

U N C L A S S I F I E D

AGENCY FOR INTERNATIONAL DEVELOPMENT

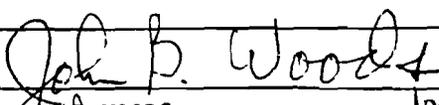
Washington, D.C. 20523

PROJECT PAPER

SOUTH PACIFIC REGIONAL: Regional Aids Prevention  
(879-0022)

September 26, 1990

U N C L A S S I F I E D

AGENCY FOR INTERNATIONAL DEVELOPMENT <b>PROJECT DATA SHEET</b>				1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete		Amendment Number _____		DOCUMENT CODE <b>3</b>	
2. COUNTRY/ENTITY SOUTH PACIFIC REGION				3. PROJECT NUMBER 879-0022					
4. BUREAU/OFFICE APRE				5. PROJECT TITLE (maximum 40 characters) REGIONAL AIDS PREVENTION					
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 09 30 95				7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4) A. Initial FY 90 B. Quarter 4 C. Final FY 94					
8. COSTS (\$000 OR EQUIVALENT \$1 = )									
A. FUNDING SOURCE			FIRST FY 1990			LIFE OF PROJECT			
			B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total	
AID Appropriated Total									
(Grant)			( 80 )	( 182 )	( 262 )	( 900 )	( 1,600 )	( 2,500 )	
(Loan)									
Other U.S.	1. AIDSCOM					30		30	
	2.								
Host Country SPC				40	40		230	230	
Other Donor(s) SEE PP									
TOTALS			80	222	302	930	1,830	2,760	
9. SCHEDULE OF AID FUNDING (\$000)									
A. APPRO- PRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	B-510	569				2,000		2,000	
(2) SD	B-510	569				500		500	
(3)									
(4)									
TOTALS						2,500		2,500	
10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 550								11. SECONDARY PURPOSE CODE	
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)									
A. Code		PVON	TNG	BU	DEL				
B. Amount		20%	10%	100%	100%				
13. PROJECT PURPOSE (maximum 480 characters) <div style="border: 1px solid black; padding: 10px; text-align: center; margin: 10px 0;">To promote behavior that will thward STD/HIV/AIDS transmission.</div>									
14. SCHEDULED EVALUATIONS					15. SOURCE/ORIGIN OF GOODS AND SERVICES				
Interim		MM YY 10 92	MM YY		Final		MM YY 09 95	<input checked="" type="checkbox"/> 000 <input type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input type="checkbox"/> Other (Specify) _____	
16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)									
17. APPROVED BY		Signature 					18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCU- MENTS, DATE OF DISTRIBUTION		
		Title JOHN B. WOODS Regional Director, RDO/SP					Date Signed MM DD YY 10 9 24 90		
							MM DD YY 		

REGIONAL AIDS PREVENTION PROJECT

879-0022

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ACTION MEMORANDUM FOR THE DIRECTOR

DATE: September 26, 1990

FROM: James Osborn, Assistant Regional Director

SUBJECT: Authorization of the Regional AIDS Prevention Project (879-0022), Approval of the Project Paper and Approval of the Grant Agreement for South Pacific Commission

Problem:

The documents for the authorization and initial obligation of the Regional AIDS Prevention Project have been completed and require your signature.

Background:

A two-person team, Dr. Robert Benjamin and Dr. John David Dupree under AIDSCOM and AIDSTECH sponsorship, surveyed the AIDS scene in several countries of the region in October and November, 1988. Based on their report, RDO/SP submitted a PID to AID/W on December 16, 1988 for a \$5.0 million project. The PID was rejected by AID/W as being for too much money, not having explored the potential role of other donors, and for not having adequate data about the magnitude of the problem (State 046564, February 14, 1990).

RDO/SP contracted with Dr. Loel Callahan under PSCs for several time periods between February, 1989 and September, 1990 to guide the design of this project. A revised PID for a \$2.5 million project was submitted to AID/W on November 8, 1989. The ANE Bureau held its review on November 22, 1989 and approved the PID on May 3, 1990 (State 142650). The Bureau's guidance for design was faxed to RDO/SP at the time of PID approval.

The project paper was prepared with the assistance of people from several organizations, including consultants provided by AID/W and the Australian foreign aid agency (AIDAB) and in full cooperation with the South Pacific Commission (SPC). The PP, with some changes, responds to a portion of the SPC's revised proposal of May, 1990 entitled "Information and Communication Project for the Prevention of AIDs and STDs in the Pacific." The various issues and questions raised by AID/W have been addressd in the PP (see summary in Annex A with PID cable approval cable).

The project is fully justified and described in the attached PP. The suggestions of Regional Legal Advisor, Paul Scott, as sent to us in two faxed messages of September 20, 1990, have been incorporated into the PP.

A major issue has been how to apply AID's procurement and source/origin rules to the SPC grant. Handbook 13, Chapter 5 makes a distinction between a situation where A.I.D. is the sole contributor to a public international organization's (PIO) project or activity (A.I.D. procurement rules and source/origin apply) and where A.I.D. is not the sole contributor (A.I.D. relies on the PIO's rules and audits). This was complicated by the Administrator's new Buy America policy (State 276461 and 265071) for which detailed instructions have not yet been sent to the field.

Our request to AID/W for guidance (Suva 3086, September 6, 1990) was answered on September 21 (State 320540). The response said that if other donors are to be involved, then A.I.D. would rely on the procurement policies of the PIO and the Buy America policy would not apply. However, if A.I.D. funds are used separately for identified purposes, the Buy America and other policies would apply. The cable left it up to RDO/SP to decide which situation applied in this project.

The faxed message from RLA Scott on September 20 indicated that Mr. Scott did not think our project was one where other donors would also contribute. On September 24, we sent additional information to Mr. Scott by fax re the extent of involvement of other donors. This was followed by a telephone conversation later that day by Ralph Singleton with Mr. Scott in which Mr. Scott indicated that the additional information was not sufficient for him (Scott) to change his earlier conclusions. Therefore, the PP and the grant agreement with SPC include audit requirements as called for in HB 13, Chapter 5.

The second major issue was source and origin which is linked to the same factors although HB 13 does not make this distinction. Mr. Scott felt that the language of State 320540 would permit us to include local cost financing in the authorization provided the PP budget identified, by line item, the amounts to be spent for local costs and provided a justification for each local cost (why U.S. procurement would not be feasible). The PP now includes this information and the authorization includes local cost financing, thereby eliminating the need for waivers later for each local cost procurement action.

Mr. Scott further said that under the circumstances (SPC headquarters in Noumea and some project costs to be incurred there), he thought that local cost financing could include procurement in Noumea as well as the ten countries of RDO/SP region. The PP reflects this position. A few waivers might be needed for procurement of a limited amount of commodities from code countries but this should not be a major burden. The grant agreement with SPC also includes these source/origin restrictions.

The details of some contributions from other sources have either not yet been confirmed officially or were changed within the last few days of PP writing. Expected contributions from AID/W projects which faded away in recent days totalled about \$420,000 (condoms and short term technical assistance) or about 13 percent of total project budget. These losses may be replaced by possible new contributions from AIDAB. Minor modification in implementation details may be needed soon (e.g., who will provide condoms) and contributions from other sources might not be just as described in the PP. Some last minute changes had to be made in the PP to reflect such information as:

(1) The planned SOMARC project for PNG has not yet been completely negotiated with GPNG so changes in amount, scope of activities, etc. may be made later.

(2) On September 21, we learned that management changes in the AIDSCOM and AIDSTECH projects meant that all TA and other assistance would come from AIDSCOM only whereas earlier we had been advised that both projects would provide buy-in possibilities.

(3) On September 25, we were advised that S&T/Population would not be able to provide a donation of three million condoms that had been promised for many months (estimated value \$150,000).

(4) Also on September 25, we learned that AIDAB would be interested in using a portion of its planned A\$1.0 million grant to SPC and WHO for regional AIDS activities to finance: (a) condoms to support our project's community grants activities and (b) SPC's hiring a media expert to work at the SPC Regional Media Center in Suva.

(5) On September 26, we were advised by AIDSCOM that (a) their planned contribution to the project through buy-ins had been reduced to \$30,000 from expected \$300,000 and (b) the ratio of AIDSCOM money to project money has been reversed. Earlier the ratio was \$3.00 of AIDSCOM to \$1.00 of project money; now it is to be \$1.00 of AIDSCOM for \$3.00 of project. As a result, instead of a \$400,000 component funded \$300,000 by AIDSCOM and \$100,000 by project, we have a \$130,000 component funded \$30,000 by AIDSCOM and \$100,000 from project.

The Congressional Notification was sent to Congress on June 28, 1990 (State 226880) and expired without objection (State 238891). On September 14, Program Officer Kirk Dahlgren called Ms. Ellen Bailey, ANE/PD to clarify that Congress had been notified regarding the plans to obligate \$200,000 from HE and \$61,700 from SDA in FY 1990. Ms. Bailey, after checking her records, confirmed that Congress had been notified of these amounts.

The FY 1990 allotment of funds (\$261,700) is to be obligated by the grant agreement with SPC (\$200,000 HE funds) and by a personal services contract with Dr. Callahan (\$61,700 SDA funds).

The AA/ANE delegated authority to the Regional Director to authorize the project as part of the PID approval process (State 142650, May 3, 1990).

Dr. Callahan will handcarry the grant agreement to Noumea on Thursday, September 27 for signing.

Recommendations:

1. That you approve the project paper by signing the PP face sheet at Tab A;
2. That you authorize the project by signing the authorization at Tab B;
3. That you obligate funds to SPC by signing the grant agreement upon receipt of SPC's signature of the grant letter which is to be faxed from Noumea by Assistant Director Osborn (copy at Tab C); and
4. That you obligate \$61,700 in the PSC with Dr. Callahan (to be submitted separately).

Attachments: Tab A - Project Paper  
Tab B - Project Authorization  
Tab C - Grant Agreement

Clearances: KDahlgren, PRO *KD*  
DCalder, HPN (by phone)

Drafted: *H for* LCallahan, RAA and *RP* RSingleton, PDA  
doc. 0088Y

Distribution: Reading File and Chron File (w/o attachments),  
Project File 879-0022

1

PROJECT AUTHORIZATION

NAME OF COUNTRY: SOUTH PACIFIC REGION  
NAME OF PROJECT: Regional AIDS Prevention Project (RAP).  
NUMBER OF PROJECT: 879-0022

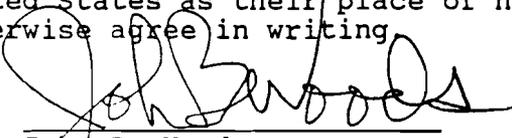
1. Pursuant to Sections 104(c) and 106 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Regional AIDS Prevention Project (879-0022), involving planned obligations not to exceed Two Million Five Hundred Thousand United States Dollars (\$2,500,000) in grant funds over a five year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allowance process, to help finance foreign exchange and local currency costs of the project. The planned life of project is five years from the date of initial obligation.

2. The project consists of activities designed to minimize the impact of STD/HIV/AIDS in the South Pacific through the strengthening of AIDS public education programs at the community and regional levels. Project activities will include grant assistance to the regional AIDS education activities of the South Pacific Commission (SPC), support for the community level AIDS education programs and the promotion of increased cooperation and coordination among AIDS prevention program donors.

3. The grant and other agreements, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. Source of Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the project shall have their source of origin in the South Pacific Region (A.I.D. Geographic Code 879) or in the United States (A.I.D. Geographic Code 000), except as A.I.D. may otherwise agree in writing. Suppliers of commodities or services shall have the South Pacific Region or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing.

  
John B. Woods  
Regional Director  
Regional Development Office/South Pacific

Date 9/26/90

Clearances: ARD: JOsborn: (draft) M  
HPN: DCalder: (phone) M  
PROG: KDahlgren M

Drafted: M for LCallahan, PSC RAD, RSingleton, PSC PSA, Paul Scott, RLA: M for

BASIC DATA - SOUTH PACIFIC REGION

Country	Land Area (sq. ml)	Sea Area (sq. ml)	Population (1985)	Population Density (per sq.ml)	Population Growth Rate (% p.a.)	GDP (year) (\$m)	GDP Per Capita (\$)	Exports	Imports	Balance	Aid
									(\$m, 1984)		(\$m, 1984)
Cook Is.	96	732,000	17,600	73	0.3	35.4(1985)	2020	3.7	20.8	17.1	8.1
Fiji	7310	480,000	715,000	38	2.0	1022.8 (1985)	1460	250.6	451.1	200.5	31.3
Kiribati	276	1,420,000	64,000	93	2.0	27.7(1984)	444	11.0	18.4	7.4	11.9
Niue	104	156,000	2,900	11	2.6	4.1(1983)	1394	0.1	2.4	2.3	3.2
PNG	184,676	1,240,000	3,480,000	7	2.1	2380.3 (1985)	717	896.7	974.4	77.7	321.8
Solomon Is.	11,022	520,000	286,000	10	3.5	159.6(1983)	632	94.0	66.5	+27.5	19.4
Tonga	280	280,000	106,000	135	0.3	81.0(1983)	849	9.1	40.6	-31.5	15.7
Tuvalu	10	351,000	8,600	331	2.8	3.4(1985)	325	11.2	3.4	- 2.2	5.5
Vanuatu	4,752	272,000	145,000	11	3.3	79.6	667	44.0	68.5	-24.5	24.5
W. Samoa	11,745	116,000	160,000	55	0.6	113.3	717	20.2	39.2	-19.0	20.2

DEFINITIONS  
(From CDC and WHO)

AIDS refers either to the specific clinical entity, the acquired immunodeficiency syndrome, or to the entire spectrum of health problems associated with HIV infection.

Human Immunodeficiency Virus (HIV) is used throughout this paper for the virus that causes AIDS. HIV has replaced earlier names for the virus, which include lymphadenopathy virus (LAV-1) and human T-lymphotropic virus type III (HTLV-III). Related retroviruses include LAV-2, HTLV-IV, SBL 6669 and other recently recognized retroviruses infecting humans. Throughout this paper HIV stands for all those viruses.

HIV-infected persons include all individuals, regardless of their clinical status, who are infected with the virus, as shown by positive serological tests, usually enzyme-linked immunosorbent assay (ELISA), confirmed by immunoblot (Western blot) immunofluorescence or radioimmunoassay, and/or isolation of the virus.

STD refers to sexually transmissible diseases such as syphilis, donovanosis, gonorrhea, chlamydia that result in genital ulcers and have been linked to HIV transmission.

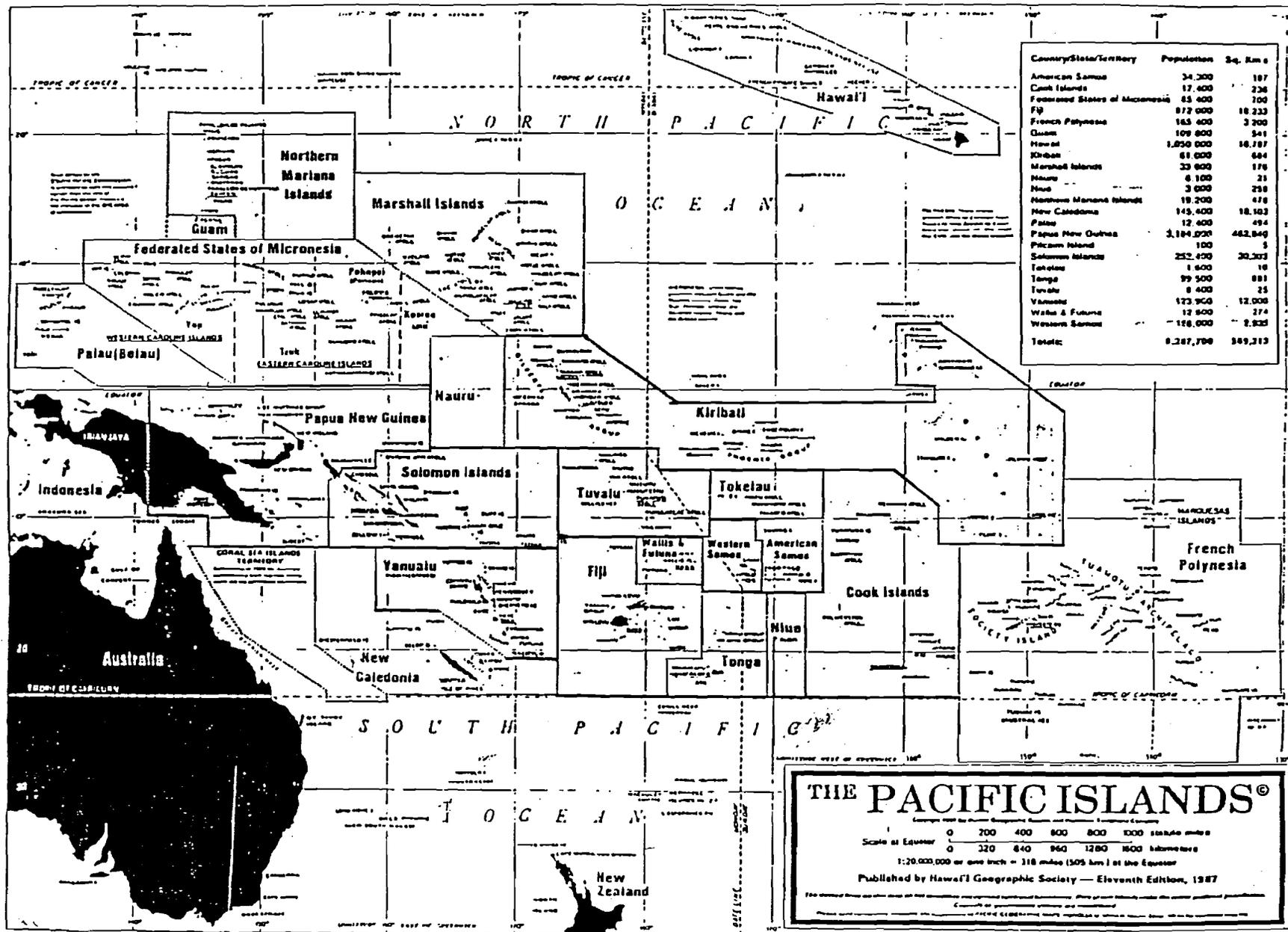
The combined term STD/HIV/AIDS is used to indicate the relationship between HIV transmission and Sexually Transmissible Diseases (STD) - especially those STDs that result in genital ulcers.

KAPB Studies refers to scientific studies carried out through the response by selected informant to questionnaires presented by interviewers to determine the knowledge, attitudes, practices and belief of a well defined groups of persons about a specific topic. In this PP, KAPB refers to surveys that will provide information about STD/HIV/AIDS transmission and prevention, as well as sexual practices.

ACRONYMS

A.I.D.	Agency for International Development
AIDAB	Australian International Development Assistance Bureau
AIDSCOM	AIDS Communications Project (A.I.D.)
CDC	Centers for Disease Control (U.S.A.)
CYP	Commonwealth Youth Program
EEC	European Economic Community
GPA	Global Program on AIDS (of WHO)
HGO	Host Government Organization
HPN	Health, Population and Nutrition Division of RDO/SP
INFONET	Information Center at SPC
IV	Intravenous method of taking drugs
JICA	Japanese International Cooperation Agency
KAPB	Knowledge, Attitudes, Practices and Beliefs Study
LRC	League of Red Cross
MTP	National Medium Term Plan for AIDS Prevention
NAC	National Aids Committee(s)
NGO	Non-Governmental Organization
ODA	Official Development Assistance (U.K.)
PIO	Public International Organization
PNG	Papua New Guinea
PP	Project Paper
PSC	Personal Services Contractor
PVO	Private and Voluntary Organization
RAA	Regional AIDS Advisor
RAP	Regional AIDS Prevention Project
RDO/SP	Regional Development Office/South Pacific, A.I.D. located in Suva, Fiji.
RDO/SP/PNG	RDO/SP's Branch Office in Port Moresby
RDSS	Regional Development Strategy Statement (RDO/SP)
RPA	Regional Program for AIDS Prevention (WHO)
SOMARC	Social Marketing II Project (A.I.D.)
SPC	South Pacific Commission
TAG	Technical Advisory Group (AIDS donors in the Pacific)
UNESCO	United Nations Education, Scientific and Cultural Organization
WHO	World Health Organization

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(VI)

## EXECUTIVE SUMMARY

### A. Recommendation:

RDO/SP recommends the authorization of a \$2,500,000 project to prevent the spread of AIDS in the South Pacific. The project will be for five years, concluding on September 30, 1995. The project will include a grant to the South Pacific Commission totaling \$850,000 for thirty months. Based upon the finding of an evaluation, SPC performance and the availability of funds, the grant's level of funding and time period may be extended. The implementing agency for the SPC will be the Community Health Services Office of SPC.

### B. Why?

The linkage between sexually transmitted diseases (STD) and HIV virus transmissions has been long established. Five factors indicate that while the incidence of HIV/AIDS in the South Pacific is low at this time, failure to mount a successful prevention campaign will likely result in a rapid spread of the disease not only among men, but among women, adolescents and infants as well:

- the increasing rate of STD across the Pacific; (e.g., 651% increase in syphilis in PNG over recent nine year period; 45% increase in gonorrhoea in Fiji over recent three year period). Similar increases have been reported in the Solomon Islands, Vanuatu, Tonga and Western Samoa but no statistics are available at this time.

- the established presence of HIV and AIDS in PNG (283% increase of AIDS in PNG in 1 1/2 years) Western Samoa, Tonga and in Fiji (six known cases of HIV positive in Fiji today vs. none 18 months ago);

- sexual practices among the Pacific societies;

- indications that the spread of HIV is likely to follow the African experience (heterosexual spread), which would mean that the entire population of a country may be at risk rather than small, high risk groups within the country; and

- the incidence of STDs and HIV/AIDS probably is much higher due to poor reporting, lack of medical coverage in many places, and cultural restrictions while monitoring the spread of HIV/AIDS. Targeting preventative campaigns are made difficult for the same reasons.

The South Pacific Commission (SPC), the donors and the countries, under the leadership of WHO, have established a large, complex strategy to thwart the spread of AIDS within the region. The various donors have focused on policy development, blood screening, medical professional training and school curricula. The broad and basic area of community education on AIDS prevention has been largely unattended.

Therefore, this Regional AIDS Prevention Project (RAP) is concentrated on community education for AIDS prevention.

C. What?

The purpose of the A.I.D. project is to promote behavior change that will thwart STD/HIV/AIDS transmission. The A.I.D. project will work at two levels:

- at the regional level, it will strengthen the capability of SPC's Community Health Services Program to carry out an AIDS and STD information and communication project among its member countries; and

- at the national and community level, it will strengthen the AIDS education programs of NGOs and the social marketing of condoms in the countries served by RDO/SP.\*

This five year A.I.D. project is to support the SPC's "Information and Communication Project for the Prevention of AIDS and STDs in the Pacific." The SPC project\*\* is broader than just this A.I.D. project as it includes, among other things:

- an information exchange center (INFONET) financed by WHO and UNESCO;

- health education activities supported by AIDAB until the A.I.D. project is in place; and

- the involvement of a full range of existing SPC programs that can support the AIDS prevention effort.

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\* The ten countries served by RDO/SP are: Papua New Guinea, Fiji, Solomon Islands, Western Samoa, Vanuata, Tonga, Kiribati, Cook Islands, Tuvalu and Niue.

\*\* To avoid confusion in terminology, the PP will use the title "Regional AIDS Prevention Project" or RAP or the "Project" to refer to the A.I.D. project and the title "SPC Program" or SPC AIDS Prevention Program" to refer to the SPC broader project.

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The project activities include: (a) baseline data collection and monitoring; (b) community education activities; (c) AIDS educational materials prepared in the region and locally; and (d) networking among donors and among community organizations.

The project inputs include: (a) a long term AIDS communications specialist at SPC along with a secretary and office equipment, (b) regional training, (c) community grants, (d) some equipment for SPC's Regional Media Center, (e) knowledge, attitudes, practices and beliefs (KAPB) studies, and (f) short term technical assistance provided by AIDSCOM and other centrally financed projects through buy-ins. The project will also finance a personal services contractor (PSC) in RDO/SP to serve as a Regional AIDS Advisor.

Life of Project Budget  
(US \$ 000)

<u>Component</u>	<u>Admin. by</u> <u>RDO/SP</u>	<u>Grant to</u> <u>SPC</u>	<u>Total</u>
1. Technical Assistance		575	575
2. Training		300	300
3. Community Grants		500	500
4. SPC Media Center Support		130	130
5. KAPB Studies		160	160
6. TA Buy-ins		100	100
7. Evaluations and Audits		125	125
8. Contingency		110	110
9. RDO/SP Monitoring	500		500
TOTAL PROJECT 879-0022	500	2,000	2,500
10. AIDSCOM Contribution	30	-	30
11. SOMARC	300		300
TOTAL A.I.D. Contribution	830	2,000	2,830
12. SPC Contributions		230	230
TOTAL PROJECT COSTS	830	2,230	3,060

D. How?

Most of the project is to be implemented by SPC, a public international organization recognized in HB 13, Chapter 5. The grant will be for 30 months. A formal evaluation will be made after the first two years of implementation. Based on the results of the evaluation, the availability of funds, and the mutual agreement of RDO/SP and SPC, the grant may be extended for the second half of the project. The above budget is based on the assumption that the grant to SPC will be extended.

