ASIAN DEVELOPMENT BANK

RRP: REG 38599

REPORT AND RECOMMENDATION

OF THE

PRESIDENT

TO THE

BOARD OF DIRECTORS

ON A

PROPOSED

ASIAN DEVELOPMENT FUND GRANT

TO THE SECRETARIAT OF THE PACIFIC COMMUNITY

FOR THE

HIV/AIDS PREVENTION AND CAPACITY DEVELOPMENT

IN THE PACIFIC PROJECT

October 2005

ABBREVIATIONS

ADB	−	Asian Development Bank
ADF	−	Asian Development Fund
ARV	−	antiretroviral
BCC	−	behavior change communication
GFATM	−	Global Fund to Fight AIDS, Tuberculosis, and Malaria
NGO	−	nongovernment organization
PDMC	−	Pacific developing member country
PICT	−	Pacific island countries and territories
PMU	−	project management unit
PNG	−	Papua New Guinea
PPMES	−	project performance monitoring and evaluation system
PRHP	−	Pacific Regional HIV/AIDS Project
PRS	−	Pacific regional strategy
PRSIP	−	Pacific Regional Strategy Implementation Plan
SPC	−	Secretariat of the Pacific Community
STI	−	sexually transmitted infection
UNAIDS	−	Joint United Nations Programme on HIV/AIDS

NOTE

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

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CONTENTS

GRANT AND PROJECT SUMMARY

Grantee	Secretariat of the Pacific Community (SPC)
Beneficiaries	Cook Islands, Republic of Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Samoa, Solomon Islands, Kingdom of Tonga, Tuvalu, and Vanuatu
Classification	Targeting classification: Targeted intervention Sector: Health, nutrition, and social protection Subsector: Health programs Themes: Inclusive social development, regional cooperation, and capacity development Subthemes: Human development and other vulnerable groups
Environment Assessment	Environmental Category: C The Project will not have adverse environmental effects.
Project Description	The Project has four components: (i) **Strengthening surveillance.** This component focuses on developing national HIV/AIDS surveillance capacity, with a focus on developing methodologies and skills for conducting second-generation surveys to better understand the status of and risk factors governing HIV infection and prevention among high-risk subpopulations across the region. The activities will focus mainly on building capacity so that the countries and the region can mobilize and target resources to curb growing rates of infection. (ii) **Community-based interventions for HIV/AIDS prevention.** This component will provide support for a regional condom social marketing program, including the design and delivery of mass media and targeted communication programs promoting condom use and the supply of male and female condoms; for behavior change communication (BCC) programs, including the development of tailored BCC materials and the design and delivery of BCC programs; and for sexually transmitted infection (STI) treatment and care programs, including the provision of training for local health care workers and of equipment and materials for STI treatment facilities. (iii) **Targeted interventions for vulnerable groups.** This component focuses on supporting targeted interventions for vulnerable populations in the project Pacific developing

member countries (PDMCs), including (a) establishing five drop-in centers for seafarers and their communities with information about HIV/AIDS, STIs, and safe sex and referrals to appropriate services; (b) developing and distributing information, education, and communication materials for vulnerable groups; (c) providing targeted training for nongovernment organizations working with vulnerable groups; (d) providing support for regional maritime schools in training on HIV/AIDS and STIs; (e) providing training in enhancing livelihood skills for HIV-positive people; and (f) providing antiretroviral drugs for HIV-positive people.

(iv) **Project management.** This component will manage the Project and includes project planning, monitoring, and evaluation.

Rationale

The potential for the spread of HIV/AIDS in the Pacific is high. All PDMCs have detected HIV infections and also have unreported and unidentified cases because of the lack of testing facilities and generally low levels of surveillance. Significant risk factors for HIV exist, including high prevalence of STIs, low condom use, high levels of interregional and intraregional mobility, prevalence of multiple sex partners, and high rates of transactional sex. The region has experienced highly disparate levels of development, resulting in variable levels of access to information and services. Some Pacific countries have poorly functioning health systems with weak capacity to operate safe blood supplies, treat STIs, provide counseling and testing, and prevent mother-to-child transmission.

The socioeconomic impacts of the HIV/AIDS epidemic are potentially significant. Social impacts include the pain and suffering of individuals and communities affected by the illness and the death of family members. At the household and individual levels, economic impacts include decreased discretionary spending by households affected by loss of income together with increased expenditure on care, treatment, and funerals. Economic impacts arise from productive sector losses and from the added burden on the health sector. HIV/AIDS exacerbates poverty by limiting the opportunities of the poor to lift themselves out of poverty and by driving economically vulnerable people below the poverty line.

The current response to HIV/AIDS in the Pacific is underfunded. Pacific governments have committed to a comprehensive regional strategy and various programs are under way. Existing efforts urgently need to be scaled up and extended.

Impact and Outcome	The impact of the Project will be to reduce the spread and impact of HIV/AIDS in the Pacific. The outcome of the Project will be improved management and delivery of HIV/AIDS prevention activities in the Pacific through the targeting of vulnerable populations.
Cost Estimates	The total project cost is estimated at $8.0 million equivalent.
Financing Plan	The Asian Development Bank (ADB) will provide a grant of $8.0 million equivalent from ADB's Special Funds resources to finance the Project.
Grant Amount and Terms	A grant of $8.0 million will be provided to SPC from the Special Funds resources of ADB (Asian Development Fund IX Grants Program) with terms and conditions substantially in accordance with those set forth in the draft grant agreement presented to the Board.
Period of Utilization	Until 30 September 2010
Estimated Project Completion Date	31 March 2010
Executing Agency	SPC is an international organization, founded by an intergovernmental treaty, that serves 22 Pacific island countries. SPC will be the executing agency for the Project. SPC will establish a Project Steering Committee. The Steering Committee will include representatives from key stakeholder organizations with expertise in HIV/AIDS in the Pacific, including project PDMC governments, civil society organizations, people living with HIV/AIDS, development partners, SPC, and ADB.
Implementation Arrangements	SPC will implement the Project.
Procurement	ADB-financed goods and related services will be procured in accordance with the *Guidelines for Procurement under ADB Loans.* A package of equipment and medical supplies estimated at more than $100,000 will be procured by international shopping, and by direct purchase for a package estimated at less than $100,000. SPC as the executing agency will manage the procurement of equipment and medical supplies.

Consulting Services

Conducting the specialized activities described for all four project components will require 221 person-months of international consulting services and 161 person-months of domestic consulting services. The consultants will provide assistance to SPC in the areas of surveillance, information and communications technology, condom social marketing, BCC, HIV prevention, peer education, STI case management, project management, seafarer support, and nongovernment organization support. Selection and engagement of consultant services will be undertaken in accordance with ADB's *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB on the engagement of domestic consultants.

Project Benefits and Beneficiaries

Direct beneficiaries of the Project include (i) people who do not become infected with HIV and their families and communities; (ii) people living with HIV/AIDS who have access to antiretroviral treatment and improved livelihood skill development; (iii) regional and country-level institutions and actors that will have adequate resources (tools, equipment, and information) to sustain their HIV/AIDS prevention activities; (iv) health systems in the PDMCs that will be relieved of the burden of an increased epidemic; and (v) national economies.

The Project will result in lower HIV infection rates and will benefit those who would have been infected had they not been educated about the likelihood of infection from risk-taking behaviors and had been unable to choose to modify this behavior accordingly because of lack of access to information, voluntary confidential counseling and testing, and condoms.

The Project will generate considerable national economic benefits as a result of a decrease in disease prevalence and the maintenance of low prevalence levels of HIV infection. The region's health systems will avoid or minimize the impact of an HIV/AIDS epidemic and be able to apply health sector resources to other health priorities.

Risks and Assumptions

Project risks fall into four categories: (i) financial, (ii) technical, (iii) institutional, and (iv) social.

The key financial risk is that the Project is supporting a much larger coordinated regional effort that depends on the continuing support, both financial and political, of the relevant governments, development partners, and civil society actors.

The main technical risks exist in the levels of absorptive capacity at country level to implement community-level activities effectively. This risk is moderate and is mitigated by the considerable focus in the Pacific regional strategy on developing government and civil society capacity.

The institutional risk is that SPC may not be able to effectively manage the Project in addition to its other HIV/AIDS project responsibilities and to retain its human resource capability and expertise.

The key social risk for the Project is that project impacts rely on people changing their sexual behavior. Project outputs will provide information, education, and condoms to affect behavior change under the assumption that determinants of sexual behavior outside the control of the Project remain favorable or neutral.

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on a proposed grant to the Secretariat of the Pacific Community (SPC) for the HIV/AIDS Prevention and Capacity Development in the Pacific Project.

II. RATIONALE: SECTOR PERFORMANCE, PROBLEMS, AND OPPORTUNITIES

A. Performance Indicators and Analysis

1. Background

2. HIV/AIDS is a real and present threat to Pacific developing member countries (PDMCs). Once HIV makes its way into the tiny populations in the Pacific islands, diffuse epidemics are likely to follow.[1] The Pacific region is characterized by acute vulnerability to external shocks. Weak economies, rapidly changing social norms, and the uneasy coexistence of traditional and modern cultures have led to an increase in social problems. Social and economic marginalization has increased. Conflict and insecurity have also become more common in the region in the past decade. Prevention strategies that minimize the risk of HIV infection and that reduce and treat STIs are urgently needed.

3. The potential for the spread of HIV/AIDS is high. All PDMCs have detected HIV infections. In Papua New Guinea (PNG),[2] the epidemic is now in the general population. There are certainly unreported and unidentified cases because of the lack of testing facilities and the generally low levels of surveillance.

4. Significant risk factors for HIV exist, including the high prevalence of STIs; the low level of condom use, the high levels of interregional and intraregional mobility, cultural practices such as taboos on frank discussion of sexual issues; the practices of tattooing, polygamy, and multiple sex partners; and the high rates of transactional sex. Pacific cultures are typically conservative, and intolerance and misunderstanding may marginalize affected or vulnerable individuals and isolate them from information and services that reduce risk and vulnerability.

5. The Pacific region has experienced highly disparate levels of development, resulting in variable levels of access to information and services. Some Pacific countries have poorly functioning health systems with weak capacity to operate safe blood supplies, treat STIs, provide counseling and testing, and prevent mother-to-child transmission.

6. The socioeconomic impacts of the HIV/AIDS epidemic are potentially significant. Social impacts include the pain and suffering of individuals and communities affected by the illness and death of family members, the children who lose parents and are left without someone to love and raise them, the increased social exclusion of those affected by intolerance and stigmatization, and the rupture of community and societal bonds. At household and individual levels, economic impacts include decreased discretionary spending by households affected by income loss together with increased expenditure on care, treatment, and funerals. Economic impacts are to be expected from productive sector losses in such countries as Kiribati and Tuvalu, where the earnings of seafarers, a particularly high-risk population, account for 25% of

[1] Joint United Nations Programme on HIV/AIDS. 2004. *AIDS Epidemic Update 2004*. Geneva.
[2] It is proposed that PNG will receive Asian Development Bank support for fighting HIV/AIDS in a separate project.

gross domestic product. HIV/AIDS exacerbates poverty by limiting the opportunities of the poor to lift themselves out of poverty.

7. The impact on health sectors of an increase in HIV/AIDS will be significant. Pacific health systems are already facing a double burden of prevention and treatment of persistent, traditional infectious ailments along with a rising tide of new "lifestyle" diseases, and have little scope for dealing with HIV/AIDS. Even a low-level epidemic would divert resources from other health priorities to accommodate demand for tertiary care facilities and the costs associated with minimizing risks to health care workers. Appendix 1 presents the sector analysis.

2. Status of the Epidemic

8. Since HIV was first reported in a Pacific island country in 1984, more than 11,000 cases have been detected. Table 1 presents the current situation in the Asian Development Bank's (ADB's) PDMCs. Because of low levels of surveillance, actual prevalence rates are likely to be higher than official figures indicate. ADB considers it likely that under-reporting in the region is considerable, possibly by a factor of 10.[3]

Table 1. Incidence of HIV/AIDS, Selected PDMCs, December 2004
(number of cases)

Item	COO	FSM	FIJ	KIR	NAU	PAL	RMI	SAM	SOL	TON	TUV	VAN	Total
HIV cases	2	25	182	46	2	8	10	12	5	13	9	2	316
AIDS cases	0	15	25	28	1	4	2	8	2	9	2	2	98
AIDS deaths	0	12	17	23	1	3	2	8	2	8	2	0	78

AIDS = acquired immune deficiency syndrome, COO = Cook Islands, FSM = Federated States of Micronesia, FIJ = Fiji Islands, HIV = human immunodeficiency virus, KIR = Kiribati, NAU = Nauru, PAL = Palau, PDMC = Pacific developing member country, RMI = Marshall Islands, SAM = Samoa, SOL = Solomon Islands, TON = Tonga, TUV = Tuvalu, VAN = Vanuatu.
Source: Asian Development Bank estimates.

9. In the Pacific region, HIV/AIDS is predominantly a sexually transmitted disease. While heterosexual transmission is most common, there are documented cases of transmission between men who have sex with men (MSM), injecting drug users and from mother to child. Vulnerable groups include young people; women; prisoners; prison officers; police officers; mobile populations, such as seafarers, fishermen, government officials, students studying abroad, members of the armed forces, international peacekeepers; and the sexual partners of these people.

10. The situation in PNG is especially serious. Unlike in the rest of the Pacific, PNG is experiencing a generalized epidemic with an estimated 75,000 people now living with HIV, with the number doubling every 2 years. The nature and scale of the response required in PNG is fundamentally different to that required in the low-prevalence PDMCs. ADB has been providing support in the health sector in PNG for some years and is currently responding to a request from the Government of PNG to provide a grant for a project to prevent and control the spread of the disease in rural areas. For these reasons, PNG is not included in the current Project.

[3] ADB. 2005. *Development, Poverty, and HIV/AIDS: ADB's Strategic Response to a Growing Epidemic*. Manila.

3. Response to the Epidemic

a. Pacific Regional Strategy on HIV/AIDS 2004–2008

11. Governments, key civil society organizations, and development partners recognize the Pacific Regional Strategy (PRS) on HIV/AIDS 2004–2008 as the umbrella framework for HIV/AIDS activities in the Pacific. The PRS followed the first regional strategy for 1997−2000 on AIDS and STIs, endorsed in 1998, that aimed to provide a broad framework within which regional stakeholders would be encouraged to address HIV/AIDS and STIs. The PRS was developed through an extensive consultative process that took into consideration the unique features of the Pacific region and issues related to HIV/AIDS, including lessons learned from countries that have successfully halted and reversed the spread of HIV/AIDS. The strategy was endorsed by 22 Pacific island countries and territories (PICTs)[4] in 2004, and responsibility for developing the PRS implementation plan (PRSIP) was given to SPC. The PRSIP is under development and was to be considered by the Pacific Forum Leaders Group in October 2005. A description of the strategy and implementation plan is presented in Appendix 2.

12. The PRS will support national efforts to prevent and control HIV/AIDS and STIs and strengthen work at the regional level through improved coordination, collaboration, and partnership between regional organizations and national programs. The strategy's goal is to reduce the spread and impact of HIV/AIDS while embracing people infected and affected by the virus in Pacific communities. The PRS is based on principles that acknowledge the traditional, cultural, and religious values of the Pacific communities. It affirms the protection and promotion of human rights, is based on partnerships and a multisectoral approach, and is sensitive to gender differences and the concerns of vulnerable groups.

13. The strategy aims to increase the capacity of PICTs to achieve and sustain an effective and sustainable response to HIV/AIDS; to strengthen coordination of the regional response and mobilize resources and expertise to help countries achieve their targets; and to help PICTs achieve and report on their national and international targets in response to HIV/AIDS.

14. The draft PRSIP has been costed at about $15.0 million, and as of June 2005 faced a funding shortfall of about $8.5 million. However, the PRS Working Group, which also worked on the preparation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) round 5 submission, found several program gaps in the draft PRSIP and estimated that the total shortfall of funding is considerably higher, even after taking into account the anticipated funding from the GFATM round 5 submission from the Pacific.

b. Secretariat of the Pacific Community

15. In 2002, SPC established the HIV/AIDS Unit in its Public Health Program. An HIV/AIDS and STI adviser leads activities in this area. A second professional position was added in 2005 to help manage the rapidly expanding work program. These two long-term positions are in addition to those funded at SPC for specific projects. SPC facilitated the development of the PRS and has coordinated efforts to generate resources for implementing it. SPC's maritime program has also conducted HIV/AIDS activities aimed at seafarers.

