Susan Ivatts	AusAID
Rob Condon	Public Health Physician
Dr Clement Malau	Burnett Institute

Imaima Havea	Executive Director, Tonga Family Health Association
Dr Liliti Ofanova	Director of Health, MOH (Tonga)
Dr Ake Malake	Director of Public Health, MOH (Tonga)
Dr Luisa Fonua	HIV/STI Officer
Savoi Penitaio	HIV/STI Officer
Elaine Howard	Tonga National Youth Congress
Manitasi Leger	Tonga National Youth Congress
Fatai Tokolahi	Tonga National Youth Congress
Moana Kioa	Tonga National Youth Congress
Betty Blake	Legal Literacy Project
Sr Kit Ann Kanougataa	Consultant
Edgar Cocker	Civil Society Association
Ashley Fua	Police Academy
Rev Fili Lilo	Tonga Life Line/Langikapo
Drew Havea	Tonga National Youth Congress
Rev Siketi Tonga	Tonga National Council of Churches
Simoine Silapelu	Tonga National Association of NGOs
Safely Lavelua	Salvation Army
'Oneto Vanisi	Central Planning Department (Tonga)
Dr George Malefoasi	Under Secretary for Health Improvement, MOH (Solomon Islands) NAC
Dr John Paulsen	Health Improvement, MOH (Solomon Islands)
Isaac Muliloa	Health Improvement, MOH (Solomon Islands)
Elliot Paiahi	Counsellor, MOH (Solomon Islands)
Alby Lovi	Health Promotion, MOH (Solomon Islands)
Junilyn Pikacha	Reproductive Health, MOH (Solomon Islands)
Dr Tenneth Dalipanda	National Referral Hospital (Solomon

	Islands)
William Horoto	National Medical Store
John Kelleher	Country Director, Solomon Islands Oxfam
Rose Maebiru	Save the Children Fund
Judith Fananlasu	Solomon Islands Christian Association
Frank Rodie	Ministry of Education (Solomon Islands)
Josephine Teakeni	Vis Belong Meri
Sarah Dyer	National Council of Women
Ella Kouhue	National Council of Women
Sister Julie	Caritas
Gibson Ado	Prison Services (Solomon Islands)
Dina	Prison Services (Solomon Islands)
Cherry Galo	Adventist Development Relief Agency
Dr Leigh Trevillian	Health Sector Adviser, AusAID (Solomon Islands)
Myriam Abel	Director General, MOH (Vanuatu)
Marina Laklotal	MOH (Vanuatu)
Joe Kalo	MOH (Vanuatu)
Dr Daniel Wanja	Volunteers Working for a Better World
Moses Matovu	Volunteers Working for a Better World
Hugh MacLeman	Country Director, Volunteers Working for a Better World
	PLWHA
	Vanuatu Rural Development Training Centres
Siula Bulu	Wan Smol Bag
Dr Corinne Capuano	Country Liaison Officer, WHO (Vanuatu)
Melissa Pearson	Senior Program Officer, AusAID (Vanuatu)

Nicky Rattle	Red Cross (Cook Islands)
Julianne Westrupp	Red Cross (Cook Islands)
Vereara Maeava	Cook Islands Association of Non Government Organisations
Luisa Nicholls	Cook Islands Association of Non Government Organisations
Jeannine Samil	Ministry of Finance (Cook Islands)
Dr Raro Daniel	Secretary of Health/CEO, MOH (Cook Islands)
Edwina Tangoroa	Health Educator, MOH (Cook Islands)
Marie Bopp	Executive Director, PIAF
Zoe Blake-Paterson	Communication Officer, PIAF
Yi Ching Chua	PIAF
Pia Bustos	PIAF
Debbie Fisher	Ministry of Education
Tavae Tuava	Family Welfare

Bernadette Schuman	Health Department, Guam
Brenda	Epidemiologist
Alex Silverio	Guahan Project
Gerhard Schwab	University of Guam