SPC, with the assistance of RDO/SP, will prepare a work plan that will include: a schedule of major events and activities, materials development and distribution, criteria for grants to NGOs involved in AIDS prevention, reporting and element tracking.

A recently formed group of participating donors will become the Technical Advisory Group (TAG) to provide continued collaboration and coordination of activities and support.

The project activities will be supported by supplemental efforts from the other donors within the larger strategy involving commodity supply, social marketing, epidemiology, data gathering and sharing, blood screening and testing, and counseling.

SPC, through its Community Health Services Program (Office), will manage and coordinate grant activities, using A.I.D. approved operations and management procedures which include procurement, conflict of interest, financial management, accounting and auditing systems, personnel management, program supervision, and institutional contracting.

SPC will hire a long term AIDS communications specialist under the grant for project implementation. It will contract directly for specific KAPB studies to be made. In addition, SPC will contract with private firms for production of educational materials. SPC will identify appropriate and qualified NGOs. It will plan and implement training including observational travel and study in the region. Lastly, SPC will establish the necessary administrative and management systems for implementation of a grant system to provide limited financial support to NGOs involved in community oriented AIDS education activities.

RDO/SP, using wherever appropriate the services of a PSC financed by the project, will monitor the project, coordinate with other donors, supervise and manage mission buy-in agreements with AIDSCOM, SOMARC and other centrally funded resources in support of the project, and participate in the TAG.

E. Conclusions:

This project was designed under the leadership of a personal services contractor (PSC) working for RDO/SP over a 1 1/2 year period in close collaboration with SPC and other donors.

The PID was submitted to AID/W on November 8, 1989, reviewed on November 22, 1989 and approved on May 3, 1990 (State 142650). The substance of this PP has been reviewed by SPC and their comments incorporated into the final design.

All issues identified during the PID review and in the project design have been resolved. The project is technically, financially, socially and administratively sound. The activities are responsive to the needs of the region as identified during the project design and are consistent with A.I.D. policy on AIDS prevention.

The Regional Director, RDO/SP, has been delegated authority to authorize the project (State 142650). The Congressional Notification waiting period expired without objection on July 13, 1990 (State 226880 and State 238891). Therefore, the project should be authorized as presented in this PP.

Project Paper Drafter & Design Leader: Dr. Loel Callahan, RAA, PSC  
Project Paper Editor: Ralph M. Singleton, PDA, PSC

RDO/SP Project Committee: John Woods, Regional Director  
Jim Osborn, Assistant RD  
Kirk Dahlgren, Program Officer  
Dr. David Calder, Chief HPN  
Ivan Peterson, Controller

Contributors to Project Design:

Dr. Don Gardener	AIDAB	Social Soundness
Dr. Ann Martin	AIDSTECH	Economic Analysis
Mr. Don Levy	AIDSCOM	Social Marketing
Dr. Francois Bach	SPC	Epidemiology
Ms. Karen Heckert	WHO/Fiji	Strategy Development
Mr. James Mullally	WHO/PNG	Epidemiology
Ms. Jane Foster	CYP	Country Profiles
Ms. Bronwyn Koncz	NSWAIDS	Community Education
Ms. Margaret O'Callaghan	AIDAB	Bridge Financing

## I. PROJECT RATIONALE AND DESCRIPTION

### A. RATIONALE

RDO/SP, as mandated by Congress and the approved Regional Development Strategy Statement (RDSS), is charged with the formulation and implementation of an effort to minimize the spread of HIV/AIDS in the South Pacific.

#### 1. The Problem:

The linkage between STDs and HIV transmission has long been established. The increasing STD rate across the Pacific, the established presence of HIV and the emerging incidence of AIDS in the more populous nations of the region mean that attention must be given to combating this disease.

In PNG, gonorrhoea has increased from 910 reported cases in 1975 to 1,655 in 1984 (82% increase in nine years) while syphilis has increased from 69 cases to 518 (651% increase) during the same period. In Fiji 16,173 cases of gonorrhoea were reported in 1983 and 23,528 cases in 1986 (45% increase in three years) while cases of syphilis has increased from 5,755 in 1983 to 7,936 cases (38%) during the same period. Other island countries report similar increases. For reasons such as cultural restrictions, poor reporting and lack of medical coverage in many places, the incidence of STDs is believed to be much higher.

The numbers of cases of AIDS and HIV seropositives are low in comparison to Australia, New Zealand, Tahiti and the U.S. However, the trend is upward at an alarming rate reminiscent of the early 1980s in the U.S. when the number of cases was doubling every six months.

In PNG in late 1988, there were 16 reported AIDS cases. Today there are forty-six known cases, a 187% increase in 1 1/2 years. Since blood screening for HIV was not done in 1988, we have no baseline data yet, but in a recent testing of some 28,100 people in PNG, fourteen resulted in seropositives.

In Fiji in late 1988, there was one case of AIDS officially reported and no HIV positives. Today, there are six known cases of HIV in Fiji.

Both the demand and supply of condoms, the best single tool to reduce the spread of STDs (including HIV), are low in the region. The availability of condoms is unreliable to non-existent. Most condoms are distributed free by government agencies, such as hospitals, health posts and STD clinics. Small amounts of condoms are sold through private sector channels such as pharmacies. Obstacles to greater private sector marketing

of condoms include the small size of the markets in many countries and competition from government agencies giving away condoms. The market price of condoms in the urban areas is considered reasonable (about 20 U.S. cents for one in Suva), but high in the rural areas where incomes are lower and marketing costs higher.

In addition to the disturbing rapid rate of increase of STD/HIV/AIDS, two other factors are significant in analyzing the problem: (a) intravenous (IV) drug use is uncommon or non-existent in the island countries and (b) women are well represented among the AIDS and HIV seropositive groups. The late 1988 group of 16 AIDS cases in PNG included seven women. While there are no large homosexual communities in the South Pacific, bisexual practices are common in some countries.

Therefore, it is only reasonable to expect that the spread of HIV in the South Pacific is more likely to follow the African experience (heterosexual spread) than the U.S./Western European experience (mainly IV drug use and homosexual spread). This means that the entire population is at risk, although urban groups may be at higher risk than others. Consequently the education, monitoring, and screening programs must be directed to the entire population rather than small, high risk groups.

The incidence of HIV/AIDS in the South Pacific is low now. However, STDs, linked to HIV transmission, are rapidly spreading. Given the sexual practices among Pacific island societies, a low rate of public health surveillance, and the high movement of people (tourists and travel of the people of the region), once HIV is introduced into these countries, the epidemic could grow rapidly larger and more tragic well into the next century. In addition, failure to mount successful prevention campaigns will allow the disease to spread more readily from adult males to women and adolescents, who were once believed to be relatively safe.

## 2. Responses to the Problem:

The categories of effective response for HIV/AIDS prevention available for consideration are limited: (a) vaccine research, (b) community education, (c) blood screening, (d) technical training, (e) the provision of equipment and commodities, and (f) epidemiologic monitoring.

Effective response to the problem will require several types of effort. The South Pacific has neither the personnel or financial resources to support vaccine research. Blood screening, epidemiologic monitoring, equipment and commodities, formal school oriented education programs, technical training and mass media campaigns have been proposed and will be or are being funded by other donors. Longer range plans to incorporate counseling and medical care have been established. The development of appropriate national prevention programs has been undertaken by island nations with the assistance of WHO.

The central element of an AIDS prevention program is community education capacity to encourage behavior change, including a large increase in the use of condoms. This part of the regional AIDS prevention strategy has, until now, been largely unaddressed. Appropriately designed and implemented community education programs can be the most resource effective response to the potential HIV/AIDS problem in the Pacific.

### 3. Role of Other Donors:

A Technical Advisory Group (TAG) composed of donors will be formalized under the leadership of WHO and SPC to advise and coordinate AIDS prevention activities being carried out by SPC. TAG is largely a result of the RDO/SP networking efforts over the last year, primarily by its PSC (Regional AIDS Advisor) who had a large number of individual and group meetings with other donors. This donor collaboration, in covering all aspects of STD/HIV/AIDS prevention, has produced a wide ranging support strategy for prevention activities

The ten donors who have been collaborating on an informal basis since May, 1989 and will comprise the TAG include: RDO/SP, AIDAB, New Zealand, LRC, WHO, ODA, France, EEC, JICA, and SPC.

Some examples of the activities already supported or planned to be supported by other donors include the following:

- RDO/SP promoted the placement of a CDC epidemiologist advisor, through WHO/GPA, in Port Moresby, PNG.

- WHO and UNESCO have agreed to mutually support the establishment at SPC of an INFONET system that will gather and publish AIDS related information and data for all South Pacific nations.

- AIDAB will provide funding for some small grants for AIDS prevention campaigns, a grant of laboratory equipment and supplies that will upgrade HIV testing capacities in selected countries and will continue limited support to SPC for health education efforts related to STD/HIV/AIDS.

- WHO leads the way through continued refinement of MTPs, curriculum development for professionals, public schools and universities, technical training for improved testing and very limited KAPB surveys.

- ODA will provide limited medical staff assistance to medical schools and some lab equipment.

- JICA will provide lab and hospital construction support, lab equipment and later commodity support to selected national governments.

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The larger strategy includes the following components for which other donors (and A.I.D. projects other than this RAP Project) are contributing as follows (see list of acronyms in the front of the PP):

- National Prevention Planning ..... WHO
- Training of Health Professionals ... WHO, AIDAB, A.I.D.,  
SPC, NZ, CYP
- Laboratory Equipment .....A.I.D., AIDAB, JICA, WHO
- Curriculum Development .....WHO, AIDAB
- Blood Banking/Screening.....LRC, NZ, AIDAB, A.I.D.,WHO
- Community Education .....AIDAB, WHO
- Condom Supply .....UNFPA, WHO,HGOs
- Technical Assistance .....WHO, A.I.D., CDC, EEC
- KAPB Studies .....WHO
- Community Level Grants .....AIDAB

A listing of known planned contributions of other donors (and A.I.D. from projects other than this RAP project) for the period CY 1990 - 1995 in terms of money is below:

<u>Participant</u>	<u>Role</u>	<u>Est. Value</u> (US\$)
1. A.I.D.	Lab Equipment (part of Fiji CIP)	100,000
	Training for Lab Equip.	<u>10,000</u>
		(110,000)
2. AIDAB	Social Soundness Analysis	50,000
	Bridge Funding to SPC	200,000
	National AIDS Committee Support	20,000
	Other support to AIDS activities	<u>1,000,000</u>
		(1,270,000)
3. AIDSCOMM	Training	30,000
4. CYP	Country Profiles	15,000

5.	WHO	Review PID/Comment	1,000
		CDC Epidemiologist PNG-WHO/GPA	750,000
		IEC Advisor PNG & Fiji 5yrs.	750,000
		KAPB Surveys	70,000
		INFONET	200,000
		Training	100,000
		National AIDS Committees	<u>50,000</u>
			(1,921,000)
6.	UNESCO	INFONET	50,000
7.	SOMARC	Social Marketing Analysis in PNG	60,000
8.	CDC	Analysis (SPC/PNG)	15,000
9.	SPC	Epidemiology	10,000
10.	New Zealand	Training	50,000
		Blood Banking	<u>50,000</u>
			(100,000)
11.	ODA	Medical School Faculty	2,310,000
		Health Center Construction	924,000
		Equipment (% of larger grant)	<u>70,000</u>
			(3,304,000)
12.	JICA	Medical School	100,000
		Lab Equipment	<u>70,000</u>
			(170,000)
	TOTAL		\$ 7,055,000

4. The A.I.D. Selected Area of Concentration:

The uncovered area of AIDS prevention programming is at the community/public education level. Therefore, RDO/SP has decided to concentrate its limited resources (project funding amounts to only US\$ 0.10 per year per capita) to assist in the promotion of training, planning and media assistance to NGOs so they can prepare and implement community education campaigns for STD/HIV/AIDS prevention.

A major objective of an AIDS education program must include a substantial increase in the use of condoms. However, without a reliable supply of condoms at a reasonable price and readily available everywhere, efforts to increase demand will fail. Continuing the free distribution of condoms by government agencies is not the long term solution to increased use as the governments and donors will not continue this cost indefinitely. Therefore, the program to increase condom usage will include efforts to increase the private sector marketing of condoms.

Because the disease does not recognize national boundaries, a regional program of AIDS prevention can not be effective if it is limited to only ten nations of the South Pacific or carried out on a country-by-country basis. An implementing agency whose scope is broad enough to deal with this issue is required. The South Pacific Commission (SPC) is the only agency with the broad mandate and a programmatic scope large enough to deal efficiently with the international complexities involved in effective STD/HIV/AIDS education.

Project activities will focus on assisting local community organizations develop programs to change behavior and thereby thwart HIV transmission. This will be difficult to accomplish and assess. Therefore, some flexibility will be needed in implementation; e.g., the mechanisms for delivering inputs and the selection/content of specific activities.

## B. PROJECT DESCRIPTION

Project Features: Part of larger group of multi-donor supported, wide ranging regional AIDS prevention activities; donor collaboration and networking; community education activities; encouragement of private sector participation; social marketing of condoms; use of regional organization for implementation.

### 1. Goal, Purpose and Beneficiaries:

The goal of the project is to minimize the impact of STD/HIV/AIDS in the South Pacific. The purpose is to promote behavior change that will thwart STD/HIV/AIDS transmission.

The project is expected to accomplish its purpose at two levels. First, at the regional level it will help the SPC establish an effective AIDS education resource to serve the region. Second, at the national level, it will act through the SPC to strengthen AIDS education in community level programs of the ten countries served by RDO/SP.

The primary beneficiaries will be the people who do not become infected with HIV as a result of the project's educational efforts. It is impossible to estimate how many people might become infected with HIV with or without the project. However, the cost of AIDS (both medical care costs and community costs) and the tragedy of unnecessary loss of life are so high that if only a handful of people don't become AIDS victims as a result of the project, the return on investment would be worthwhile.

The secondary beneficiaries include (a) the families, friends and communities that don't have AIDS victims, and (b) the general population in the sense that medical resources that might otherwise be used for treating AIDS patients can be directed to other health problems.

2. End of Project Status (EOPS):

At the end of the five year project life, the following will indicate that the purpose has been achieved (note: baseline data needed to measure these indicators will be obtained early in the project):

- There is increased public awareness about HIV/AIDS prevention, spread and control;
- The sale of condoms in the region will have increased approximately 350%;
- SPC continues AIDS education activities in a manner appropriate to the circumstances at the end of the project.

3. Strategy:

The strategy guiding the design and planned implementation of this project includes the following:

a. Participation in the Broader Regional Effort: The challenge of reducing the spread of AIDS in the South Pacific is so large and complex that no one donor has the resources to finance the entire campaign. Other donors had already begun some activities prior to the design of this project. The various components of a comprehensive program to prevent the spread of AIDS lend themselves to separate discrete financing by different donors (e.g., blood testing equipment), but the inter-relationship of the different components require close coordination among the donors and their clients or recipients (e.g., SPC's Regional AIDS community education efforts financed by A.I.D. requires the services of SPC's INFONET - earlier called the Information Exchange Center - financed by WHO and UNESCO).

b. Coordination with other Donors: Section I.A.3 above shows the range of involvement of the donors. With a large number of donors contributing to the AIDS prevention program within a short time period, coordination to avoid duplication and gaps is critical. The RDO/SP's PSC (Regional AIDS Advisor) has had a large number of individual and group meetings with other donors in the design of this project. RDO/SP will use the TAG as a means of coordinating its efforts with the other donors.

Implementation of this project will require a considerable amount of funding by the SPC AIDS Communications Specialist and the RDO/SP project office. Many of the activities are linked to activities of other donors. The networking should be done through both the TAG and directly with the various donors.

c. Use of A.I.D. Central Funded Projects: Due to the limited financial resources of the project and the broad scope of Pacific societies and cultures, the project should make use of AID/W's centrally funded projects.

The budget has a \$100,000 line item for buying into the AIDS Communications Project (AIDSCOM). AIDSCOM will provide technical assistance to plan and implement workshops, seminars and training courses in campaign planning, project preparation, media, materials and curricula development and testing. AIDSCOM and others will provide assistance for tracking project elements, and consulting with RDO/SP and SPC on methods to better use and encourage private sector participation in project activities.

Another possible resource is the Social Marketing II Project (SOMARC) which is interested in having a contraceptive social marketing project in PNG due to its being the largest country in the region with the highest numbers of STD and HIV/AIDS cases. SOMARC is negotiating with the GPNG for a pilot test market activity for a 26-month period in four provinces. SOMARC is expecting to provide \$300,000 of an estimated \$813,000 cost (not including commodities) with the balance of the funds to come from other sources. This collaboration with SOMARC's planned activity in PNG will encourage improved social marketing activities and condom sales.

d. Promotion of Community Organizations and Private Sector: The main action to educate the public about AIDS prevention will take place at the community level by community organizations. The project will support local organizations in four ways: (1) by grants to community organizations, (2) by materials produced by local media firms and the SPC Regional Media Center (posters, radio programs, videos, etc.), (3) by technical assistance provided by the SPC's AIDS Communications Advisor and short term advisors if needed, and (4) by regional and national workshops and training programs.

The private sector will be involved in at least two ways: (1) by distribution/sales of condoms and (2) through the preparation/publication of posters, videos, etc.

Effective use and expansion of public health and AIDS education in the South Pacific will require the exploitation of private sector resources. The limited funding of this project, limited resources of other donors and overstressed government health budgets mean that alternative and sustainable sources of support must be developed. The obvious source for this support lies in (1) the private sector and (2) NGOs. The problem in developing marketing systems involving both entities is that it has previously been tried only on an occasional basis.

There is a growing public demand for both AIDS information and condoms which must be met over the longer term. To meet the social and fiscal requirements of public education and commercial sales, the existing market for both must be enlarged to make it attractive for the private sector to supply the demand.

Therefore, this project proposes that SPC use private sector companies and agencies to work with ministries of health and NGOs to prepare, publish and distribute AIDS prevention education. This is particularly the case in PNG where Department of Health (DOH) resources are limited. Existing private sector entities have already produced health education materials and are involved in creative marketing approaches such as "walk-a-bout theater" and radio science broadcasting. These private sector entities have the resources in place, require no staff expansion, have existing translating capabilities and the interest necessary to prepare and distribute AIDS prevention and condom promotion information in culturally sensitive and appropriate ways. Combined with technical assistance from the DOH and SPC messages will be distributed so they will reach the majority of the concerned public.

These public education messages will be combined with the use of the existing NGO distribution networks. In PNG and Fiji, NGOs have the capacity to distribute not only information but also commodities through their existing programs and field workers.

AIDAB is considering a large grant to SPC for AIDS educational purposes which might include condoms to support the project's community grants. However, if the AIDAB donation does not materialize, a portion of the community grants may be used to purchase condoms locally or project funds might be used to buy an initial supply of condoms through the S&T/Population program. This assistance will establish sustainable sources of condom distribution and respond to the growing public demand for these services. Once the NGO systems are in place, reordering through private sector suppliers will follow, insuring longer term provision and expansion of the marketplace. Eventually, nearly all condom distribution should be through the private sector.

e. Use of a Regional Organization for Implementation:  
The rationale for using SPC for implementation of this project is in A.4 above. In May, 1990, SPC's Community Health Services prepared a revised proposal for its "Information and Communication Project for the Prevention of AIDS and STDs in the Pacific." A part of the proposal is being financed by this project and the remainder by WHO and UNESCO.

SPC has an existing health education program and training center staffed to deal with regional issues. In addition, other SPC divisions provide a large network of NGO contacts. SPC has a mandate from its membership to attack the problem of AIDS in the South Pacific. With minor upgrading, existing facilities are sufficient to house the AIDS education expansion. Accounting, reporting and financial management capacities have been reviewed and accepted by A.I.D.

SPC will be able to use its existing networks to reach community and professional groups through its Women's Bureau, the Youth Development Program, the Community Health Services, the Community Education Training Center, the Rural Development Program, and the Fisheries Program. These programs maintain on-going contacts with community workers through national AIDS committees. Their own stand alone activities will use bulletins, newsletters, information circulars, Peacesat telecommunication satellite network as well as project training and limited resources to promote AIDS education. The networks will be expanded to include churches, non-government organizations, sports and recreation committees, trade unions, etc.

The involvement of SPC, a recognized public international organization (Handbook 13, Chapter 5), will enable the project to tap this existing, extensive network for widespread community level educational efforts. It also will establish the regional characteristics of the program and help promote donor coordination.

The SPC Media Center in Suva, Fiji will be the center for major project activities, such as training and materials development. The Center occupies six buildings on the outskirts of Suva - five for training and production, one for administrative and support services. It is staffed by seven professionals and four support persons. The Center provides training and production support of ongoing SPC programs, as well as providing consulting and training services for member governments. The grant to SPC will provide for limited office and media production equipment to enhance the existing facility.

In addition to this A.I.D. project, WHO and UNESCO have agreed to jointly fund the establishment of a regional AIDS information and data gathering component of the SPC AIDS education program to collect and distribute information on AIDS activities, research, programming and policies relevant to the region. This will be called INFONET to be located in Noumea. The SPC's South Pacific Epidemiological and Health Information Service (SPEHIS) will supplement both INFONET and the project with epidemiological reporting that will include STDs and AIDS statistics for the South Pacific. There is also the possibility that AIDAB will be making a grant to SPC to support educational activities.

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4. Activities and Outputs:

a. Baseline Data and Monitoring: To better manage its efforts to prevent the spread of STD/HIV/AIDS, the project will need baseline data on the extent of STD and HIV infection as well as information on behaviors and attitudes toward sexual practices in specific groups of the community. This will be accomplished through contracts or grants from SPC (using project funds) to selected universities, research institutions or individuals.

The knowledge, attitudes, practices and beliefs studies (KAPB) financed by the project will be designed to meet the special needs of the project. The studies will be simple and direct, easily administered, efficient to implement and easily assessed. The surveys will provide both a basis for preparing educational programming and comparing the effectiveness of AIDS prevention activities over time. In addition, the data will be used to judge performance during the mid-term and final evaluations. These KAPBs will be in addition to surveys that will be carried out in different localities in the region by WHO.

The project activity is the monitoring of progress and planning of educational and community activities (this overlaps with the next activity below). The output is baseline data and improved monitoring. The project input will be the KAPB studies made by selected universities, research organizations or individuals.

b. Community Education Activities: The heart of the project will be the educational activities carried out on the community level by NGOs.

After assistance in planning and developing AIDS prevention programs, NGOs will begin serious community level education campaigns, culturally appropriate, directed at their constituencies. Educational materials, developed with the assistance of the project, will be distributed to encourage the behavioral change necessary to stop STD and HIV transmission.

SOMARC has completed two market surveys in PNG and one in Fiji which suggest that condom promotion is a sustainable activity within those countries. In addition to involvement of NGOs, private sector involvement will be sought for advertising, educational program development and later for commodity support. Condoms to be donated to South Pacific by AIDAB or purchased locally under community grants will be used for community-level activities.

The output from the community education activities will include: (a) ten active community AIDS educational programs going on in selected countries, (b) condom sales up by 350 percent, and (c) 35 percent reduction in predicted STD rates.

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The project inputs will include community grants from SPC, media materials produced from the project activity described below, training involving both national and regional workshops and training programs, and technical assistance from the SPC Communications Specialist.

c. AIDS Educational Materials Prepared in Region and Locally: Much of the AIDS educational materials used by the community organizations must be country or community-specific; i.e., radio programs, posters, etc. prepared by the SPC Regional Media Center or imported from outside the region must be modified to conform to local conditions, culture and language. The materials must be both inexpensive and appropriate to the local culture. This means that most of it must be prepared locally. The community organizations will select, design and buy the materials based on their needs, using their own funds and the project grants from SPC.

Therefore, an activity of the project will be both the preparation of the materials and the improvement in local private sector media/advertising firms to produce quality, low cost materials. The project outputs will be (a) materials produced for community organizations and (b) local media production capability increased. The project inputs include the community grants to finance purchase of materials and technical assistance from the SPC Regional Media Center to local media firms.

d. Networking: In many ways networking among the donors and by SPC with the community organizations is not a project activity as such but an implementation device. However, it is so important to the success of the project and should occupy sufficient time and effort by SPC and donors as to be considered both a project activity and an implementation method.

The need for donor coordination or networking was described as one of the elements of the project strategy (I.B.3 above). However, networking in the sense of this activity is broader than just donor coordination. It involves SPC's Communications Specialist working closely with the community organizations on the activities financed directly by community grants plus SPC's promoting the networking activities among the community organizations themselves. It also involves the networking by the RDO/SP's Project Officer with community organizations and NACs.

The output from this activity will be better coordination plus the exchange of information, experiences, and ideas for continuing refinement and modification of efforts as well as planning new activities. Inputs will be the promotional efforts of the SPC Communications Specialist and RDO/SP Project Officer, a regional newsletter, regional and local workshops for exchange of ideas and contacts as well as training and program development.