[4] American Samoa, Cook Islands, Fiji Islands, French Polynesia, Guam, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Pitcairn, PNG, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.

c. United Nations System

16. The United Nations agencies present in the Pacific (World Health Organization, United Nations Children's Fund, United Nations Population Fund, United Nations Development Fund for Women, International Labor Organization, and United Nations Development Programme) are collectively working with UNAIDS to carry out work on HIV/AIDS from the perspectives of their different mandates. Their efforts have included reviewing the sexual abuse and exploitation of children and developing school curricula (United Nations Children's Fund); providing support for local condom social marketing (United Nations Population Fund); reviewing HIV-related legal issues (United Nations Development Programme); providing laboratory support, training in the treatment and care of HIV-infected patients, and holding a workshop on second-generation surveillance (World Health Organization); and holding meetings with the police, the military, and other occupational groups about workplace policies (International Labor Organization, UNAIDS). UNAIDS has used its project acceleration funds for a variety of small projects. In addition, the Asia-Pacific Leadership Forum, funded by the Australian Agency for International Development, the US Agency for International Development, and others, has been working to develop advocacy capacity among government, religious, private industry, and community leaders. External assistance provided to the sector is shown in Appendix 3.

d. Pacific Regional HIV/AIDS Project

17. In 2003, the Australian Agency for International Development invested A$12.5 million over 5 years in the Pacific Regional HIV/AIDS Project (PRHP), implemented by the Burnet Institute, International Development Support Services, and SPC. To date, this project has helped 11 PDMCs[5] develop national strategic plans.[6] The overall aim is to provide funding to implement national plans. Eight national AIDS commissions have been given grants, and agencies designated as community development organizations are given funds to become focal training agencies for smaller local organizations. The latter can compete for multiyear grants to implement programs. There is also a small grants component for funding meetings and other small efforts. In addition, through its SPC component, the project has also supported the development and implementation of the PRS.

e. Franco-Australian Pacific Regional HIV/AIDS and Sexually Transmitted Infection Initiative

18. Implemented by SPC, this 5-year project brings together the SPC component of the Australian PRHP and a component funded by the Government of France that focuses mainly on surveillance. The budget of approximately €1.0 million matches Australia's contribution to SPC.

f. Global Fund to Fight AIDS, Tuberculosis, and Malaria

19. In 2002, 11 Pacific island countries successfully applied for GFATM round 2,[7] receiving a multicountry grant of about $5.0 million, to be implemented and coordinated by SPC. The second submission from the Pacific region for support from GFATM round 5 covers 14 Pacific

[5] Cook Islands, Fiji Islands, Marshall Islands, Federated States of Micronesia, Nauru, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu. Other non-PDMCs supported include Niue and Tokelau.

[6] The Government of France added funds to this Project to support improved second-generation surveillance in the French-affiliated territories. Six US-affiliated islands, such as Guam and the Northern Marianas, are included through funding from the United States.

[7] Cook Islands, Fiji Islands, Kiribati, Federated States of Micronesia, Niue, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

PICTs[8] and seeks a total grant of $9.946 million. The submission recognizes the PRS as the strategic framework for national and regional activities throughout the Pacific and has been formulated to address specific funding gaps in four high-priority areas: (i) advocating condom use and the distribution and social marketing of condoms, (ii) working intensively with vulnerable and high-risk individuals (STI patients, mobile populations, transactional sex workers, men who have sex with men, and their partners); (iii) scaling up voluntary confidential counseling and testing services; and (iv) adopting an aggressive approach toward strengthening STI diagnosis and treatment. The submission acknowledges that additional resources are required for improving surveillance; scaling up access to care, treatment, and support for people living with HIV/AIDS; and enhancing care and treatment services. The submission was developed through a widespread and comprehensive consultative process involving governments; development partners; and a broad representation from civil society, including nongovernment organizations (NGOs), community-based organizations, and faith-based organizations. The submission has about 40 signatories representing these key stakeholders.

g. National AIDS Strategies and Action Plans

20. As with many public health issues in the Pacific, nearly all HIV/AIDS activities in the region are funded by external agencies, and substantial coordination is required to ensure optimum allocation of resources and minimize duplication. Governments and stakeholders have demonstrated their recognition of this by preferring regional approaches for their activities and by delegating responsibility for the PRS to SPC.

21. All PDMCs now have HIV/AIDS strategic plans and national AIDS committees to guide policies and program strategies. Both the plans and the committees are of varying quality and effectiveness. Most have been, and still are, receiving support for these efforts from the PRHP. However, most countries lack the financial and/or human resource capacity to give effect to their strategies, and only a few have translated the plans into actionable and funded programs. While the commitment of Pacific governments to effectively address HIV/AIDS has varied considerably to date, all PDMCs have signed on to the PRS and are cosignatories of the GFATM round 5 submission. The Fiji Islands and PNG have come closest to actualizing their strategies and have allocated budgets to them, and both Kiribati and Tuvalu, with their highly vulnerable seafaring populations, have responded to the issue by creating viable national AIDS committees, but for the smaller PDMCs with low prevalence rates, their capacity to mount an effective and sustainable response to the epidemic is extremely low. Most ministries of health have limited numbers of staff they can assign to HIV/AIDS activities. Similarly, most of the small PDMCs have few civil society actors capable of or interested in addressing what is still often regarded as a remote threat.

B. Analysis of Key Problems and Opportunities

1. Surveillance and the Knowledge Base

22. Concerns have been identified in relation to the adequacy of HIV and STI surveillance in the region,[9] and consequently in relation to the reliability of existing data. For example, surveys may be inappropriate for low-prevalence populations, sample sizes may be inadequate, and

[8] American Samoa, Cook Islands, Fiji Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

[9] 2004. *Franco-Australian Pacific Regional HIV/AIDS and STI Initiative: Situational and Response Analyses for HIV/AIDS and STI Prevention, Control, Care, and Support Services in the Pacific Region in Relation to the Components of the 1997–2000 Regional AIDS/STI Strategic Plan*. Noumea, New Caledonia.

behavioral surveys may not be covering the same groups being surveyed by HIV or STI surveys. Thus actual prevalence rates are probably higher than officially stated rates.

23. The PDMCs have low capacity for HIV and STI surveillance as facilities and technical capacities are inadequate. Good estimates of the number of people vulnerable to infection do not exist. Estimating the course of the epidemic requires knowing the size of populations at risk and the overlaps of groups practicing high-risk behaviors. Regular behavioral surveillance and social science research are necessary to ensure good data. Without a sound knowledge base, targeted programs enabling effective and efficient use of scarce resources cannot be designed. Similarly, monitoring and evaluation efforts will be ineffective in the absence of good information.

2. Risk Factors for HIV Transmission

24. STI prevalence rates and high rates of teenage pregnancy indicate high levels of risk-taking behavior and low rates of condom use. These are significant risk factors for HIV transmission. Young people, particularly young women, are particularly vulnerable to HIV. Women are physiologically more susceptible to infection from sexual intercourse than men. If global patterns are followed in the Pacific, at least twice as many young women as young men will contract HIV. Women are subject to abuse and exploitation and are likely to be exposed to unprotected and/or unwanted sex. In addition, young people and women are often ignorant of ways to protect themselves and minimize these risks.

25. As in other regions, the mobile populations of the Pacific are highly vulnerable to HIV and STIs. More than 4,000 people work as seafarers. For small island countries such as Kiribati and Tuvalu, seafarers are a significant source of wealth, accounting for more than 25% of the gross domestic product of each country. Seafarers are likely to practice high-risk behaviors such as alcohol abuse, sexual activity with commercial sex workers, inconsistent use of condoms, and multiple sex partners. Coupled with a pre-existing high infection rate of STIs and poor knowledge of safe sexual practices, their risk of contracting HIV is high.

26. HIV/AIDS awareness programs have been implemented through the network of 10 maritime institutions and have been considered effective. Nevertheless, there is a continuing requirement to update the training curricula, materials, and information packages to ensure that the institutions retain the capacity to deliver effective prevention programs and reach the maximum number of seafarers. Some STI and voluntary confidential counseling and testing clinics are available that offer various services for seafarers, but access to such services is limited for seafarers' families, and a holistic approach toward promoting prevention efforts is needed.

27. Since 2001, STI incidence has increased markedly in the 15−44 age group. Capacity building in STI diagnosis and treatment is being supported by the GFATM round 2 funds, but a funding gap remains for the provision of skills training, clinical equipment, and supplies.

28. Condom availability varies greatly across countries. Free distribution from government sources is hampered by inadequate supplies, sole designation for family planning clinics, and lack of easy access by the unmarried and by men. Where pharmacies or other shops stock condoms, availability is accompanied by relatively high prices, and many people still feel embarrassed purchasing them. Rural areas have limited access. Even though the United Nations Population Fund regularly procures condoms for 13 Pacific countries that supply free condoms under family planning or AIDS programs, demand for both male and female condoms

is still low. The GFATM HIV/AIDS project has contracted a regional condom social marketing NGO, Marie Stopes International, to implement a condom social marketing program initially in Fiji Islands, Kiribati, Samoa, and Tuvalu, with the possibility of expansion subject to additional funding.

29. Behavior change communication (BCC) programs have been under way across the region in various forms. However, a significant unmet demand exists for producing and promulgating targeted mass media materials.

30. Opportunities for highly cost-effective interventions to reduce vulnerability and prevent the transmission of HIV in Pacific island communities exist in a number of areas, notably in improving the knowledge base regarding vulnerable groups and conducting better-targeted surveillance, working intensively with vulnerable and high-risk individuals, advocating condom use and condom distribution and social marketing, enhancing BCC, and strengthening STI diagnosis and treatment.

3. Care and Treatment for HIV-Positive People

31. While there are HIV-positive people in all PDMCs, not all have access to care and treatment. Antiretroviral (ARV) drug treatment is being funded under GFATM round 2, which is establishing a regional procurement mechanism through Fiji Pharmaceutical Services. Under GFATM round 5, SPC will assume responsibility for procuring and managing the supply of HIV/AIDS drugs and health products. The high cost of ARVs puts them out of reach of individuals and most PDMC government health budgets. Only Samoa and the Solomon Islands provide ARV treatment through their ministry of health pharmaceutical budgets. ARV treatment is essential for HIV-positive people and the availability of such treatment programs is also vital to encourage people at risk to undergo voluntary testing. Of the 56 HIV-positive people in the PDMCs other than the Fiji Islands, only 6 are currently receiving treatment. To ensure the sustainability of ARV treatment programs over the long term, a revolving fund is being established that will operate under World Health Organization guidelines that require government commitment to long-term financing for such programs.[10]

32. In addition to treatment, HIV-positive people also need support to live in their communities with dignity and without fear of discrimination, reprisal, and enforced dependency on their families and communities. Many HIV-positive people lack the skills to generate income despite retaining sufficient health to remain economically productive.

4. Human Rights, Participation, and Gender Issues

33. The issues of stigmatization and discrimination need to be addressed. Some aspects of Pacific cultures tend to act as a barrier to understanding the risks of contracting HIV, and this is likely to affect institutional and community approaches to behavior change programs and other prevention initiatives. Discrimination may also have a detrimental impact on access to treatment, prevention, care and support for people living with HIV/AIDS.

34. HIV/AIDS is a gender issue in the Pacific. Women lack political power in government and community decision making, lack access to health services and targeted information and education materials, suffer from legal discrimination in family law and human rights, are often powerless in negotiating sexual relations, are subject to high levels of domestic and sexual

[10] The revolving fund will be established with financing from external funding agencies and participating countries.

violence, and are discriminated against by customary practices such as the payment of a bride price, and have little say in reproductive decision making and the cultural condoning of rape in marriage.

35. Young people have been identified as being particularly vulnerable to HIV/AIDS and generally lack a strong voice in Pacific power and decision-making structures. Other vulnerable groups, such as men who have sex with men and transgender communities, share similar levels of disempowerment and exclusion. The PRS aims to eliminate HIV-related stigmatization and discrimination and to involve people living with HIV/AIDS as key partners in the response. To this end, the PRS advocates for the development of legislation, policies, and ethical guidelines.

5. Regional and Country Capacity

36. Country-level capacity within the health sectors is limited. While government commitment has been varied to date, most governments do not have the financial and human resources to implement effective and sustainable responses to HIV/AIDS. All the countries have undertaken strategic and action planning exercises to varying extents and have established national AIDS committees. Few have the facilities and skills to undertake effective surveillance, to provide voluntary confidential counseling and testing services, and to deliver STI treatment services and behavior change programs. Few are currently delivering treatment and care programs for people who are HIV-positive. Of the project PDMCs, only Kiribati, Solomon Islands, and Tuvalu have allocated funds for HIV/AIDS programs in their national budgets. Civil society capacity is also, for the most part, limited. The most active NGOs are those with international partnerships and funding.

37. Much of the effort to date from the United Nations, GFATM, and bilateral programs has been directed at supporting the development of country-level capacity. The PRHP focuses on capacity building in both government and civil society. The PRS addresses leadership and advocates for adequate resourcing both regionally and nationally and for the incorporation of national AIDS action plans in country development plans.

38. Few PDMCs have legislation and an appropriate regulatory framework in place to address discrimination and human rights in relation to HIV/AIDS. The PRS commits to addressing this deficiency, and resources have been committed to support country efforts in adapting a good practice model of legislation. UNAIDS and the International Labor Organization are taking the lead in this area.

39. The predominantly regional approach taken to date is based on evidence that national actions in the Pacific needed to be strengthened by adopting a coordinated regional response, by sharing best practices, and by maintaining cohesion among the countries in arresting the epidemic and that the regional impact in halting and beginning to reverse the incidence and prevalence of HIV/AIDS will be larger than the sum of country-by-country outcomes. In addition, the regional approach addresses the limited human resource capacity of PDMCs. Prior successes with regional approaches point to regional integration as the best mechanism for achieving efficiency among small island economies. The Pacific region continues to promote regionalization in a number of areas, including HIV/AIDS.

6. Lessons Learned

40. The development of the PRS took into account a number of lessons learned from the first regional strategy, including the importance of enhancing access to treatment, prevention,

and care, people living with HIV/AIDS and the desirability of approaches based on human rights to combat stigmatization and discrimination. From countries where the epidemic has taken hold, the Pacific has learned that approaches to prevention, care, treatment, and impact mitigation must be sustained and comprehensive in order to effectively address the epidemic.

7. Strategic Context

41. ADB's strategy in the Pacific is formulated within the framework of ADB's overall HIV/AIDS strategy for Asia and the Pacific and ADB's Pacific strategy, the memorandum of understanding ADB has signed with UNAIDS, and the grant arrangements under the Asian Development Fund (ADF) IX replenishment.

42. **ADB HIV/AIDS Strategy for Asia and the Pacific.** ADB will help developing member countries achieve Millennium Development Goal 6, target 7: to have halted and begun to reverse the spread of HIV/AIDS by 2015. The purpose of ADB's intervention is to have an effective response to HIV/AIDS in place at the country and regional levels in Asia and the Pacific. The priorities for action are to be the following:

(i) Leadership support. Strengthen the commitment of regional leaders to address HIV/AIDS.
(ii) Capacity building. Increase capacity at the country and regional levels to address HIV/AIDS.
(iii) Targeted programs. Expand HIV/AIDS interventions that mitigate risk among the poor, the vulnerable, and the high-risk groups.

43. In pursuing activities in each of these areas, ADB will subscribe to principles of maintaining country and government leadership; partnership and consultation with other development agencies, civil society, and people living with HIV/AIDS; mainstreaming gender issues; targeting and capacity building based on sound technical knowledge; flexibility and innovation; and timely monitoring and evaluation.

44. **ADB and UNAIDS Memorandum of Understanding.** This memorandum of understanding states that the collaboration between ADB and UNAIDS will be guided and built upon by the following principles and fundamental action: (i) the co-ownership of processes, with a focus on deriving synergies from shared activities and cooperation; (ii) the development and promotion of technically sound approaches to addressing the AIDS epidemic; (iii) the use of inclusive approaches that involve civil society, vulnerable populations, and people living with HIV/AIDS and promote gender equity; (iv) the integration and application of prevention, care, treatment, and support initiatives in relation to HIV and AIDS; and (v) the strengthening of national responses.

45. **ADB's Pacific Strategy.** One of three strategic objectives for ADB's Pacific Strategy 2005−2009 is to enhance the supply of and demand for quality, basic social services. To this end, ADB has identified three key result areas: social sector strategies relevant and responsive to national objectives and client needs; effective public, private, and development partner resource allocations for basic social services; and capacity building in relation to managing and delivering of quality basic social services. ADB has committed to explore innovative approaches for providing social services, including coordinated donor approaches at the regional level for such public goods as surveillance and prevention of HIV/AIDS. ADB is also providing regional

technical assistance[11] to enhance knowledge in relation to HIV/AIDS programs and policies and increase awareness and understanding among key decision makers of critical HIV/AIDS issues.

46. **ADF IX Grants for HIV/AIDS.** The ADF 2005−2008 includes a grant program to combat HIV/AIDS and other infectious diseases. Regional grants can be made to an appropriate regional institution in circumstances where ADB considers that better results would be achieved by providing the grant to such an institution than from awarding the grant to individual member governments.

III. THE PROPOSED PROJECT

A. Impact and Outcome

47. The Project will promote regional public goods and provide support to Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru,[12] Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu, hereinafter referred to as the project PDMCs. The impact of the Project will be a reduction in the spread and effects of HIV/AIDS in the Pacific. The outcome of the Project will be improved management and delivery of HIV/AIDS prevention activities in the Pacific through the targeting of vulnerable populations. The project design and monitoring framework is in Appendix 4.