Johnny Habel	MOH (FSM)
Judy Gold	Burnet/PRHP Consultant
Susie Yom	Red Cross
Morgan David	Red Cross
Nena Nena	Department of Health, Education & Social Affairs (FSM)

Dr Airam Metai	MOH (Kiribati)
Dr Kynuna	MOH (Kiribati)
Dr Teatao Tiira	HIV and AIDS Officer
Kirata Aisai	Kiribati Islands Overseas Seafarers Union
Yuleba Tekee	Kiribati Islands Overseas Seafarers Union
Ioteba Nirakina	Family Planning
Roko Timeon	Kiribati Association of Non Government Organisations
John Collins	Kiribati Association of Non Government Organisations
Buraua Otimwemwe	Kiribati Association of Non Government Organisations
Pamela Messervy	WHO
Tekaniuea Uriam	Maritime Training College
Komera Otea	Foundation of the People of the South Pacific

Dr Ninkama Moiya	Director, NAC
David Passirem	Community Care & Counselling Advisor, NAC
Roslyn, Lady Moratu	PNG Alliance of Civil Society Organisations Against HIV AND AIDS (PASCO)
Noah Ariku	PACSO
Cheryl Kelly	Team Leader, Cardno Acil National HIV AND AIDS Support Project
Christine Bradley	Gender Consultant
Peter Momas	Igat Hope

The following meetings were attended by the team leader to present the draft report and receive feedback.

SPC Public Health Program Review reference group meeting – Noumea, New Caledonia	11–13 October 2006
Pacific Island Regional Country Coordinating Mechanism (GFATM) meeting – Nadi, Fiji	16–19 October 2006

Pacific Regional Strategy Implementation Plan annual joint planning meeting, Suva, Fiji	26 October 2006
SPC 36 th Meeting of the Committee of Representatives of Governments and Administrations – Noumea, New Caledonia	16 November 2006

APPENDIX TWO: METHODOLOGY

The methodology adopted was prescribed in the terms of reference for the Mid Term Review of the Pacific Regional Strategy on HIV and AIDS (2004–2008). The methodology was:

1. review of relevant documentation
2. consultation with regional partners
3. consultation with national partners

The review was conducted by a three-member team. David Fowler was the team leader. The other team members were Sister Vika Tikinatabua and Bill O’Loughlin. All team members were involved in conducting consultations prior to the submission of the first draft report. David Fowler presented and received feedback on the first and second draft reports. The report and its recommendations are endorsed by each of the team members.

Stage One

The review commenced on 7 August 2006.

Review of relevant documentation. Key documents reviewed were:

- the Pacific Regional Strategy on HIV and AIDS (2004–2008)
- the Pacific Regional Strategy Implementation Plan
- the UN integrated work plan and joint programming 2006–2011
- the PRHP annual reports and work plans
- PICT national strategies on HIV and AIDS
- key GFATM reports
- main ADB planning documentation

A range of other documents providing further information relevant to HIV and AIDS in the Pacific region and the activities implemented in response were also reviewed.

Consultation with regional partners. During the first week of the review, consultations were held with Pacific Regional Strategy staff at SPC as well as with staff working in other sections. Interviews were conducted with individuals and teams.

Interviews were conducted with regional partners during the second week of the review. Interviews were again conducted with teams and individuals. Generally interviews followed a semi-structured format around key questions and issues reflecting the terms of reference for the review.

Interviews were conducted with PICT partners from 28 August till 4 October. Interviews were conducted with teams and individuals and generally followed a semi-structured format around key questions and issues reflecting the terms of reference for the review. The team split up to conduct PICT visits. However, the initial visits to Fiji and Samoa were conducted by all three team members to ensure a common approach on subsequent visits to other PICT.

The team met frequently during the period to discuss common themes and issues arising from the consultations.