5. Inputs (does not include inputs financed by other A.I.D.-funded projects):

a. Technical Assistance: This consists of (a) an AIDS Communications Specialist hired by SPC for five years to manage the project. This component includes the costs of a secretary, regional travel and per diem, communications and office supplies, and office equipment; and (b) about seven months of short term technical assistance provided through buy-ins to the A.I.D. AIDSCOM Project or contracts with individuals.

b. Training: The types of training to be supported by the project include (1) national and regional workshops and training courses on AIDS education, (2) observational travel within the region, to the U.S. and third countries for selected national and community leaders to observe how community level educational activities are conducted, and (3) training sponsored by the SPC Regional Media Center for NGO and other personnel in the countries on how to (a) plan and implement effective community campaigns; and (b) prepare poster, radio programs, and videos for the educational programs. No long or short term academic training is anticipated. The project will provide a limited amount of equipment and supplies to the Regional Media Center to increase its training and production capabilities needed to support the project.

c. Community Grants: This input consists of small grants made to community/national NGOs, and perhaps some national AIDS committees which are legal entities that can accept grants, to carry out community level STD/HIV/AIDS educational activities. An important element of the first work plan to be prepared jointly by SPC and RDO/SP is an agreed upon criteria for eligibility for grants, minimum size grants, use of grants, reporting and accountability of funds, etc. If AIDAB does not provide condoms to support the grants, a portion of grant funds may be used to buy condoms or the project may obtain condoms through the S&T/Population program.

d. KAPB Studies: Little is know about South Pacific sexual knowledge, attitudes, practices and beliefs. The project will provide limited funding for KAPB studies to be performed among target groups to be decided upon during the preparation of the work plan. These studies will be in addition to similar studies among other target populations planned by WHO. Together these studies will provide valuable base line data that will be used for planning better interventions and evaluating their level success. SPC will contract with regional and U.S. research institutions, universities or individuals to design, collect and analyze the resultant data.

## II. COST ESTIMATES AND FINANCIAL PLAN

### A. Cost Estimates:

1. Technical Assistance - Long Term: The project will finance one AIDS communications specialist at SPC at an annual cost of \$70,000 (salary and fringe benefits) for five years. Annual average support costs for this person include the following: (a) travel and per diem \$15,000 per year; (b) office supplies and equipment \$10,000 (more the first year for office equipment such as a computer, typewriter, office furniture, etc.); (c) communications \$10,000; and (d) secretary \$10,000. Total five year cost is \$575,000.

Technical Assistance - Short Term: This is to be provided by buy-in to the AID/W AIDSCOM project. The project's matching funds is expected to be on a \$1 to \$3 ratio, so the project's \$100,000 would be matched by \$30,000 for short term technical assistance from the AID/W project. The \$130,000 total is expected to finance about seven person months of short term TA.

2. Training: The \$300,000 budgeted for this component will finance several regional workshops at an estimated cost of about \$40,000 each (based on actual cost of a regional workshop held by SPAFH in 1989 for 20 people from the region), plus several country workshops and some observational travel trips.

3. Community Grants: A lump sum of \$500,000 is earmarked for grants to be made by SPC to NGOs and NACs to carry out community level educational activities.

4. SPC Media Center Support: This \$130,000 is for equipment for the SPC Regional Media Center for the production of AIDS information materials and for training of media personnel in the countries. The equipment list is in Annex K.

5. KAPB Studies: The \$160,000 budgeted for this item is for base line and monitoring studies to be made of the South Pacific countries.

6. Evaluations and Audits: This line item is to finance two evaluations at \$50,000 each and external audits (\$25,000) if the audits should be required.

7. Contingency: A small amount of \$110,000 is set aside for contingencies, including possible purchase of condoms.

8. RDO/SP Monitoring: This \$500,000 is the cost of one American personal services contractor (PSC) to be based in RDO/SP, Suva to serve as technical advisor and assist with monitoring. It is based on the costs of existing PSCs in the South Pacific.

9. SPC's Contributions: The estimated value of SPC's in-kind support for the project (from its core budget) is \$230,000. This includes the value of (a) office and storage space for the AIDS communication specialist and secretary, (b) participation of SPC officers in various activities, especially in health, (c) support services from the library staff and equipment resources and other services such as translation/interpreting services, travel arrangements, (d) publications, communication, and other administrative services, and (e) the services of the SPC's INFONET and Regional Media Center.

10. Other A.I.D. Contributions: This includes (a) \$30,000 from AIDSCOM and (b) an estimated \$100,000 of lab equipment for Fiji (plus \$10,000 in training costs), which will be used in part for blood screening and testing, financed by A.I.D.'s CIP for Fiji. It is to be delivered in late 1990. (see page 9)

11. Other Donors Contributions: A table in the Project Description (page 9) lists the contributions of other donors to the overall regional AIDS program for the South Pacific. The estimated value of expected donations is over \$7.0 million.

Not included in these tables is a possible contribution from the U.S. Peace Corps which is interested in participating. However, the precise level and content of such participation has yet to be determined. It will depend upon both the availability of volunteers and funds. The relationship of volunteers to SPC and/or participating NGOs will be determined at the appropriate time. Volunteers will not be financed by the project.

B. Financial Plan:

1. Grant to SPC: Most of the project funds will be obligated through a grant to SPC, a public international organization (PIO), following the guidelines in HB 13, Chapter 5. The grant will be for a 2 1/2 year period, with \$200,000 being obligated in FY 1990. Depending on the outcome of the evaluation after the end of two years, the grant to SPC may be extended for another 2 1/2 years. The attached budget tables show which project funds will probably be channeled to SPC and which will be handled directly by RDO/SP.

An initial advance of funds for the first 90 days of expenses will be made through a check issued out of the USDO in Bangkok. SPC may replenish the advance for subsequent 90 day periods upon presentation of the usual documents and following the established procedures. SPC's quarterly progress reports will provide details about the use of project funds to supplement the information in the financial documents to obtain advances.

2. SPC Capability to Manage the Funds: SPC has received a number of grants from A.I.D. over the last decade. For example, all of the \$2.5 million in the SPC Multi-Project Support Project (879-0006) was obligated through annual block grants to SPC. Other grants of smaller amounts have been given to SPC. An A.I.D.-financed and controlled audit of SPC's management of the SPC Multi-Project Support Project will be made in late 1990 at the request of the A.I.D. Regional Inspector General. SPC has its own accounts audited annually by an the auditing arm of the Government of New Zealand and provides copies of the audit to its member countries, including the United States. RDO/SP is satisfied that SPC is capable of managing this grant.

3. Audits and Evaluations: According to HB 13, Chapter 5, paragraph 5.G, A.I.D. policy is that when A.I.D. is the sole contributor to an international organization's special project or activity, A.I.D. must reserve audit rights for the GAO and for the A.I.D. IG. The opinion of the Regional Legal Advisor (fax memorandum of September 20, 1990) is that since A.I.D.'s funds are for specific costs which are not being partially funded by other donors, A.I.D. must be considered as the sole contributor to this project. Therefore, the grant agreement with SPC will have the standard provision concerning audit and inspection of books.

Two evaluations, as described in Section IV, will be made and financed by project funds.

4. RDO/SP Monitoring: RDO/SP will monitor the implementation of the project as more fully described in Section III. The monitoring includes review of the financial data submitted with requests to replenish the advances and with the quarterly progress reports.

Table 1

Life of Project Budget  
(US \$ 000)

<u>Component</u>	<u>Admin. by RDO/SP</u>	<u>Grant to SPC</u>	<u>Total</u>
1. Technical Assistance		575	575
2. Training		300	300
3. Community Grants		500	500
4. SPC Media Center Support		130	130
5. KAPB Studies		160	160
6. TA Buy-ins		100	100
7. Evaluations & Audits		125	125
8. Contingency		110	110
9. RDO/SP Monitoring	500		500
	<hr/>	<hr/>	<hr/>
TOTAL AID PROJECT 879-0022	500	2,000	2,500
Other Contributions			
10. AIDSCOM Contribution	30		30
11. SOMARC	300		300
12. SPC In-Kind Contributions		230	230
	<hr/>	<hr/>	<hr/>
TOTAL PROJECT COSTS	830	2,230	3,060

Table 2

Grant To SPC for First 2 1/2 Years  
(US \$ 000)

	<u>First Year</u>	<u>30 Months</u>
1. Technical Assistance		
AIDS Communications Specialist (salary, fringe benefits)	70	175
Travel & Per diem	15	40
Office Supplies & Equipment	10	25
Communications & Misc.	10	25
Secretary	10	25
	<hr/>	<hr/>
	(115)	(290)
2. Training	50	125
3. Community Grants	60	125
4. SPC Media Center Support	30	75
5. KAPB Studies	40	80
6. TA Buy-In	25	50
7. Evaluations & Audits	-	50
8. Contingency	40	55
	<hr/>	<hr/>
	360	850

Table 3

Technical Assistance - Long Term

	<u>US\$</u>
Salary, including fringe benefits (\$70,000/yr for 5 years)	\$350,000
Travel & per diem	75,000
Office Supplies, equipment	50,000
Communications	50,000
Secretary	<u>50,000</u>
TOTAL	575,000

Table 4  
Project Budget by Currency  
(US\$ 000)

<u>Component</u>	<u>Foreign Exchange</u>	<u>Local Costs</u>	<u>Total</u>
1. Technical Assistance			
a. Communic. Specialist	125	225	350
b. Travel & Per Diem	10	65	75
c. Office Supplies & Equipment	10	40	50
d. Communications	-	50	50
e. Secretary		50	50
-	(145)	(430)	(575)
2. Training	20	280	300
3. Community Grants	-	500	500
4. SPC Media Center Support	70	60	130
5. KAPB Studies	-	160	160
6. TA Buy-ins	100	-	100
7. Evaluations and Audits	125	-	125
8. Contingency	40	70	110
9. RDO/SP Monitoring	400	100	500
	<u>900</u>	<u>1,600</u>	<u>2,500</u>

Justification of Local Cost Financing

1.a. Although the person is expected to be an American, a portion of this cost will be for local housing, educational allowances, etc., that can only be provided locally.

1.b. Most of the work related travel will be within the region, and American airlines do not fly the routes that will be used. Travel to and from the U.S. will be on U. S. carrier to the extend possible (e.g., from Honolulu to the mainland). Per diem would be for expenses while traveling within the region and therefore can't be provided from the U.S.

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- 1.c. Office equipment must supplement and complement existing SPC resources (French language keyboards, 250V/50c) and thus would have specifications that cannot be met from U.S. sources. Existing maintenance contracts, shelf-item purchases of non-U.S. sized paper, and other small office supply items from existing SPC support contracts would not be available from the U.S.
- 1.d. All project communications (FAX, telephone, telex and cable) will be through locally owned and operated, non-U.S. firms.
- 1.e SPC policies permit the recruiting of local secretaries only. This is an internal cost saving policy approved by the SPC membership of which the U.S. is party.
2. Except for the possibility of minimal observational travel to the U.S., all project funded training will be within the region. American airlines do not fly the routes that will be used.
3. Community grants will be made to local NGOs to plan, implement and evaluate community AIDS education campaigns. Staff, materials, in-country travel costs will be from local sources to make the campaigns sustainable. No US PVOs are presently expected to be involved.
4. Where possible, U.S. source and origin equipment will be purchased for the SPC Media Center support. Maintenance and servicing is only available from local companies. No U.S. suppliers have offices in Fiji, where the SPC Media Center is located. Other equipment must complement existing assets that have been provided by other donors. These assets are of non-U.S. source/origin.
5. All costs of the proposed KAPB studies will be incurred within the region (locally hired personnel, printing of materials, in-country travel). U.S. technicians will be sought to design and evaluate the studies and ensuing data if possible.
6. TA buy-ins will be foreign exchange costs of U.S. origin.
7. Evaluations will be procured from U.S. based sources.
8. Contingency fund be applied to both local costs and U.S procurement on a case by case basis as the need arises.

### III. IMPLEMENTATION PLAN

#### A. Major Implementation Actions:

1. Grant to SPC: Most of the project activities will be carried out by the SPC under a grant agreement with RDO/SP following the format in HB 13, Chapter 5. The source and origin to be specified in the grant will be The United States and the South Pacific Region (the ten countries served by RDO/SP plus Noumea) per cable of September 21, 1990 (State 320540), a fax message and telephone conversation with the Regional Legal Advisor on September 24, 1990. SPC will use its own procurement and contracting rules to procure services and commodities. Within SPC, the Community Health Services Program (i.e. Office) under the guidance of its Health Coordinator, will be responsible for day-by-day implementation. SPC and RDO/SP, as part of the work plans in 3 below, will agree upon procedures to use for community grants between SPC and countries' NACs and NGOs. Specific implementation actions that SPC will take include:

- a. Hire an AIDS communications specialist and one secretary. The specialist is to be an American citizen.
- b. Procure two groups of commodities: (i) office furniture and office equipment (typewriter, PC, printer, etc.) needed for the AIDS communications specialist and his secretary; and (ii) commodities for the Regional Media Center (Annex K).
- c. Arrange to have the baseline data and KAPB studies made by universities or other appropriate organizations, institutions or individuals.
- d. Arrange for all training to be carried out, especially the regional and national workshops and training programs. This and observation travel outside the region must follow the guidance of HB 10, unless RDO/SP approves an exception.
- e. Make community grants to eligible NACs and NGOs according to criteria and rules to be incorporated into the annual work plans. No grants are to be made until the criteria and work plans are prepared and approved.
- f. Prepare quarterly progress reports to RDO/SP.

2. Buy-Ins: Two AID/W projects may be contributing to this project. AIDSCOM to provide short term TA in AIDS communications and ARC to provide short term TA to help start the social marketing of condoms in PNG. RDO/SP, in full coordination with SPC will prepare the PIO/Ts and handle the arrangements with the appropriate AID/W office for the buy-ins.

3. Work Plans: Within one month after the grant agreement is signed, SPC, in collaboration as necessary with RDO/SP, will prepare a preliminary overall work plan for the entire 2 1/2 years of the grant. Within one month after the Communications Specialist has begun work, SPC will prepare a more refined work plan for the 2 1/2 years and a detailed work plan for the first six months. A new detailed work plan will be prepared every six months. Each work plan is to be submitted to RDO/SP for review and concurrence. Thereafter, no action by SPC to implement the grant shall require RDO/SP concurrence if it is in accordance with the jointly approved work plan.

4. Networking and Donor Coordination: Due to the existence of a large number of organizations involved in AIDS prevention on the local, national, regional and global levels, both the SPC AIDS communications specialist and the RDO/SP project officer must give considerable attention to:

(a) networking; i.e., exchange of information, plans and ideas of interested organizations within the region (NACs, NGOs, etc.); and

(b) donor coordination; i.e., exchange of information and plans among the donors to the regional AIDS prevention program. The TAG will be the principal mechanism for this coordination.

5. Evaluation: The importance, use and scope of the first evaluation is discussed elsewhere. It should take place soon after the end of the 24th month. The second evaluation will be done near the end of the project. RDO/SP will contract with appropriate organizations or individuals outside SPC and A.I.D. to conduct the evaluations. RDO/SP will coordinate the evaluation with SPC, including having SPC clear the PIO/T. SPC will be expected to participate in the evaluations.

6. RDO/SP Monitoring: The RDO/SP monitoring and project coordination will be done mainly with the assistance of the American personal services contractor (PSC) based in Suva in RDO/SP's Health, Population and Nutrition Division.

7. Grey Amendment and Minority Contracting: Due to the nature of the project, implementation is to be carried out by the regional organization. Other than the one American long term advisor to be hired by SPC, no other procurement from the United States is appropriate or feasible. Therefore, there will be no opportunities for Grey Amendment or minority contracting.

B. Responsibilities:

1. SPC: SPC will be responsible for carrying out the tasks described in A.1 above which will be described in more detail in the grant agreement. This includes providing in-kind contributions such as office space for the AIDS communications specialist. Normally, a grant to a PIO does not include much A.I.D. involvement in its implementation and the uses of the grant funds are not described in great detail. However, due to the complexity of this project and its interrelationship with activities being financed by other donors, the grant agreement will require SPC to do some reporting to RDO/SP and to obtain concurrence from RDO/SP for some actions (mainly approval of the work plans) which are not usually included in grants to PIOs.

2. RDO/SP: RDO/SP will execute the grant agreement with SPC and arrange for regular advances to be made. RDO/SP will also contract with a PSC to serve as its technical advisor. RDO/SP will also contract for the evaluations and arrange for the buy-in of central projects.

The RDO/SP office in Port Moresby will provide coordination and oversight of activities in PNG in close collaboration with RDO/SP in Suva and SPC.

RDO/SP will use grant implementation letters (GIL), similar to project implementation letters, for approvals/guidance to SPC.

3. AID/Washington: The appropriate offices in Washington will arrange for the provision of technical assistance from the AIDSCOM, SOMARC and other projects upon receipt of PIO/Ts or other communications.

4. Coordinating Committee: A coordinating committee to guide project implementation will consist of the SPC Health Coordinator (Chief of SPC's Community Health Services Office), the SPC AIDS communications specialist, and the RDO/SP project officer. In addition to providing overall guidance, the committee will be responsible for (a) preparation of criteria for small grant selection and review, (b) networking activities, (c) preparation of the work plan, (d) dissemination and use of project generated materials, data and information, (e) assessment of progress, and (f) liaison with TAG.

5. Technical Advisory Group: This organization of donors for the regional AIDS prevention program under the joint leadership of WHO and SPC is described in I.A.3 above. The TAG provides the mechanism for donors to exchange information, plans and to coordinate communications with National AIDS Committees and other interested parties.

C. Schedule of Major Events:

PROJECT IMPLEMENTATION SCHEDULE

<u>Action</u>	<u>Completion Date</u>	<u>Responsible</u>
1. Grant Agreement signed	9/90	RDO/SP
2. PIO/T issued for PSC	9/90	RDO/SP
3. Contract with PSC signed	9/90	RDO/SP
4. Work plan drafted	10/90	SPC & RDO/SP
5. SPC begins recruits staff	10/90	SPC
6. SPC Comm. Specialist begins work	1/90	SPC
7. 1st training starts	1/90	SPC
8. Work plans refined & community grant criteria established	2/90	SPC
9. Contracts let for design of KAPB studies	3/91	SPC
10. KAPB studies designed	4/91	SPC
11. KAPB studies begun	6/91	SPC
12. Evaluation plan developed	5/91	SPC and RDO/SP
13. Community grants begin	5/91	SPC
14. 2nd 6-month work plan	7/91	SPC and RDO/SP
15. Contracting for evaluation of SPC performance	10/92	RDO/SP and SPC

#### IV. MONITORING AND EVALUATION PLAN

##### A. Monitoring:

Much of the project monitoring work will be carried out by the PSC AIDS Advisor working in RDO/SP's HPN Division. His duties will include, but not be limited to, providing technical guidance to RDO/SP and SPC, coordinating with other A.I.D.-financed STD/HIV/AIDS prevention/education activities, participating in donor coordination efforts, assisting SPC with preparation of work plans, reports and other documents for submission to RDO/SP, preparing procurement waivers as needed, and monitoring project implementation.

RDO/SP project monitoring will consist of several levels of activity. The first level is reviewing the quarterly progress reports to be prepared by SPC on a format to be provided to SPC. The reports will include epidemiological data provided by the SPC INFONET. Quarterly reports will provide financial data, including expenditures broken out by project component.

The second level is periodic field visits in which the Mission will validate the implementation of the mutually approved work plans. Changes or actions not included in the work plan shall require RDO/SP written approval. There will be regular meetings, as often as needed between SPC and RDO/SP staffs either in Noumea, Suva or other regional locations, to discuss project issues, problems, plans and revisions.

The quarterly report for the fourth quarter of each fiscal year will serve as the basis for an annual progress review to be conducted jointly by RDO/SP and SPC.

##### B. Evaluation:

Two external evaluations will take place during the life of the project. The first will take place within six months of the completion of the second year of implementation and will assess project progress on the work plan. These conclusions will then be compared against Project Paper objectives, the regional strategy goals and key project assumptions as stated in the Logical Framework. The evaluation team will recommend necessary actions to be taken to assure continued success and/or ways in which to improved project progress toward achieving the stated or revised goals and outputs. A decision would be made as to whether to extend the SPC grant or otherwise modify implementation. The criteria for evaluation will include, but not be limited to the following:

1. The performance of SPC in (a) complying with the terms of the grant, and (b) carrying out the activities included in the grant project description and work plans to be prepared.

2. The performance of SPC in collaborating with RDO/SP and other donors.

3. The performance of SPC in maintaining and keeping accurate, up-to-date data and statistical analyses related to STD/HIV/AIDS incidence.

4. The performance of SPC in exploiting its NGO network to plan and implement AIDS prevention activities, including the Grantee's making at least five community grants.

5. Performance of the recipients of community grants in implementing their grant-funded AIDS prevention activities.

A final evaluation will assess the end of project status and whether the purpose and all outputs were achieved. Progress will also be measured by the comparison of first year KAPB data with that gathered at later intervals during the project.

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V. SUMMARY OF CONCLUSIONS OF ANALYSES

A. General Summary of Analyses:

The analyses, found in the Annexes, agree on several points:

1. The project is feasible.
2. Project design should be flexible.
3. Coordination among participating donors, agencies and nations is necessary for success.
4. Costs will require tracking during the project to assure accurate information from which both better planning and long term sustainability can be based.

B. Summary of Technical Analysis:

The technical analysis, prepared by RDO/SP personnel, concluded that:

1. The use of community organizations (NGOs) rather than the formal educational system is the best way to reach the target groups with messages on AIDS prevention.
2. The social marketing of condoms is feasible, but will be difficult. NGOs should be involved with building up the market for condoms.
3. The AIDS education campaign should be separate from a country's general health education programs.

C. Summary of Social Soundness Analysis:

The following conclusions are from the subject analysis written by Dr. Don Gardener of Australian National University, Canberra, Australia. Dr. Gardener is an anthropologist with many years experience in the South Pacific. Dr. Gardener's services were provided to RDO/SP by AIDAB.

1. For most Pacific Islanders disease and health are both physical and moral conditions.
2. South Pacific beliefs concerning disease may make it harder to persuade people that the presence of HIV infected persons do not place them at risk. This is a notoriously difficult area of AIDS education under any circumstance and in the South Pacific it is one to which particular attention needs to be paid.

3. The kinds of beliefs found in the South Pacific might easily subvert another very important message about HIV infection - that there is no cure for it.

4. The patterns of STD transmission and the increasing incidence of sexual crimes suggest that there is still an undercurrent of liberality of attitude towards sexuality in the South Pacific that is relevant to a concern over HIV transmission.

5. A woman is not able to control the form and conditions of sexual relations.

6. From the point of view of defining risk groups the evidence suggests caution.

7. This project, as part of a much larger effort, aims to modify the sexual behavior of these people. In the process it will need to come to grips with people's understanding of disease and their responses to those who suffer from it.

8. Given the inaccessibility of many people in the Pacific it is recommended to employ local personnel in the planning, design and production of IEC efforts and not just in their implementation.

9. All information suggests the need for skill and sensitivity in the design of IEC material: graphic, but not symbolic; simple but not too easily ignored; thought-provoking, but not frightening; innovative but culturally appropriate.

10. The churches of the South Pacific have to be dealt with sensitively. Every attempt has to be made to accommodate their demands without compromising the project's aims. Unsubtle promotion of condom use will run the danger of stimulating church opposition.

11. It is important that effective lines of communication be maintained with the churches of the South Pacific. Many of them have access to their own - often substantial - IEC resources and any breakdown in communication between them and AIDS prevention personnel is undesirable.

12. AIDS represents a new but chronic and very important problem, for which long-term strategies of containment need to be found.

D. Summary of Economic and Financial Analysis:

The purpose of this analysis was to determine whether the project is a good investment and warrants the expenditures of scarce resources. It was prepared by Dr. Ann Martin, a health economist provided by AIDSTECH, who reached the following conclusions:

1. The absence of data in the Pacific Islands renders it impracticable to perform conventional financial or economic analysis on the types of interventions proposed in this project. This paper focuses on the demand for the proposed project and the most cost-effective technical approach.

2. Experience gained in dealing with the worldwide HIV epidemic indicates that early prevention programs have the greatest impact on reducing the number of HIV infections and are most cost effective. A total project expenditure of \$2.5 million has the potential to result in savings of \$4.0 million for STDs and \$90.4 million for AIDS for a total savings of \$94.4 million (\$300 million if indirect costs are included) through reduced numbers of HIV/STD cases.

3. A successful AIDS prevention program in the Pacific region could avert 50% of potential HIV infections.

4. Estimates of STD costs suggest that the demand for scarce health resources for treating STDs will increase rapidly. The cost burden of this increasing rate of STD transmission is considerable especially in the context of stagnant or declining health care service expenditure.

5. Public expenditure cuts into the 1990s will affect all sectors of public service including health care expenditure which is expected to be reduced by 5% in real terms per annum.

6. The burden of the direct treatment costs of AIDS in the South Pacific will primarily fall to the public health sector. Critical public policy and resource allocation issues will be raised by projections of AIDS treatment costs in this region.

7. Estimates of the opportunity costs of the care allocated to HIV-positive patients need to be determined.

8. To maximize return for the existing funding, the most cost-effective technical approach should be undertaken. This approach should assure the expansion and sustainability of the project activities.

9. The scope of this project should be sufficiently focused to assure that realistic objectives are established and desired outcomes are accomplished. All technical inputs into project activities should be targeted toward defined objectives.

10. The high risk behavior should be clearly definable and easy to reach with clear messages. Training, IEC messages, promotion campaigns and distribution strategies should be aimed toward achieving quantifiable targets within this focused activity.

11. The implementing agencies working in the project should form a close collaborative relationship to assure that tasks evolve in a uniform and dynamic way. The RDO/SP HPN Project Officer, along with SPC, should be given support and responsibility for overall management and coordination of project activities. A main function of this role will be to bring these organizations together in all planning and implementation phases of the project.