48. The Project will constitute a core part of the PRSIP and will promote synergies between the PRS and the activities funded by the GFATM round 5 and other development partners to ensure the efficient use of resources and the avoidance of duplication of effort, waste of resources, policy confusion, and lack of coordination.[13] It will complement and augment existing activities. The Project will lead to improvements in the health status of Pacific populations, reduce poverty through higher economic growth, and underpin progress toward achieving the health-related Millennium Development Goals.

B. Outputs

49. The Project has four components to be implemented over a 4-year period: (i) strengthening surveillance, (ii) community-based interventions for HIV/AIDS prevention, (iii) targeted interventions for vulnerable groups, and (iv) project management.

1. Component 1: Strengthening Surveillance

50. Component 1 focuses on developing national HIV/AIDS surveillance capacity by developing methodologies and skills for conducting second-generation surveys to better understand the status of and risk factors for HIV infection and prevention among high-risk subpopulations across the region. The activities will focus mainly on building capacity so that the countries and the region can mobilize and target resources to curb growing rates of infection. The outputs of this component will be (i) a vulnerability-mapping study to identify vulnerable populations; (ii) an expanded second-generation HIV surveillance survey program; (iii) the expansion of routine surveillance capacity; (iv) the design and delivery of specific surveillance programs for identified groups; (v) an improvement in countries' laboratory

[11] ADB. 2005. *Regional Technical Assistance for Socioeconomic Implications of HIV/AIDS in the Pacific.* Manila.

[12] ADB's policy of not extending financing to countries in nonaccrual status is not applicable to ADF IX grant assistance provided for HIV/AIDS projects undertaken on a regional basis.

[13] ADB has committed to the UNAIDS '"three ones" Principle: one agreed framework of action, one national AIDS coordinating authority, and one agreed country-level monitoring and evaluation system.

capacity; and (vi) the development of a regional data warehouse to collect, analyze, and disseminate regional HIV/AIDS surveillance data. Consultants will be engaged to develop necessary information and communications technology platforms and train national counterpart staff in the sustainable use of these systems.

2. Component 2: Community-Based Interventions for HIV/AIDS Prevention

51. This component will reduce the burden of HIV/AIDS across the 10 target countries of the Project. The component will target evidence-based interventions that currently have insufficient levels of investment. Component 2 is divided into three subcomponents: (i) support for a regional condom social marketing program, including the design and delivery of mass media and targeted communication programs promoting condom use and an improved supply of male and female condoms; (ii) support for BCC programs, including the development of tailored BCC materials and the design and delivery of BCC programs; and (iii) support for STI treatment and care programs, including the provision of training for local health care workers in STI treatment and care and the provision of equipment and materials to STI treatment facilities.

52. **Condom Social Marketing**. A condom social marketing program already in place will be augmented. A range of tools, including product launch events, mass media, and peer education, will be used to generate demand for condoms, to raise brand awareness, and to increase the availability of condoms through commercial channels. In addition, market research will be conducted to better define effective distribution channels and identify target populations. The regional condom social marketing organization implementing the GFATM condom social marketing project will be contracted for these activities.

53. **Behavior Change Communication**. The Project will support BCC activities to provide information about HIV prevention to change social norms and behaviors in order to reduce vulnerability to HIV infection. At the country level, the Project will assist with ongoing efforts to (i) identify priority groups, (ii) develop a strategy specific to address local needs in a participatory manner, and (iii) organize community action. The Project will use existing channels and infrastructure to reach the priority groups. Facilities will be strengthened through training and the provision of BCC materials and condoms for distribution. Peer education will be used for groups that are hard to reach.

54. **Care and Management of STIs**. The number of facilities providing STI diagnosis and treatment will be increased. Capital and recurrent resource needs of 20 STI clinics in the 10 project PDMCs will be supported. Capacity development in relation to laboratory diagnosis will also be supported in selected facilities in the project PDMCs.

3. Component 3: Targeted Interventions for Vulnerable Groups

55. Component 3 focuses on supporting targeted interventions for vulnerable populations within the project PDMCs. A number of activities will be undertaken, including (i) providing support for five new drop-in centers for seafarers and their communities that provide information on HIV/AIDS, STIs, and safe sex and referrals to appropriate services;[14] (ii) developing and distributing information, education, and communication materials for vulnerable groups; (iii) providing targeted training for NGOs working with vulnerable groups; (iv) supporting regional maritime schools in training on HIV/AIDS and STIs; (v) providing training in enhancing livelihood skills for HIV-positive people; and (vi) providing ARV drugs for HIV-positive people.

[14] In Kiribati, Marshall Islands, Solomon Islands, Tuvalu, and Vanuatu.

4. Component 4: Project Management

56. This component will manage the Project and includes project planning, monitoring, and evaluation. SPC will be the executing agency for the Project. A project management unit (PMU) will be established to manage the Project and will be responsible for regional coordination, data and document collection, support of international consultants, provision of logistics support, and organization of project workshops and training. The Project Steering Committee will operate within the framework of the coordinating and oversight vehicle established for the PRSIP. The SPC Public Health Program and HIV/AIDS Unit, BCC Program, and Surveillance Program will provide oversight, technical guidance, and specialist expertise to the Project.

C. Special Features

57. The Project will adopt a regional approach based on the commitment of all key stakeholders to supporting the PRS. In particular, the regional approach addresses the limited capacity in the project PDMCs. The Project is part of the PRS and will complement existing activities. In almost all respects, the Project will scale up and supplement current efforts.

58. Consistent with the Project's regional approach, SPC will be the grant recipient.[15] SPC serves 22 Pacific island countries (including all of ADB's PDMCs except Timor-Leste) and territories by means of technical assistance, training, and research. Its work covers a range of sectors, including natural resources (for example, agriculture and fisheries) and social and economic programs (for instance, culture, health, statistics, women, and youth). SPC is the largest and oldest regional organization concerned with development in the Pacific.

59. At the regional level, SPC is a leading organization in public health matters in general and HIV/AIDS in particular. SPC has well-established links with the health agencies of the Pacific governments, NGOs, and multilateral and bilateral partners. SPC manages multicountry health programs and projects and is the focal point for many health activities in the Pacific. SPC has the experience, as well as the operational, financial, and governance systems, required for managing regional and multicountry programs. SPC's member governments have asked SPC to develop and manage implementation of the PRS and have nominated SPC as the principal recipient of grants provided by GFATM. SPC is authorized to negotiate with donor agencies on behalf of its member countries. As the Project adheres to and operates under the mandate of the PRS, SPC is the most logical and appropriate recipient of grant funds for the Project. SPC will contribute counterpart staff and certain other direct incremental costs to the Project.

60. ADB's Charter specifies that ADB may provide financing to international or regional agencies or entities concerned with the economic development of Asia and the Far East.[16] Access to the ADF for this purpose is permitted by ADF regulations.[17] The ADF IX grants facility recognizes the need for sustained regional cooperation in the context of HIV/AIDS and other communicable and infectious diseases. As an intergovernmental regional entity involved with ADB member countries and concerned with the economic development of the Pacific region,

[15] SPC was founded in 1947 by an intergovernmental treaty and has the status of an international organization. Its current members are American Samoa, Australia, Cook Islands, Fiji Islands, France, French Polynesia, Guam, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, New Caledonia, New Zealand, Niue, Northern Mariana Islands, Palau, PNG, Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, United States, Vanuatu, and Wallis and Futuna.

[16] ADB. 1966. *Agreement Establishing the Asian Development Bank*. Manila. (Article 11 Recipients and Methods of Operations. Reprinted with corrections June 2002.)

[17] ADB. 2005. *Regulations of the Asian Development Fund*. Manila. (Section 3.02 Eligible Recipients.)

SPC satisfies the criteria for receiving ADF funds for the ultimate benefit of ADB's ADF-eligible PDMCs. As the regional agency empowered by the PDMCs to coordinate and implement regional HIV/AIDS activities under the PRS, SPC is particularly well suited to receive ADF IX grant funding for purposes of the Project. As a grant to a regional organization consisting of ADB member countries, the proposed financing is classified as a public sector grant.

D. Cost Estimates

61. The total project cost is estimated at $8.0 million equivalent. Cost estimates include (i) staff costs, including travel, training, and overhead; (ii) international and domestic consulting services; (iii) information and communications technology costs; (iv) laboratory and equipment costs; (v) research and studies costs; (vi) medical supplies; (vii) condoms; (viii) costs of setting up maritime drop-in centers; and (ix) contingencies.[18] Cost estimates are shown in Table 2 and detailed in Appendix 5.

Table 2: Cost Estimates
($ million)

Component	Total
A. Base Cost	
1. Surveillance and Surveys	1.82
2. Community-Based Response	2.92
3. Targeted Interventions	1.09
4. Project Management	1.64
Subtotal (A)	**7.47**
B. Duties and Taxes[a]	**0.00**
Subtotal (B)	**7.47**
C. Contingencies	
Physical Contingencies[b]	0.08
Price Contingencies[c]	0.45
Subtotal (C)	**0.53**
Total	**8.00**

[a] The Secretariat of the Pacific Community is a tax exempt body. All unit costs are net of taxes.
[b] Based on latest Asian Development Bank data.
[c] Based on latest Asian Development Bank data.

E. Financing Plan

62. ADB will provide a grant of $8.0 million equivalent from ADB's Special Funds resources to finance 100% of the Project. Table 3 shows the summary financing plan.

Table 3: Financing Plan
($ '000)

Sources	Total Cost	Percentage
Asian Development Bank Grant	8,000.0	100
Total Cost to be Financed	8,000.0	100

[18] Contingencies are calculated at 6.56% to include physical contingencies and local and foreign price escalation.

63. SPC will contribute the resources of the Public Health Program and the Maritime Program as required for project implementation.

F. Implementation Arrangements

1. Project Management

64. SPC will be the executing agency for the Project. A financial management assessment found that SPC's systems for financial and management accounting, reporting, auditing, and internal controls were satisfactory as reported in Supplementary Appendix B. SPC will establish a project steering committee. SPC will be responsible for project implementation.

2. Implementation Period

65. The project duration is 4 years. It is expected to end in March 2010. The bulk of the investment will occur in the first 3 years. The implementation schedule is in Appendix 6.

3. Procurement

66. ADB-financed goods and related services will be procured in accordance with the *Guidelines for Procurement under ADB Loans*. A package of equipment and medical supplies estimated to cost more than $100,000 will be procured by international shopping and a package estimated to cost less than $100,000 will be procured by direct purchase. The procurement of equipment and medical supplies will be managed by SPC as the executing agency. An indicative list of procurement is in Appendix 7, Table A7.1.

4. Consulting Services

67. Expected needs for consulting are 221 person-months of international and 161 person-months of domestic consulting services to conduct specialized activities for all four project components. The consultants will help SPC in the areas of surveillance, information and communications technology, condom social marketing, BCC, HIV prevention, peer education, STI case management, project management, seafarer support, and NGO support. Outline terms of reference for consulting services are in Appendix 8.

68. Selection and engagement of consultant services will be undertaken in accordance with ADB's *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB on the engagement of domestic consultants.

69. Marie Stopes International will be directly selected for the condom social marketing subcomponent. Direct selection is justified because Marie Stopes International is the regional NGO contracted for condom social marketing activities under the GFATM project and has unique experience and qualifications for this subcomponent, which will be scaled up under the Project. Other consultants will be engaged on an individual basis.

5. Disbursement Arrangements

70. SPC will establish an imprest account immediately after grant effectiveness. Replenishment of the imprest account will be supported by appropriate withdrawal applications and related documentation. The initial amount to be deposited in the imprest account will not exceed $500,000 equivalent. The statement of expenditures procedure may be used for

reimbursement of eligible expenditures and liquidation of imprest account expenses. The statement of expenditures procedure is applicable to individual payments not exceeding the equivalent of $50,000. Detailed arrangements for establishing and operating the imprest account and statement of expenses procedure will be in accordance with ADB's *Loan Disbursement Handbook* of January 2001.

6. Accounting, Auditing, and Reporting

71. SPC will maintain separate accounts for the Project that will contain detailed descriptions of the sources of receipts and expenditures. In addition, a full set of financial statements (income statement, balance sheet, and cash flow and related notes) will be prepared. The annual project accounts and annual financial statements will be audited by independent auditors acceptable to ADB and will be submitted to ADB no later than 6 months following the end of the fiscal year to which they relate. SPC was informed about ADB's policy on submitting audited financial statements and possible penalties for delays in submission.

72. SPC will prepare and submit to ADB regular progress reports on a semi-annual basis. The progress reports will identify problems and difficulties, if any, encountered during implementation and a summary of financial accounts for the Project that will consist of project expenditures during the reporting period, year to date, and total to date. A project completion report will be provided no later than 3 months following completion of the Project.

7. Project Performance Monitoring and Evaluation

73. Project performance monitoring indicators that were agreed to during project preparation include quality standards for the surveillance program, completion of the condom social marketing program, STI and HIV infection rates and project milestones. The relevance and practicability of data collection for the proposed measures have been confirmed with SPC. At the beginning of the Project, SPC will develop procedures for a comprehensive project performance monitoring and evaluation system (PPMES) to systematically generate data on inputs for and outputs of the four project components and the agreed indicators to be used to measure project impacts. SPC will refine the PPMES framework, confirm achievable goals, refine monitoring and recording arrangements, and establish systems and procedures no later than 6 months following grant effectiveness. The PPMES framework will be based on the monitoring and evaluation framework adopted for the PRSIP.

74. Under the PPMES framework, SPC will report baseline and progress data at the requisite time intervals and will be responsible for analyzing and consolidating the data through its documentation, issues resolution, and management information systems. The PPMES will be designed to permit adequate flexibility to adopt remedial action in relation to project design, schedules, activities, and development impacts. SPC, through the PMU, will monitor and assess activities and report to ADB on the implementation and financial aspects of the Project to ensure that progress and impacts are monitored and reported in line with ADB requirements.

8. Project Review

75. Regular ADB review missions are envisaged throughout the project period and a midterm review will be undertaken within 18 months of the start of project implementation. This review will include a detailed evaluation of the Project's scope, implementation arrangements, achievement of scheduled targets, and progress of activities. The review will take into account the PRS 2005−2008 and will assess the continuing appropriateness of the Project in achieving

the goals of that broader strategy. The midterm review will provide a basis for ADB and SPC to identify and discuss any necessary changes in project design and/or implementation arrangements.

IV. PROJECT BENEFITS, IMPACTS, AND RISKS

76. The Project will result in a robust, effective regional response to preventing the spread of HIV by strengthening and consolidating the efforts of Pacific governments to implement the PRS on HIV/AIDS 2004-2008. The Project will ensure that resources are committed and efforts channeled according to the priorities identified in the regional strategy, that the possibility of overlapping efforts and duplication is removed, that the risk of gaps remaining unmet because of poor coordination is minimized, that policy debate is coherent and coordinated, and that administration is streamlined. The economic and social analysis is in Appendix 9.

77. Direct beneficiaries of the Project include (i) the people who do not become infected with HIV and their families and communities, (ii) the people living with HIV/AIDS who have access to ARV treatment and means for developing improved livelihood skills, (iii) the regional and country-level institutions and actors that will have adequate resources to sustain their HIV/AIDS prevention activities, (iv) the health systems in the PDMCs that will be relieved of the burden of an increased epidemic, and (v) the national economies.

A. Social Benefits

78. The Project will result in lower HIV infection rates and will benefit those people who would have been infected had they not been educated about the likelihood of infection from risk-taking behaviors and had not been able to choose to modify this behavior accordingly because of lack of access to information, voluntary confidential counseling and testing, and condoms. The Project will achieve better information and understanding of the issues surrounding HIV/AIDS and promote more open dialogue within Pacific communities, resulting in reduced stigma attached to the infection and reduced discrimination against people living with HIV/AIDS and their families. The summary poverty reduction and social strategy is in Appendix 10.

B. Economic Benefits

79. The Project will generate considerable national economic benefits. Research conducted by the Commission on Macroeconomics and Health 2001[19] indicates that a high prevalence of diseases such as malaria or HIV/AIDS is associated with significantly lower rates of economic growth. Investments resulting in a decrease in disease prevalence are therefore likely to generate considerable national economic benefits. Infectious diseases tend to disproportionately affect poor people, who tend to suffer from poor nutrition and have limited resources to apply to health care and better education. In addition, some of the most vulnerable groups in the region, including seafarers, are sources of remittances and generate significant export earnings. Increased prevalence among these groups would result in decreased household revenues, and in some cases, reduced performance of national economies.

80. The region's health systems will avoid or minimize the impact of an HIV/AIDS epidemic and be able to apply health sector resources to other health priorities.

[19] WHO. 2001. *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva.

81. The quantitative cost-benefit analysis for the Project follows the methodologies outlined in *ADB's Guidelines for the Economic Analysis of Projects*. Key assumptions include the following:

(i) **Discount rate.** The economic opportunity cost of capital was assumed to be 12%. Most health project analyses use 3% as a discount factor; therefore future benefits are likely to be given greater value. To harmonize this analysis with other project appraisals in nonhealth sectors, a higher discount rate is used.
(ii) **Projection of project benefits and costs.** The period of analysis covers 20 years and benefits and costs are converted into constant 2006 dollar prices.
(iii) **Economic cost of labor.** The opportunity cost of labor or the shadow wage rate for both urban and rural adults was calculated at $2,000 per year.[20]

82. **Economic Costs.** Base investment costs are in constant 2006 dollar prices. Incremental recurrent costs are calculated for the 20 years following the 4-year project implementation period.