Stage Two

A first draft report was submitted to SPC in early October. The draft was circulated to regional and national partners for feedback. The team leader attended the following meetings to present the first draft report and receive feedback:

- SPC Public Health Program Review reference group (11–13 October)
- Pacific Island Regional Country Coordinating Mechanism (GFATM) Meeting (16–19 October)
- PRSIP annual joint planning meeting (26 October)

Stage Three

A second draft was forwarded to SPC on 9 November. It was presented to a meeting of the Committee of Representatives of Governments and Administrations on 14 November.

Following further feedback, the final report was submitted to SPC at the end of November 2006.

APPENDIX THREE: IMPLEMENTATION OF MID TERM REVIEW RECOMMENDATIONS

This appendix describes the implications of the recommendations of the Mid Term Review for PRSIP and the next Pacific Regional Strategy on HIV and AIDS. It also identifies some actions that should be undertaken in ongoing interventions.

SPC, as the commissioning agent of the review, will develop a more detailed implementation plan. This will be in the context of identifying its response to the recommendations and how it intends to implement those it adopts.

RECOMMENDATION	2008 PRSIP	2009–2014 STRATEGY	OTHER
<p>1. That a multi-sectoral response to HIV and AIDS focus on consolidating broad political awareness and capacity for advocacy regarding the potential development threat of HIV and prioritise interventions on those themes and sectors where action is of most immediate relevance and/or preparedness is most important. At the regional level and in all PICT, those themes will include gender, human rights, religion and culture. Sectors will include (in addition to health) education, justice, uniformed services, and transport (including maritime services).</p>	<ul style="list-style-type: none"> • Activities aimed at strengthening political leadership are consolidated. • Activities targeting other sectors or multi-sectoral are prioritised. 	<ul style="list-style-type: none"> • Principle of multi-sectoral approach is endorsed. • Priority sectors across region are identified. • Criteria for prioritising other sectors at national level or adding over time are stated (e.g. preparedness, risk, vulnerability, relationship to national development). 	<p>Assistance provided to PICT in strategy or program planning integrates recommendation. This would include, for example, support given by PRHP to PICT in strategic planning.</p>

<p>2. That in PICT, the principle of one national AIDS authority be interpreted as common agreement to institutional arrangements for governance. The objectives of those arrangements are:</p> <ul style="list-style-type: none"> • active participation in decision making • facilitating partnership between government and civil society agencies in planning and coordination • ensuring the best available expertise and experience are utilised in decision making • enhancing multi-sectoral involvement • enhancing collaboration between and within sectors • strengthening high-level leadership support for addressing HIV <p>Mechanisms adopted to achieve these objectives should be guided by principles of accountability, transparency and partnership and based on a realistic assessment of the</p>		<p>The objectives and principles outlined in the recommendation are integrated into the strategy.</p>	<p>Objectives and principles inform assistance provided to PICT in developing governance structures.</p>
--	--	---	--

resources required and available for different governance structures.			
3. That existing measures to strengthen the involvement of positive people be closely monitored and remedial action taken if they are not effective.	Activities are modified if existing measures ineffective.	Principle of Greater Involvement of Positive People is endorsed.	Ensure measures are in place in annual evaluation to assess effectiveness of existing measures.
4. That a common program framework for implementation plans be promoted at regional and PICT levels. The HIV/STI program framework will include the following components: <ul style="list-style-type: none"> • prevention • clinical services (ART, STIs, VCCT, procurement, laboratory) • care and support • governance (organisational structures and funding arrangements) • enabling environment (leadership projects, community development, gender, national development) • capacity development (human resources, 	PRSIP is developed in common program framework.	Program objectives are included.	PICT are assisted in framing existing programs in common framework. PICT developing new programs are encouraged and assisted to adopt common framework. Regional agencies should commence mapping of activities against components, where practical, as a basic step in operational planning – e.g. ART services.