12. The regional strategy to promote the privatization of health services and coordinate with other public/private organizations should be an integral part of this project.

13. In addition to promoting increased AIDS control support from the private sector, effort should be made to increase donor contribution to AIDS control and to coordinate these contributions with this A.I.D. project.

14. Cost recovery opportunities need to be assessed in the context of the political infrastructures and economies. The level of condom demand by groups at high risk for transmitting HIV is unknown. The proposed cost recovery strategy should not assume that persons at high risk of transmitting HIV will behave rationally to condom pricing and promotion. Condom demand elasticity for targeted high risk groups should be assessed prior to imposing charges to assure that condom use will be increased not deterred by the promotional and pricing strategies of the social marketing effort. Condom sales to this market segment should be closely monitored during the life of this project. The social marketing program should clearly identify the market segment we are trying to reach.

15. Evaluation of this project should be carried out both concurrently and retrospectively. A concurrent cost-output information system will enable the RDO/SP to monitor project efficiency and change the project design as needed. Two KAPB surveys will collect both baseline data and cost outcomes of project activities.

16. Start-up costs should be separated from recurrent costs particularly for SPC's budget. Each activity should have identifiable costs and outputs associated so that cost-output analysis can be made.

E. Summary of Social Marketing Analysis:

The social marketing analysis was undertaken and completed by Mr. Tennyson Levy who was provided to the Mission by AIDSCOM and SOMARC. Mr. Levy reached the following conclusions:

1. Very little is being done to inform or promote condom use in the Pacific.
2. There is increasing demand for knowledge and condoms in urban and to a lesser extent, rural areas. The demand is being driven by a fear of AIDS.
3. The private sector could manage the marketing and distribution associated with an STD/HIV/AIDS prevention campaign.
4. Initial donations of commodities promoted at lower prices could eventually be replaced by condoms obtained through direct private sector investment. Pricing will move in line with inflation and product related costs. Donated commodities should be sold to the distributor. The resulting income would constitute a return to the project representing recovered program costs.
5. A plain, lubricated condom, branded PANTHER, would be available and acceptable to the South Pacific market.
6. Urban markets should be the first target.
7. Promotion should be impactful and motivational but, culturally sensitive.
8. The project should cover advertising costs for the first two years, shared with the distributor during year three and left to the private sector thereafter.
9. Market research should be project generated and supported.
10. Retailers will require special training.
11. An investment of US\$ 228,100 over three years will establish a viable and sustainable market.
12. Some waivers would be required.

F. Summary of Institutional Analysis:

The Institutional Analysis, performed by RDO/SP, concluded:

1. SPC has able and trained staff as well as a political mandate from its constituency to implement AIDS prevention activities in the region. It is the agency of choice to network local agencies into a large AIDS prevention effort.

2. SPC has a close working relationship with all 22 Pacific island governments and administrations which enables it to respond to country requests with minimum bureaucratic delays.

3. SPC has an intimate knowledge of the Pacific islands region, its diverse cultures and peoples, as a result of over 40 years experience of working exclusively in the region.

4. SPC has a wide range of programs in various social, economic and cultural fields which allows for a truly integrated, multi-disciplinary approach to development.

5. SPC has a community health program which includes health education, disease surveillance and control, nutrition, and environmental health.

6. SPC has extensive experience in collaborating with a range of international organizations, NGOs, regional institutions, and country donors.

7. SPC has flexibility in its work programs that allows program officers to respond promptly to country requests.

8. There is sufficient interest among NGOs to promote AIDS prevention activities. Some NGOs are fully capable, with minimal training, to implement effective campaigns. The analysis identified a large number of NGOs in the ten countries and make an in-depth report on several leading NGOs in PNG and Fiji. This list and analysis are available in HPN for reference.

G. Summary of Environmental Analysis:

A categorical exclusion to exempt this project from Environmental Assessment and/or an Environmental Impact Statement was authorized in the PID. A copy of that exemption is in Annex I.

## VI. CONDITIONS AND COVENANTS

The project will not be obligated by a bilateral project grant agreement. Therefore, the usual conditions and covenants are not applicable. The standard format for a grant to a public international organization (PIO) does not include conditions and covenants, such as authorized representatives, evaluation, etc.

The project plan for an evaluation after two years of implementation is included in the description section of the grant agreement. In effect, SPC by signing the grant agreement is agreeing to a covenant (without calling it that) for evaluation.

The grant agreement includes a provision that SPC will make no community grants until certain criteria is prepared and included in the approved work plan. This, in effect, is a condition precedent.

The source and origin of the project authorization will be included in the grant agreement with SPC; i.e., foreign exchange costs from the United States and local costs from the ten countries served by RDO/SP plus Noumea.

No other conditions and covenants shall be needed for the grant agreement with SPC.

## Annexes

- A. PID Approval Cable
- B. Logical Framework
- C. Statutory Check List
- D. Request For Assistance
- E. Technical Analysis
- F. Social Soundness Analysis
- G. Institutional Analysis
- H. Economic and Financial Analysis
- I. Social Marketing Analysis
- J. Initial Environmental Examination
- K. Media Center Equipment List
- L. Country Profiles:
  - 1. Cook Islands
  - 2. Fiji
  - 3. Kiribati
  - 4. Niue
  - 5. Papua New Guinea
  - 6. Solomon Islands
  - 7. Tonga
  - 8. Tuvalu
  - 9. Vanuatu
  - 10. Western Samoa
- M. Profiles of Several NGOs in PNG and Fiji



~~TO EDUCATION/COMMUNICATION~~ BECAUSE THE PROPOSED A.I.D. ACTIVITY IS LIMITED TO EDUCATION/COMMUNICATION ELEMENTS WHICH CANNOT BE FULLY EFFECTIVE UNLESS IMPLEMENTED AS PART OF A LARGER CONTROL PROGRAM. OTHER DONOR AND ORGANIZATIONAL SUPPORT IS NEEDED FOR ELEMENTS OF THE BROADER PROGRAM SUCH AS THE PROVISION OF CONDOMS, SEXUALLY TRANSMITTED DISEASE (STD) PREVENTION/CONTROL, RELATED MEDICAL SERVICES, AND OPERATIONAL RESEARCH.

THE MISSION CLEARLY HAS STIMULATED PROMISING DISCUSSION AND COOPERATION AMONG DONORS AND HEALTH ORGANIZATIONS WHICH IN THE PAST HAVE NOT ALWAYS COORDINATED CLOSELY. THE AIDAB (AUSTRALIA) DECISION TO PROVIDE QUOTE BRIDGE FINANCING ENDQUOTE FOR PROMPT INITIATION OF KEY PROJECT ACTIVITIES ILLUSTRATES THE EFFICACY AND IMPORTANCE OF THIS APPROACH. EAGLEBURGER

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## ANNEX A

### RDO/SP RESPONSE TO PID GUIDANCE CABLE

The ANE/PD PID approval cable referred to a separate guidance cable. Although a draft of the guidance was faxed to RDO/SP on May 1, the official guidance cable was never received. The following comments are in response to the faxed draft cable on the assumption that the draft accurately reflects the concerns of the ANE review group.

Para 2.A - Indicator re condom use: The PID referred to increased condom use of 25 percent. This was changed in the PP to a 35 percent increase in sales of condoms. Not only would condom usage would be very difficult to measure but be very difficult to define; e.g., how to compare those who use condoms all the time vs. those who use them sometimes or rarely; how to measure the size of target groups to provide a basis for determining increase in usage; what target groups to measure, etc. Therefore, the PP design is focussed on increase in sales (commercial and subsidized NGO sales) of condoms as this indirectly provides an indication of usage.

Para 2.b - Baseline Data: Baseline data collection is built into the project design.

Para 2.c. - Behavioral Change: The project includes KAPB studies to monitor behavioral change.

Para 3 - Condom Availability: At the last moment in project design, S&T/Population cancelled its commitment to provide a one time donation of three million condoms. It appears that AIDAB might donate condoms to support the community grants program in support of the effort to increase demand for condoms. In PNG condom marketing will be started in the SOMARC project. The Red Cross is willing to market condoms in an effort to establish a financially sustainable condom supply. The demand (market) must be increased substantially before the private sector suppliers will show much interest in marketing condoms.

Para 4 - Lessons Learned: AIDSCOM, AIDSTECH and SOMARC, in contributing to the project design, brought lessons learned into the design.

Para 5.a - Target Groups: The project initially will focus on urban populations in four highest-risk countries.

Para 5.b - Illustrative Messages: The design personnel rejected this suggestion as being premature. However many discussions were held with PVOs and government officials.

Para 6 - Reduction of STD: The output target for reduction of STD has been increased to 35 percent. Aspects of STD/HIV/AIDS prevention program which are outside this project are described in the PP.

Para 7 - Tracing Partners: This is not a part of the project as project resources are already spread very thin and other donors are active in activities more closely linked to tracing partners.

Para 8 - Local Institutions: The project includes community grants to support local institutions.

Para 9 - WHO Advisors: WHO is assisting SPC and will be a member of the Technical Advisory Group.

Para 10 - IEE: The IEE was revised per instructions. A copy of the approved IEE is in a PP annex.

Para 11 - Blood System Security: Other donors are providing assistance in this area as described in the PP.

Para 11 - Donor Coordination: Donor coordination is described in the PP in terms of component, level of support and overall program. Donor coordination and networking has been made one of the project activities. The establishment of the Technical Advisory Group, which grew out of meetings begun by the RDO/SP PSC, is a tangible expression of donor coordination.

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SOUTH PACIFIC REGIONAL AIDS PREVENTION PROJECT

ILLUSTRATIVE LOGICAL FRAMEWORK

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions For Achieving Goal Targets
<b>Project Goal</b>			
To minimize the impact of STD/HIV/AIDS in the South Pacific.	Projected rate of STD increase reduced by 35%.	1. Epidemiological Reports 2. SPC and WHO Reports 3. KAPB Results	1. Governments and communities adopt measures and behavioral changes necessary to prevent and combat the spread of HIV/AIDS. 2. Behavior change will reduce STD and AIDS 3. Donor cooperation and coordination is maintained.
<b>Project Purpose</b>			
To promote behavior that will thwart STD/HIV/AIDS transmission.	1. Increased public awareness about HIV/AIDS prevention, spread and control. 2. Sale of condoms increased by 350%. 3. SPC continues AIDS education programs.	1. Project Reports, evaluation & monitoring. 2. STD/HIV/AIDS Epidemiology Reports. 3. KAPB surveys 4. Condom sales records	1. Behavioral change possible. 2. Effective public information programs are established and maintained. 3. Continued interest and commitment by SPC & its members.

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Outputs	Magnitude of Outputs	Means of Verification	For Achieving Outputs
<u>Regional</u>			
1. Baseline data and monitoring	1.a KAPB results from countries in use. b. Epidemiological data base established for target populations. c. Data system in use. d. SPC Quarterly AIDS Newsletter. e. SPC Regional AIDS Educa-Unit maintains uptodate STD/HIV/AIDS public attitude data.	1. Project and donor reporting, evaluations and monitoring. 2. Epidemiological reports 3. Condom sales records.	1. Suitable individuals, policies, programs and techniques can be identified to implement anti HIV/AIDS efforts in a timely and effective manner. 2. Donors willing to coordinate efforts. 3. SPC can recruit staff & open program quickly. 4. Sufficient donor support (funds, personnel, etc.) provided.
2. AIDS educational materials prepared in region & locally	2a.SPC Media Center prepares materials. b.Local media production capability increased.		
<u>National</u>			
3. Community education activities	3a.Active community AIDS educational programs in ten countries. b. Condom sales up 350% c. 35% reduction in STD rate.		
4. Networking	4. Regular meetings of donors and exchange of info.		

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Inputs	Implementation Targets (Illustrative)	For Providing Inputs
	<u>(\$'000)</u>	
1. Long Term TA	575	1 Expert
2. Training	300	Workshops, etc.
3. Community Grants	500	About 10 grants
4. SPC Media Center	130	Equipment
5. KAPB Studies	160	Several
6. TA Buy-ins	100	About 7 PM
7. Evaluations & Audits	125	2 Evaluations
8. Contingency	110	
9. RDO/SP Monitoring	<u>500</u>	1 PSC
TOTAL	2500	

- Project documentation
1. Required funding can be made available on a timely basis.
  2. Expert can be found to live in Noumea.
  3. Appropriate management arrangements can be established.

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## 5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

NA. This is regional project to a regional organization.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified? Yes. Congress has been notified
2. FAA Sec. 611(a). Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? Yes. Plans are in PP.
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? No legislative action needed.

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4. FAA Sec. 611(b); FY 1990 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) NA
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? NA
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. Yes. Project is being executed by regional organization.
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. Re(b) project will promote private section marketing of condoms and preparing health education material.
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). Limited U.S. procurement is possible or expected.

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9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. SPC and Local NGOs will contribute some local costs.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No
11. FY 1990 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? NA
12. FY 1990 Appropriations Act Sec. 547. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? NA
13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other No

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wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? NA
15. FY 1990 Appropriations Act, Title II, under heading "Agency for International Development." If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? NA
16. FY 1990 Appropriations Act Sec. 537. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? NA
17. FY 1990 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? NA

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18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).
- No project agreement involved.
19. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2 (and as implemented through A.I.D. policy). Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?
- NA, Project does not include Activities involving measurements.
20. FY 1990 Appropriations Act, Title II, under heading "Women in Development." Will assistance be designed so that the percentage of women participants will be demonstrably increased?
- Many women will be involved in NGOs and regional training.

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21. FY 1990 Appropriations Act Sec. 592(a).  
If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies, has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

NA

Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

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**B. FUNDING CRITERIA FOR PROJECT****1. Development Assistance Project Criteria**

NA

a. FY 1990 Appropriations Act Sec. 546 (as interpreted by conference report for original enactment). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

b. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Yes

c. FAA Sec. 281(b). Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

Project design is based on needs assessments of region involving health people in these countries. It provides IA and training to use the intellectual resources of the region.

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- d. FAA Sec. 101(a). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth? Yes in sense that it is to prevent serious diseases.
- e. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will: (1) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries. 1,2,3,4 NA  
Re 5, project involves regional cooperation.
- f. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Does the project fit the criteria for the source of funds (functional account) being used? Yes
- g. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for NA

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use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U. S. Government?

h. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Yes

i. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Not required as project is regional.

j. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Project is designed to reduce spread of STD and AIDS to all people, including poor majority.

k. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

Duplicates item c on page 7. See answer there.

l. FY 1990 Appropriations Act, under heading "Population, DA," and Sec 535 Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

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<p>Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?</p>	No.
<p>Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?</p>	No.
<p>Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?</p>	NA
<p>In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning?</p>	NA
<p>Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?</p>	No.
<p>m. <u>FAA Sec. 601(e)</u>. Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?</p>	NA to grant to SPC. SPC uses competitive procedures for its procurement.
<p>n. <u>FY 1990 Appropriations Act Sec. 579</u>. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and</p>	None. All funds to regional organization.

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private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

o. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a

Yes. See IEE

NA for specific questions.

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condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; and (11) utilize the resources and abilities of all relevant U.S. government agencies?

p. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project: (1) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (2) take full account of the environmental impacts of the proposed activities on biological diversity?

NA

q. FAA Sec. 118(c)(14). Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

NA

r. FAA Sec. 118(c)(15). Will assistance be used for: (1) activities which would result in the conversion of forest lands to the rearing of animals; (2) the construction, upgrade, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (3) the

NA

colonization of forest lands; or (4) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

s. FY 1990 Appropriations Act Sec. 534(a). If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

NA

t. FY 1990 Appropriations Act Sec. 534(b). If assistance relates to energy, will such assistance focus on improved energy efficiency, increased use of renewable energy resources, and national energy plans (such as least-cost energy plans) which include investment in end-use efficiency and renewable energy resources?

NA

Describe and give conclusions as to how such assistance will: (1) increase the energy expertise of A.I.D. staff, (2) help to develop analyses of energy-sector actions to minimize emissions of greenhouse gases at least cost, (3) develop energy-sector plans that employ end-use analysis and other techniques to identify cost-effective actions to minimize reliance on fossil fuels, (4) help to analyze fully environmental impacts (including impact on global warming), (5) improve efficiency in production, transmission, distribution, and use of energy, (6) assist in exploiting nonconventional renewable energy resources, including wind, solar, small-hydro, geo-thermal, and advanced

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Biomass systems, (7) expand efforts to meet the energy needs of the rural poor, (8) encourage host countries to sponsor meetings with United States energy efficiency experts to discourage the use of least-cost planning techniques, (9) help to develop a cadre of United States experts capable of providing technical assistance to developing countries on energy issues, and (10) strengthen cooperation on energy issues with the Department of Energy, EPA, World Bank, and Development Assistance Committee of the OECD.

u. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA"

NA

(as interpreted by conference report upon original enactment). If assistance will come from the Sub-Saharan Africa DA account, is it: (1) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (2) being provided in accordance with the policies contained in section 102 of the FAA; (3) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (4) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. NA

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? NA

c. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? NA

3. Economic Support Fund Project Criteria

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? NA

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes? NA

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? NA

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## 5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

1. FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? To the extent practical.
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him? Yes
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? NA. Regional project.
4. FAA Sec. 604(e). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) No such procurement in project.

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5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) No construction in project.
6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No shipping in project.
7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes.  
No.
8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? Yes.
9. FY 1990 Appropriations Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes.

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10. FY 1990 Appropriations Act Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? NA
11. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2 (and as implemented through A.I.D. policy). Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? NA
12. FAA Secs. 612(b), 636(h); FY 1990 Appropriations Act Secs. 507, 509. Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. None available in South Pacific
13. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No.
14. FAA Sec. 601(e). Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? SPC will use competitive procedures.

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B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? NA
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? NA
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress? NA

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? NA
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? NA
3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes.

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4. Will arrangements preclude use of financing:
- a. FAA Sec. 104(f); FY 1990 Appropriations Act under heading "Population, DA," and Secs. 525, 535.  
(1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion? Yes.
- b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes.
- c. FAA Sec. 487. To or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? (Section 487 requires the taking of "reasonable steps to ensure that assistance" (under the FAA and the Arms Export Control Act) is not provided in the foregoing cases.) Yes.
- d. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes.
- e. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.

fb

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- f. FAA Sec. 662. For CIA activities? . Yes.
- g. FAA Sec. 636(1). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes.
- h. FY 1990 Appropriations Act Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes.
- i. FY 1990 Appropriations Act Sec. 505. To pay U.N. assessments, arrearages or dues? Yes.
- j. FY 1990 Appropriations Act Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes.
- k. FY 1990 Appropriations Act Sec. 510. To finance the export of nuclear equipment, fuel, or technology? Yes.
- l. FY 1990 Appropriations Act Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes.
- m. FY 1990 Appropriations Act Sec. 516; State Authorization Sec. 109. To be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? Yes.
5. FY 1990 Appropriations Act Sec. 574. Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? Yes.

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6. FY 1990 Appropriations Act Sec. 582.

No.

Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

**DISPATCHED ON**

PRO 2/18/5

- 3 JUL. 1990

2 July 1990

Mr John B. Woods  
Regional Director  
South Pacific Regional  
Development Office  
US Agency for International Development  
The American Embassy  
P.O. Box 218  
Suva

Dear John

The enclosed proposal for an information communication project for the prevention of AIDS and STD in the Pacific is the update version of the AIDS project submitted to you last year. This project was finalised following discussions with your agency, WHO, AIDAB and member countries in 1989-90. Three components are included under this project.

One has been particularly discussed with WHO (The WHO/SPC information exchange center). The two others (coordination and media unit) were finalised during a 3 weeks mission by Dr Bach in Suva last February and are the components submitted to USAID for funding.

We understand that the initial level of funding proposed in the PID may have to be revised, however following our discussions the budget is presented for a total of 2.5 M USD for five years.

We are starting at the end of June the information exchange project and we are hopeful that the USAID funding will enable us to set up the coordination unit before the Thirtieth South Pacific Conference in October and the media production activities by the end of this year.

We are planning to hold a session of the Thirtieth South Pacific Conference on the theme of government's AIDS policies in the Pacific with the presence of Dr Han WHO Regional Director.

We look forward to hearing from you on the progress of this project which, as you would appreciate, has to be considered as a matter of urgency.

Yours sincerely



Atanraoi Baiteke  
Secretary-General

Encl.. AIDS Communication and Information proposal

## TECHNICAL ANALYSIS

A. Introduction1. Purpose:

The purpose of this analysis is to determine whether or not the Regional AIDS Prevention Project (RAP) proposed by RDO/SP is technically feasible. The feasibility of the project in terms of social, cultural, and economic/financial aspects was examined in other analyses.

2. Background:

Only known since 1981, the HIV retrovirus has spread at an alarming rate throughout the world. WHO estimates 5.2 million people infected by HIV through June 1990. The AIDS pandemic has become a serious threat to all public health efforts. It affects sexually active people particularly between the ages of fifteen and fifty. To date the best scientific knowledge is that no one has survived HIV infection. The very dangerous attributes of the disease are its long incubation period before the virus can be detected in the blood (six months), the length of time for symptoms to develop (several years) and its incurability.

The disease is transmitted in three known ways:

- through contact with infected blood;
- through sexual contact;
- from mother to fetus.

There are two classic epidemiological patterns to AIDS transmission: through homosexual contact and shared needles by IV drug users as is common in Europe and North America and through heterosexual contact as in Africa.

Myths about AIDS transmission run rampant. It is believed in some quarters that AIDS is uniquely a homosexual problem; it can be contracted through casual contact; or that it is some kind of judgment on mankind.

The positive aspect of the HIV/AIDS danger is that transmission can be stopped. Blood can be screened; needles can be sterilized; sex can be practiced in a safe manner. All it takes is a will to change existing behavior and knowledge about safe preventive practices. Thus the purpose of the project is to promote behavior that will thwart STD/HIV/AIDS transmission.

B. Why should the A.I.D. project concentrate on education?

A comprehensive campaign to reduce the spread of the HIV virus would include many activities besides community education: blood screening, technical training of medical personnel, blood testing equipment, etc. The text of the project paper describes what other donors are doing in the South Pacific in support of the regional AIDS prevention strategy. The one important area not being adequately covered by other donors is public education. Therefore, it is technically sound for the A.I.D. RAP Project to concentrate on public education, and specifically on community education.

C. Why is a separate AIDS education campaign needed?

All countries of the South Pacific have health education programs of some type and magnitude. It is desirable to have a separate AIDS education program rather than including information about AIDS in the regular health education program because:

1. An AIDS education program is directed to different target groups than are regular health education programs;
2. AIDS education requires a much greater sensitivity than health education programs in general;
3. AIDS education concentrates more on changing behavior than do other health education programs;
4. There is a greater time urgency for AIDS education as it is critical to prevent the AIDS virus from gaining a foothold in the South Pacific. Experience elsewhere indicates a doubling of infected people every six months in the early stages of the epidemic. Thus a six month or year delay in reaching people about AIDS prevention within a few years can make a big difference in the number of people infected with HIV.
5. The lack of a cure for this fatal disease means that only prevention can help people -- not medical treatment after infection has occurred.

D. Why is the community organization a more desirable vehicle than the formal educational system or other vehicles?

Other donors are providing assistance to help the countries distribute information about AIDS in the formal educational system. However, information about AIDS must be provided outside the formal school system as well since most of the at-risk people have already finished their formal education and thus would not be reached by programs directed at students.

Education programs must be focused on well-identified target groups of people whose behavior puts them at risk. Given the social realities of Pacific societies and the facts that intravenous drug use and prostitution are not widely practiced, it becomes extremely difficult to identify a well defined target group beyond those who are sexually active.

Behavioral change in the matter of sexual relationships is a delicate topic. It is intimate and personal. It is closely linked with a person's identity. If not skillfully presented, AIDS education can be both religiously and culturally offensive. In closely knit societies such topics are not openly or easily discussed with outsiders. The message must come from friends or familiar and trusted companions.

Factors influencing promotion of behavior change include:

- the perceived risk of AIDS to the person being educated;
- the attractiveness of the safe sex behaviors being presented as alternatives to existing sexual practices;
- the credibility of the educator.

These findings and other reports point to the effectiveness of AIDS education by trained peers or peer groups.

This project proposes to get the message on the street by working with well known and trusted local non-governmental organizations (NGO) to educate their constituent members in AIDS prevention. Community campaigns, mounted by these NGOs, are the only cost effective and sustainable way to get the message to those sexually active people who are presently curious, uninformed or ignorant about AIDS prevention. It is only on the personal level - at critical periods of time - that behavioral change can be encouraged. NGOs offer the only means open to reach people in an effective, efficient, confidential and timely manner.

Many of these NGOs are small and face enormous budget constraints. SPC will establish as funding mechanism to provide grants to local NOGs to enable them to plan and implement their AIDS prevention activities.

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E. Why should the project work through SPC instead of directly with NGOs?

Since AIDS easily crosses national boundaries, a regional program of AIDS prevention cannot be effective if it is limited to only the ten countries covered by RDO/SP or carried out on a country-by-country basis. The management burden on RDO/SP to implement the project on a bilateral basis would be so high as to be unacceptable. In addition, the need for AIDS education will not end within five years, so a long term, sustainable regional effort is needed. Therefore, an implementing agency is needed which can deal with AIDS on a broad, regional basis over a long time period. The South Pacific Commission (SPC) is the only organization with the broad coverage and a programmatic scope large enough to deal effectively with the international complexities involved in an effective STD/HIV/AIDS education program. See the Institutional Analysis for details about SPC.