83. **Economic Benefits.** The Project will improve the socioeconomic condition of the target beneficiaries. Key project benefits are to be estimated in the following ways: (i) cost savings resulting from increased health awareness and reduced disease prevalence, and (ii) enhanced income of both rural and urban income earners who care for the sick.

84. Improved HIV and STI management will reduce the burden of these diseases and generate economic benefits largely through reduced out-of-pocket expenditures and will decrease the costs associated with lost labor through decreased numbers of sick days. In summary, key benefits include cost savings due to increased health awareness and improved HIV and STI control. Resource or out-of-pocket savings may flow from (i) increased access to health services to reduce transport costs, and (ii) reduced costs of treatment because of more efficient and rational diagnosis and treatment.[21] Thus improvements in health status as a result of health awareness activities lead to significant decreases in out-of-pocket health expenditures.

85. The Project is estimated to lead to the avoidance of nearly 4,000 HIV infections across 10 Pacific countries over a 20-year period and to an annual decrease of nearly 2,000 STI cases per year. The economic internal rate of return from this impact is estimated to be 13%, and an economic net present value of $0.5 million is calculated.

C. Technical and Institutional Benefits

86. The Project will achieve better HIV/AIDS surveillance in the Pacific. Sound information about incidence and prevalence rates and about which groups are most vulnerable will mean that better policy decisions can be made about prevention efforts and better budgetary decisions can be made about where to allocate scarce resources. The Project will result in better monitoring and evaluation for future decision makers by identifying sound baselines and tracking the progress of different approaches and programs. Thus the key institutions and actors working on HIV/AIDS in the Pacific will benefit from the Project. The investment in skill development; tools and resource kits; and targeted information, education; and communication packages will result in more effective and sustainable efforts in HIV/AIDS prevention.

[20] WB. 2004. *World Bank Development Indicators.* Washington DC.
[21] ADB. 2002. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Kingdom of Cambodia for the Health Sector Support Project.* Manila.

D. Environmental Impact

87. The Project will not have adverse environmental effects. The Project will finance some preventive medical activities that leave limited by-products. Project supervision will closely monitor the issue of medical waste. SPC has a medical waste disposal initiative (LabNet)[22] in place through which it promotes proper disposal practices.

E. Project Risks

88. Project risks fall into four categories: financial, technical, institutional, and social. The key financial risk emerges from the fact that the Project is supporting a much larger, coordinated regional effort that depends on the continuing support, both financial and political, of the relevant governments, development partners, and civil society actors. The pursuit of a regional approach because of the resulting synergistic benefits and economies of scale that would not arise if a country-level, disaggregated approach were taken increases the risk that financial support may be withdrawn to an extent that compromises the integrity of the PRS. In addition, the GFATM round 5 submission for about $10.0 million may not be approved in its entirety because of the significant reduction in the overall size of the fund available for disbursement in round 5. Governments may also be challenged by other economic priorities and divert funds away from HIV/AIDS. However, the financial risk is moderate and is mitigated by the fact that the PRSIP and the GFATM round 5 proposal will ensure that funds are prioritized and dedicated to those core activities that will result in the most effective interventions for preventing HIV infection.

89. The main technical risks concern the extent of absorptive capacity at the country level to implement community-level activities effectively. This risk is moderate and is mitigated by the considerable focus on developing government and civil society capacity in the PRS.

90. Institutional risk pertains to the reliance placed on SPC to effectively manage the PRS, the GFATM-funded projects, and this Project. SPC will need to retain the confidence of its stakeholders by maintaining its high-level capacity to deliver results. Specifically, SPC needs to retain its human resource capability and expertise. This risk is mitigated by the considerable resources being committed to the project management component and to the provision of support to SPC for administrative expenses associated with the Project.

91. The key social risk for the Project is that its impacts rely on people changing their sexual behavior. Project outputs will provide information, education, and condoms to affect this behavior change and there is an assumption that the determinants of sexual behavior outside the control of the Project will remain favorable or neutral. Another social risk is that the features of Pacific culture that discourage open discussion about sexual issues and cultural taboos may hinder the Project's activities. Faith-based groups and conservative actors may generate a backlash and promote misunderstanding that could counter the efforts of the Project. This risk is considered to be moderately high and will be mitigated by special efforts aimed at Pacific leaders and champions of change and by the Project's clear focus on information, education, and communication. The PRS emphasizes this issue.

[22] LabNet is a Pacific-wide laboratory training and quality assurance program.

F. Overall Assessment

92. The Project addresses a regional public good that is not currently receiving adequate levels of investment. Economic returns from investments in health have been shown to be substantial. The private market, however, fails to invest appropriately in health prevention and care because of asymmetries of information, externalities in some markets, and differences between private and social discount rates. The economic analysis suggests that investment in HIV/AIDS control in the Pacific will be economically attractive and financially sustainable. The risks are moderate overall and are mitigated. Vulnerable groups will be the key beneficiaries.

V. ASSURANCES

A. Special Assurances

93. In addition to the standard assurances, the SPC has given the following assurances, which are incorporated in the legal documents.

94. **Status and Organization of Grantee**. SPC will maintain its existence as a regional intergovernmental organization. SPC will notify ADB immediately upon receipt of a project PDMC's intention to withdraw its membership from SPC.

95. **Project Management**. SPC will be the executing agency for the Project. SPC will be responsible for providing overall Project guidance and coordinating implementation of the Project. To ensure coordination and integration of the Project, the executing agency will be assisted by a Steering Committee. The Steering Committee will include representatives from key stakeholder organizations with expertise in HIV/AIDS in the Pacific, including project PDMC governments, civil society organizations, people living with HIV/AIDS, development partners, SPC and ADB. The Steering Committee will operate within the framework of the coordinating and oversight vehicle established for the PRSIP and will be responsible for: (i) the policy and strategic direction of the Project; (ii) monitoring and reviewing project implementation; and (iii) providing necessary guidance as appropriate. The Steering Committee will be maintained until project completion and will meet as often as necessary to implement the Project and no less than twice per year. SPC will establish a PMU with administrative and management authority over all project components. The PMU will be responsible for day to day coordination and overall implementation of the Project and establish processes for project PDMCs coordination and consultation with stakeholders, including development partners, civil society and project affected people. SPC will ensure that the resources of the SPC Public Health Program, including the Public Health Program Manager, the HIV/AIDS and STI Advisor, BCC Specialist, HIV/AIDS Surveillance Specialist and HIV/AIDS Section Administrator are available to the PMU as required for project implementation. SPC will ensure that the PMU is maintained until project completion.

96. **Donor and Strategy Coordination**. SPC will ensure that the Project is implemented in accordance with the PRS and PRSIP, and that all project activities complement the HIV/AIDS activities funded by the GFATM.

97. **Environmental Standards**. SPC will monitor project activities resulting in medical waste. Through its LabNet[23] initiative SPC will assist project PDMCs in complying with their respective national medical waste disposal laws, regulations and standards.

[23] LabNet is a Pacific-wide laboratory training and quality assurance program,

98. **Project Performance Monitoring, Evaluation and Review.** SPC will develop a Project Performance Monitoring and Evaluation System (PPMES) based on the monitoring and evaluation framework adopted under the PRSIP. The PPMES will systematically generate data on inputs and outputs of all Project components utilizing the PPM indicators to measure project impacts. No later than 6 months after grant effectiveness, SPC will refine the PPMES framework and attendant monitoring and recording arrangements and establish concrete systems and procedures for utilizing the PPMES framework to measure project impacts. The PPMES will be in form and substance satisfactory to ADB.

99. **Progress Reports**. SPC, through the PMU, will submit to ADB semi-annual progress reports and a project completion report within 3 months of project completion, each in form and substance acceptable to ADB.

100. **Project Review.** SPC and ADB will jointly undertake a mid-term review of the Project within 18 months of grant effectiveness to assess progress and identify any necessary changes in project design, the project implementation schedule and/or implementation arrangements.

B. Conditions for Grant Effectiveness

101. The following actions will be required prior to grant effectiveness: (i) the PMU will have been established and become operational in a manner satisfactory to ADB; and (ii) the Project Manager will have been appointed, and shall possess experience and qualifications acceptable to ADB.

C. Condition for Grant Disbursement

102. The following action will be required before any disbursements are made to finance project activities in any project PDMC: the project PDMC has provided evidence, satisfactory to ADB, that such PDMC supports the activities to be undertaken by the Project in its territory.

VI. RECOMMENDATION

103. I am satisfied that the proposed grant would comply with the Articles of Agreement of the Asian Development Bank (ADB) and, acting in the absence of the President, under the provision of Article 35.1 of the Articles of Agreement of ADB, I recommend that the Board approve the grant not exceeding the equivalent of $8,000,000 to the Secretariat of the Pacific Community from ADB's Special Funds resources for the HIV/AIDS Prevention and Capacity Development in the Pacific Project in accordance with the terms and conditions set forth in the Grant Agreement presented to the Board.

JOSEPH B. EICHENBERGER
Vice President

17 October 2005

SECTOR ANALYSIS

A. Performance Indicators and Analysis

1. Background

1. HIV/AIDS presents genuine threat to Pacific developing member countries (PDMCs) and all the PDMCs have detected HIV infections. Once HIV makes its way into the tiny populations in the Pacific diffuse epidemics are likely to follow.[1] The Pacific region is characterized by acute vulnerability to external shocks. Weak economies, rapidly changing social norms and the uneasy coexistence of traditional and modern cultures have led to social problems such as drug and alcohol abuse, domestic violence, teenage pregnancies, high levels of sexually transmitted infections (STI) and social and economic marginalization.

2. Significant risk factors for HIV include high prevalence of STIs, low condom usage, high levels of inter and intra regional mobility, cultural practices such as taboos on frank discussion of sexual issues, the practice of tattooing, polygamy and multiple sex partners, and high rates of transactional sex. Social problems, such as youth unemployment, teenage pregnancy, suicide, drug and alcohol abuse, and sexual and domestic violence are symptomatic of social and economic exclusion, a situation not conducive to greater HIV preventive practices.

3. The socioeconomic impacts of the HIV/AIDS epidemic are potentially significant. Social impacts include the pain and suffering of individuals and communities affected by the illness and death of family members, children losing a parent are left without someone to love, raise and care for them, the loss of hope of affected households and communities, the increase in social exclusion of those affected by intolerance and stigma, the increase in orphans and disrupted families, and the rupture of community and societal bonds. At household and individual level economic impacts include decreased discretionary spending from households affected by loss of income together with increased expenditure on care, treatment and funerals. Economic impacts are to be expected from productive sector losses such as in Tuvalu and Kiribati where 25% of gross domestic product is contributed by the earnings of seafarers, a particularly high risk population. HIV/AIDS exacerbates poverty by limiting the opportunities of the poor to lift themselves out of poverty and by driving economically vulnerable people below the poverty line.

4. The Pacific region experiences highly disparate levels of development, resulting in variable levels of access to information and services. Some Pacific countries have poorly functioning health systems with weak capacity to operate safe blood supplies, treat STIs, provide counseling and testing and prevent mother-to-child transmission. The impact on health sectors of an increase in HIV/AIDS will be significant. Pacific health systems are already facing a double burden of prevention and treatment of persistent, traditional infectious ailments along with a rising tide of new 'lifestyle' diseases and have little scope to deal with HIV/AIDS.

2. Status of the Epidemic

5. Since HIV was first reported in a Pacific island country in 1984, over 11,000 cases have been detected. See Table A2.1 for the current situation in the Asian Development Bank's Pacific countries. Over 95% of detected HIV infections have been from five Pacific countries[2]—with 93% occurring in PNG where it is estimated that about 75,000 people are living with the virus. In the

[1] UNAIDS. 2004. *AIDS Epidemic Update*. Geneva.
[2] These five countries are Fiji Islands, French Polynesia, Guam, New Caledonia, and Papua New Guinea.

10-years period before 2001, the cumulative reported HIV infections in 20 small Pacific island countries had reached 820, rising to 956 by 2004, but this could easily be a significant misrepresentation of the true situation. The rates per 100,000 people, based on reported cases, are Papua New Guinea (198), Tuvalu (94), Kiribati (46), Marshall Islands (18) and Fiji Islands (17). These latter rates, however, are based on very few cases detected through limited screening mainly of antenatal mothers and STI patients with syphilis. Where STI surveys have taken place results reveal high prevalence levels of any STI, 21% and 30% respectively. Because of low levels of surveillance it is likely that actual prevalence rates are higher than official figures indicate. The Asian Development Bank considers it likely that under-reporting in the region (including Papua New Guinea) is considerable, possibly by a factor of 10.[3]

Table A2.1: Incidence of HIV/AIDS in Selected PDMCs
(as at December 2004)

Item	COO	FIJ	FSM	KIR	NAU	PAL	RMI	SAM	SOL	TON	TUV	VAN	Total
HIV cases	2	182	25	46	2	8	10	12	5	13	9	2	316
AIDS cases	0	25	15	28	1	4	2	8	2	9	2	2	98
AIDS deaths	0	17	12	23	1	3	2	8	2	8	2	0	78

AIDS = acquired immunodeficiency syndrome, COO = Cook Islands, FIJ = Fiji Islands, FSM = Federated States of Micronesia, HIV = human immunodeficiency virus, KIR = Kiribati, NAU = Nauru, PAL = Palau, RMI = Marshall Islands, SAM = Samoa, SOL = Solomon Islands, TON = Tonga, TUV = Tuvalu, VAN = Vanuatu.

6. In the Pacific, HIV/AIDS is predominantly a sexually transmitted disease. While heterosexual transmission is most common, there are documented cases of transmission between men who have sex with men (MSM), between injecting drug users, and from mother to child.

7. A number of vulnerable groups have been identified, particularly young people and women, but also prisoners, prison officers and police, and mobile populations such as seafarers, fishermen, government officials, students studying abroad, servicemen, peace-keepers and the sexual partners of these people.

3. Risk Factors

a. Economic and Demographic factors

8. Economic factors alone cannot explain the distribution of HIV. Poverty as such is not closely associated with the spread of HIV, partly because knowledge and skills for preventing HIV are independent of income. Indeed, HIV is often associated with higher incomes, particularly during the early stages of an epidemic, where men with such incomes use them to access multiple sex partners. Over time, however, HIV pools among those with lower levels of education and income level, and after being infected with HIV, the poor get poorer as they spend family funds on medical care while, at the same time, their earning ability is compromised by sickness.

9. Unequal distribution of income contributes to greater vulnerability to an HIV epidemic through several mechanisms. First, the poor have less access to HIV prevention services,

[3] ADB. 2005. *Development, Poverty and HIV/AIDS: ADB's Strategic Response to a Growing Epidemic*. Manila.

including STI treatment, and therefore less knowledge about the risks of HIV and prevention methods. Second, poverty restricts earning options and can induce low-income women and men to engage in commercial or transactional sex, which may be fueled by migration from rural to urban areas in expectation of income-earning opportunities. Third, poor men must often delay marriage. Fourth, if they cannot find jobs locally, spouses may leave the household in search of jobs. Whatever the mechanism, international evidence suggests that sustainable growth and more equal distribution of income help reduce the spread of HIV. In the Pacific, 20 percent or more of the populations of Fiji Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Solomon Islands, Tuvalu, and Vanuatu live on less than $1 a day. If poverty is calculated as basic needs poverty, the list extends to Samoa and Tonga .

b. Sexual Behavior

10. Various studies of young men and women in the Pacific indicate high levels of sexual activity and low levels of condom use; however, a significant handicap in the Pacific is the inability to discuss, research, or manage public attempts at objectivity about human sexual behavior. Traditional taboos prevent such discussions between specific and religious teachings are strong and limit openness about the nature of sex and sexuality in most Pacific populations.

11. Anecdotal evidence indicates the existence of widespread formal and informal sex trading throughout the Pacific. In the Fiji Islands, Chinese sex workers have been brought in to service Asian sailors and fishermen and are apparently organized in brothels by Chinese managers. Fijian sex workers can be found in suburban residences, on streets, in parks, in clubs, and increasingly on call through an organized cell phone network.