<ul style="list-style-type: none"> • institutional strengthening) • strategic information (surveillance, monitoring/evaluation, behavioural/social research, operational research) 			
<p>5. That the common program framework incorporate planning based on the following processes:</p> <ul style="list-style-type: none"> • setting operational objectives • establishing quantifiable targets necessary to achieve operational objectives • identifying mechanisms to achieve targets • assessing the costs and benefits of different mechanisms • determining the human and financial capacity needs to develop/strengthen selected mechanisms • establishing policies, protocols and guidelines to implement programs • developing monitoring and reporting systems, including quality management and 	<p>Processes are adopted in developing PRSIP.</p>	<p>Planning processes are endorsed.</p>	<p>Processes are integrated into PICT planning assistance.</p>

<p>improvement processes</p> <ul style="list-style-type: none"> adopting implementation plans specifying inputs, outputs, timelines, roles and responsibilities, and costings 			
<p>6. That universal access to ART for those who need it be adopted as an urgent and key objective of the Pacific Regional Strategy on HIV and AIDS.</p>	<p>Activities are included that ensure ART is available to all those who need it.</p>	<p>Universal access to ART is included as a principle in the strategy.</p>	<p>An implementation plan is developed by SPC in collaboration with regional partners that ensures universal access to ART is available within 12 months of this review.</p>
<p>7. That over the remaining years of the Pacific Regional Strategy, increased priority be given to scaling up access to quality services (particularly prevention and STI services) at the PICT level.</p>	<p>Increased coverage and quantifiable targets are included.</p>		<p>Allocation of discretionary funds (e.g. PRHP grants) is aligned with targets. Costing is developed to extend coverage to countries not included in ADB and NZAID grant. Round seven GFATM submission is developed (see recommendation 12).</p>
<p>That scaling up STI services and HIV/STI prevention programs be a key focus of a funding proposal for round seven of the GFATM. Prevention programming will include the priorities identified in the 2005</p>	<p>Activities funded through GFATM round seven are included.</p>		<p>Assistance is provided to PICT in developing fully costed proposals for inclusion in round seven submission.</p>

<p>review of the Pacific Regional Strategy (i.e. a stronger focus on targeted outreach to vulnerable and higher-risk individuals,* condom advocacy, targeted distribution and social marketing, scaling up of voluntary confidential counselling and testing services, an aggressive approach to strengthening STI diagnosis and treatment, enhancement of targeted prevention of mother-to-child transmission).</p> <p>The proposal should be based on detailed operational planning and costing in those countries intended to be included in the proposal. Assistance to PICT in developing the proposal should be a key priority in the first half of the 2007 PRSIP.</p>			
---	--	--	--

* The analysis identified the following groups as vulnerable to and at increased risk of HIV transmission:

- commercial seafarers and their partners
- individuals with sexually transmitted infections
- internationally and internally mobile populations
- individuals who engage in “transactional” sexual practices with multiple sexual partners
- men who have sex with men

Priority interventions required were noted as: behaviour change communication, HIV and STI related counselling and support, and reliable access to simple and rapid diagnostic testing and condoms.

<p>8. That regional agencies involved in PRSIP move beyond coordination of separately developed implementation plans to joint planning within a common program framework.</p>	<p>Mechanisms for development of PRSIP are based on joint planning.</p>	<p>Joint program planning is endorsed.</p>	<p>Mechanism is developed and agreed to in 1st quarter 2007.</p>
<p>9. That regional agencies involved in PRSIP develop joint work teams on common function areas, e.g. monitoring and evaluation.</p>			<p>Function areas are identified and joint work teams developed in 1st quarter 2007.</p>
<p>10. That the PRHP website and SPC HIV and AIDS website be amalgamated to become the website for the Pacific Regional Strategy. It should include the proposed program framework and implementation plan. Against each component, a mix of the following information should be included:</p> <ul style="list-style-type: none"> • model policies, procedures and protocols developed regionally and by PICT • comparative data from PICT against performance indicators • outline of technical, financial or other support available 	<p>Activities regarding website are included.</p>		<p>Websites are amalgamated in 1st quarter 2007.</p>