SPC has a mandate from its membership to attack the problem of AIDS in the Pacific. WHO, UNESCO and AIDAB have already agreed to provide resources to support SPC's "Information and Communication Project for the Prevention of AIDS and STDs in the Pacific." SPC is the only regional organization with staff, programs and facilities suitable for implementing this project. In each country, SPC will use either the Ministry of Health and/or the National AIDS Committee as its point of entry for contact with local NGOs.

Many of the countries of the region are small, highly religious and conservative. AIDS education will necessarily require careful, sensitive presentation. In addition, protocol arrangements between SPC and its member states require strict observation. The up-coming SPC Committee of Representatives of Governments and Administrations (CRGA) will focus on AIDS prevention activities.

Therefore, the A.I.D. RAP is a natural and logical addition to the SPC regional AIDS program.

F. Why are the major components of the project the most appropriate?

SPC, to carry out a long term program of AIDS education, needs additional staff and some equipment for its Regional Media Center. This is an investment in building up a regional capability that will continue after the A.I.D. project ends.

The heart of the AIDS educational program, however, is in the community organizations. Therefore, the project will provide grants to NGOs (and perhaps to a few national AIDS committees if they have a legal existence that makes it possible to receive grants) to carry out AIDS educational activities at the community level. Many of these NGOs are small and face enormous budget constraints. The community grants will provide financing for the NGOs to plan campaigns, train staff, prepare and produce educational and promotional materials. The training and short term technical assistance components will assist the NGOs in the most effective use of these grants.

Baseline studies (knowledge, attitudes, practices and behavior - KAPB) will be carried out regularly to measure progress and evaluate results of the project's activities.

G. Why should social marketing be included in the project?

A project element integral to AIDS prevention is to increase the use and availability of condoms. It does no good to encourage condom use, if condoms are not easily available. Social marketing studies demonstrate that condom use is increasing in the region. Condom availability is not. Further, the social marketing analysis suggests that a grant of condoms to private suppliers, plus, assistance in market research and advertising will ensure long, consistent and inexpensive availability of condoms.

Major suppliers of condoms contacted by RDO/SP have implied that Pacific markets are too small and remote to be of much interest. Some condoms are available in pharmacies and other retail outlets in the urban areas, but not many retailers carry condoms and the availability at any given time is uncertain. The market demand is still too small for retailers and wholesalers to be interested in pushing and advertising condoms. Like the incidence of the disease itself, sales figures are going to be low when compared with the rest of the world, although interest and usage are increasing. The problem, therefore, is one of creating an attractive market place where none existed before.

We know little about sexual behavior in the Pacific. Behavioral and marketing research has been minimal. Only persons and agencies with a credible service record and familiarity with service delivery problems have the expertise to provide solutions to the fundamental questions related to encouraging condom marketing. Remoteness among countries in the region means not only small, closely knit numbers of clients but also great distances between them that are expensive and time consuming to traverse.

The most cost effective, least time consuming and sustainable way to create a market for condoms is to use existing networks and logistical systems. NGOs make up that existing network and have their own logistical systems in place.

This means providing condoms to interested NGOs for sale to their memberships along with their AIDS prevention campaigns. With proper planning and management these same NGOs can restock with purchases from private sector suppliers. At least among major NGOs the capacity to manage and implement such a programs exists. The NGOs, with project assistance, will develop campaigns, prepare advertising and educational materials and maintain condom supplies - particularly among difficult to reach rural populations.

The efforts of NGOs to increase the usage of condoms should build up the demand for condoms over the life of the project to a point where commercial marketing of condoms can replace the distribution efforts of the NGOs.

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## SOCIAL SOUNDNESS ANALYSIS

Introduction

This document assesses socio-cultural factors and aspects of the general administrative environment affecting the establishment of an AIDS prevention project in the South Pacific.

I. Socio-cultural contextA. Background:

The South Pacific area under consideration for AIDS prevention activities is comprised of nine comparatively new nation states and Tonga, a kingdom under strong colonial influence but never under foreign rule. The region as a whole is conventionally divided up into three zones: Micronesia, Polynesia and Melanesia. Of the ten countries under discussion, Papua New Guinea, the Solomon Islands and Vanuatu comprise most of Melanesia, Fiji, Tonga Western Samoa, Tuvalu, the Cook Islands and Niue are Polynesian while most of Kiribati is intermediate between Micronesia and Polynesia. These labels, which originate from the early explorations of Europeans, are often of limited utility in that they may be used both to indicate geographical regions, with no implication concerning cultural characteristics, and to imply broad cultural or racial groupings. In this document the terms will be used to designate broad cultural features but, from the socio-cultural perspective, these labels obscure important differences within each area, and conceal other important similarities that cut across the boundaries.

The underlying patterns that the three labels refer to are explicable in terms of the three phase history of migration into the Pacific.

Between fifty and sixty thousand years ago, hunters and gatherers from the west moved into New Guinea and Australia, but they did not move out into the Pacific Islands. Later migrants joined them in over the following millenia. By about five thousand years ago these Melanesians had been joined in the region by people speaking languages very different from their own, with navigational skills and very different in appearance. These were the ancestors of today's Polynesian people and where they met Melanesians there was frequently intermarriage and cultural exchange. These exchanges and borrowings produced the distribution of cultures in existence when the third wave of migrants, the Europeans, entered the South Pacific some five hundred years ago. Ironically, many of the descendants of those first migrants did not meet with those in the third wave until the middle of the twentieth century, a fact of some importance for the matters to hand.

This thumbnail sketch goes some way towards explaining the rich pattern of cultural diversity found in the South Pacific today. It is important to stress that even within some of the nations under consideration there is very considerable socio-cultural diversity. Especially in Papua New Guinea, Solomon Islands and Vanuatu (which together make up most of Melanesia) we find very great variation in features of cultural and political life. Moreover, in all countries we need to distinguish between rural areas and urban communities.

No area of the world, no segment of its population, displays as much linguistic and cultural richness as the ten nationstates discussed here.

It is necessary to acknowledge differences within the region: variations in size, ecological characteristics and colonial history have interacted to produce a range of political environments. This traditional diversity is now encompassed within more recent political structures of the nationstate.

The people of Niue and the Cook Islands have citizenship of New Zealand and at any one time many of them are living in that country on a short or long term basis. More generally the people of Polynesia and Micronesia, and certain segments of those of Melanesia, are characterized by high rates of migration to metropolitan centers in the wider region. There are also significant patterns of rural-urban migration within each country as well as within the South Pacific as a whole. All of these have an impact upon HIV transmission.

Many states have built into their national political processes a concern with what they take to be the traditional ethos of local cultures. (It does not follow, however, that this conception corresponds to the actual traditional ethos as it was or as it continues in the area.) This means, in effect, that South Pacific governments have sensitivities which are not well-represented in the cultures of donor-states. As Father Doggett, the Chairman of the Melanesian Council of Churches, put it:

In the countries of the South Pacific there is no separation of state and church or of spiritual and political matters.

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The proposed project comes at a very significant time in the South Pacific. The incidence of HIV in the general population is not high, as yet, but, to paraphrase a seasoned US physician 'because there is no reason to panic it does not follow that we do not have to be very careful.' The African, US and European experiences provide rich sources concerning the necessity of effective, humane Information, Education and Communication (IEC) campaigns if intense suffering on a wide scale is to be avoided. It seems apparent that in the South Pacific HIV will be transmitted primarily by heterosexual means. And given the transmission characteristics of the virus - the "terrible arbitrariness" with which it moves through a community, affecting some but not others of those equally at risk - it is unlike any other disease found in the area. Other STDs, which are prevalent, have a more regular and therefore, for most people, a more comprehensible pattern of transmission.

These characteristics make HIV comparable only to bubonic plague and leprosy in human history in its capacity to divide communities and stigmatize its sufferers. All the resources of the great medical establishments in the US and Europe were unable to prevent completely the "demonization" of HIV positive persons in segments of popular culture and the press. In the South Pacific, where governments and powerful churches are very sensitive and comparably powerful medical establishments are absent, the danger of the epidemiologically counter-productive stigmatization of persons who are HIV positive must be avoided. This can only be accomplished if people have access to high-quality information about the disease. If people know how to protect themselves and understand the infection then the South Pacific may yet escape the worst consequences of the spread of HIV.

## B. The people and their culture

### Population

Most of the people of the South Pacific still lead a largely rural existence. They are very unevenly divided across the nations that comprise the region. The widely-dispersed Polynesian/Micnesian territories are small and their populations together account for less than 30% of the total; moreover, of this fraction approximately 70% are found in Fiji. The Melanesian populations, over 70% of the total, are spread through many square miles of rugged terrain and are often only accessible by air.

## Socio-cultural characteristics

### i) Community structures:

For the overwhelming majority of people in the South Pacific life begins and thereafter always remains rooted within a small-scale, territorially localized group of people who regard themselves as closely related kinsfolk. The individual is located within this group, in virtue of his/her birth, and, through the rules for classifying people beyond the immediate family as types of kinsfolk, acquires a set of social and political relations (concerning access to productive resources, marriageable persons and numerous rights and obligations) with others living within and outside the immediate settlement. In short, the individual's primary social and emotional identification is with a kin-based community of a kind that has existed in the region for millenia. The networks of social relations into which an individual is born are extended and transformed upon marriage and the birth of children, whereupon a whole new set of rights and obligations are acquired.

If the community defines the early part of life it continues to exercise enormous importance regardless of the successes achieved by individuals outside that community. The most successful Pacific islander, in business or politics, finds it impossible to disregard entirely the claims and obligations inherited by the circumstances of birth. For the overwhelming bulk of the South Pacific population the local community remains the primary arena in which daily life is lived out. It is unreasonable to assume that this will change dramatically within the foreseeable future.

In the urban context, finding somewhere to live and employment may depend very much upon one's kinship networks or the obligations one can induce through traditional means. In Suva, for example, migrants may still find some land upon which to erect a small makeshift house by the ceremonial presentation of a traditional whale's tooth to the chief of the settlement. Thereafter the grantee is obligated to help the chief in such matters as the raising of a child's school-fees, marriage valuables or any one of a number of similar undertakings.

The local community also constitutes the basic political unit of social life, if not the most significant in contemporary circumstances. Accordingly, leadership of such units is also of great significance, for leaders act as more or less effective gate-keepers to their communities. Any efforts to introduce new ideas will encounter enormous difficulties if community leaders do not find them acceptable. In Melanesia the basic unit

is most often led by a man who has achieved his position through his pursuit of preeminence in those fields valued by the community at large. In Polynesia leadership tends to be ordered in a nested hierarchy of formal positions that are inherited; there is in theory nothing an individual can do to move from commoner to chiefly status. The differences between Polynesian and Melanesian systems of leadership can be overdrawn, however: apart from exceptions to the general pattern in each area, Melanesian leaders are often able to establish dynasties - if only short and unstable ones - and Polynesian chiefs can lose power if they prove incompetent, although modern political processes has made it more difficult for this to happen.

In either case the local community acts as a corporate unit in respect of property and marriage. The individual relies upon the fellow members of the group, and especially its leaders, in ensuring access to subsistence resources and those valuable required for exchange on occasions of birth, marriage and death.

The gate-keeping role of community leaders, despite their virtual invisibility from the perspective of national politics, and the role they play in shaping and maintaining community attitudes, stems from their place in the control of resources. This they maintain in large part due to the kind of cultural understanding adverted to by Father Doggett in the quote above. Since leadership is conceptualized as an aspect of the general cosmology, the actions of leaders, and others in relation to leaders, have a significance beyond that of secular politics. Nowhere in the Pacific for the population at large is leadership entirely separated from a religious context; most Pacific islanders have not yet come to live in what Max Weber called a "disenchanted world".

This religious context is at the national level largely Christian. At the community level this is more or less embedded in a non-Christian and more ancient set of beliefs.

Faced with these facts it is tempting to view the contemporary Pacific dualistically, with the traditional structures predominating in the rural areas and modern ones doing so in the cities. This viewpoint is widely favored by national elites in whose interests it is to be seen as possessing unique bi-cultural competence. However, this view is at best not quite right, and at worst is seriously misleading. In reality, the effects of international communications and the dissemination of industrial cultural values and technologies are being felt - in different ways - in Pacific towns and villages alike.

Under these circumstances it is hard to make definite predictions in anything like the long term. The key to successful intervention is a flexible approach to issues combined with careful monitoring and evaluation of outcomes.

ii) The cultural context:

The community-centered nature of social life discussed above has to be seen against the background of both physical and cultural environments. In both these realms there is diversity but, as with the distribution of population through the South Pacific, the distribution of diversity is not uniform across the area. The people of Polynesia share a broadly similar culture, sharing many central cosmological beliefs and ritual practices, and speak closely related languages. In Melanesia, by contrast, there is very great diversity in languages and culture. Some cultures there place great emphasis on the segmentation of the sexes in daily life while others are indifferent on the matter. Some insist upon marriage with those born outside the local community or kinship group while others encourage marriage within such units. Some cultures invest enormous resources and time in staging complex rites, each lasting many weeks and organized in a series stretching over decades, that mark the religious progress of men through life while others enjoin men and women to amass as many valuables as possible (including today substantial sums of cash) with the sole purpose of giving it away in competitive exchange ceremonies. Some cultures regard the idea of male-male sex with amused disdain while others regard the insemination of youths by older (but unmarried) men as an essential precondition of their maturation.

Since the bulk of the population to benefit from this project live in Melanesia the variety of cultural forms has to be born in mind.

It may be platitudinous to point out that no human experience is ever interpreted outside of a culturally provided set of categories and presumptions, but when a project deals with such fundamental aspects of existence as health, sexuality and death it is a point worth stressing. Even after many years exposure to western beliefs a culture may still transform the earnest explanations of well-intentioned people into their own cosmological forms. Melanesian millenarian movements ("cargo cults") are a case in point. The people of Karkar Island in PNG have been involved in commodity production for over a century, ever since German plantations were first established, and have since that time been exposed to enormous efforts to westernize their conceptions of the supernatural. Yet, every decade or so people have reformulated their experiences into a new version of the old cosmology and have begun to prepare for the arrival of European consumer durables with the millennial era.

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Beliefs about health are, for the great majority of people living in the South Pacific, embedded in the wider cosmological framework. Health is not simply a physical condition of the body nor is disease a straightforward aspect of a person's organic condition. Disease and health are at once physical and moral conditions.

In the traditional systems of belief the judgments and caprice of ancestral spirits, the observation of taboos and the anger of non-human spirits living in the world are all central to an individual's state of mental and physical health. Connected with these other conditions, and of the utmost social consequence, was the state of a person's relations with other people in the local and neighboring communities. Beliefs that others could attack a person, if angry, offended or malicious, through the use of special magical techniques or powers, play a special role in the diagnosis of ill-health and especially death. Such diagnoses are a major factor in the ebb and flow of relations of alliance and enmity between local communities, especially in Melanesia. In dealing with HIV, whose victims are predominantly in the 20-40 age cohort, it is worth stressing that levels of enmity between communities in Melanesia are greatest when the death of someone in his/her prime occurs.

A grim lesson here is afforded by the slow virus disease known as kuru which developed among, and decimated, the Fore people of highlands PNG before its cause was discovered in the 1960's. Despite huge efforts to persuade people that only impersonal forces were responsible for the inevitable fatal disease, the Fore, at best, accepted that science had discovered only the proximate cause - the virus - but had no way of working out who had caused a particular infection, i.e. the sorcerer. For them the epidemic was still fundamentally an internecine struggle of all against all in which sorcery was the main weapon. Authorities had to commit considerable resources to prevent an outbreak of hostilities each time an important person died.

South Pacific beliefs concerning disease may make it harder to persuade people that the presence of HIV infected persons, the sharing of seats, swimming pools, cups and so forth, do not place them at risk. This is a notoriously difficult area of AIDS education under any circumstances (in the US in late 1988 over half the adults surveyed believed kissing was likely or very likely to transmit HIV), and in the South Pacific it is one to which particular attention needs to be paid.

The kinds of beliefs we find in the South Pacific might easily subvert another very important message about HIV infection - that there is no cure for it. In Port Moresby, in conversation with a non-English speaking taxi driver, I was told that there is a cure for AIDS that had been discovered by a Philippino spirit-medium. Surveys in parts of central Africa that had had extensive awareness campaigns, and which have a high incidence of HIV, reveal that as many as two thirds of people believe that there is a cure for AIDS. In Fiji too, in certain areas, it is believed that AIDS was known in the time of the ancestors and that the condition is curable. It hardly needs stating that beliefs like this can undermine the work of expensive media campaigns if they become widespread.

More generally the point is that messages couched purely and simply in terms of micro-organisms cannot be presumed to be capable of giving people an adequate understanding of the nature of HIV. In Melanesia I have met well-educated people who have no difficulty in integrating their knowledge of micro-organisms into a cultural framework dominated by ghosts, demons and sorcerers. Lest this be regarded as too extraordinary, it is also worth pointing out that many westerners, as well as many leaders of South Pacific nations, explain the vagaries of disease within a similar personal/moral framework in invoking the will of God.

The following points seem to arise from this consideration of beliefs about illness from the perspective of HIV/AIDS prevention:

It is very important that people gain the best possible understanding of HIV and the means by which it is transmitted

Such understanding will only come with sensitivity and perseverance on the part of those involved in IEC.

Relations between men and women constitute one of the most delicate of issues, and also one of the most important for an understanding of the context of HIV transmission in the South Pacific.

Ever since Europeans first encountered Pacific Islanders they have portrayed the Polynesia as characterized by a sensuous eroticism and a liberal attitude towards sexuality - male-male as well as male-female sex. Polynesia has also been seen as one in which women are relatively free and on terms of equality with men. Most of Melanesia, by contrast, has been seen as less free in sexual matters and its women firmly subordinated to men.

The generalizations are accurate up to a point. But, while ignoring important exceptions to the general pattern within each area, they also distort by only giving part of the picture.

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In Polynesia while women may be accorded high status, this is an aspect of the social ranking system. In fact, women of high birth may have an almost sacred character and all women have something of this quality in relation to their immediate kin group. Despite regarding women of their own group in these terms, men do not usually have the same respect for other women. It has been widely reported in the anthropological literature that men, while vigilant in trying to maintain the honor of the women of their own group, delight in a "sporting" attitude towards the search for sexual conquests. While, this attitude is not confined to Polynesia, it does seem to have been highly developed here, perhaps as a strong undercurrent to official cultural dogmas, despite emphatic denials by contemporary national figures.

At very deep levels in Polynesian cultures there seems to be close associations between masculinity and fertility and of masculinity with sexual prowess. This is reflected in the common Polynesian conception of the relationship between warriors and the chiefs they served as symbolically one between husbands and wives.

In the contemporary setting, it is fair to say, the evidence of those in family planning and women's groups as well the patterns of STD transmission and the incidence of sexual crimes all suggest that there is still an undercurrent of liberality of attitude towards sexuality that is relevant to a concern over HIV transmission.

In Melanesia the picture contrasts with that of Polynesia, at least for the most part. (There are very "Polynesian" areas in coastal and island Melanesia.) In many Melanesian societies stress was laid on the sexual continence of men. It was widely believed that a man's physical prowess and bodily well-being depended upon the retention and control of semen, a substance with sacred powers (on par with or surpassing that of blood) that is the source of bone uniting men of the clan and - in some cultures - is also the source of the milk a mother gives to her offspring.

Such views were and still are an important dimension of the "official" beliefs articulated by senior men on ritual occasions or when lecturing young men. However, there is evidence that these beliefs did not always completely express the attitudes and practices of men. Pre- and extra-marital sex did occur, and not rarely. More importantly, contemporary evidence of very high STD rates in Melanesia indicates that whatever patterns formerly prevailed there are today high levels of sexual activity.

Despite variations in degree and some exceptions, relations between the sexes in Melanesia are unambiguously asymmetrical. Men dominate women: brothers their sisters, husbands their wives. In both Polynesia and Melanesia, then, women are on the whole subordinate to men and this is most apparent in the context of the domestic household. A man is chief in his own house.

Communal values and decision-making procedures, as well as the division of labor, tend to make women considerably less assertive and resistant than men. In some parts of the South Pacific it seems that women are introduced to sexual activity quite early in life.

These circumstances alone would make it unlikely that a woman would ordinarily find it very easy to control sexual activity between herself and her partner. However, if we consider that sex frequently occurs in the context of status, wealth or power differentials that favor men then it will be even more likely that a woman will not be in a position to control the form and conditions of sexual congress.

We need to refer to another aspect of South Pacific cultures. Sexual activity is seen as an aspect of the emotional quality of a relationship. In a setting that is still predominantly characterized by social exchange rather than commodity transactions, a woman or girl may find it psychologically as well as socially difficult to refuse the sexual requests of a man who has by local standards been generous to her in some way. When we have thorough-going social differentiation as we do in the area, the interest a man shows in a woman may itself be regarded as an act of generosity.

The treating of sex as a commodity - prostitution - does of course occur in the South Pacific. But even here it seems to be dominated by individuals who take opportunities when they occur, with a tourist or when a ship is in port, on an irregular basis or when a temporary need makes it attractive, accommodating it in the normal run of things. So even here the context of prostitution is largely social rather than purely commercial. As such prostitution shades over into those social relationships in which sex in return for acts of generosity.

Although all this is strenuously condemned by those in political and ecclesiastical authority - to the point sometimes of outright denial - this behavior is based upon longstanding patterns as well as contemporary need for disposable income. As such it is unlikely to disappear easily.

Mention should also be made of male-male sex, still widely believed to be the primary form of sexual activity responsible for the spread of HIV. Here too South Pacific cultural categories and those of western cultures do not coincide. The former distinguish between roles in male-male sex in the way that "gay" and "homosexual" do not. Instead they distinguish between the active, inseminating partner and the passive partner; the former is regarded as an essentially masculine role while the latter is not seen in this way. Men who would not consider taking the passive role in male-male sex do not thereby have an aversion to taking an active role. Accordingly many Pacific men are reported at some point in their lives to have had male-male sex and passive men state that a significant number of their active partners are men who also have sex with women, either wives or lovers.

Many of the points made in this section have deep implications for HIV/AIDS prevention strategies, for the question of target groups and for the transmission characteristics of the virus. The information derives both from ethnographic sources and from experienced workers in relevant fields, and given the difficulties in obtaining precise, quantifiable data, it must be regarded as the best available.

The patterns of sexual relations discussed here derive from South Pacific mores as these are manifest in actual behavior. It is worth pointing out that whatever difficulties they present for HIV control are magnified by a further association, strenuously promoted by modern advertising and prominent western cultural values, between the consumption of alcohol and masculinity.

From the point of view of defining risk groups the evidence suggests caution. There is a general move in medical circles to define categories of activity as risky rather than categories of person. In the South Pacific, where western categories of person are in any case hard to apply without distortion, this seems a sensible approach. It is already clear that transmission is occurring through heterosexual relations. It is a sobering thought that in the South Pacific, as in parts of Africa, a faithful, trusting and appropriately obedient wife married to a philandering, forceful husband may be more at risk than an assertive, well-informed professional prostitute. Patterns of urban-rural migration ensure that very few geographical areas of the South Pacific will be isolated from HIV-infection.

## II. Beneficiaries of the Project

The direct beneficiaries of the project will be all those who learn enough to avoid unsafe practices and those who might have otherwise been placed at risk by such people - notably, but not exclusively, wives and children.

It is important to note that in the wide and dense social networks establish by classificatory kinship and corporate groups any personal tragedy automatically affects numerous people beyond the immediate family.

Given that HIV tends to infect the most productive cohort in the population, the capacity of a social unit to sustain itself economically would be greatly affected by its introduction to a community. In parts of Africa AIDS has been dubbed "the grandmother's burden" in recognition of the tasks that fall to the aged (and these are predominantly female) in caring for their surviving grandchildren after the parents of the children have died of the disease.

Under very bad circumstances labor-intensive industries and the economies to which they contribute may be affected by HIV infection. In the South Pacific, where national economies are heavily dependent on development assistance, any diversion of contributions into health that HIV might necessitate could affect the long-term future.

In brief, in both the short and the long-term prevention of the transmission of HIV benefits a nation from the community level upwards.

The immediate beneficiaries of the project will be SPC's AIDS Education Unit and those having access to its resources, which is to say all countries of the South Pacific. All these have established the need for access to resources enabling the production of IEC material for community use.

### III. Impact of the Project

The project, though its immediate objectives, would help minimize the effects of HIV on the people and nations of the South Pacific.

Since the project will advocate the practice of safer sex, through the use of condoms and other prudent tactics, it will also be expected to impact on the very high STD rates in the area. Indeed, high as the reported rates are, they are believed by experts to under-represent the real incidence. Obviously any impact in this area will be of real benefit and might in itself be thought a good reason for such a campaign.

The experience of Haiti suggests very strongly that any significant increase in the incidence of HIV in the South Pacific will impact upon tourism. Any project that helps prevent HIV transmission will therefore be beneficial for tourism.

### IV. Participation of Target Groups

As designed the project will involve the participation of SPC, USAID and other groups involved in preventing the spread of HIV. Health personnel and representatives of PVOs will also be involved in the implementation of the project and through them so will the communities and their members they represent. Members of local communities will also participate in the planned evaluation and monitoring of the project that will occur during its implementation.