12. Studies of STIs among antenatal women have recently been conducted in several island nations. In Samoa, a survey of 427 pregnant women found high levels of chlamydia (30.9%) and trichomoniasis (20.8%). Even though levels of gonorrhea and syphilis were much lower and no HIV infections were found, overall, 42.7% of the women had at least one STI. Those younger than 25 were three times more likely to have an STI than older women.[4] Similarly, in Vanuatu, 547 pregnant women were tested and 39% had one or more STI. The most common infection was trichomoniasis (27.4%), followed by chlamydia (21.4%) and gonorrhea (5.9%); 2.4% had syphilis and none had HIV.[5]

4. Response to the Epidemic

a. Pacific Regional Strategy on HIV/AIDS 2004−2008

13. The first Regional Strategy for the Prevention and Control of STD/AIDS in Pacific Island Countries and Territories, 1997–2000 was developed in 1997 to provide a broad framework within which regional stakeholders could address HIV/AIDS and STIs. At a regional consultation workshop in Nadi, Fiji Islands, in 2001,[6] following the United Nations General Assembly Special Session on HIV/AIDS, there was a call for strengthening the regional response to accommodate the Pacific leaders' commitment at the session to further develop the regional strategic

[4] 2004. *Prevalence of sexually transmitted diseases and human immunodeficiency virus among women attending prenatal services in Apia, Samoa.* International Journal of STD and AIDS, 15:116−119.

[5] 2003. *Prevalence of sexually transmitted infections among antenatal women in Vanuatu, 1999−2000.* Sexually Transmitted Diseases, 30(4): 362-6.

[6] SPC. 2001. *Report on AusAID/SPC Consultative Workshop for Regional Program on HIV/AIDS and STI.* Noumea, New Caledonia.

HIV/AIDS framework, coordinate regional activity, advocate to effectively address the issue in the region, and support national action on HIV/AIDS.

14. As a result, the *Pacific Regional Strategy (PRS) on HIV/AIDS* 2004–2008[7] was developed and endorsed by 22 Pacific island countries and territories[8] in 2004. Responsibility for developing the Pacific Regional Strategy Implementation Plan (PRSIP) was given to the Secretariat of the Pacific Community (SPC). The PRSIP is under development and was to be considered by the Pacific Forum Leaders Group in October 2005. A description of the strategy and implementation plan is presented in Appendix 3.

15. The PRS is recognized by governments, key civil society organizations and development partners as the umbrella framework for HIV/AIDS activities in the Pacific.

b. Secretariat of the Pacific Community

16. In 2002, SPC decided to establish a new core budget funded position of HIV/AIDS and STI Adviser to lead its own activities in this area. A second professional position has been added in 2005 to help manage the rapidly expanding work program. These two long-term positions are additional to those funded at SPC by specific projects. SPC facilitated the development of the Pacific regional strategy and has been successful in raising additional resources for its implementation (although as noted, a funding shortfall persists).

c. National AIDS Strategies and Action Plans

17. All PDMCs have HIV/AIDS strategic plans and national AIDS committees to guide policies and program strategies, even though they differ in quality and effectiveness. Line ministries lack the financial and/or human resource capacity to give effect to their strategies, and only few have translated the plans into funded programs. Similarly, most of the PDMCs have few civil society actors capable of or interested in addressing what is still often regarded as a remote threat.

18. As with many public health issues in the Pacific, nearly all HIV/AIDS activities in the region are funded by external agencies and there is a substantial requirement for coordination to ensure optimum allocation of those resources and minimization of duplication. Governments and stakeholders have demonstrated their recognition of this by preferring regional approaches for their activities and by delegating responsibility for the PRS to SPC.

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[7] SPC. 2004. *Pacific Regional Strategy on HIV/AIDS 2004−2008.* Noumea, New Caledonia.

[8] American Samoa, Cook Islands, Federated States of Micronesia, Fiji Islands, French Polynesia, Guam, Kiribati, Marshall Islands, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Pitcairn, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu and Wallis and Futuna.

PACIFIC REGIONAL STRATEGY AND IMPLEMENTATION PLAN

A. Regional Strategy

1. Overview

1. Estimates indicate that 6.4 million people are currently living with HIV/AIDS in the Asia and Pacific region. HIV/AIDS was first reported in the Pacific in 1984, and about 10,000 cases of HIV infections have been reported in the region to date. Recent evidence indicates that HIV/AIDS is on the rise in places as remote as Kiribati and Tuvalu, and the rate of increase in some areas is alarming.

2. In 2002, the Pacific Islands Forum meeting discussed HIV/AIDS for the first time and acknowledged that HIV/AIDS was a development issue and one that could have a potentially devastating impact on the health, economies, societies, and security of the region. In August 2003, Pacific island leaders called for the development of a regional strategy on HIV/AIDS. This initiative resulted in the Pacific Regional Strategy (PRS) on HIV/AIDS 2004−2008 to provide a strategic framework for national and regionally-funded activities throughout the Pacific. The PRS has three main purposes: (i) to increase Pacific island countries' capacity for an effective and sustainable response to HIV/AIDS, (ii) to strengthen coordination and mobilize resources and expertise, and (iii) to help countries achieve and report on their national and international targets for HIV/AIDS.

3. The PRS, endorsed by Pacific island leaders in 2004, is based on the recognition that the many challenges inherent in implementing effective responses to HIV/AIDS affect the entire region and have to be addressed collectively. The strategy guides the region’s response to the pandemic for the next 5 years. The strategy guides current HIV/AIDS prevention, treatment, and care activities as well as proposals for future projects, which are designed so as to complement the strategies of individual countries.

4. Addressing HIV/AIDS in the Pacific region faces the following 11 key challenges: (i) inadequate surveillance and monitoring capacity at all levels; (ii) long distances and communication difficulties; (iii) need to provide sustained leadership at all levels; (iv) lack of resources; (v) culture as a barrier to understanding and prevention initiatives, including lack of understanding of gender relations; (vi) lack of capacity in responding to HIV; (vii) difficulties in sustaining comprehensive national responses; (viii) need for coordination at the national and regional levels; (ix) need to deal with vulnerable groups; (x) need to address stigmatization and discrimination; and (xi) need to build capacity to provide treatment to those with AIDS.

5. Globally, the HIV/AIDS pandemic has already had a devastating impact. In the Pacific, where HIV prevalence rates are still relatively low compared with those in the rest of the world, the spread of HIV/AIDS needs to be halted and reversed immediately. Decreasing the number of infections has a direct link to the region’s sustainable health, economic, and social development.

6. HIV was first reported in a Pacific island country in 1984. Subsequently, 8,268 confirmed HIV infections and 1,672 AIDS cases have been reported. More than 95% of reported HIV infections have been in five Pacific island countries and territories (PICTs): Fiji Islands, French Polynesia, Guam, New Caledonia, and Papua New Guinea. The HIV epidemic in the Pacific is diverse, with the primary mode of spread being heterosexual. HIV/AIDS cases have been reported from all Pacific member countries, with significant increases in Kiribati and Tuvalu,

where maritime workers and their spouses and children account for up to 65% of the infected population. However, these numbers are based on a few cases detected through limited screening, mainly of antenatal mothers and sexually transmitted infection (STI) patients with syphilis, and are likely to be much higher.

2. Development of the Strategy

7. The PRS was developed through an extensive consultative process, taking into consideration the uniqueness of the Pacific region and issues related to HIV/AIDS, including lessons learnt from countries that have successfully halted and reversed the spread of HIV/AIDS. The first Regional Strategy for the Prevention and Control of STD/AIDS in Pacific Island Countries and Territories, 1997–2000 provided a framework for action by PICTs when the disease first emerged in the region. Based on the impact evaluation and outcomes of the first regional strategy, the PRS for 2004−2008 has been drafted and set up. A major challenge has been to accommodate the varying views and concerns in this region of diverse cultures and religious backgrounds and differing national HIV epidemics, while at the same time having a strategy that is based on such universal principles as leadership; prevention; reduced vulnerability; and provision of care, support, and treatment. Nevertheless, the region has successfully formulated a strategy that reflects the Pacific's needs and course of action in its fight against HIV/AIDS.

8. Following the regional HIV/AIDS coordinating meeting in October 2003 in Nadi, Fiji Islands, the Regional Strategic Reference Group was established. The group consists of representatives of the main subregions of the Pacific, including the American-affiliated Pacific island countries and the French territories; of people living with HIV/AIDS; of nongovernment organizations; of the Joint United Nations Programme on HIV/AIDS; and of technical agencies. The PRS's concepts and components were discussed during several meetings of the Regional Strategic Reference Group.[1] As a result, the PRS was formulated. The strategy reflects the region's experience in dealing with the diseases and identifies emerging issues that need to be addressed immediately.

3. Key Direction of the Strategy

9. The regional strategy will support national efforts to prevent and control HIV/AIDS and other STIs and strengthen work at the regional level through improved coordination, collaboration, and partnership between regional organizations and national programs. The strategy builds on the following eight Pacific themes: (i) leadership; (ii) a safe and healthy Pacific islands community; (iii) access to good quality services; (iv) human rights and greater involvement of people with and affected by HIV/AIDS; (v) coordination, collaboration, and partnership; (vi) funding and access to resources; (vii) planning, monitoring and evaluation, surveillance, and research activities; and (viii) addressing vulnerability.

10. The strategy's goal is to reduce the spread and impact of HIV/AIDS while embracing people infected and affected by the virus in Pacific communities. The strategy has three main

[1] The following were the major meetings: (i) regional meeting in Suva, Fiji Islands (March and April 2004); (ii) Joint Fiji Great Council of Chiefs–Joint United Nations Programme on HIV/AIDS meeting on Accelerating Action Against HIV/AIDS in the Pacific, Vuda, Fiji Islands (March 2004); (iii) World Council of Churches (Pacific office) meeting in Nadi, Fiji Islands (March 2004); (iv) Regional Workshop on HIV/STI Surveillance, Nadi, Fiji Islands (May 2004); (v) Council of Regional Organizations in the Pacific Working Group on Health and Population meeting in Suva, Fiji Islands (May 2004); and (vii) Pacific Regional Consultation on Gender and Development, Nadi, Fiji Islands (May 2004).

components: (i) to increase the capacity of PICTs to achieve and sustain an effective and sustainable response to HIV/AIDS; (ii) to strengthen coordination of the regional response and to mobilize resources and expertise to help countries achieve their targets; and (iii) to help PICTs achieve and report on their national and international targets in response to HIV/AIDS. The strategy is framed within principles that acknowledge the traditional, cultural, and religious values of the Pacific communities. It affirms the protection and promotion of human rights, is based on partnerships and a multisectoral approach, and is sensitive to gender differences and the concerns of vulnerable groups.

B. Pacific Regional Strategy Implementation Plan

11. Following the formulation of the PRS in 2004, members of the Pacific community developed the Pacific Regional Strategy Implementation Plan (PRSIP) in January 2005. Building on the strategy's eight themes, the PRSIP defines thematic objectives, strategies, and key actions. It articulates a 5-year plan for implementation by regional governments; civil society organizations, including nongovernment organizations and the media; regional agencies; and development partners. During the implementation phase, reviews and monitoring and evaluation will be conducted to ensure that the purposes of the strategy are achieved. The implementation plan draws clear links between the suggested project objectives and the regional strategy. Table A3.1 summarizes the eight themes that guide and inform the PRS and shows how they relate to each component of the PRSIP.

Table A3.1: Pacific Regional Strategy and Implementation Plan: Themes and Components of the PRS and PRSIP

PRS Theme	PRSIP Component
1. Leadership	1. Leadership and governance
2. A safe and healthy Pacific islands community	
3. Access to good quality services	2. Access to good quality services
4. Human rights and greater involvement of people with and affected by HIV/AIDS	
5. Coordinate collaboration and partnership	3. Regional coordination
6. Funding and access to resources	
7. Planning, monitoring and evaluation, surveillance and research	4. Program management
8. Addressing vulnerability	

PRS = Pacific regional strategy, PRSIP = Pacific Regional Strategy Implementation Plan.
Source: Pacific Regional Strategy on HIV/AIDS 2004−2008.

12. As shown in Table A3.1, the links between the PRS and the PRSIP are clear. Leadership support will strengthen the commitment of regional leaders to address HIV/AIDS. This is in line with theme 1 and the outputs of component 1 of the PRSIP. The support for capacity building at the country and regional levels to address HIV/AIDS is in line with themes 2, 3, 4, and 5 and a number of outputs under components 1 and 2 of the PRSIP. Targeted programs implemented under the strategy, such as the expansion of HIV/AIDS interventions that mitigate risk among the poor, the vulnerable, and the high-risk groups, are in line with theme 8 and components 1 and 3 of the PRSIP.

13. The PRS highlights addressing vulnerability as one of its fundamental themes and identifies a number of key vulnerable groups, namely: women; commercial seafarers and their partners; individuals with STIs; mobile populations, including international peacekeepers and individuals involved in international tourism ventures; prisoners; commercial and transactional sex workers; and men who have sex with men. Special attention will be given to these vulnerable groups to ensure that HIV/AIDS prevention, treatment, and care programs are extended to them.

14. The PRS provides the overarching direction and the PRSIP sets out specific interventions, identifies gaps, and specifies the budget for each activity. The costs of the PRSIP have been estimated at just over $15.0 million and a funding shortfall of $8.5 million has been identified. In addition to project-related funding gaps, several program gaps have been identified during the preparation of the Global Fund for AIDS, Tuberculosis, and Malaria round 5 submission. The PRSIP Working Group estimates that the total shortfall of funding will be considerably higher, even taking into account the anticipated funding from round 5.

15. Implementing agents at the country level include the ministries of health, women's affairs, and youth; civil society and nongovernment organizations; and national AIDS committees or their equivalent. Civil societies and nongovernment organizations have links with representatives of vulnerable and high-risk groups and represent their interests through the regional mechanism for implementing the round 2-funded HIV/AIDS projects.

16. Implementation of the PRS will involve (i) the development and implementation of a regional communications strategy that raises the profile of HIV among regional policy makers and opinion leaders through advocacy and awareness- raising efforts; (ii) the development of generic behavior change communication materials that can be readily adapted to the information needs of different PICTs; and (iii) data from better surveillance of HIV infections and behaviors will providing opportunities to share across the region through networks.

EXTERNAL ASSISTANCE

1. The Pacific region has three major regional HIV/AIDS projects that all fall within the overarching guiding principles of the Pacific Regional Strategy on HIV/AIDS 2004-2008 (PRS) (Appendix 3): (i) the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM); (ii) the Pacific Regional HIV/AIDS Project, funded by the Australian and French governments; and (iii) the Regional Sexually Transmitted Infection(STI)/HIV/AIDS Development Program of the Joint United Nations Program on HIV/AIDS' (UNAIDS). In addition, bilateral donors such as France and New Zealand are active in HIV/AIDS and STI prevention, treatment, and care activities at the national level. In all cases, every donor has been assigned specific activities under the PRS Implementation Plan (PRSIP).

A. The Global Fund to Fight AIDS, Tuberculosis, and Malaria

2. GFATM was established in 2001 to increase resources to fight three of the world's most devastating diseases—HIV/AIDS, tuberculosis, and malaria—and to direct those resources to areas of greatest need. As a partnership between governments, civil society, private sectors, and affected communities, GFATM represents an innovative approach toward international health financing. Its funds provide for products, such as antiretrovirals and other drugs, condoms, and diagnostic equipment. Currently 55% of committed funds go for the purchase of drugs and other commodities, and the rest is used to strengthen infrastructure and expand the training of health care workers and support personnel.

3. GFATM finances programs over a period of 5 years by first committing money for 2 years and then for an additional 3, depending on the results achieved during the first phase. Total pledges by all donors through the end of 2008 amount to $5.4 billion. These donors include 45 countries (Australia, Japan, New Zealand, the United States, and several European countries), major foundations, and private donors. GFATM has approved a total of $3.1 billion over 2 years to almost 300 programs in 127 countries and 3 territories.

4. GFATM has had five rounds of applications. The call for applications for round 5 of financing was closed in June 2005 and is currently being reviewed. In 2002, 11 small Pacific island countries[1] applied for round 2 and were approved for a multicountry HIV/AIDS grant of $6.034 million to be implemented and coordinated by staff of the Secretariat of the Pacific Community (SPC). The 5-year Pacific Islands Regional Multicountry Project, which is still being implemented, aims at (i) strengthening STI, HIV, and behavioral surveillance in five countries and enhancing laboratory capacity, including blood safety; (ii) improving STI and HIV services by 2007; and (iii) reducing the risk of HIV and other STIs through targeted interventions.

5. Specific activities under the Pacific Islands Regional Multicountry Project include (i) holding workshops and planning meetings for HIV surveys to be conducted in six sites (Fiji Islands, Kiribati, Samoa, Solomon Islands, Tonga, and Vanuatu) ($44,000); (ii) strengthening regional and local laboratories ($120,607); (iii) improving STI and HIV services by developing curricula, training health staff and traditional healers, holding workshops, and providing drugs ($75,973); (iv) developing a comprehensive care, treatment, and support system by conducting needs assessments ($15,000); and (v) reducing the spread of HIV and STIs by means of targeted interventions for youth by developing information, education, and communication

[1] Cook Islands, Federated States of Micronesia, Fiji Islands, Kiribati, Niue, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

materials, distributing condoms, conducting training of trainer programs for peer educators, and developing advocacy programs.