<ul style="list-style-type: none"> • key contacts • links to other relevant information 			
<p>11. That a team working across regional agencies be established and develop a joint work plan to better coordinate and strengthen assistance to PICT in mainstreaming efforts.</p>			<p>Team is established 1st quarter 2007. Joint work program is adopted.</p>
<p>12. That scaling up STI services and HIV/STI prevention programs be a key focus of a funding proposal for round seven of GFATM. Prevention programming will include the priorities identified in the 2005 review of the Pacific Regional Strategy (i.e. a stronger focus on targeted outreach to vulnerable and higher-risk individuals,* condom advocacy, targeted distribution and social marketing, scaling up of</p>	<p>Activities funded are included if proposal is successful.</p>		<p>SPC through the Global Fund team and HIV/STI team coordinate assistance by regional agencies to PICT in developing funding proposal.</p>

* The analysis identified the following groups as vulnerable to and at increased risk of HIV transmission:

- commercial seafarers and their partners
- individuals with sexually transmitted infections
- internationally and internally mobile populations
- individuals who engage in “transactional” sexual practices with multiple sexual partners
- men who have sex with men

Priority interventions required were noted as: behaviour change communication, HIV and STI related counselling and support, and reliable access to simple and rapid diagnostic testing and condoms.

<p>voluntary confidential counselling and testing services including at ANCs, an aggressive approach to strengthening STI diagnosis and treatment, enhancement of targeted prevention of mother-to-child transmission programs).</p>			
<p>13. That a fully costed strategy and program implementation plan (utilising the framework recommended in this report) be developed for the five-year period post 2008. This would include identification of those functions that can be best done regionally in line with the principles of the Pacific Plan and those that should be implemented at a PICT level. Over the five-year period 2008–2013, funds provided to the Pacific Regional Strategy to supplement PICT-level core functions should be allocated according to an agreed formula. Such a formula would include demographic factors, HIV risk and vulnerability, availability of bilateral donor funds and development need. Conditions</p>	<p>Planning processes established for 2008 PRSIP are the 1st stage of five-year program development.</p>	<p>Overall broad strategy is developed for endorsement at 2008 Pacific Islands Forum Leaders’ Meeting. Five-year, costed implementation plan is developed for endorsement at following CRGA meeting.</p>	<p>Discussions are undertaken with donors regarding in-principle support for next strategy and mechanisms to reduce timing gaps in adoption and implementation.</p>

of funding would include governance arrangements that provide for equitable participation by civil society organisations, including access to grants.			
14. That the establishment of a common fund for receiving donor funds for the regional strategy be considered by regional agencies and donors. Utilising the existing infrastructure established for GFATM could be considered.			
15. That, following the conclusion of existing funding arrangements, consideration be given to amalgamating functions currently separately administered for PRHP and the Pacific Regional Strategy. The role of SPC as an agency of PICT should be considered in determining the most appropriate auspice organisation.			This recommendation should be considered in the upcoming review of AusAID funding for PRHP.
16. That a joint programming approach be adopted between the HIV strategy and Adolescent Health and Development Program in areas of common	The SPC ARH project team should participate in the joint planning process.	The 2009–2014 strategy should be an HIV and STIs strategy. The desirability of expanding the number of countries covered by the ARH project	SPC should establish mechanisms to improve coordination between the HIV Section and Adolescent Health and Development Section.