### V. Socio-cultural feasibility of the Project

The people of the South Pacific have over the last few centuries modified their behavior in numerous ways at the behest of governments, missionaries, churches, health workers and business. This project, as part of a much larger effort, aims to modify the sexual behavior of these people. In the process it will need to get to grips with people's understanding of disease and their responses to those who suffer from it.

The project's feasibility depends in crucial ways on the larger effort to which it contributes. The feasibility of both depend on the extent to which they are implemented in a flexible manner and are guided by the responses of those they address.

There is no doubt that short term plans have brought HIV/AIDS to the attention of large numbers of people in the South Pacific. They know it is a threat to the general community and they desire to neutralize it.

We do not have a clear idea yet of just how people construe the disease, the threat it represents to them personally or how they will react to its spread. Given the inaccessibility of many people of the South Pacific and the limitations of KABP studies, it is unlikely that anything but a flexible, responsive campaign will work.

There is evidence that there has recently been increased demand for condoms in the STD clinics of the area, where they are distributed at no cost to the user. We also know, however, that the acceptability of condoms for family planning purposes had not been high. In Tonga, for instance, research suggests that only 7% of women use any form of contraception and of these only 8% use condoms. In PNG the pattern is not very different.

Part of the problem here is that women are primarily the recipients of family planning advice while men, as husbands or community leaders, regard children as paramount and in most cases ultimately make the decisions. In Africa campaigns to persuade men to wear condoms have resulted in large increases in the demand for condoms. But in Zaire, where the increase was almost eight-fold in two years, no more than 28% of men involved with sexual partners to whom they were not married said they used condoms with their current partners; only 2% of married men said they used condoms with their wives.

In the South Pacific, cultural attitudes to semen and masculinity must be recognized and, I believe, tackled head-on. Using sporting heroes and other cultural stereotypes of masculinity perhaps, the attempt has to be made to change as far as possible the nexus of associations which inhibit men from wearing condoms.

The use of shock or scare tactics will not be successful. The low infectivity of HIV, the long periods of latency of the virus and the cultural obstacles to persuading people that sexual intercourse (or any purely physical state of affairs) can in itself be a sufficient cause of a disease, all militate against such tactics.

The issues here are complex: in countries like the US it is not always easy to persuade young heterosexual people to feel that HIV is a real threat to them. This is especially true of young men for whom, the STD figures suggest, the dangers are the greatest. Just as many people cite ancient chain-smokers as counter-evidence to the claim that smoking causes ill-health. Young people often point to individuals who frequently change sexual partners and yet remain uninfected. Young people, who are often inclined to take risks in any case, can, while the incidence is low, easily rationalize messages from authority figures about HIV as veiled attempts to curtail sexual activity. These same difficulties will be encountered in the South Pacific and they will compound those already discussed which derive from the cultural beliefs of the area.

These considerations, in the context of an organism that is more than usually capricious in the way it infects those equally at risk (because its low infectivity and long periods of latency result in low probabilities of infection per exposure), indicate that the feasibility of this campaign depends upon the perseverance and adaptability of those managing it. While the incidence of the virus is low attempts to simply scare people will not work; worse still they may increase the likelihood of its transmission by leading people to deny the danger and by precipitating hysterical responses to those that do contract the infection.

While flexibility is important in any AIDS prevention campaign it is also necessary to prevent the proliferation of messages. Many people have expressed the need to generate consistent and culturally appropriate messages. Confusion has already been caused by failure to ensure that messages are clear or consistent with one another in the context in which they are received. For example, in a village near the capital of one South Pacific country there was recently a misunderstanding about the relationship between AIDS and STDs which led to trouble when it was discovered that a number of its residents had contracted gonorrhoea.

The trouble in the village raises one more issue about this project. The fracas came to the attention of, and was handled by, local Family Planning Association personnel. This highlights the desirability of spreading the ability to inform and educate beyond the boundaries of governmental agencies as represented by NACs, while still ensuring that accurate information is disseminated. Given the hierarchical nature of national institutions any wrong moves at the top result in their reproduction lower down. One safeguard here is the focal role of the WHO/GPA in coordinating AIDS prevention activities. However, this role also involves the NACs which may remain insulated by many layers from the feedback provided by PVOs like FPA.

In PNG the Prime Minister's department has just established a National Literacy & Awareness Council to coordinate awareness activities and intends, in the near-future, to promote a private company to specialize in such campaigns.

Obviously there is need of some subtle skills and good organization here in ensuring, on the one hand, that confusion is avoided and only good quality IEC material reaches the community, and, on the other, that there are more than one or two channels for its communication.

## VI. Issues

The specific circumstances of the South Pacific raise a number of issues to be considered.

### Language

There is enormous linguistic diversity in the South Pacific, yet the language of government and education is English. This state of affairs creates the danger that language will be overlooked as an issue in IEC projects - with potentially very unwelcome consequences.

There is very limited proficiency in English in the area as a whole. Even where it is spoken routinely it is important to bear in mind how quickly the introduction of technical terms can confuse or mislead rather than enlighten an audience. While this warning is hardly needed by health educators it is worth giving in the South Pacific environment because of the association between language and status. English is a high-status language in the South Pacific and there is a considerable social pressure upon people to deny or conceal any uncertainty they might have as to what is being said to them. A very competent English speaker in PNG pointed out how important it is that communicators use languages in which people are thoroughly at home if they wish to ensure that people understand what the message is. He said that he had listened to many explanations in English about HIV but found that the speaker lapsed into technicalities altogether too readily: by contrast, he pointed out, it is very difficult to do this in Tok Pisin.

An even more striking example comes from an evaluation of the video "AIDS in the South Pacific" done by Margaret Winn. She reports that four members of an audience of English-speaking soldiers in a South Pacific nation interpreted the statement, "You cannot catch AIDS by giving blood" to mean that giving blood would confer immunity to AIDS upon those so doing. From Africa too there are some important lessons to be learned. In Uganda a sophisticated poster, employing a clever double entendre, worked well in the major cities and among the well-educated but was baffling to most rural adults.

Another point to be made is that literacy is restricted in the South Pacific and government statistics are almost certain to over- rather than underestimate the levels. Moreover, STD clinic experience suggests that people either do not like to carry away incriminating pamphlets or find reading them too tedious.

A related point, prompted once more by a consideration of Melanesian populations, is that interpreting advertisements, posters, radio-dramas and television is a relatively new activity for many Pacific Islanders. People with experience of public awareness campaigns in the area have stressed repeatedly the need for culturally appropriate material and to pretest it thoroughly beforehand. As Margaret Winn's experience suggests it is also desirable that IEC material be presented with enough time afterward for question and answer periods, and in an atmosphere in which the audience feels sufficiently relaxed to reveal any difficulties they might be having.

A final point relates to another dimension of linguistic communication. HIV concerns the most emotive topics possible and there is, in the nature of things, a strong inclination to euphemize discussion about it or otherwise try to avoid direct mention of what is at issue. But euphemisms are culturally very specific and they do not translate well. In PNG the Lutheran Church has produced a pamphlet in Tok Pisin in which intercourse is euphemized with a literal translation of the English "sleep with", presumably because the usual verb - goap - is too graphic. The outcome is that at least some people now believe that it is possible to contract HIV by sleeping next to someone who is seropositive.

On the other side, given the ecclesiastical atmosphere in which some national governments are swathed, IEC material needs to be framed in neutral language. For example, in the context of medical discourse a term like "promiscuous" may imply little or no moral evaluation on the part of the speaker, but its probable rhetorical impact in the South Pacific should not be overlooked.

These considerations recommend the extensive employment of in-country personnel in the planning, design and production of IEC efforts and not just in their implementation. This suggestion is also made by many nationals involved in AIDS prevention, who feel there is too much reliance on overseas experts and authority.

They also underline the need for skill and sensitivity in the design of IEC material: graphic, but not symbolic; simple, but not too easily ignored; thought-provoking, but not frightening; innovative, but culturally appropriate.

### Churches

The churches of the South Pacific have to be dealt with sensitively. Every attempt has to be made to accommodate their demands without compromising the project's aims. Unsubtle promotion of condom use will run the danger of stimulating church opposition.

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Unfortunately, it seems that there is already some tension between some churches and aspects of WHO/GPA. Father Doggett of the Melanesian Council of Churches, for instance, argues that this world body has failed to understand the cultures and needs of South Pacific and acts in an ethnocentric fashion, importing inappropriate western values with their campaigns. This position draws angry denials from WHO personnel who then go on to stress the purely medical imperatives to which they are responding. Such a response, if made publicly would of course be grist for the Father's mill: for, he would maintain, holding that there are such things as "purely medical imperatives" is a peculiarly western perspective which is inappropriate for the South Pacific. Neither side has its own or the other side's position quite right. What is important is that care needs to be exercised if an unproductive polarization is to be avoided.

The difficulties that can arise here, even when efforts have been made to accommodate the churches, is evidenced by the recent suspension of Family Life Classes in Kiribati schools after objections from Catholic and Protestant churches. The curriculum had been designed with representatives of both major churches but, it turned out, they did not have the mandate they and UNESCO thought they had. Negotiations are continuing. It is worth pointing out that the government of Kiribati is publicly committed to family planning in the light of its population problems

It is important that effective lines of communication be maintained with the churches of the South Pacific. Many of them have access to their own - often substantial - IEC resources and any breakdown in communication between them and AIDS prevention personnel is undesirable. The case of the Lutheran Church's AIDS leaflet is sufficient to show this.

#### Private Sector Organizations

Private companies and employee organizations have a real interest in AIDS prevention which might be pointed out to them.

Companies operating in labor-intensive industries are sensitive to the ill-health of workers. Others, such as mining companies, concentrate men and money and their operations are liable to become centers of high-risk activity. Their employees also frequently travel for R & R to places with highly-developed sex-entertainment industries.

In PNG some of the large mining operations already carry out limited HIV surveillance and education. The PNG Chamber Of Mines has publically stated they would support a policy of HIV education for mine workers.

Employee organizations have an obvious interest in the welfare of their members and a history of involvement in health and welfare education. At least some union leaders in PNG have shown a desire to learn more about HIV and a concern for the issues of AIDS education.

Neither of these kinds of organization have figured largely in the MTPs of the South Pacific but some mining companies have thought it reasonable to become involved in the prevention of HIV transmission. Others may prove willing and important contributors to HIV awareness campaigns. Once again, there is need of coordination of activities and the monitoring of the messages contained within any IEC material produced.

Non-religious PVOs, like FPA, Red Cross, women's and youth organization and Apex have already become involved in AIDS awareness campaigns in the South Pacific. They are generally eager to maintain or expand their participation in this activity.

These organizations often have extensive networks at the community level and have knowledge of, and contacts with, the populations on the ground. They are often more flexible and adaptable to local circumstances than government agencies. They are often able to present information in the context of "peer" communication an approach shown to be especially useful in reaching young and/or low status persons. PVOs are comparatively cost-effective in getting disseminating messages.

On the other hand such organizations, since they tend to act independently of one another, may reinvent the IEC wheel each time they enter an area, and they may, if acting outside mainstream awareness channels, make mistakes that go undetected, especially if enthusiasm outruns technical expertise.

All this suggests that acting as part of a wider network, and with good liaison with other agencies, private sector organizations have much to offer the South Pacific in its efforts to minimize HIV transmission.

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### Conclusion

HIV has set the world many problems. It is sometimes difficult to prevent solutions to one from increasing the severity of others.

It is important that people realize they can control the epidemic: other experts argue that we need to increase people's levels of anxiety in order to induce them to accept condoms. The need for people to have accurate information may lead some to conclude that a strong central authority is required and others to push for this to be avoided at all costs. Some see the medical threat as so great that moral imperatives must be disregarded: others see the moral threat as so great that merely medical imperatives cannot be paramount.

We know from history and from contemporary epidemics that people who have great fear of a disease and the feeling that they cannot control its spread often treat those with the disease with great callousness. The probability that this will occur is dependent upon the degree to which bodily health and moral status are linked (and no culture has ever completely dissociated the two). It behooves, therefore, those involved in IEC activity in the South Pacific to be circumspect. Luckily the epidemiological picture also permits the development of a controlled and cautious approach.

At the moment HIV does not seem to be spreading as quickly as might have been predicted a year ago. Yet there is no reason for complacency. The rate at which HIV spreads through a population is a function of i) the probability of transmission in an act of intercourse; ii) the frequency with which people change sexual partners; and iii) the length of the period in which an infected person is infectious to others. The incidence of STDs suggests that i) will be high and the best evidence we have about ii) suggest that it too will be high. For the worst possible reasons - the general health of the South Pacific population - it might be that (iii) is low; the period between infection and death is likely to be short in the South Pacific as a whole.

Under these circumstances is HIV in the South Pacific should not be approached in crisis-mode. The virus at the moment does not constitute a crisis: it does represent a new but chronic and very important problem, for which long-term strategies of containment need to be found.

There is need of an energetic awareness/education campaign. Shock tactics will not work (for reasons outlined earlier). They may make it much harder to formulate effective long-term strategies and thereby ensure that HIV will spread.

Under these circumstances it is sensible to dispense with the notion of high-risk or target groups. The metaphoric association of this latter phrase already suggests the danger of demonization of individuals that this approach runs. Given experiences elsewhere in the world, it may be, for example, that in cities the least risky sexual partner (for a single person) is a professional prostitute - of either sex.

This last point raises one final issue: such a thought would be scandalous to many members of South Pacific national elites, even if physicians and epidemiologists can contemplate it with equanimity. The nations of the area are new and engaged in the ticklish task of trying to build national identities out of a colonial past over which they had no control. Sometimes this struggle results in what looks like rather too robust a nationalism. This is occasionally evident in the discussions about AIDS policies and who should implement them.

These difficulties have to be regarded as another aspect of the cultural setting of AIDS prevention and dealt with patiently and respectfully.

## INSTITUTIONAL ANALYSIS

## SOUTH PACIFIC COMMISSION (SPC)

1. The Organization:

The South Pacific Commission (SPC) is a non-political, regional technical organization which, on request of member countries and on its own initiative, provides technical and training assistance and dissemination of information in the economic, social cultural and environmental fields to twenty-two governments and administrations of the South Pacific Region.

The Commission's role is advisory and consultative. Its programs are closely coordinated with those of the countries of the Pacific for which it works. The Commission does not wish to concern itself with the politics, nor does it attempt to control development programs of governments or administrations within the region.

The guiding philosophy of the SPC is one of service to its island member countries and cooperation with other regional and international organizations working to improve the region.

2. History:

The SPC was established by the Canberra Agreement in 1947 by six metropolitan governments: Australia, France, the Netherlands (withdrew in 1962), New Zealand, the United Kingdom, and the United States of America to help dependent territories. With the gradual admission of island country members and the political independence of many of these island territories, the Commission has, over the years, changed from an organization aimed at helping dependent island territories to a Pacific Islands organization in which all members (whether governments or administrations) have full and equal membership. An important aspect of this change was the assumption of financial responsibility by all member governments and administrations on an assessed basis.

3. Aims:

In response to changing realities and needs in the Pacific, the Sixteenth South Pacific Conference in 1976 adopted the following mandate:

- (a) to provide a common forum within which the island peoples and their governments can express themselves on issues, needs and ideas common to the region, with a view to maintaining the opportunity for all islands to be heard, viewed, considered and assisted on equal terms with one another;

- (b) to be a vehicle for the development and implementation of the concept of regionalism;
- (c) to assist in meeting the basic needs of the peoples of the region;
- (d) to foster and develop means to facilitate the flow of indigenous products, technical know-how and people among the islands;
- (e) to serve as a catalyst for development of regional resources that are beyond the capability of individual island governments to develop;
- (f) to serve as an aid-organizing machine for islands which are otherwise unable to reach aid sources outside the Island or outside the region itself;
- (g) to act as a center for collection and dissemination of information on the needs of the region and also as a depository for such information;
- (h) to undertake such other appropriate activities as may be determined by the South Pacific Conference.

It was also decided that the orientation of SPC's work program was to be rural and that assistance would be provided at the grassroots level based on the expressed needs of the countries.

#### 4. Countries Served:

The current membership of the SPC is twenty-seven including five metropolitan country members:

American Samoa	Nauru	Tokelau
Australia	New Caledonia	Tonga*
Cook Islands*	New Zealand	Tuvalu*
F.S. Micronesia	Niue*	United Kingdom
Fiji*	No. Mariana Islands	United States
France	Palau	Vanuatu*
French Polynesia	Papua New Guinea*	Wallis and Futuna
Guam	Pitcairn Islands	Western Samoa*
Kiribati*	Solomon Islands*	
Marshall Islands		

\*A.I.D. - assisted

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5. Location:

The headquarters of the SPC is located in Noumea, New Caledonia. Member states have called for increasing decentralization of its base to other member island countries. Suva, Fiji, a secondary base of operations for the SPC, is expected to expand with the move towards decentralization. Programs currently located in or near Suva, Fiji include:

- Community Education Training Center
- Regional Media Center
- Plant Protection Office

6. Staffing:

The current senior management of the SPC is:

Atanraoi Baiteke (Kiribati)	Secretary General
Jon Jonassen (Cook Islands)	Director of Programs
Helene Courte (new Caledonia)	Deputy Director of Programs
Iosefatu Reti (Western Samoa)	Coordinator, SPREP

Over one hundred staff members are based at SPC headquarters in Noumea; approximately thirty are based in Fiji; and around ten are normally based in various countries within the region for training programs.

7. Organizational Structure:

The SPC is led by a management team headed by the Secretary-General, who is the chief executive officer of the Commission, with the Director of Programs and the Deputy Director of Programs as members. This team approach to management was established in November 1976 with the installation of what came to be called the Management Committee. The Director of Programs oversees sections in finance, administration, information services, translation services, and the integrated work program through which all regional activities and field programs are conducted.

SPC activities in the region are undertaken as part of a projected three-year integrated work program reviewed and approved by its membership at the annual South Pacific Conference. The conference to review the 1990 work program was held in Guam in October 1989. A Committee of Representatives of Governments and Administrations (CRGA) functions as a technical secretariat for the conference, meeting biannually to evaluate the preceding year's work program and draft the subsequent year work program and budget.

The integrated work program is directly shaped by the evaluations and recommendations of island countries themselves, expressed through appropriate official channels and technical meetings, and by the CRGA itself. As the island countries now have much more local autonomy than before, they have significant input in determining their own development programs and needs, which in turn is reflected in SPC's work programs activities.

All the program activities of the Commission are reviewed in an effort to improve the integrated nature of their approach, to look at long-term solutions to needs, and to plan program in order to derive maximum benefit.

8. Programs/Country Specific Projects:

Current activities of the SPC include programs in agriculture, plant protection, coastal marine resources, tuna and billfish assessment, South Pacific Regional Environment Program (SPREP), rural development and technology, women's programs, health, nutrition, regional statistics, demography, population data, economic development, community education, media, youth and cultural conservation.

9. Finances/Budget:

The Commission's regular or core operating budget is derived from proportional assessed contributions from all its members. The largest contributors in 1989 were:

Australia	US\$1,455,079	(33.3%),
United States	736,225	(16.8%)
New Zealand	705,914)	(16.1%)
France	606,304	(13.9%)
the United Kingdom	532,639	(12.2%)

Voluntary or "extra-budgetary" contributions are also received annually from some member countries, other governments such as Canada, various national and international aid agencies and other external sources. Extra-budgetary contributions now make up more than half of the SPC total budget and largely finance the implementation of the annual work program. While the metropolitan countries' contributions are significant, the donors policy is to respect the SPC as an island countries organization and hence leave the islanders to take the lead in all decision-making.

The total approved SPC budget for CY1989 was US\$10,556,152 (USD1 = 113 CFP). Related to this, the U.S.-FY 1989 funded share included US\$736,225 in core budget contributions (routed through the State Department) and US\$600,000 in extra-budgetary contributions from A.I.D.

10. Support From Donors:

The major donors' contributions to extra-budgetary support during CY 1988 were:

United States of America	US\$746,576
France	649,747
Australia	620,748
New Zealand	555,841
UN Population Fund	324,493
UN Development Program	268,244
Int'l Center for Ocean Development	225,038
UN Environment Program	196,719

11. History of A.I.D. Support:

A.I.D. extra-budgetary assistance to SPC began in 1979, shortly after the opening of the A.I.D. South Pacific Regional Development Office (RDO/SP) in Suva. During 1979-1984, A.I.D. contributed \$2.3 million to SPC extra-budgetary program activities through multiple individual grants for projects in tuna research, water and sanitation, the South Pacific Regional Environment Program (SPREP), health education and the SPC Community Education Training Center.

The A.I.D. SPC Multi-Project Support Project (879-0006) consolidated A.I.D.'s assistance into a single five-year flexible grant instrument for multiple activities. It was initiated in 1985 for \$2.5 million and ended 30 September 1989. This grant has funded the following activities:

<u>SPC-MPS Grant-Funded Activities 1985-1989</u>		<u>US\$</u>
01	Tuna and Billfish Assessment Program	670,000
02	Small Scale Rural Water and Sanitation Project	30,000
03	Community Education Training Center (Suva)	493,376
04	So. Pacific Regional Environment Program (SPREP)	336,000
05	Food Composition Tables (nutrition values)	300,187
06	Festival of Pacific Arts	60,936
07	Regional Heads of Broadcasting Meeting	38,094
08	Health Education Materials	152,438
09	Rural Development Program	83,906
10	Integrated Rural Development Project	41,783
11	Crop Protection	20,704
12	Computerization	70,000
13	Regional Media Center (Suva)	188,567
GRAND TOTAL		<u>2,485,991</u>

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12. Additional Points of Information:

(a) Future of A.I.D. Support:

The countries of the South Pacific are beginning to recognize a growing need to organize geographically to confront critical region-wide issues such as STD/AIDS prevention, economic and trade development, and environmental management and protection. Also, the region is so far flung there is an obvious need to improve vehicles for regional coordination of development initiatives among the island countries, multiple donors and international organizations. The SPC, as a long established and politically accepted regional development organization and trans-Pacific forum for its 22 island country members, has the potential to play an important role in the future development of the region.

A.I.D. in 1988 approved a new Regional Development Strategy FY 1990-FY 1994 for the South Pacific which recognized overall the need for targeted investment planning and performance-based programming and budgeting in the region. A major goal is to achieve higher impact per dollar of assistance committed. Its objective is to have a broad impact on incomes by concentrating on environmentally sound commercial opportunities using agricultural and marine resources, on supporting family planning and selected health interventions including AIDS education, and on providing leadership and expertise in natural resource conservation and management.

The new strategy is a departure from block or small grant assistance where A.I.D. provided financing for a diverse and scattered portfolio of small activities in the work programs of SPC, NGOs and the Peace Corps. Instead, the new projects feature a performance-based, long range work plans and multi-year contracts and grant agreements for a limited number of development sectors within the RDSS.

A.I.D. projects, for which grants will be made to SPC for implementation, are planned to reflect RDO/SP's strategic sector focus in marine resources, agriculture, health and environment. An important project objective will be to develop a model system of program accountability for A.I.D.-financed SPC activities that will better permit SPC members to evaluate SPC's performance and guide future commitment of its resources.

The RAP Project represents the first project designed by RDO/SP to be carried out by SPC as previous grants have always been to financially support programs initiated and designed by SPC.

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(b) U.S. Arrears in Core Budget Funding:

The U.S. Government is the only SPC member of among 27 to stand in arrearage on core budget assessed contributions for 1986 and 1987. The outstanding amount is US\$400,000. While 79 percent of the assessed contribution for 1986 and 65 percent of that for 1987 were paid on time, the SPC claims the shortfall on the U.S. approved budget contribution has put the organization in a deficit position for two years running. The U.S. contribution for 1988 and 1989 were paid in full with the payment for 1989 made before the end of 1988 to help the SPC with their cash flow shortage.

(c) Regional AIDS Prevention Project:

There is a growing problem with AID/STDs in the South Pacific, with the largest problems apparent thus far in PNG and Fiji. SPC members are concerned that a regional health communications program for AIDS prevention be mobilized in the region before the situation becomes more serious. This led SPC, in consultation with RDO/SP, to prepare in May, 1990 a proposal entitled "Information and Communication Project for the Prevention of AIDS and STDs in the Pacific." The RAP Project is designed to support and contribute to SPC's program of AIDS prevention which is also being supported by other donors.

13. Conclusions:

The SPC has a number of unique attributes among agencies in the region that make it particularly well suited to carrying out the activities of this A.I.D. project. These attributes include:

- A close working relationship with all 22 Pacific island governments and administrations which enable it to respond to country requests with minimum bureaucratic delays.
- An intimate knowledge of the Pacific island region, its diverse cultures and peoples, as a result of over 40 years experience of working exclusively in the region.
- A wide range of program areas in various social, economic and cultural fields which allows for a truly integrated, multi-disciplinary approach to development.

- A community health program which includes health education, disease surveillance and control, nutrition, and environmental health. Health program officers have extensive experience "in the field" in conducting many of the activities that the proposed project would involve, including information dissemination, in-country technical assistance for health education activities, design and production of education materials, and technical training. In the area of AIDS prevention, the SPC has been regularly distributing relevant information to all member countries and routinely tracks the incidence of AIDS and HIV-infection in the region through the South Pacific Epidemiological and Health Information Service (SPEHIS). The SPC has also funded graphic artists in-country to assist in developing locally produced AIDS educational materials.
- Extensive experience in collaborating with a range of international organizations, including, United Nations agencies, non-governmental organizations, regional institutions such as the University of the South Pacific, research institutes, and biomedical laboratories. Most SPC health activities and programs involve collaborative arrangements in the planning execution and funding of these activities.
- Flexibility in the work program that allows program officers to respond promptly to country requests, often in a matter of weeks.