6. Despite successful implementation of GFATM round 2, specific funding gaps exist in the following high-priority areas: (i) advocating condom use, including distribution and social marketing; (ii) working intensively with vulnerable and high-risk individuals (for example, STI patients, mobile populations, transactional sex workers, men who have sex with men, and the partners of these people); (iii) scaling up voluntary confidential counseling and testing services and ensuring good access by vulnerable and high-risk groups; and (iv) adopting an aggressive approach to strengthening STI diagnosis and treatment. To address some of these gaps, 14 Pacific island countries submitted a proposal for GFATM round 5 for $9.946 million. This proposal was developed through extensive consultative processes with stakeholders from ministries of health and civil and nongovernment organizations (NGOs) and with country coordinating mechanisms.[2]

B. Bilateral Donors

1. Australia

7. Australia has two regional HIV/AIDS-related projects in the Pacific. The 5-year Pacific Regional HIV Project (PRHP) commenced in 2004, with A$12.5 million in funding from the Government of Australia and €1 million from the Government of France. (SPC, in cooperation with other institutions, is responsible for implementing this project. The PRHP has been designed to help strengthen the capacity of Pacific island governments, NGOs, and communities to develop, implement, and evaluate multisectoral responses to HIV/AIDS. The project is a direct response to the need for cooperation, planning, technical design, and management and evaluation of HIV/AIDS responses in the Pacific. The PRHP consolidates progress made under earlier regional initiatives and assists countries to develop or strengthen multisectoral national planning and response. In addition, Australia and New Zealand are cofunding a UNAIDS program coordinator position in the amount of A$246,000 for 3 years (2003−2006). The position is important for coordinating United Nations activities that will complement the new regional HIV/AIDS project. The project aims to increase political understanding and commitment, strengthen the management and surveillance of STIs, and improve care for people with HIV/AIDS.

8. The PRHP contributed to the development of a regional strategy on HIV/AIDS, including a regional communications strategy and enhancement of HIV/AIDS and STI surveillance capacity in the region. Today the PRHP assists the capacity development of national governments and NGOs to effectively implement HIV/AIDS and STI prevention and control activities. The second component of the PRHP incorporates a grant facility to support local projects. The aim of the scheme is to provide both government and NGOs of 14 independent states in the Pacific[3] with access to funds that will contribute to the development and implementation of their multisectoral, national HIV/AIDS and STI strategic plans. This will

[2] PDMCs that were consulted include Cook Islands, Fiji Islands, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Palau, Samoa, Solomon Island, Tonga, Tuvalu, and Vanuatu. Regional organizations that were consulted include the Fiji School of Medicine, International Federation of Red Cross, Marie Stopes International, International Planned Parenthood Federation, the United Nations system, Institute of Applied Legal Studies, People Islands AIDS Foundation, Pacific Regional HIV/AIDS Project, and Wan Smol Bag.

[3] The 14 countries are Cook Islands, Federated States of Micronesia, Fiji Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, and Vanuatu.

support the functions of national AIDS councils or their equivalent, ensure a local response to identified priorities, and enable effective scaling up of national HIV/AIDS responses by offering support to a wider range of organizations. To date, this project has helped 12 of the 14 countries develop national strategic plans.[4]

2. France

9. In the Pacific, France concentrates on francophone countries, including French Polynesia, Maurice Island, New Caledonia, Seychelles, Vanuatu, and Wallis and Futuna. France, together with Australia, established the Franco-Australian Pacific Regional HIV/AIDS and STI Initiative (component 1 of the PRHP). The goal of the initiative is to reduce the vulnerability to and impact of HIV/AIDS in Pacific island countries and territories (PICTs). The purpose is to strengthen the capacity of Pacific island governments, NGOs, and communities to undertake an effective, sustainable, multisectoral response to HIV/AIDS. The project identifies a regionally coordinated approach as integral to preventing HIV transmission within and between PICTs. The project supported the development of the Pacific Regional Strategy on HIV/AIDS 2004-2008, which sets the groundwork for a regional coordinated response to HIV/AIDS in the Pacific. In addition, on a regional basis, France funds A$2,119,262 for surveillance and survey activities through SPC. Specifically, France is funding a regional surveillance specialist in Noumea, New Caledonia, and funds surveys in countries that are not covered under GFATM.

3. New Zealand

10. New Zealand is committed to ensuring that the eight Millennium Development Goals are reached by 2015 by focusing specifically on three of the goals: goal 4: reduce child mortality; goal 5: improve maternal health; and goal 6: combat HIV/AIDS, malaria, and other diseases. New Zealand's core geographical focus in health is the Pacific region.

11. Regionally, New Zealand is spending NZ$730,000 to fund the Pacific Islands AIDS Foundation for 3 years. The organization works to raise awareness and mobilize support for HIV/AIDS action in the Pacific by promoting positive living, positive health, positive partnerships, and positive action and prevention. Furthermore, New Zealand contributes NZ$175,000 annually to a direct mail project that distributes information on safe sex and condoms by mail. The project allows people in remote and urban areas to access information confidentially. Advertisements in newspapers and on the radio and a web site inform people about the availability of free information. Since the service became available in November 2002, it has dealt with more than 8,500 requests and distributed 200,000 condoms. Safe sex information is also distributed through night clubs, taxi stands, shoeshine boys, and street boys.

4. United Nations System

12. The United Nations agencies present in the Pacific (World Health Organization, United Nations Children's Fund, United Nations Population Fund, United Nations Development Fund for Women, International Labor Organization, and United Nations Development Programme) are collectively working with UNAIDS to carry out work on HIV/AIDS from the perspectives of their different mandates. Their efforts have included reviewing the sexual abuse and exploitation of children and developing school curricula (United Nations Children's Fund); providing support for

[4] The French government added funds to this project to support improved second-generation surveillance in the French-affiliated territories. Six US-affiliated islands, such as Guam and the Northern Marianas, are included through funding from the United States.

local condom social marketing (United Nations Population Fund); reviewing HIV-related legal issues (United Nations Development Programme); providing laboratory support, training in the treatment and care of HIV-infected patients, and holding a workshop on second-generation surveillance (World Health Organization); and holding meetings with the police, the military, and other occupational groups about workplace policies (International Labor Organization, UNAIDS). UNAIDS has used its project acceleration funds for a variety of small projects. In addition, the Asia-Pacific Leadership Forum, funded by the Australian Agency for International Development, the US Agency for International Development, and others, has been working to develop advocacy capacity among government, religious, private industry, and community leaders.

12. UNAIDS is the main advocate for global action on HIV/AIDS by leading an expanded response to the epidemic. In the Pacific, UNAIDS has been providing ongoing technical advice and support to ministry of health focal points and liaising with the National Advisory Committee on AIDS. In addition, UNAIDS, together with the Asia Pacific Leadership Forum, aims to (i) increase political understanding of and commitment to HIV/AIDS and development issues, (ii) strengthen STI management and surveillance, (iii) create a more caring and compassionate environment for people living with HIV/AIDS and their families, (iv) increase the extent of condom use to help prevent HIV and STIs, (v) strengthen civil society organizations dealing with HIV/AIDS, and (vi) reduce high-risk behavior by young people.

13. The International Labor Organization seeks to mobilize the labor sector in reducing the spread and impact of HIV/AIDS while embracing people infected and affected by the virus in Pacific communities. For the Pacific, this goal includes (i) creating and implementing a regulatory environment that supports good practices in relation to HIV/AIDS in the workplace, (ii) having employers and employees develop workplace policies, and (iii) having employers adopt a wider community response to HIV.

14. The United Nations Population Fund, together with the United Nations Educational, Scientific, and Cultural Organization, is engaged in helping ministries of education integrate sex education, through secondary school curricula. The United Nations Population Fund office in Suva, Fiji Islands, is responsible for an HIV/AIDS program in the South Pacific subregion and contributes to the (i) strengthening of PICT capacity to develop, implement, monitor, and evaluate multisectoral national HIV/AIDS strategic plans; (ii) the creation of a supportive environment for HIV/AIDS responses; and (iii) the improvement of service delivery systems for HIV prevention.[5]

15. The World Health Organization has provided technical support throughout the Pacific to develop plans and conduct training in relation to AIDS and STIs and has helped ministries of health strengthen STI services and review alternative testing strategies for HIV. In Kiribati, for example, The World Health Organization assisted the Ministry of Health to conduct a cross-sectional survey of STI prevalence that collected demographic, behavioral, and clinical information from about 400 seafarers and women. The World Health Organization serves as the lead agency within the United Nations system for HIV/AIDS treatment, care, and support and for preventing mother-to-child transmission of HIV.

[5] The subregion includes the following countries: Cook Islands, Federated States of Micronesia, Fiji Islands, Kiribati, Marshall Islands, Nauru, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, and Vanuatu.

C. International Nongovernment Organizations

16. Across the region, a range of local, regional, and international NGOs is implementing HIV/AIDS and STI activities along with comprehensive sexual and reproductive health programs. NGOs active in HIV/AIDS prevention programs in many PICTs include the Red Cross, the National Council of Women, the National Council of Churches, youth councils, and the Council of Chiefs.

17. The International Federation of the Red Cross and Red Crescent supports activities focusing on safe blood and HIV/AIDS implemented under GFATM. In 2004, the International Red Cross in the Pacific improved the quality of ongoing first aid training and promoted blood donor recruitment through a series of targeted workshops at the national level. Guidelines have been developed to promote the integration of HIV/AIDS awareness into all core programs of national Red Cross societies. A project using puppet shows to disseminate information about HIV/AIDS was implemented in Cook Islands, Fiji Islands, and Samoa. Other activities in the fight against HIV/AIDS are being implemented in 11 PICTS[6] and include (i) safe blood activities; (ii) HIV education and prevention programs through national societies, including peer education; (iii) care and support programs; (iv) advocacy; and (v) anti stigmatization and discrimination campaigns.

18. One of the most influential NGOs in the region is the church. Regional seminars on HIV/AIDS prevention and education involving key church leaders have been conducted, and some church groups support sexual and reproductive health issues. For example, the World Council of Churches in the Pacific brought together religious leaders from various Pacific countries, including Cook Islands, Fiji Islands, Kiribati, Marshall Islands, New Caledonia, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu, to address the HIV/AIDS issue from theological, cultural, and sociological perspectives. The meeting culminated in the Nadi Declaration, which states the churches' commitment to HIV-positive people and sets priorities for the churches in improving knowledge about HIV/AIDS.

[6] The 11 countries are Cook Islands, Federated States of Micronesia, Fiji Islands, Kiribati, Marshall Islands, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
Impact Reduction of the spread and impact of HIV/AIDS in the Pacific	A trend of decreased incidence of HIV by 2012 Reduced economic and social impact of the HIV/AIDS epidemic Reduced mortality and morbidity attributed to AIDS in the region	Regional Millennium Development Goal reports produced by the United Nations Development Programme Regional reports by UNAIDS Monitoring and evaluation reports of the Pacific Regional Strategy on HIV/AIDS 2004–2008 UNGASS reports	**Assumptions** • The baseline prevalence of HIV/AIDS is as low as it is currently believed to be or at least within a range of 10%. • Regional programs such as GFATM continue to support HIV/AIDS efforts in the Pacific. **Risks** • The economic situation in PDMCs worsens and detracts governments' attention from HIV/AIDS efforts. • Other health issues assume greater urgency in PDMCs and detract health authorities' attention and focus.
Outcome Improved management and delivery of HIV/AIDS prevention activities in the Pacific through the targeting of vulnerable populations	By 2009, HIV infection rates in vulnerable populations are no more than 1%	Regional reports by UNAIDS and the World Health Organization Monitoring and evaluation reports of the Pacific Regional Strategy on HIV/AIDS 2004–2008 UNGASS reports	**Assumption** • The Secretariat of the Pacific Community is able to retain its HIV/AIDS staffing and expertise.
Outputs 1. Strengthening surveillance for HIV and STIs 2. Community-based response to HIV and STIs	National strategies and responses of all project PDMCs are modified based on the results of surveillance programs By 2009, a condom social marketing program is fully implemented in all PDMC countries By 2009, 80% of all respondents report	Regional reports by UNAIDS and World Health Organization UNGASS reports GFATM reports Regional reports by UNAIDS Monitoring and evaluation reports of the Pacific regional strategy on	**Assumptions** • Country-level capacity to undertake activities is sufficient with support provided. • Determinants of sexual behavior outside the Project's control remain neutral or favorable. • Other funding partners continue financial support for condom social marketing and BCC activities • Country-level capacity

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
	having used a condom during their last sexual encounter with a non-cohabiting partner from an estimated base level in 2006 By 2009, the prevalence of STIs is reduced to less than 10% among antenatal population	HIV/AIDS 2004-2008 UNGASS reports GFATM reports	to undertake activities is sufficient with support provided. • Country-level capacity to undertake activities is sufficient with support provided. • SPC has the capacity to maintain its focus on HIV/AIDS activities.
3. Targeted interventions for vulnerable groups	By 2009, 80% of vulnerable populations have access to HIV education to acquire the necessary skills to reduce their vulnerability to HIV infection (baseline to be established in 2006)	Regional reports by UNAIDS Monitoring and evaluation reports by the Pacific regional strategy on HIV/AIDS 2004-2008 UNGASS reports GFATM reports	
4. Project management	Project milestones are achieved	Project reports	
Activities with Milestones 1. **Strengthening Surveillance for HIV and STIs** 1.1 Establish a regional surveillance data warehouse (by the 2nd quarter of 2008) 1.2 Conduct a vulnerability-mapping study to identify vulnerable populations by the 2nd quarter of 2007) 1.3 Expand the second-generation HIV surveillance survey program (by the 4th quarter of 2008) 1.4 Expand routine surveillance capacity (by the 4th quarter of 2008) 1.5 Design and deliver specific surveillance programs for identified groups (by the 2nd quarter of 2010) 1.6 Improve country-level laboratory capacity (by the 2nd quarter of 2009) **2. Community-Based Response to HIV and STIs** 2.1 Condom social marketing program in place (by the 2nd quarter of 2010) 2.1.1 Conduct research into condom packaging and branding 2.1.2 Develop HIV/AIDS information, education, and communication materials 2.1.3 Design and deliver peer education training and workshop program 2.1.4 Design and deliver condom distribution program 2.2 BCC program in place (by the 1st quarter of 2010) 2.2.1 Develop tailored BCC information, education, and			**Inputs** ADB $1.817 million ADB $2.918 million

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
communication materials 2.2.2 Design and deliver BCC programs 2.3 STI services in place (by the 4th quarter of 2008) 2.3.1 Provide training for local health care workers in STI treatment and care 2.3.2 Provide equipment and materials to STI treatment facilities 2.3.3 Develop STI information, education, and communication materials			
3. Targeted interventions for vulnerable groups 3.1 Establish seafarer/community drop-in centers (by the 3rd quarter of 2007) 3.2 Develop targeted information, education, and communication materials for vulnerable groups (by the 1st quarter of 2008) 3.3 Conduct training for nongovernment organizations working with vulnerable groups (by the 3rd quarter of 2008) 3.4 Provide training for maritime schools (by the 2nd quarter of 2010) 3.5 Provide livelihood skills training for HIV-positive people (by the 2nd quarter of 2010) 3.6 Provide antiretroviral drugs for HIV-positive people (by the 3rd quarter of 2009)			ADB $1.092 million
4. Project management 4.1 Manage the Project (by the 3rd quarter of 2010) 4.2 Conduct baseline monitoring (by the 3rd quarter of 2010) 4.3 Monitor and evaluate project progress and outputs (by the 3rd quarter of 2010)			ADB $1.640 million plus ADB $0.533 million in contingencies

ADB = Asian Development Bank, BCC = behavior change communication, GFATM = Global Fund to Fight AIDS, Tuberculosis, and Malaria, MDG = millennium development goal, PDMC = Pacific developing member country, STI = sexually transmitted infection, UNAIDS = Joint United Nations Programme on HIV/AIDS, UNGASS = United Nations General Assembly Special Session, WHO = World Health Organization.

COST ESTIMATES AND FINANCING

Table A5. ADB Grant: by Category by Year
($'000)

Item	2006	2007	2008	2009	2010	Total
A. Base Costs						
I. Investment Costs						
A. Equipment	177.6	35.4	23.1	0.0	0.0	236.1
B. Research and Studies	170.0	296.0	122.0	42.0	0.0	630.0
C. Training/ Workshops	64.0	338.2	292.2	115.2	0.0	809.5
D. Materials and Supplies	0.0	179.1	146.1	132.1	0.0	457.3
E. Consulting Services						
International	307.6	742.5	549.0	431.5	0.0	2,030.6
National	24.0	204.9	229.4	261.0	0.0	719.3
F. Project Management	347.0	391.1	391.1	383.6	127.8	1,640.5
II. Recurrent Costs						
A. Supplies	2.0	245.2	220.6	222.4	222.4	912.5
B. Communications	5.5	7.0	7.0	7.0	5.0	31.5
Total Base Costs	1,097.7	2,439.3	1,980.5	1,594.8	355.1	7,467.4
B. Taxes	0.0	0.0	0.0	0.0	0.0	0.0
C. Contingencies						
I. Physical Contingencies[1]	59.6	11.9	7.8	0.0	0.0	79.3
II. Price Contingencies[2]	66.6	148.1	120.2	96.8	21.6	453.3
Total	**1,224.0**	**2,599.2**	**2,108.4**	**1,691.7**	**376.7**	**8,000.0**

Source: Asian Development Bank estimates.