<p>coverage. These include HIV/STI and sexuality/family life education targeted at school-based and out-of-school youth. Consideration should be given to providing additional funding to the Adolescent Reproductive Health Program to expand the number of PICT currently covered.</p>		<p>should be considered in developing the five-year implementation plan.</p>	<p>SPC should develop a feasibility paper addressing expansion of the number of countries covered by the ARH project and relevant costings.</p>
<p>17. That, in order to more specifically address gender in the context of the regional strategy, the following actions should be adopted:</p> <ul style="list-style-type: none"> • employ a gender specialist focusing on HIV and STIs in one of the Pacific Regional Strategy implementing agencies • establish a gender team across regional agencies • undertake a situational review/assessment of gender in the context of HIV in the Pacific • integrate a specific consideration of gender in developing the next strategy implementation plan 	<p>Gender issues are specifically addressed in planning.</p>	<p>Gender should be a key consideration in development of the 2009–2014 strategy.</p>	<p>In the 1st quarter 2007 a gender team consisting of staff from regional agencies should be established. In the 1st quarter 2007 the regional agencies' gender team should develop a job description for a gender specialist and identify which agency the gender specialist should be located with. Donors should be approached to fund the gender specialist. In the 1st half of 2007 a situational review of gender in the context of HIV in the Pacific should be undertaken.</p>

<p>(program implementation framework)</p> <ul style="list-style-type: none"> assist PICT in integrating gender into program planning <p>In developing the next regional strategy, ensure the findings of the situational review/assessment of gender are considered.</p>			
<p>18. That capacity development interventions, where possible, be specifically tailored to, and better integrated with PICT program interventions. This includes:</p> <ul style="list-style-type: none"> training programs specifically tailored to PICT circumstances and needs more localised training provision integration of training into program/project implementation refresher training and follow-up assessment development of partnering and mentoring arrangements 	<p>Criteria outlined should be integrated into capacity development activities planned.</p>		<p>Agencies should review current training in light of the findings of the review.</p>

between PICT agencies and between regional and PICT agencies			
19. That, to enhance quality of advocacy and prevention programming in the NGO sector, sufficient funding be provided to at least one lead NGO at a PICT level to establish a critical mass of staff and projects. This should be considered in the upcoming review by PRHP of CDOs.	Activities are identified to implement recommendation.		Recommendation is considered in PRHP review of CDO role.
20. That NGOs review existing arrangements for the funding and functioning of a peak NGO organisation at the Pacific regional level.	Peak regional NGO is involved in planning. Peak regional NGO is given principal responsibility for capacity development in advocacy for NGOs.		GFATM should establish a process to review past funding for a peak regional NGO and make recommendations for future functioning and funding. A steering committee should be established to oversee the process. The majority of steering committee members should represent NGOs.

REFERENCES

- ¹ SPC, 2005. The Pacific Regional Strategy on HIV AND AIDS 2004–2008. Noumea, New Caledonia: Secretariat of the Pacific Community.
- ² World Council of Churches Office in the Pacific, 2004. The Nadi Declaration: World Council of Churches Pacific Member Churches' Statement on HIV AND AIDS. Suva, Fiji: World Council of Churches Office in the Pacific.
- ³ UNAIDS, 2005. Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. Final Report, Geneva.
- ⁴ AusAID, 2005. Pacific Regional Strategy on HIV AND AIDS, 2004–2008 and Draft Regional Strategy Implementation Plan. Analysis of programmatic and funding gaps. Unpublished report. AusAID, Canberra.
- ⁵ Pacific Islands Forum Secretariat, 2005. The Pacific Plan for Strengthening Regional Cooperation and Integration. Pacific Islands Forum Secretariat. Suva, Fiji. p.5
- ⁶ Ibid. p.19
- ⁷ Ibid. p.5
- ⁸ AusAID, 2005. Op. cit. p.10
- ⁹ SPC, 2005. Op. cit. p.31
- ¹⁰ Triennial Conference of Pacific Women and Pacific Ministerial Meeting on Women 2005. Volume 1. Revised Pacific Platform for Action on Advancement of Women and Gender Equality 2005 to 2015: a regional charter. Noumea, New Caledonia: Secretariat of the Pacific Community.
- ¹¹ Bradley C., 2006 Strengthening a Gendered Approach to HIV AND AIDS in PNG: Some Issues for Donors and Development Partners. Port Moresby, Papua New Guinea. National HIV AND AIDS Support Project. p.3
- ¹² Ibid. p.2