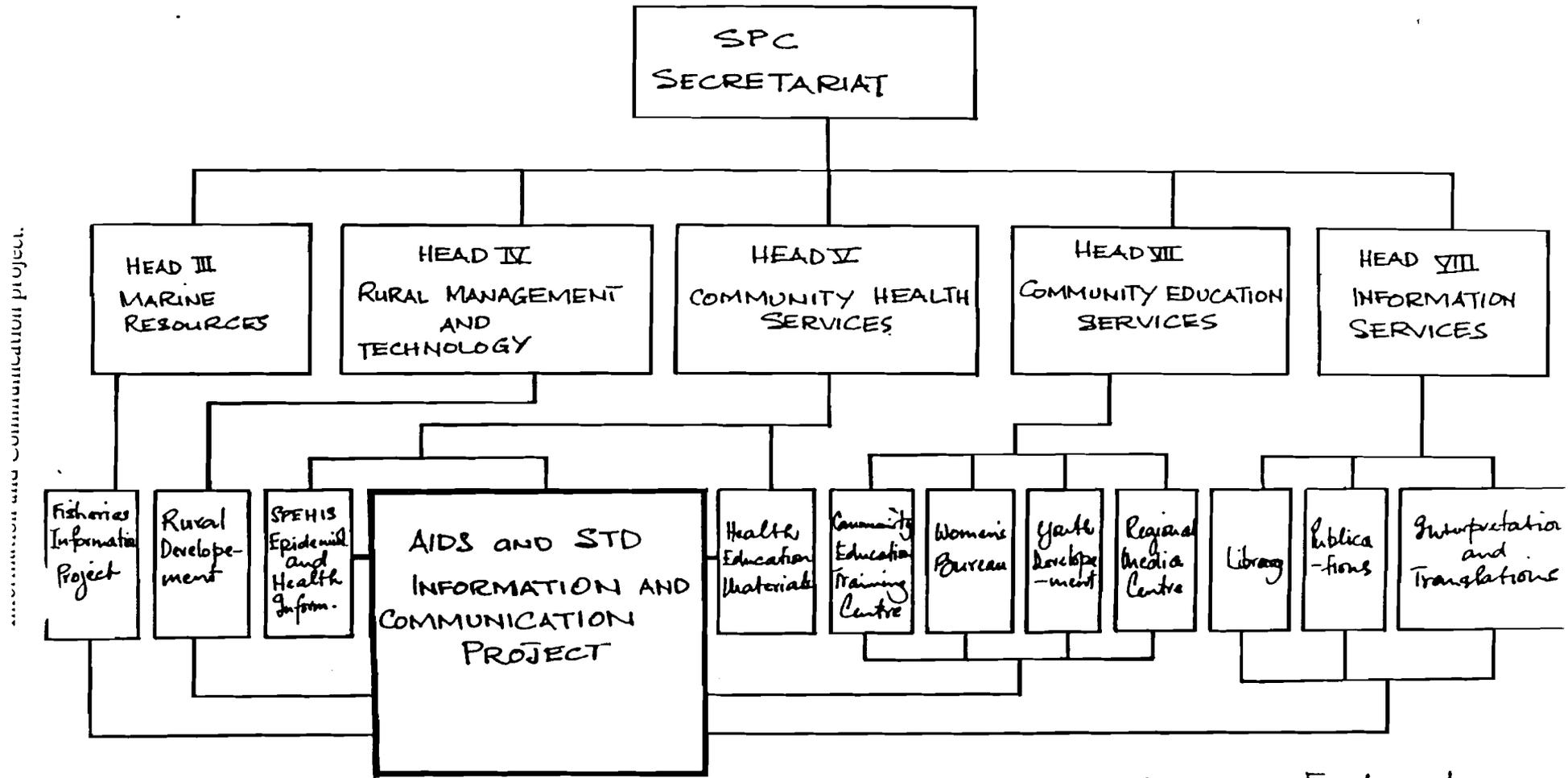
14. NGOs That Might Receive Project Grants from SPC:

The above analysis has concerned SPC only as nearly all project funds will be granted to SPC for project implementation. However, an important part of the project will be grants to local organizations for community education. No commitments have yet been made to any of these NGOs, and criteria for eligibility to receive grants from SPC will be a part of the work plans. Therefore, this analysis has not included NGOs that might receive these grants. During project design, hundreds of NGOs in the ten countries were identified and a limited analysis made of the several leading candidates in PNG and Fiji. This list and analysis are available in HPN for reference.

Attachment: SPC Organization Chart

doc. 0058Y

# ORGANISATIONAL CHART OF SPC WORK PROGRAMME IN RELATION TO THE AIDS AND STD INFORMATION AND COMMUNICATION PROJECT



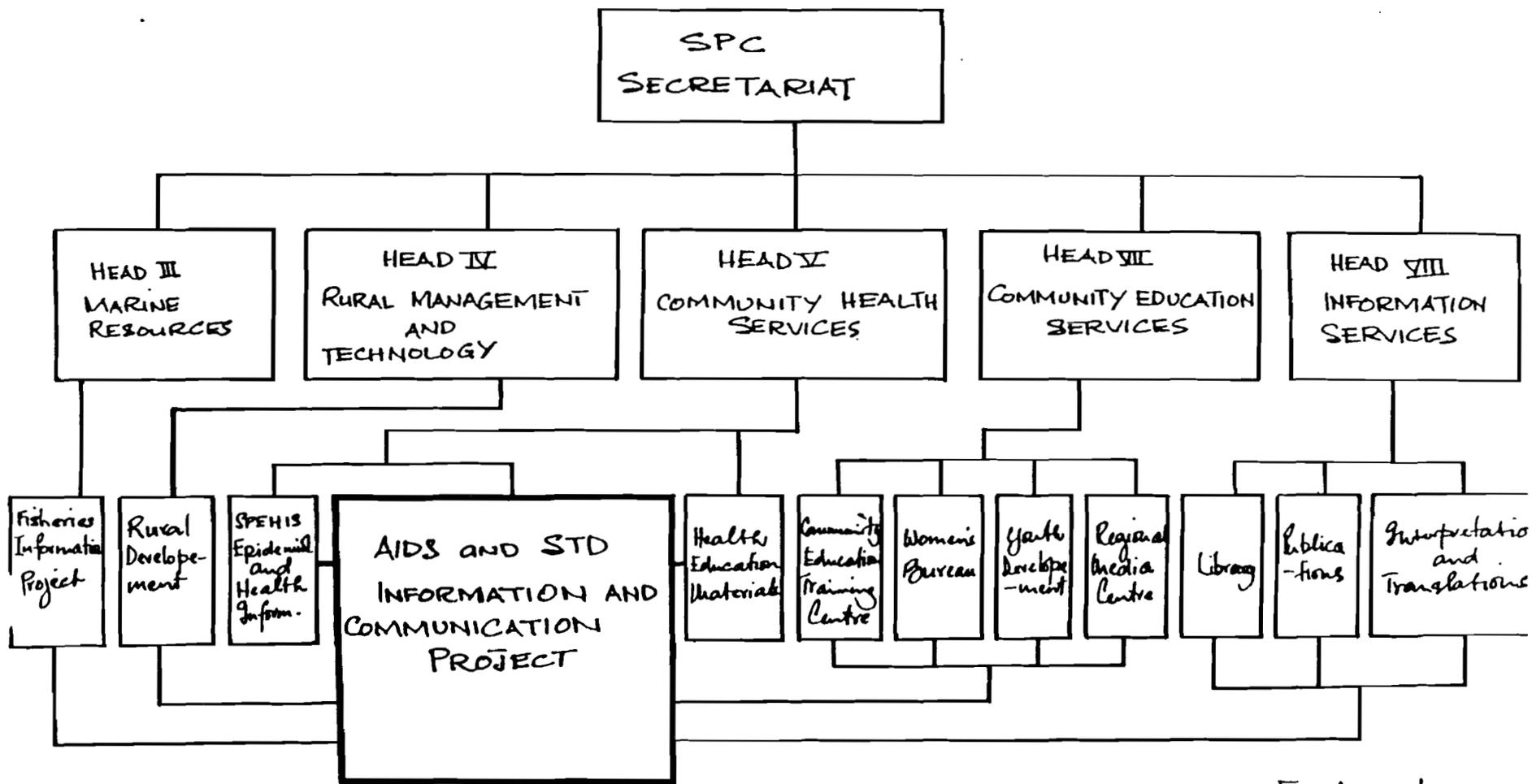
NOTE: Other programme areas not directly related to this project are: Food and Materials and Socioeconomic Statistical services

NOTE: Other Community Health Services include Nutrition, Environmental Health and Dental Services as well as other disease control and prevention activities.

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# ORGANISATIONAL CHART OF SPC WORK PROGRAMME IN RELATION TO THE AIDS AND STD INFORMATION AND COMMUNICATION PROJECT



NOTE: Other programme areas not directly related to this project are: Food and Materials and Socioeconomic Statistical services

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## ECONOMIC AND FINANCIAL ANALYSIS

This Annex assesses the economic and health care finance factors affecting the establishment of an AIDS prevention project in the South Pacific. The primary purpose for this analysis is to determine whether the project is a good investment and warrants the expenditures of scarce resources. This analysis will also assess the opportunity for sustaining the project and for monitoring and evaluating its cost-effectiveness.

Human infrastructure projects do not lend themselves to complex financial or economic analysis. Further, economic analysis of AIDS intervention projects requires adequate data on the incidence and prevalence of HIV as well as AIDS treatment costs. The absence of this data in the Pacific Islands renders it impractical to perform conventional financial or economic analysis on the types of interventions proposed in this project. Therefore, this paper focuses on the demand for the proposed project and the most cost-effective technical approach. Due to the lack of data in some areas, this analysis concentrates on the two major countries, PNG and Fiji, which contain over 90% of the population in the region.

## I. Background

The ten countries covered by this project have considerable economic diversity. In general, economies have stagnated or weakened during the past few years but are expected to sustain slow economic growth during the 1990s. For the major country, PNG, agricultural and, increasingly, mining are the mainstay of the economy. In Fiji, agriculture and tourism trade are key to the economy with an expected shift toward industrialization over the next decade. Both PNG and Fiji suffered major economic setbacks in the late 1980s, including the closing of a major copper mine in PNG, due to political strife. The prospects for PNG's economy in the next two years remain bleak while Fiji's economy is beginning to show signs of economic recovery.

The expectation for slow economic growth into the 1990s is, in part, due to the fiscal restraint shown by both governments. In PNG, sharp reductions in public expenditure are planned and will need to continue so long as the future of the economy remains uncertain. These cuts will affect all sectors of public service including health care expenditure which is expected to be reduced by 5% in real terms per annum.<sup>(1)</sup> This will occur at the same time as per capita disposable income will be reduced due to expected very serious levels of unemployment. In Fiji, tight expenditure controls have been imposed on many public service

sectors and are likely to continue while the government pursues its goal of raising government savings. The result of this policy has been an estimated 30% reduction in the health care budget(2) with the expectation of a move toward less reliance on government support toward a user-pay principle.

In general, government policies and trends in government finance are important determinants of health services delivery. As TABLE 1 illustrates the trends in level of health care expenditure in PNG and Fiji parallel these economic indicators.

TABLE 1 (3-5)

Indicator	PNG (87) (K\$)	FIJI (86) (F\$)
1. Total Health Expenditure	99.4 (1990)	33.6
2. % of Government Expenditure	9.1	7.7
3. Average total per capita Expenditure from all sources	25.06	48.0
4. Real % change of government expenditure per capita 1986-90	-6.89	-1.06

Real public expenditure for health care cannot be expected to increase in the near future. In PNG, where the health sector had maintained considerable support, 3.5% share of the GDP (1980-1986), recent declines show a trend toward less public support for health programs. Particularly when population growth is taken into account, available health resources on a per capita basis will continue to decline in the future. In fact, government expenditure for health is expected to decline in real terms (i.e. taking into account the effects of inflation and population increases) by 6.9% per capita over the next five years.(6) Likewise, real per capita expenditure declined by 25% between 1985 and 1988. Most of health care expenditure (96%) is spend on recurrent costs and "the provision of sufficient recurrent funding to maintain and expand the existing health services is a vital and pressing problem."(7) Similarly, in Fiji, where health budgets have varied between 7-9% of the national annual budget, the impact of stagnating budget levels and population growth has resulted in real declines in budget and per capita expenditure.

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## II. Direct Costs of AIDS

The burden of the direct treatment costs of AIDS in the South Pacific will primarily fall to the public health sector. Only 3 and 9% of health care expenditure are paid privately in Fiji and PNG respectively. Critical public policy and resource allocation issues will be raised by projections of AIDS treatment costs in this region. Particularly at a time when there is no real growth in health expenditure due to the need for fiscal restraint, the extra burden on the health care system represented by alarming increases in the rate of STD and HIV transmission may be prohibitively high.

If opportunity costs are calculated these costs become significantly higher. Up to 50% of admissions in hospitals in other developing countries are filled with HIV positive persons. This implies that a significant displacement of "regular" admissions, who are likely to have more treatable medical problems, is occurring. This trend has been correlated with an increase of mortality in HIV negative patients, suggesting only the most serious conditions may be admitted. Estimates of the opportunity costs of the care allocated to HIV-positive patients will need to be determined to guide policy decisions regarding health resource allocation between, for example, AIDS treatment, other curative illnesses and primary health care programs..

Estimates of STD costs suggest that the demand for scarce health resources for treating STDs will become increasingly high. In general, the reported incidence of STDs has risen approximately 50% in the last five years.(8) Inter-related socio-economic and cultural factors such as changing values and growing urbanization, have led to this dramatic increase in STD rates and thus the increased risk of HIV transmission within these countries. The extent of this problem varies somewhat between countries. In PNG, where rates of STDs are much higher than elsewhere in the region, the expense of diagnosing and treating STDs will be a much greater burden on the health care system. In Fiji, where there are fewer cases of STDs, but where the rate of growth has been at a much higher level, current treatment costs are lower but will increase more rapidly.

Table 2 illustrates the reported rate of growth of STDs during the past five years. In Fiji, it is estimated that only 10% of STD cases are reported so that real figures for 1989 may be closer to 8,630 and 12,530 for syphilis and gonorrhoea respectively. This data suggests that sexual practices are emerging that will undoubtedly contribute to rapid dispersion of the HIV virus among the sexually active population at risk.

TABLE 2 STD CASES AND RATES

Country	STD	Reported Cases	Incidence (per 1000)
Fiji (75-89)	Syphilis	69-863	.65
	Gonorrhoea	910-1253	2.02
PNG (83-86)	Syphilis	5755-7936	1.20
	Gonorrhoea	16,173-23,528	3.42

TABLE 3 shows cumulative cases of STDs projected during 1989-95 assuming an 8% and 28% per annum increases in gonorrhoea and syphilis rates respectively(9).

Fiji	Syphilis	142,677
	Gonorrhoea	111,760
PNG	Syphilis	275,175
	Gonorrhoea	264,447

Total 794,059

If current trends continue rates may reach over 200,000 to 300,000 STD cases in Fiji and 500 - 600,000 in PNG during the next five years. The cost burden of this increasing rate of STD transmission is considerable especially in the context of stagnant or declining health care service expenditure. The health care costs of treating STD could reach an annual burden in these two countries alone of \$US 3.8 million (see Appendix 1 for unit cost calculation) or at least 4% of health care expenditure.

This cost would be significantly greater if data from the other regional islands were added. For example, the Solomon Islands report rapidly escalating levels of STDs. One recent survey in each of the capitals revealed between 20-30% of women attending pre-natal clinics infected with STDs.

It is against this background of rapidly increasing STD rates that we should view the current very small number of reported HIV and AIDS cases:

Country	No. of HIV/AIDS as of June 1990
PNG	54
Fiji	7
Tonga	5

Experience in other countries suggests that if effective prevention measures are not undertaken; the spread of HIV infection will parallel the growth of STDs - but with much greater costs, both social and financial.

HIV transmission experienced among high risk groups in developing countries suggests that the incidence of HIV infection can double every 1 to 2 years. The impact of this brief doubling time is considerable: populations, such as PNG, Tonga and Fiji, with only 66 reported cases of HIV/AIDS cases can lead to as many as 75,000 cumulative HIV/AIDS cases over a ten year period.(12) A more realistic prediction for South Pacific countries is that rates of transmission will be over three times this pattern. For example, in Fiji, forecasting models using data on the current incidence of STDs predict 90,000 to 100,000 accumulated HIV infections and a corresponding number of AIDS-related deaths over the next 30 years.(13) Thus cumulative cases of HIV/AIDS in PNG, Tonga and Fiji alone could reach as high as 350,000 over the next ten years.

The estimated direct costs of treating an AIDS patient range from \$US1727 to \$US4257 in Fiji and \$US1800 in PNG exclusive of indirect costs including home care and transportation. Assuming this is typical for the region, the cost of treating AIDS could grow from current levels of \$US44,000 to as much as from \$US35 to \$US80 million per year by the end of the decade (depending on incubation periods for HIV and death rates). This would account for over half of health care budgets in these countries. This cost would be increased to \$US320 per year if indirect costs are included (See below, Indirect Costs).

This projected demand for treatment and associated health care cost creates critical resource allocation issues for these countries. Further these costs do not include the high costs to families of caring for AIDS patients or the costs of preventing and controlling AIDS.

### III. Indirect Costs of AIDS

Another major issue is the cost of AIDS to society due to the loss of productive lives . This places an economic value on lost time and premature death or on the value of foregone earnings. To do this, a human capital method can be applied which estimates the total number of future years of healthy life lost on an average HIV-infected person and discounting (4-7%) future lost years to the year of infection.

This level of analysis is critical where scarce talent is disproportionately affected by the disease and its outcome. To predict the full economic cost of HIV transmission, estimates of all social costs should be determined. Specifically, attention should be paid to industries dependent on highly skilled labor and the tourist industry which has suffered in other countries with high rates of HIV transmission. In Fiji, emigration is already high as a result of a significant shortage of skilled and professional manpower which poses a serious problem for the long-term development of the economy. Further threat to this population due to AIDS morbidity or mortality rates could be potentially threatening to the economy. Likewise, a threatened tourist industry, especially in countries with sex industries, could threaten GDP growth.

#### IV. Cost Savings Potential of Program

Experience gained in dealing with the worldwide HIV epidemic indicates that early prevention programs have the greatest impact on reducing the number of HIV infections and are most cost effective. The reason again relates to the observed rapid rate of spread of HIV among high risk groups. If this rate is slowed by taking measures that lead to:

- .reduced numbers of partners or
- .reduced probability of transmission

in the early stage of the epidemic the effect 10 years out is dramatic. If, for example, doubling rates are slowed from 1 year to 3 years the effect on total AIDS cases is illustrated below.

	YEAR					
	1	2	3	4	5	10
One year doubling	10	20	40	80	160	5120
3 year doubling	10			20		80

While it is not possible to achieve this type of impact in societies where AIDS is already widespread, it may be possible to greatly reduce the spread of the disease when only a very small number of individuals are currently infected.

As a rough indicator a successful AIDS prevention program in the Pacific Region has the potential to avert 50% of potential HIV infections. Thus the financial and social costs of some 175,000 HIV/AIDS cases over a ten year period could be saved. This equates to potential savings of at least \$US90.4 million in direct costs alone. Potential savings may be as much as \$US300 million if indirect costs are considered.

In addition, the AIDS prevention program will have an impact on the spread of other STDs. For PNG and Fiji alone, cumulative gonorrhoea and syphilis cases during 1989-1995 are almost 800,000. A 25% prevention success rate would avert some \$US4.0 million in gonorrhoea and syphilis diagnosis and treatment costs.

Hence the total project expenditure of \$2.5 million has the potential to result in total savings of \$US 4.0 million for STDs and \$US80.4 million for AIDS for a total savings of \$US84.4 million (\$US300 million if indirect costs are included) through reduced numbers of HIV/STD cases.

V. Sustainability

The scope of effort proposed for this project design is an important but only a part of the total programs proposed by country Medium Term Plans. To maximize return for the existing funding the most cost-effective technical approach should be undertaken. This approach should assure the expansion and sustainability of the project activities.

A. Project Design

1. Technical approach

The scope of this three year project should be sufficiently focused to assure that realistic objectives are established and desired outcomes are accomplished. Focused activities targeted toward specific high risk groups (i.e. CSWs, men having sex with men, youth, prisoners) will best ensure measurable success within the constraint of the existing funding.

The following model illustrates the suggested targeted framework for project implementation:

All technical inputs into project activities should be targeted toward the defined targeted objectives. The following is a guiding framework for project implementation.

PROJECT OBJECTIVES	CAPACITY BUILDING	REACH HRGs ABOUT AIDS (define HRG i.e. CSWs)	
PROJECT ACTIVITIES		IEC PROMOTION	DISTRIBUTE
PROJECT INPUTS	SPC	ADVERTISING	DISTRIBUTE.
PROJECT OUTPUTS	TRAINING TO — NGO/PVOS ON IEC DEV.	IEC MESSAGES REACHING	CONDOM DISTRIBUTION TO
PROJECT OUTCOMES	7 NGO/PVOS PRODUCING IEC MATER.	CONDOM USE INCREASED 25% IN TARGETED POP. INC. HRGs	CONDOM SALES INCREASED 25% IN TARGETED POP. INC. HRGs

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## A. Project Activities

To maximize return on the existing funding, to assure reliable evaluation and promote sustainability of the project, the scope of training, IEC activities and condom promotion/distribution should be focused. The high risk groups to be reached should be clearly definable and easy to reach and a clear message developed (i.e. have sex with only one partner). Training content, IEC messages developed, promotion campaigns and distribution strategies would than be aimed toward achieving quantifiable targets within this focused activity.

The three implementing agencies working in the project; SPC, a private advertisement company, and a private distributor, will form a consortium to accomplish several tasks:

1. Develop and implement training programs for NGO/PVOs to build in-country capability for producing and distributing IEC materials which promote condom use as a way to prevent AIDS and STDs. (Primary responsibility - SPC).
2. Develop IEC messages which will be used as a prototype by NGO/PVOs in producing and distributing country specific materials. (Primary responsibility - advertising company(ies)).
3. To design and implement condom promotion campaigns (Primary responsibility - advertising company(ies))
4. To distribute and sale condoms. (Primary responsibility - distribution company).
5. To coordinate with other NGO/PVOs and donor groups to assure that project activities supplement and support other activities and do not duplicate efforts of these organizations. This will include collaborating with groups doing AIDS control training and education such as UNESCO, ILO, WHO and the Red Cross. (Primary responsibility - SPC).

### 3. Employee organizations including union leaders

Several employee organizations have expressed interest in AIDS control and should be encouraged to develop educational AIDS prevention programs in collaboration with this project.

4. Promoting and coordinating efforts with NGOs/PVOs (i.e. churches, Red Cross, APEX, family planning).

The RDO/SP has made a strong commitment to closely coordinating this project with other NGOs/PVOs. This effort should concentrate on the following areas:

1. Coordinating and training curriculum development with UNESCO and the Red Cross.
2. Coordinating with WHO should be made a priority particularly in regards to condom promotion and IEC activities.
3. Coordinating with family planning associations in relation to condom promotion and STD IEC.

In addition to promoting increased AIDS control support from the private sector, effort will be made to increase donor contribution to AIDS control and to coordinate this contribution with USAID projects. In this regard, the Mission has already succeeded in mobilizing substantial donor collaboration on epidemiological and blood testing areas. In addition, the Mission is coordinating its efforts with other USAID initiatives such as child survival and family planning programs

Quantifiable targets for resource mobilization should be established and monitored throughout the life of this project to assure that important results are captured.

#### B. South Pacific Commission (SPC)

The Mission will be granting resources to SPC, to carry out three major components of the project: coordination, media development and training.

An assessment of SPCs commitment and capability to enhance the sustainability of this project was made.

SPC has an excellent reputation for carrying out community level activities through a strong network of in-country counterparts. With locally hired consultants, SPC will target its efforts on building in-country capability for AIDS education activities. It is expected that the role of SPC will be decreased to the extent that AIDS related technical assistance will be easily integrated with its regular activities by the end of the project. SPC expects to continue its AIDS activities although this will not require much less resource input after the project funding. Resources for this continued activity will most likely come from other donor groups.

To coordinate its activities and continue to mobilize outside resources, SPC has formed a technical advisory group to include WHO and other funding agencies. Through this group SPC will

continue to seek resources to assure the longevity and expansion of this project. In this regard, the USAID contribution is considered to be only one component of an evolving partnership for providing AIDS education activities throughout the Region. Already, Australia has contributed \$US200,000 to SPC for the development of an information exchange program in partnership with WHO. Through SPC efforts, it is expected that other donor groups will join in financing ongoing AIDS educational activities in this Region.

SPC is currently providing \$US200,000 per year of in-kind resources to support this project. Most of this resource is provided to meet overhead and expert staffing costs not funded through the project.

In conclusion, potential for sustainability and expanding this project is increased with a partnership with SPC because it:

- .Provides an established network of community-based human and organizational resources.

- .Has a demonstrated record in mobilizing donor resources in support of AIDS education activities.

- .Has committed organizational resources to the project and expressed an interest in continuing to invest in AIDS education past the life of this project.

- .Is expressly committed to building in-country capability and relying on in-country resources as much as possible.