Financing Plan
($'000)

Sources	Total Cost	Percentage
ADB Grant	8,000.0	100
Total Cost to be Financed	**8,000.0**	**100**

Source: Mission estimates.

[1] 5% for physical contingency used for equipment and research.
[2] ADB international cost escalation factors 2005−2009 used.

IMPLEMENTATION SCHEDULE

Activity	2006			2007				2008				2009				2010	
	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2
1. Strengthening Surveillance																	
1.1 Establish regional data warehouse																	
Procure systems																	
Develop database																	
Train counterparts																	
1.2 Map vulnerable populations																	
Conduct mapping exercises																	
1.3 Expand second-generation surveys																	
Provide survey training																	
Conduct surveys																	
1.4 Expand routine surveillance																	
1.5 Design and deliver specific surveillance programs for identified groups																	
1.6 Improve country laboratory capacity																	
2. Community-based response to HIV/AIDS care and prevention																	
2.1 Condom social marketing																	
Conduct market research																	
Procure condoms																	
Carry out peer education																	
2.2 Behavior change and communications																	
Prepare programs																	
Train counterparts																	
2.3 STI services																	
Procure STI equipment																	
Provide training in STI case management																	
3. Targeted interventions for vulnerable groups																	
3.1 Seafarers/community drop-in centers																	
Establish drop-in centers																	
Provide educational resources to maritime schools																	
3.2 Develop targeted information, education, and communication materials for vulnerable groups																	
3.3 Training for nongovernment organizations																	
Conduct HIV technical courses																	
3.4 Provide training for maritime schools																	
3.5 HIV-positive people																	
Provide livelihood skills courses																	
3.6 Provide antiretrovirals																	
4. Project management																	
Establish committees																	
Establish and implement reporting systems																	
Carry out monitoring and evaluation																	

HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, STI = sexually transmitted infection.
Source: Mission estimates.

CONTRACT PACKAGES

Table A7.1: Indicative Procurement Packages

Description	Indicative Packages	Contracts	Base Cost Estimates (US$)	Mode of Procurement	Responsible Agency
1. Laboratory equipment	1	1	50.0	DP	SPC
2. Computer equipment	1	1	22.0	DP	SPC
3. Laboratory supplies	1	1	46.2	DP	SPC
4. Seafarer Centers	1	1	119.8	IS	SPC
5. Medical Supplies	2	2	690.8	IS	SPC
6. Condom Social Marketing	1	1	1,175.9	IS	SPC
7. Educational Supplies (printed materials)	1	1	30.0	DP	SPC

DP = direct purchase, IS = international shopping, SPC = Secretariat of the Pacific Community.
Source: Mission estimates.

Table A7.2: Training Packages

Types of Training	Persons per Session	Location	Days	Training Sessions (no.)	Comments
1. Strengthening Surveillance					
Regional Training in Second Generation Survey Methods	20	REG	7	1	Initial training of 7 days in regional centre
National Training in Second Generation Survey Methods	5	NAT	3	10	Follow-up on regional training for survey teams at country level. Resources for IEC materials and other miscellaneous costs
2. Community-Based Response					
National Training in Peer Education Methods	5	NAT	2	10	Seminars on peer education methods
Regional Training in BCC Methods	20	REG	14	1	Follows Stepping Stones Approach to BCC
Sub Regional Training in STI Case Management	10	SUB REG	7	3	Average of 10 people per session. Varies across region with 13 from Polynesia, 8 from Micronesia and 10 from Melanesia
Country Level Training in STI Case Management	10	NAT	7	10	One week course conducted in each country

Types of Training	Persons per Session	Location	Days	Training Sessions (no.)	Comments
3. Targeted Interventions for Vulnerable Groups					
Teacher Education Workshops	10	REG	7	10	Seminars on HIV education for youth
HIV Technical Skills for NGOs	10	REG	5	2	Workshops for NGOs
Life Skills for HIV Positive People	35	REG	14		Workshops for PLWHAS
Community Leader Seminars		NAT	1	10	Allocations for community based seminar – with variable participation rates

BCC = behavior change communication; HIV = human immunodeficiency virus; IEC = information, education and communication; NAT = national; NGO = nongovernment organization; PLWHAS = people living with HIV/AIDS; REG= regional, SUB REG = subregional.
Source: Mission estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTING SERVICES

Field	Qualifications	Assignments
Component 1: Strengthening Surveillance		
Lead surveillance specialist (international, 42 person-months)	7 years' experience in surveillance with masters degree or PhD	(i) Provide support for the coordination of planning activities for quantitative and qualitative surveys. (ii) Develop and coordinate monitoring and evaluation mechanisms for HIV/AIDS and STI prevention activities, including both epidemiological and behavior change. (iii) Coordinate training with regional institutes. (iv) Develop evaluation and monitoring tools. (v) Facilitate and organize a team for developing a regional data warehouse. (vi) Develop long-term and annual work programs in consultation with the epidemiologist and key stakeholders. (vii) Manage the work of the surveillance component of the joint initiative and ensure that required reports are prepared and submitted to donors, meeting necessary timelines and quality requirements.
Epidemiologist (international, 16 person-months)	5–7 years' experience in developing database systems	(i) Provide technical guidance for conducting infectious disease surveillance in developing countries. (ii) Participate in sero-prevalence, STI and behavioral change surveys, training workshops, and associated activities planned for the Pacific region in order to improve surveillance and management of HIV/AIDS and STIs. (iii) Provide regular information to regional stakeholders relating to HIV/AIDS and STI surveillance through the preparation of scientific papers and other documents. (iv) Provide in-country assistance and training to the project team and recipients.
Database developer and information technology systems specialist (international, 24 person-months)	5 years' experience in developing database systems	(i) Provide technical guidance for developing and implementing a database system for surveillance data. (ii) Draft specifications and tenders for the information system hardware and software. (iii) Assist in procuring and installing the system network (iv) Design an interface, database format, and system; develop and update the project database system. (v) Provide regular maintenance and updating of the information system. (vi) Provide assistance and training to the project team

Field	Qualifications	Assignments
Laboratory specialist (international, 18 person-months)	Bachelor's degree in chemical, physical, biological, or clinical laboratory science, 4–5 years' experience in clinical laboratory testing	(i) Help laboratories develop and implement the laboratory quality management system, including preparing manuals for individual laboratories. (ii) Help develop and implement the standard operating procedures manuals related to STI and HIV laboratory diagnostic, monitoring, and referral procedures. (iii) Facilitate the introduction of a suitable technique for immunological and virological monitoring of HIV/AIDS patients. (iv) Provide the training required to participate in or facilitate the development of proposed laboratory distance learning modules. (v) Improve routine laboratory STI and HIV data collection, collation, analysis, and use by national STI and HIV programs, ministries of health, and the second generation surveillance program. (vi) Strengthen the diagnostic specimens referral system. (vii) Strengthen the information technology proficiency of laboratory staff.
Mapping coordination specialist (international, 6 person-months)	Master's degree, 5 years' experience in conducting surveys	(i) Consult with key stakeholders in government and civil society organizations to qualitatively identify types of risk groups. (ii) Review existing data sources to gain details of activity levels in risk groups. (iii) Conduct enumeration exercise among identified target groups. (iv) Conduct focus group discussions to identify tailored activities. (v) Conduct geographic mapping exercise to identify locations of those at risk (vi) Compile final report of the findings, that is, list of identified vulnerable groups, descriptive demographics and features of identified groups, contact details and key informants, and son on and activities, stating recommendations to be implemented.
Component 2: Community-Based Response		
Condom social marketing specialist (international, 7 person-months)	Degree in marketing or equivalent and at least 10 years experience in health sector social marketing	(i) Identify targets and channels for condom distribution. (ii) Conduct focus groups and market research for product positioning and market entry strategies. (iii) Train local counterpart staff in marketing methods and approaches. (iv) Monitor the impacts of condom social marketing programs.

Field	Qualifications	Assignments
Condom social marketing peer education specialist (national, 24 person-months)	At least a bachelor's degree in social sciences focusing on human resources development; strong knowledge of HIV/AIDS and the epidemic in the Pacific region	(i) Assist the condom social marketing specialist in conducting focus groups and market research for product positioning and market entry strategies. (ii) Review the availability of condoms in target countries and make recommendations accordingly. (iii) Prepare and deliver sexual health information to peer leaders. (iv) Organize and oversee the translation, printing, and dissemination of all information material to be used for setting up peer systems in Pacific developing member countries. (v) Oversee the recruitment of trainers and the practical arrangements for the training (vi) Draft a final report on the training and help produce a final evaluation report that will include the lessons learned.
BCC specialist (international, 35 person-months)	At least 10 years' experience in BCC	(i) Assess BCC needs across the Pacific through a process of mapping of risk situations, analyzing the frequency and nature of risky behavior, designing interventions to reduce risk, and identifying resources that can be used. (ii) Strengthen the capacity of PICTs to identify, develop, plan, and implement BCC activities with vulnerable groups, maximizing the use of available resources and partnerships. (iii) Develop and implement training, refresher training, and support for BCC activities on a regional level and directly with PICTs. (iv) Produce IEC and BCC materials for use in the region and help PICTs tailor generic materials to meet local needs. (v) Encourage networking between agencies, governments, and NGOs across the region.
Peer educator and BCC specialist (national, 84 person-months)	At least 5 years' experience in peer education and BCC	(i) Update and tailor regional peer training materials for each of the 10 target countries. (ii) Develop plans of action for both outreach and monitoring of outreach following regional peer training, for example, by using the draft quality outreach checklist as a basis for these discussions. (iii) Develop and implement training, refresher training, and support for BCC activities on a regional level and directly with PICTs. (iv) Design, administer, and collate the pretest and post-test evaluation for training programs. (v) Encourage between agencies, governments, and NGOs across the region.
STI specialist (international, 10 person-months)	Documented experience in training health care providers in the management of STIs and BCC program implementation	(i) Provide training for health care providers, including pharmacists, in the syndromic/presumptive management of STIs. (ii) Provide input to BCC programs (iii) Prepare IEC materials tailored for Pacific conditions. (iv) Design in-country training courses. (v) Develop monitoring instruments.

Field	Qualifications	Assignments
Component 3: Targeted Interventions for Vulnerable Populations		
HIV support specialist (international, 9 person-months)	Documented experience in supporting HIV-positive people	(i) Mentoring AIDS support groups (ie. roll out of Fiji AIDS support networks, Pacific Islands AIDS Foundation) (ii) Sourcing and/or preparation of IEC materials for people living with HIV/AIDS (iii) Design of in-country training courses
Seafarer support officer (international, 6 persons-months)	Bachelor's degree, 5 years' experience in community participation activities, 5 years' experience working with seafarers or seafarer unions in the Pacific	(i) Provide logistical and technical support in setting up five drop-in centers. (ii) Conduct stakeholder consultations with maritime colleges, women's associations, NGOs, and seafarer unions to set up a work plan for each drop-in center. (iii) Oversee the purchasing of equipment for the drop-in centers. (iv) Establish a work plan for each drop in center. (v) Create linkages with local voluntary confidential counseling and testing and STI clinics and set up a referral system. (vi) Create linkages with local NGOs and set up a plan for NGOs to conduct HIV/AIDS awareness activities at the centers.
Component 4: Project Management		
Chief advisor (international, 46 person-months)	At least 10 years' experience in regional coordination, preferably with a background in public health and BCC	(i) Plan day-to-day management of project activities. (ii) Prepare a detailed plan, timetable, and annual budget for project implementation. (iii) Prepare work plans, timetables, and budgets for project implementation. (iv) Establish operating procedures for all project activities, procurement, disbursement, reporting, and monitoring. (v) Supervise and monitor the activities of consultants. (vi) Provide guidelines, formats, and training to consultants. (vi) Prepare regional communications materials. (vii) Facilitate and arrange regional workshops, meetings, and seminars.
Project officer, monitoring and evaluation focus (national, 46 person-months)	Master's degree in statistics or related field and at least 5 years' experience in monitoring and evaluation systems	(i) Provide support for health services analysis. (ii) Organize meta-analysis of surveys and report writing. (iii) Conduct monitoring training program for provincial and district staff. (iv) Develop and test supervisory checklist.

AIDS = acquired immune deficiency syndrome; BCC = behavior change communication; HIV = human immunodeficiency syndrome; IEC = information, education, and communication; NGO = nongovernment organization; PICT = Pacific island countries and territories.
Source: Mission estimates.

ECONOMIC AND SOCIAL ANALYSES

A. Project Objectives

1. The overall objective of the Project is to reduce the spread and impact of HIV/AIDS in the Pacific. The outcome of the Project will be to consolidate the effective prevention responses being undertaken by the Pacific developing member countries and the various key stakeholders active in the fight against HIV/AIDS. The project outcomes are (i) improved targeting and management of HIV/AIDS in the Pacific; (ii) improved coverage of prevention and care of HIV in vulnerable populations, in particular seafarers, men who have sex with men, commercial sex workers, and young people; (iv) enhanced management of non-HIV sexually transmitted infections (STIs) through the establishment of a network of STI clinics; and (iii) focused project management.

B. Project Beneficiaries

2. Research conducted by the Commission on Macroeconomics and Health 2001[1] indicates that high prevalence of diseases such as malaria or HIV/AIDS is associated with significantly lower rates of economic growth. For example, the impact of HIV/AIDS on the annual rate of economic growth ranges from 0 to 0.2% increase in adult prevalence.[2]

3. Investments resulting in a decrease in disease prevalence, are therefore; likely to generate considerable national economic benefits. Infectious diseases tend to disproportionately affect poor people who suffer from poor nutrition and often live in crowded conditions. The proposed project interventions have been designed to specifically address the poor through capacity development, improved access to health facilities, and provision of equipment and drugs in areas of priority need. Marginalized women are at particular risk of being drawn into commercial sex work, where the risk of HIV infection is high.

4. A number of vulnerable groups in the region, which include seafarers, transport workers, members of the military, and participants in international peacekeeping, are sources of remittances and generate significant export earnings for many Pacific nations. Increased prevalence among these groups would result in decreased revenues for dependent families and in some cases reduced performance of national economies. Investment in interventions to curb infection among these subpopulations would therefore have significant positive economic and equity impacts.

C. Rationale for Investment

5. The total Asian Development Bank (ADB) investment of $8.0 million for this Project will focus on infectious disease prevention and care activities that the private market has undersupplied. A key element of the Project will be capacity development to enhance the Pacific's response to the pandemic. A number of training activities will be pursued within each of the components, including training in surveillance techniques and improved STI case management and support for HIV-positive people.

6. The private market also undersupplies health information and products because of incomplete information about the benefits of investments in health and nutrition and how to

[1] WHO. 2001. *Macroeconomics and Health: Investing in Health for Economic Development.* Geneva.
[2] Knowles, J. 2003. *Health Nutrition and Infectious Disease and Economic Growth in Cambodia.* Unpublished.

make such investments cost effective; externalities in some markets; differences between private and social discount rates leading to private decisions that do not adequately reflect long-term benefits; and intrahousehold decision making that favors adults (especially male adults) over children (especially, girls), leading to under-investment in children's human capital, especially in girls' human capital, relative to socially desired levels.[3]

7. The targeting of activities will ensure that vulnerable groups that are not often reached will benefit from HIV prevention and care interventions, because interventions such as youth education, seafarer training materials, and enhanced capacity of nongovernment organizations that support men who have sex with men and commercial sex workers are central to investment within component 3.

D. Cost-Benefit Analysis

8. The quantitative cost-benefit analysis for the Project follows the methodologies outlined in *ADB's Guidelines for the Economic Analysis of Projects*.[4] Key assumptions include the following:

(i) **Discount rate.** The economic opportunity cost of capital was assumed to be 12%. Most health project analyses use 3% as a discount factor; therefore, future benefits are likely to be given greater value. To harmonize this analysis with other project appraisal in non-health sectors, a higher discount rate is used.

(ii) **Projection of project benefits and costs.** The period of analysis covers 20 years and benefits and costs are converted into constant 2006 dollar prices.

(iii) **Economic cost of labor.** The opportunity cost of labor or the shadow wage rate (SWR) for both urban and rural adults was calculated at $2,000 per year.[5]

E. Economic Costs

9. Base investment costs are in constant 2006 dollar prices. Taxes and duties account for a small proportion of the project costs. Incremental recurrent costs are calculated for the 20 years following the five-year project implementation period.

F. Economic Benefits

10. The Project will improve the socioeconomic condition of the target beneficiaries. Key project benefits are to be estimated in the following ways: (i) cost savings due to increased health awareness and reduced disease prevalence, and (ii) enhanced income of both rural and urban income earners who care for the sick. Costs and benefits are outlined in Table A9.1 for investment and recurrent expenditures over a 20-year projection.

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[3] Knowles, J. 2003. *Health Nutrition and Infectious Disease and Economic Growth in Cambodia*. Unpublished.

[4] Bloom, E. and Choynowski, P. 2003. *Economic Analysis of Health Projects: A Case Study in Cambodia,* ERD Technical Note No. 6, ADB. Manila; and World Bank. P. A. Musgrove. 2003. *Health Economics in Development.*

[5] Based on GNI per capita (Atlas Method) in Pacific countries for 2004. World Bank Development Indicators.

Table A9.1: Cost-Benefit Analysis and Projection of Beneficiaries, 2006−2025

Year	Avoided HIV Cases (Number)	HIV Benefit ($m)	Reduced STI Prevalence (Number)	STI Benefit ($m)	Gross Benefit ($m)	Invest Cost ($m)	Recurrent Cost ($m)	Net Benefit ($m)	NPV (2006) ($m)
2006	0	0.0	0.0	0.0	0.0	1.15	0.0	(1.15)	(1.15)
2007	44	0.0	0.0	0.0	0.0	2.53	0.0	(2.53)	(2.26)
2008	79	0.0	643	0.06	0.06	2.05	0.0	(1.99)	(1.58)
2009	107	0.0	1,311	0.12	0.12	1.64	0.0	(1.52)	(1.08)
2010	131	0.0	1,336	0.12	0.12	0.0	0.0	0.12	0.08
2011	150	0.0	1,361	0.12	0.12	0.0	0.24	(0.12)	(0.07)
2012	164	0.0	1,385	0.12	0.12	0.0	0.24	(0.12)	(0.06)
2013	175	0.94	1,410	0.12	1.07	0.0	0.24	0.82	0.37
2014	184	1.70	1,435	0.12	1.82	0.0	0.24	1.58	0.64
2015	189	2.29	1,460	0.12	2.42	0.0	0.24	2.17	0.78
2016	201	2.81	1,484	0.12	2.93	0.0	0.24	2.68	0.86
2017	212	3.20	1,509	0.12	3.32	0.0	0.24	3.08	0.89
2018	223	3.50	1,534	0.12	3.62	0.0	0.25	3.38	0.87
2019	234	3.74	1,559	0.12	3.86	0.0	0.25	3.62	0.83
2020	246	3.92	1,583	0.12	4.04	0.0	0.25	3.80	0.78
2021	257	4.04	1,608	0.12	4.16	0.0	0.25	3.92	0.72
2022	268	4.28	1,633	0.12	4.40	0.0	0.25	4.16	0.68
2023	279	4.52	1,658	0.12	4.64	0.0	0.25	4.40	0.64
2024	291	4.76	1,682	0.12	4.88	0.0	0.25	4.64	0.60
2025	302	5.00	1,707	0.12	5.12	0.0	0.25	4.88	0.57
	3,736	**44.70**	**26,299**	**2.16**	**46.86**	**7.37**	**3.67**	**35.82**	**3.10**

HIV = human immunodeficiency virus, STI = sexually transmitted infection.
Source: Mission estimates.

11. Improved HIV and STI management will reduce the burden of these diseases and generate economic benefits largely through reduced out-of-pocket expenditures and decrease costs associated with lost labor through elevated numbers of sick days. In summary, key benefits include cost savings due to increased health awareness and improved HIV and STI control and increased incomes because of the reduction in time taken off work as sick leave or to care for sick family members.

12. Resource or out-of-pocket savings may flow from (i) increased access to health services to reduce transport costs; and (ii) more efficient and rational diagnosis and treatment to reduce cost of treatment.[6] Improvements in health status as a result of health awareness activities lead to significant decreases in out-of-pocket health expenditures. Table A9.2 presents the various health cost savings for HIV/AIDS and STIs.

[6] ADB. 2002. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Cambodia for Health Sector Support Project.* Manila.

Table A9.2: Resource Cost Savings and Labor Productivity Assumptions

Communicable Disease	Economic Cost per Case	Value of Lost Labor	Reduced Incidence/ Prevalence
HIV/AIDS	Avoided annualized cost (benefit) of $12,656 per AIDS case. Includes indirect costs.[7]	Thirty days of labor lost per case through health care seeking, valued at $5 per day, and premature death.[8]	Burden of disease modeled using a coefficient of HIV incidence reduction associated with a comprehensive response derived from the GOALS[9] model. Assumes 60% of reduced disease burden attributable to this project
STIs (non-HIV)	Average annual cost of $5 per STI case. Includes treatment and indirect costs. Assumes that only a small number of STI cases are treated.	One day of labor lost per case through health care seeking, valued at $5 per day.	Burden of non-HIV STI assumed to be reduced by 10% as a result of this Project.

AIDS = acquired immunodeficiency syndrome, HIV = human immunodeficiency syndrome, STI = sexually transmitted infection.
Source: Mission estimates.

13. Adults often have to care for sick children, or they may contract an infectious disease themselves and suffer reduced work productivity and foregone income because of premature death. The nature of these productivity losses have received limited attention in the literature, although demographic and household surveys indicate that considerable time is lost through transportation of HIV/AIDS-affected family members to health facilities in Africa and Asia.[10] Assumptions used to estimate the economic impacts of current levels of prevalence are provided in Table A9.2.

G. Economic Internal Rate of Return

14. The Project is estimated to lead to the avoidance of nearly 4,000 HIV infections across 10 Pacific countries over a 20-year period and to an annual decrease in STI cases of nearly 2,000 per year. The EIRR from this impact is estimated to be 16%, and an economic net present value (NPV) of $3.1 million is calculated.

H. Financial Sustainability Analysis

15. The Project's recurrent costs include the procurement of medical supplies for STI clinics and ongoing institutional support for surveillance. These costs represent only a small percentage of government health expenditures in the 10 target Pacific nations. Overall, they represent less than 3% of central government expenditures in the relevant countries, but note that health expenditures vary considerably across the implementation area. For example, in

[7] Schwartlander, B. et al. 2001. *Resource Needs for HIV/AIDS*. Science 292, 5526; and Stover, J. et al. 2002. Can We Reverse the HIV/AIDS Pandemic with an Expanded Response? The Lancet 360: 73-77.

[8] For concerns about using discounted future earnings to value premature death, see Koopmanschap, M.A., and F. F. Rutten, 1993, Indirect Costs in Economic Studies: Confronting the Confusion. *Pharmaconomics* 4: 446-454.

[9] ADB/UNAIDS. 2004. *Funding Required to Confront the HIV/AIDS Epidemic in the Asia and Pacific Region.* Manila.

[10] Bloom, D., P. Jacobs, and K. Fassbender. 1998. The Impact of HIV/AIDS Mortality on Households in Thailand. In *The Measurement of Indirect Costs in the Health Economics Evaluation Literature.* International Journal of Technology Assessment in Health Care 14: 799−808.

2001, health expenditure per person was estimated at $588 in Nauru and $40 per person in the Solomon Islands.[11] The estimates of annual recurrent expenditures from the project are shown in Table A9.3.

Table A9.3: Estimated Annual Recurrent Expenditures after Project Implementation 2006–2025

		ADB / SPC HIV/AIDS Prevention and Capacity Development in the Pacific Project				Pacific Ministries of Health Government Budgets	
Year		Strengthen Surveillance	Community Response	Targeted Intervention	Project Admin	Total Annual Recurrent	Estimated Proportion
		US$000	US$000	US$000	US$000	US$000	%
1	2006	549.4	92.3	147.9	356.7	0.0	0.0%
2	2007	712.0	1,009.1	447.1	409.5	0.0	0.0%
3	2008	391.2	1,008.6	312.8	416.9	0.0	0.0%
4	2009	277.8	818.6	230.9	416.2	0.0	0.0%
5	2010	4.4	234.3	23.2	141.0	0.0	0.0%
6	2011	4.5	239.0	23.7	0.0	267.2	2.7%
7	2012	4.6	243.7	24.2	0.0	272.4	2.7%
8	2013	4.7	248.4	24.6	0.0	277.7	2.7%
9	2014	4.8	253.1	25.1	0.0	282.9	2.7%
10	2015	4.9	257.7	25.6	0.0	288.2	2.7%
11	2016	4.9	262.4	26.0	0.0	293.4	2.7%
12	2017	5.0	267.1	26.5	0.0	298.6	2.7%
13	2018	5.1	271.8	27.0	0.0	303.9	2.7%
14	2019	5.2	276.5	27.4	0.0	309.1	2.7%
15	2020	5.3	281.2	27.9	0.0	314.4	2.7%
16	2021	5.4	285.9	28.4	0.0	319.6	2.7%
17	2022	5.5	290.5	28.8	0.0	324.8	2.7%
18	2023	5.6	295.2	29.3	0.0	330.1	2.7%
19	2024	5.7	299.9	29.7	0.0	335.3	2.7%
20	2025	5.7	304.6	30.2	0.0	340.6	2.7%

ADB = Asian Development Bank, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, SPC = Secretariat of the Pacific Community.
Source: Mission estimates.

16. Likewise, central government contributions to overall health spending vary from 2.9% in Tuvalu to 16.0% in Samoa. As a percentage of government health spending, recurrent costs from the ADB supported project are likely to be minimal, that is, less than 5%.

J. Conclusions

17. The literature indicates that economic returns from investments in health have been substantial. The private market, however, fails to invest appropriately in health prevention and care activities. Economic analysis suggests that investment in HIV/AIDS control in the Pacific will be economically attractive and also financially sustainable. Vulnerable groups will be the key beneficiaries from such investment, particularly young people and marginalized women.

[11] WHO. 2004. *World Health Report 2004.* Geneva.

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

A. Linkages to the Country[a] Poverty Analysis

Is the sector identified as a national priority in country poverty analysis?	☐ Yes ☒ No	**Is the sector identified as a national priority in country poverty partnership agreement?**	☐ Yes ☒ No

Contribution of the sector or subsector to reduce poverty in the Pacific region:

Progress toward poverty reduction has taken place in all project countries. Health issues and access to health services have been identified as high-priority areas for Pacific islanders in the participative poverty assessments undertaken in Pacific developing member countries (PDMCs). The region's economies are generally weak, and increasingly complex issues, including disease epidemics, rapid population growth and urbanization, and globalization, demand attention.

In recent decades, many PDMCs have achieved improvements in the area of health: life expectancy has increased, infant and child mortality rates have decreased, and immunization coverage has been extensive. However, infectious diseases such as tuberculosis, dengue fever, and malaria are on the rise. In addition, a worrying rise in the number of HIV/AIDS and sexually transmitted infection (STI) cases is apparent in several countries along with an equally worrying lack of data on the actual situation. As a result, many PDMCs are facing a double burden of prevention and treatment of persistent, traditional, infectious ailments along with a rising tide of new and nonommunicable diseases.

Under-reporting of HIV/AIDS cases and the lack of testing facilities have resulted in relatively low HIV/AIDS prevalence rates being cited in official statistics. With the exception of Papua New Guinea, the major form of transmission is through heterosexual contact. Even though HIV/AIDS prevalence rates are lower than in other regions, the underlying social, cultural, economic, and demographic conditions are such that a similar rapid spread of the disease is possible. These conditions include a youthful population with a high incidence of youth pregnancies and STIs; movements in, through, and out of the region by mobile population groups; slow or negative economic growth and the consequential, lack of employment opportunities; and sociocultural practices that pattern the behavior of men and dictate the status of women.

Infectious diseases tend to disproportionately affect poor people, who tend to suffer from poor nutrition and often live in crowded conditions. The proposed project interventions have been designed to specifically address these groups through developing capacity, improving access to health facilities, and providing equipment and drugs in areas of priority needs. Marginalized women are at particular risk of being drawn into commercial sex work, where the risk of HIV infection is, high, and special provisions will be made to address this issue. The Project will help reduce the spread and impact of HIV/AIDS and other STIs in the project countries by (i) strengthening surveillance, (ii) community-based interventions for HIV/AIDS prevention, and (iii) targeted interventions for vulnerable groups. The outcome of the Project will be improved management and delivery of HIV/AIDS prevention activities in the Pacific through the targeting of vulnerable populations. The Project will help minimize the social and economic impacts of HIV/AIDS and help target countries' progress toward their 2015 health-related Millennium Development Goals of reducing mortality rates and halting, to the extent possible, and reversing the spread of HIV/AIDS.

B. Poverty Analysis — Targeting Classification: Targeted intervention

What type of poverty analysis is needed?

Much of the Pacific is still characterized by reliance on subsistence agriculture, although urbanization is increasing. Participatory assessments of hardship in six PDMCs[b] revealed that hardship was equated with a lack of economic and employment opportunities as a result of poor education, lack of access to land for gardens or cash crops, poor access to good water and sanitation facilities, poor health, and living alone or depending on others. These pre-existing factors contribute to the spread of HIV/AIDS and other STIs.

HIV/AIDS has significant socioeconomic impacts on poor people, diverting scarce resources into health care and removing the ability to work. The Project will focus on strengthening surveillance and implementing community-based interventions for HIV/AIDS prevention. These will include targeting people at high risk, such as women, commercial seafarers and their partners, individuals with STIs; mobile populations (including international peacekeepers and individuals involved in international tourism ventures), prisoners, commercial and transactional sex workers, and men who have sex with men (including indigenous sexual minorities such as *fa'afafine* and *fakaleiti*). Project activities will benefit those at high risk, but will also benefit the poor and other vulnerable groups because of specific provisions that will be made. The poor and vulnerable suffer from a higher burden of diseases, particularly HIV/AIDS, and have limited access to both public and private health services. By improving people's health situation, especially among vulnerable groups or the poor, the Project will reduce the burden of HIV/AIDS and STIs and generate economic and social benefits as follows: (i) increased health awareness activities will lead to improvements in health status, which decreases out-of-pocket expenditures; (ii) increased STI treatment and administration of antiretroviral drugs will decrease the number of people having to miss work; and (iii) increased HIV/AIDS and STI awareness will lead to better preventive measure, increased tolerance for people living with HIV/AIDS, and reduce discrimination against people living with HIV/AIDS at the work place and in the household.

C. Participation Process

Is there a stakeholder analysis? ☒ Yes ☐ No

The Project design took into account the inputs of key stakeholders in the development of the Pacific Regional Strategy (PRS) on HIV/AIDS 2004–2008 as well as the consultative process used to develop the PRS Implementation Plan. The design also took advantage of the consultative processes and mechanisms used to develop the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) round 5 submission in June 2005. The Asian Development Bank (ADB) is a member of the GFATM Country Consultative Mechanism, which monitors the two GFATM projects. Primary institutional stakeholders include ministries of health, women's affairs, and youth; civil society, and nongovernment organizations. These organizations have existing links with representatives from vulnerable and high-risk groups and represent their interests through regional GFATM round 2 activities and mechanisms.

Is there a participation strategy? ☒ Yes ☐ No

The project design took into account the existing participation mechanism for developing the PRS. The stakeholders' involvement will continue during project implementation. The PRS is the result of extensive consultation among national health representatives, regional organizations, and bilateral and multilateral donors. The Project will build on these existing mechanisms and ensure that a participation strategy is integrated into overall project implementation. The targeting of vulnerable people in the Project will require extensive consultations, focus group discussions, surveys, and so on to design activities that are most appropriate for the target group. These activities will be incorporated into the Project.

D. Gender Development

Strategy to maximize impacts on women:

The PRS recognizes that HIV/AIDS is a gender issue and that the age at which women are being infected is decreasing. The PRS addresses gender issues by encouraging equitable attention to and participation by women in regional HIV/AIDS activities. Estimates indicate that under current major HIV/AIDS projects, between 50% and 65% of target beneficiaries are women. The ADB Project falls under the overarching goal of the PRS and will complement or expand on current activities. Every component of the Project will address gender issues.

The sector analysis identifies women as being particularly vulnerable to HIV/AIDS for various reasons, notably, their socioeconomic status and lack of power in national and community decision-making processes. Currently, many women in the Pacific are in single--partner relationships and/or are homemakers, but are accounting for an increase in HIV/AIDS infections because their partners often have multiple sex partners. For example, the wives of seafarers and other mobile workers are highly vulnerable to becoming infected with HIV by their husbands. Thus HIV/AIDS awareness workshops for seafarers and other mobile populations will be coupled with workshops for seafarers' wives. These workshops will ensure that the maximum number of women can participate through rapid needs assessments that will be conducted ahead of time.

Has an output been prepared? ☐ Yes ☒ No

E. Social Safeguards and other Social Risks

Item	Significant/ Not Significant/ None	Strategy to Address Issues	Plan Required
Resettlement	☐ Significant ☐ Not significant ☒ None	No resettlement will be required	☐ Full ☐ Short ☒ None
Affordability	☐ Significant ☐ Not significant ☒ None	Issues pertaining to affordability will not arise during the Project. The Project will improve the quality of health care and provide drugs and health services, thereby reducing health-related expenditures. The drugs and health services provided will be free for the target group.	☐ Yes ☒ No
Labor	☐ Significant ☐ Not significant ☒ None	Labor will not be an issue. The Project is expected to slightly increase the number of health workers and train existing health workers in project-related activities.	☐ Yes ☒ No
Indigenous Peoples	☐ Significant ☐ Not significant ☒ None	There are no impacts on indigenous peoples.	☐ Yes ☒ No
Other Risks and/or Vulnerabilities	☐ Significant ☐ Not significant ☒ None	There are no other impacts that would trigger safeguard policies.	☐ Yes ☒ No

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