### C. Cost Recovery

An assessment was made of cost recovery opportunities within the scope of the project. The Region has targeted its cost recovery strategy toward development of a private sector social marketing program for condom promotion and distribution. A program is already being implemented in PNG. A social marketing expert has assessed the feasibility for duplicating this effort in Fiji, the Solomon Islands and Tonga (See Annex H. Social Marketing).

#### 1. Background

Cost recovery opportunities need to be assessed in the context of the political infra-structures and economies. In most countries, the majority of health care expenditure is from the public sector with only 7% and 3% of health care expenditures coming from out-of-pocket in PNG and Fiji respectively. In PNG only 2.5% of operating costs for hospitals are collected from user fees (Coopers and Lybrand, 1986). While government policies promote the transition from reliance on the public health sector to greater privatization of health service, the issue of user fees carries a sensitive political stigma and is not likely to change

quickly at a time when per capita income is declining and unemployment is increasing. Similarly, infra-structures for collection and revolving revenues do not generally exist and would be costly to establish.

## 2. Condom Cost Recovery

Condoms are currently available free from family planning centers, STD clinics, and for about \$ from pharmacies. The level of condom demand by groups at high risk for transmitting HIV is unknown. Likewise, it is not known what, if any, portion of persons at high risk currently receive condoms free or purchase them at market price.

The proposed cost recovery strategy should not assume that persons at high risk of transmitting HIV (e.g. CSWs and their clients, men having sex with men, young men and women 13-14, prisoners) will behave rationally (i.e. the same as the rest of the market) to condom pricing and promotion. That is, that significantly reduced condom prices and effective promotion will motivate increased purchase and use. There is no empirical evidence that conclusively shows that, for example, CSWs demand and use of condoms will not be deterred by cost recovery programs (especially if there is no motivation to use condoms or if they are already free in the market). Condom demand elasticity for the targeted high risk group should be assessed prior to imposing charges to assure that condom use will be increased not deterred by the promotional and pricing strategies of the social marketing effort. Likewise, condom sales to this market segment should be closely monitored during the life of this project. It would be unacceptable if condom use decreased because of financial or accessibility barriers. Thus it is important to be fully aware of the effect of condom charges on acceptability.

The key objective of the social marketing program should be to assure that persons at most risk of transmitting HIV increase their use of condoms. To do this, several specific activities are suggested:

1. The social marketing program should clearly identify the market segment we are trying to reach i.e. CSWs, prisoners, youth.
2. Willingness and ability to pay should be assessed for this identified group. Likewise, sensitivity analysis should be undertaken prior to establishing a price for this group. This could be done by gathering baseline data through focus groups consisting of high risk group members. A survey targeted toward measurement of the ability and willingness to pay and price elasticity could be undertaken at very low cost. Similarly, other market research efforts, such as message testing could be accomplished with these focus groups.

3. Routine monitoring of sales and use of condoms for this market segment should be undertaken. Focus groups could be surveyed every six months throughout the life of the project.

Recommendation:

That the social marketing RFP require:

1. Explicit identification of the groups at most risk for transmitting HIV (i.e. CSWs, prisoners, youth) within country and locate specific locations where these groups gather.

2. Testing the demand elasticity for condoms of this group including ability and willingness to pay. This should include at least initial focus groups and examination of the accessibility of free condoms.

3. Testing the price sensitivity of this group.

4. A monitoring system to assess changes in the purchase and use of condoms by these groups. This would include, at a minimum, carrying out focus group surveys at least every six months for the duration of the project .

D. Budget and Recurrent Costs

The following is a summary of the estimated budget for the AIDS Project. Capital (C) are separated from recurrent (R) costs so that operating costs can be anticipated and planned for.

Function	YEAR 1-3		YEAR 3-5
	Capital	Recurrent	Total
1. IEC			
a. Materials	300,000	300,000	360,000
b. SPC	150,000	150,000	180,000
-development			
-distribution			
c. Advertising Company	100,000	100,000	120,000
2. SOCIAL MARKETING	85,000	200,000	240,000
3. TRAINING			
a. SPC	150,000	150,000	180,000
-development			
-implementation			
b. Materials	100,000	200,000	240,000
4. EVALUATION			
a. KAP Surveys	35,000	35,000	42,000
b. Tech. Ass.	15,000		
-U. of Hawaii			
-COMTECH			
5. TECHNICAL ASSIST.			
a. AIDSCOM	75,000		
-IEC			
-Social Marketing			
b. AIDSTECH	25,000		
-Evaluation			
6. RDO/SP	300,000		
7. CONTINGENCY		70,000	84,000
TOTAL			

Since finalized budgets were not available a complete recurrent analysis was not possible. The above summary estimates that total recurrent costs for the project will be \$US2.5 per annum over a five year period. The Project budget is adequate to support 100% of capital and recurrent costs of planned activities for this project for the three years of the project life. To carry this project into Year 5 would require an additional \$US1.3 million to meet operating costs for the five years. This is the amount which remains unobligated to meet the costs of carrying this project into Year 5. Thus RDO/SP should establish \$US1.3 as a benchmark for mobilizing additional funding during the project period

The following section suggests a system for routinely collecting costs separating start-up from recurrent costs which will serve the purpose of planning for sustainability of this project.

### III. Project Monitoring and Evaluation

The evaluation of this project will be carried out both concurrently and retrospectively. A concurrent cost-output information system will enable the RDO/SP to monitor project efficiency and change the project design as needed. It will additionally allow early planning form meeting unexpected and ongoing operational costs. Two retrospective KAPB surveys will measure the outcome of project activities. Together, the data profile will enable cost-effectiveness studies to be carried out.

#### A. Concurrent Cost-Output Monitoring System

The following are specific guidelines for developing a system for routine monitoring of project costs and outputs.

##### 1. Objectives

The purposes for this routine cost system include:

- .to monitor the operational costs of the project for planning purposes.
- .to build an accurate cost data base for future evaluation analysis.
- .to provide a data base for project output information.
- .to provide a mechanism for tracking expenditure and actual performance against the established project budget and output goals.
- .to report on capital costs that would be needed to support the program one additional year.

Capturing the real costs, productivity and expenditure data for the project will allow realistic planning for sustaining and expanding these efforts. These costs will not necessarily be met by USAID, but will provide estimates for planning or attracting funding from other sources. It will also provide a reliable data base for evaluating the project. In support of this, measurable output data should be routinely collected. Data collection on productivity levels which can be converted into unit costs will provide a data base on expenditure as well as program output.

To accomplish this, start-up costs should be separated from recurrent costs particularly for SPCs budget. All costs should be captured including hidden costs (i.e. management and depreciation costs) and those provided by SPC in-kind. This will show the total resources needed to provide the control services regardless of who pays.

## 2. Cost system components

Meaningful project activity categories should be defined which allow the measurement of relative price and performance output for the different project components. Each activity should have identifiable costs and outputs associated so that cost-output analysis can be made. The following is a list of cost centers appropriate for this project.

### 1. Health Education

- .Media campaign planning and development
- .Materials development
- .Materials distribution

### 2. Condom Services

- .General promotion (to the general population)
- .General distribution
- .Targeted promotion and distribution activities  
(i.e. high risk groups)

### 4. Training

### 5. Management/Institutional Building

### 6. Coordination of AIDS education activities

### 7. Research Activities

- .Epidemiology
- .Special studies/retrospective
- .Routine/prospective

Costs should be collected for each activity in the above list. Together, the specific cost centers will capture the total expense for carrying out each of the seven activities. The costs which should be included under each activity include:

1. staff
  - .salaries
  - .allowances
2. office space and operations
  - .rent or purchase price (even if free)
  - .maintenance and utilities
3. Equipment and maintenance
4. Supplies
  - .condoms
  - .printing/duplication
  - .other office supplies
5. Meetings/workshops/conferences
  - .transportation
  - .hotels/per diem
  - .honorarium for presenters
  - .material/supplies
6. Development/production of materials/newsletters
7. Distribution of materials/newsletters/information(other)
8. Data/information gathering
  - .survey activities
  - .record review/monitoring/routine reporting.

The following table illustrates how costs are broken into start-up and recurrent costs:

Cost	Capital Expense	Recurrent Expense
Staff	Recruitment/ training	Salaries
Equipment	Purchase	Maintainence
Supplies	one time purchase	re-purchase

### 3. Cost Data Collection

To routinely collect these costs technical and financial reports will need to be completed bi-monthly by project managers. Formats

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for these reports are included in Appendix 2. These could be used by all groups involved in the project and compiled into a cost/output data profile in the regional office.

#### B. Retrospective Evaluation

Two KAPB surveys will be carried out. The first will be implemented at the start of the project to collect baseline data on knowledge, attitudes, practices and behavior about AIDS and AIDS prevention, especially condom use. The second survey, carried out at the end of the project period will measure changes in these aspects of knowledge and behavior. Particular attention will be paid to changes in condom use which will be the most important outcome measurement for the project.

## SOCIAL MARKETING ANALYSIS

Background

Societies in the South Pacific island nations have respectively experienced significant changes in life styles occasioned by evolving economic and social conditions. Traditional values no longer constrain sexual activity, resulting in an increasing participation by youths, increased activity among those already sexually active and an increased exposure to the risks of sexually transmitted diseases. STD rates have increased by approximately 50% over the last five years. Unfortunately, public sector services to address issues of sexual behavior and treatment of STD cannot adequately deal with the increasing need and demand. It is within this context that a social marketing program for the promotion and sale of condoms as an intervention against transmission of STD/HIV/AIDS is being implemented.

Purpose and objectives

The overall purpose of the project is to promote behavioral change that will preempt the contraction and transmission of STD/HIV/AIDS in the South Pacific.

The specific objectives of the social marketing components are to assist in the realization of the projects purpose by:

- increasing the awareness and acceptance of condoms as a means of practicing safe sex and avoiding STD/HIV/AIDS;
- increasing condom use skills and encouraging consistent usage among current and potential users;
- increasing the availability and accessibility of condoms which would result in an increase in the purchase and use of condoms and
- to ensure the sustainability of the intervention by utilizing private sector resources and skills and cost recovery strategies.

The Current Market Environment

Condoms are currently available through public sources, NGOs and the private sector retail outlets primarily pharmacies. In Fiji for example, the Government Pharmacy supplies condoms to hospitals, clinics, health centers and to pharmacies. In 1989 approximately 592 thousand condoms were distributed through the Government Pharmacy. The product provided is Korean sourced, branded "Forget Me Not", and sold for ten cents each. At the time

of writing, the Government Pharmacy, all retail outlets and some public service delivery points were out of stock of condoms and have been for at least three months. Additionally, all pharmacies stocked a variety of Durex branded condoms which varied in price from \$1 to \$1.50 for a pack of three condoms. Volume of Durex sales were estimated at approximately 100 thousand per year. Very little is done to inform or promote condom usage, although the subject is included to some extent in family planning and AIDS awareness IEC activities. The prevailing attitude is that the subject is approached discretely, if at all. Random discussion with young men and women in Suva, Nadi and Lautoka would suggest an increasing demand for knowledge about and access to condoms driven by a fear of AIDS. This impression was confirmed in discussions with the Fiji Red Cross who advised of a latent demand for condoms in urban and to a lesser extent rural areas.

### Social Marketing Program Strategies

#### The Market Universe

The project as a whole is designed to provide specific services to four countries - Papua New Guinea, Fiji, Tonga and the Solomon Islands. The social marketing program, however, will exclude Papua New Guinea since a contraceptive social marketing program inclusive of condoms will be implemented concurrently through the Centrally Funded SOMARC II project. The primary target in the three countries will be specifically:

- males 20 - 34 years, residing in urban areas.

The secondary targets may vary in each country but would include:

- segments of the population involved with high risk sexual behavior e.g. prostitutes, homosexuals ( man to man sex);
- uninformed forces e.g. military, police prison wardens;
- youth - males and females 15 - 19 years old;
- sexually active females 20 - 34 years old.

#### The Management Structure

The social marketing component will be managed by a private sector marketing and distribution organization with regional capabilities. The specific responsibilities would include:

- the development of appropriate marketing plans to achieve the objectives stated;

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- the distribution of packaged and branded condoms to all appropriate retail outlets (inclusive of bars, shops, supermarkets, hotels, petrol stations as well as pharmacies) in Fiji, Tonga and Solomons;
- the promotion of proper and consistent condom usage through educational programs and advertising campaigns;
- servicing the secondary markets identified for each country;
- tracking, monitoring and reporting product sales, consumer profiles, brand awareness and consumer attitudes to the brand and marketing strategies;
- liaising with the SPC's training and IEC activities; and
- coordinating the training of specified retail outlets to improve the sensitivity and knowledge of sales personnel to condoms and STD/HIV/AIDS issues.

The marketing and distribution organization would be provided with technical assistance as needed particularly in the areas of marketing strategies directed to high risk groups and condom promotional techniques. Technical assistance would be provided by AED/AIDSCOM through a buy-in from RDO/SP.

The marketing and distribution organization would be monitored by the Missions AIDS Advisor and its performance measured against the scope of work and targets established in the annual work plans.

### Marketing Strategies

#### (a) Commodity Sourcing

A centrally sourced, donated condom will be marketed for the first two years of project activities. The rationale for utilizing a donated condom is to be able to provide a product at the most opportune price to attract consumer interest and demand and significantly grow the market. It is expected that by the third year of the project, the distributor would have generated sufficient volume for the market to be economically feasible (i.e. in terms of return on investment) for him to purchase commodities on the open market. At that time too, it is expected that negotiations can be pursued with Ansell and the distributor for a joint investment in the South Pacific condom market.

To summarize, a donated commodity will be marketed at an initially attractive low price. With the expected growth in

the market and volume realized, after two years, commodities will be sourced through private sector direct investment.

(b) Sales Estimates

Total condom distribution from all sources in Fiji, Solomons and Tonga is estimated at approximately 850 thousand units per year. Based on the anticipated demand created through condom promotion activities, the increase in STD/AIDS IEC activities by WHO and other UN organizations, SPC and other NGOs, sales volumes for the social marketing program are projected accordingly.

<u>Period</u>	<u>Fiji</u>	<u>Solomons</u>	<u>Tonga</u>	<u>Total</u>
Year 1	160,000	60,000	30,000	250,000
Year 2	190,000	75,000	35,000	300,000
Year 3	220,000	95,000	45,000	360,000

The resulting commodity costs are reflected in the project budget, Appendix 2.

(c) Product Branding

It is anticipated that the AID, plain lubricated condom, branded PANTHER, would be available and acceptable to the South Pacific markets. Packing designs already developed for the brand (i.e. Trinidad, Barbados, Jamaica) would be pre-tested in the region to determine the most acceptable design. Packaging materials (box and inserts) would be produced in Fiji by Fiji Times Ltd. (See Appendix 5 for quotations.) The bulk commodity would be consigned directly to the distributor with the appropriate waivers for duties and taxes. The distributor would then repackage the product into boxes of 100 for strip sales and packs of three. The cost estimates for packaging and labor are reflected in the budget, Appendix 2.

(d) Product Pricing

The pricing strategy is predicated on:

- the ability of the target consumer to pay
- the achievement of sustainability, and

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- the establishment of a quality image for the brand which would assist in consumer acceptability.

It is expected that the product price will move in line with inflation and specific product related costs. Consumer prices are projected over the program life cycle accordingly.

	3-PACK	SINGLES
YEAR 1	60c	20c
YEAR 2	70c	25c
YEAR 3	85c	30c

Consumer prices in Solomons and Tonga will be slightly higher to reflect transportation costs. Details of costs and margins leading to the consumer price is shown in Appendix 1.

(e) Distribution

Product distribution will be concentrated in urban markets in the first instance. It is anticipated that condoms will be available in 80% of the retail outlets targeted by the end of the first nine months of distribution. All distribution costs - transportation, sales force etc., will be borne by the distributor.

(f) Advertising and Promotion

Culturally sensitive but impactive and motivational communications campaigns will be developed by a private sector advertising agency. Communication strategies targeted to specific market segments will be determined by the distributor and the agency with technical assistance from AED/AIDS.COM. All communications activities will be directed by market research inputs which would provide guidance on consumer attitudes beliefs, practices and needs. All communications materials will be pre-tested among samples of the target audience to determine message acceptability and effectiveness. The primary communication vehicles will be radio and print (posters, newspapers, brochures) supported by point of sale material to increase brand presence in the retail outlets. Inter personal vehicles, theatre groups, community based events etc. will also form part of the media mix. A single agency will be selected by the distributor in Suva (and approved by A.I.D.) to develop campaigns for the three markets. The investment costs for advertising and promotion will be covered 100% by the project budget for the first two years and shared by the distributor in the third year. Thereafter the distributor assumes all costs for advertising activities. Cost details are shown in Appendix 2.

(g) Market Research Monitoring and Evaluation

Market research activities will be designed to provide management information for decision making. The critical decisions including branding (package design) pricing, advertising, consumer targetting, sales strategies, etc. will be addressed through focus group and small sample research activities. Market research resources will be acquired from the University of the South Pacific. Monitoring and Evaluation input will be provided through a management information system designed to provide timely and accurate data on sales activities. Performance output will also be a source of evaluating both program output and distributor efficiency. Market research costs will be fully covered by the budget for three years.

(h) Retailer Training

In order to equip sales personnel in retail outlets with the knowledge and skills to provide counselling and to motivate condom usage in addition to simply selling, a retailer training program will target all pharmacies and a selection of other retail outlets. The training curricular will provide information on STD, AIDS, safe sex practices, informed consent, and condom usage. Training will also be provided on interpersonal (customer) relationships, how to provide counselling to customers and how to encourage condom usage. Training would take place on Sundays over five hours with trainers and resource personnel provided by SPC and the distributor. Training costs will be covered in full by the budget.

Cost and Impact Analyses

(a) Projected Expenses

Social marketing programs derive three major benefits from working with the private sector -

- \* the experience and expertise of personnel, particularly management,
- \* lower overhead and start-up costs because of the infra-structure already existing in the private sector, and
- \* sharing of implementation costs.

The program expenses reflect these advantages. During the first two years, the AID budget will invest in development and recurrent costs as well as to provide technical assistance in

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communication and marketing to risk groups. In-country expenses inclusive of commodities total US\$157.6 thousand over two years with technical assistance adding another \$40 thousand. The distributor during the first two years will cover all management, personnel, transport and sales cost to distribute the product throughout the three markets. In the third year, the AID investment will be reduced to US\$30.5 thousand representing 30% of the expenditure budget for the year, the distributor will increase his investment in the program by contributing approximately 10% of operating expenses and the return to project fund (see Appendix ) will cover the remainder of the years expenses. The total investment of US\$228.1 over the three years will establish a viable and sustainable intervention. (see Expenditure Budget Appendix 2).

(b) Cost Recovery - Return to Project Funds

The donated commodities will be packaged and sold to the distributor. The income received from the distributor would constitute the return to project funds and represent the extent of program costs recovered. The commodities will be marketed in two presentations - boxes of three condoms and strip sales allowing for the purchase of a single condom. The income and price of both presentations are subsidized to the extent that for the first two years income does not cover all product costs. Anticipated program income is projected at F\$27,000 in the first year, F\$36,600 in the second year and F\$54,000 in the third year.

The distributor will be required to establish a separate interest bearing bank account into which these funds will be deposited quarterly. The funds will be allowed to accumulate over the first two years and will be used in the third year to cover the majority of the operating costs. Access to the fund can only be achieved with RDO/SP approval, and the fund can only be used for Program purposes. In subsequent years (after year 3) the distributor will share operating costs with resources from the Fund. (see Appendix 3).

The program then operates independent of AID resources (commodities or cash) achieving the objective of sustainability.

(c) Impact Analysis

The program is expected to generate 9100 consistent condom users in the three nations over three years. In addition to averting STD/HIV transmission among these direct beneficiaries there is a halo effect created by the intervention that impacts on other social circumstances.

- \* Condom usage by males also protect female partners, thereby widening the coverage and impact.
- \* The contraceptive benefits of the product should also contribute to an increase in the contraceptive prevalences rate and subsequently a reduction in the birth rate. The program should therefore have some demographic impact.
- \* The information and promotional component of the program should contribute to the level of knowledge of STD/HIV/AIDS. The motivational aspects of the program should contribute to the achievement of behavioral change even if such change involves safe sex practices other than condom usage.
- \* The investment in resources and technical assistance to build private sector partnerships achieves more than program sustainability. It should also contribute importantly to building in-country infra-structure and securing private sector institutions.
- \* This program should demonstrate to Governments of the South Pacific the effectiveness and viability of the social marketing strategy and its applicability to a wide array of development activities particularly in health.
- \* The program would generate an imperical cost per client/customer averaging US\$24.15 over three years. When measured against the cost of STD/HIV/AIDS care both to individuals and the Governments this investment in prevention could be considered very cost effective. (see Appendix 4).

#### Program Assumptions

The design of the social marketing component and its expected outcome is predicated on the following assumptions:

(i) Custom Duties and Taxes

It will be necessary to obtain a waiver on the application of import duties on the donated commodities on the grounds of the social benefits of the intervention. Additionally a waiver on the sales tax would also significantly reduce the eventual purchase price of the consumer. Whereas the program would retain its projected impact if the sales tax (10%) were to remain, failure to achieve an exemption from import duties would seriously affect viability and sustainability.

(ii) Host Country Concurrence

Although the program will co-ordinate closely with the IEC and Training activities of SPC it will not be under the umbrella or auspices of the SPC. The private sector will need some recognition, cooperation and "protection" from the host country in order to effectively implement marketing and promotional activities. This is necessary because of the expectations of marketing to high risk groups and the relatively high visibility of social marketing activities.

(iii) Complimentary Interventions

Even though social marketing programs can be a powerful intervention, they do not function successfully in a vacuum. It is expected that the various IEC plans to be implemented by WHO and NGOs will be fully operational and be contributing to the goal of addressing behavioral change among the sexually active and high risk groups. The timing of the social marketing intervention is therefore to some extent dependent on the progress of the larger activities in STD/HIV/AIDS prevention.

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CONDOM SOCIAL MARKETING  
PROJECTED COSTS & MARGINS

F\$ - Three Pack Condoms

<u>LINE ITEMS</u>	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>
Commodities	.24	.27	.33
Packaging	.04	.05	.06
Labor	<u>.04</u>	<u>.05</u>	<u>.06</u>
Price to distributor	<u>.32</u>	.37	.45
Distributor margin (25%)	<u>.08</u>	<u>.09</u>	<u>.11</u>
Price to wholesaler	.40	.46	.56
Wholesaler margin (10%)	<u>.04</u>	<u>.05</u>	<u>.06</u>
Price to retailer	.44	.51	.62
Retailer margin (37%)	<u>.16</u>	<u>.19</u>	<u>.23</u>
Price to consumer	<u>.60</u>	.70	.85
Single condom price	.20	.25	.30

APPENDIX 2

CONDOM SOCIAL MARKETING  
PROJECTED EXPENDITURE BUDGET

US \$000

<u>LINE ITEMS</u>	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>	
Commodities (CIF)	15.0	18.0	-	37.8
Local Handling	1.0	1.2	-	1.8
Packaging Materials	4.7	5.0	5.5	-
Packaging Labor	3.5	4.2	-	5.5
Market Research	5.0	5.0	5.0	-
Advertising & Promotion	45.0	35.0	15.0	25.0
Retailer training	<u>10.0</u>	<u>5.0</u>	<u>5.0</u>	<u>-</u>
Sub - Total	84.2	73.4	30.5	70.1*
Technical Assistance(AED)	<u>25.0</u>	<u>15.0</u>	<u>-</u>	
Grand Total	109.2	88.4	100.6	

\* To be covered from RETURN TO PROJECT FUNDS AND THE DISTRIBUTOR

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APPENDIX 3

RETURN TO PROJECT FUNDS

	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>F\$</u>		
			<u>YEAR 3</u>		
<u>Three Pack Condoms</u>			@ .32	@ .37	@ .45
Volume	50,000		60,000	72,000	
Income	\$16,000		\$22,200	\$32,400	
<u>Single Condoms</u>	@ .11		@ .12	@ .15	
Volume	100,000		120,000	144,000	
Income	\$11,000		\$14,400	\$21,600	
<u>Total</u>					
Volume	250,000		300,000	360,000	
Income	\$27,000		\$36,600	\$54,000	

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APPENDIX 4

IMPACT COST ANALYSIS

F\$

	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>	<u>TOTAL</u>
Expenditure Budget	163,800	132,600	150,900	447,300
Annual Income	27,000	36,600	54,000	117,600
Net Program Cost **	136,800	96,000	96,900	329,700
Projected Users	2,500	3,000	3,600	9,100
Cost Per User	\$54.72	\$32.00	\$26.92	\$36.23
US\$*	36.48	21.33	17.95	24.15

\* Conversion rate US\$1 = F\$1.50

\*\* Ecluding distributor costs.

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## INITIAL ENVIRONMENTAL EXAMINATION

Project Location: South Pacific Regional

Project Title: Regional AIDS Prevention  
(879-0022)

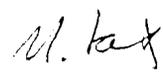
Life of Project: Five years

Funding: \$2.5 million

IEE Prepared by: L.A. Callahan, HPN/AIDS  
G.D. Adams, ANE/PD/EA

Environmental Action Recommended: Categorical Exclusion

Regional Director's Concurrence: Signature:   
Date: 1/29/90

Decision of ANE Environmental Officer:  
Approve:   
Disapprove:  
Date: 2-13-90

A. Project Description

This project will provide funding, technical assistance and limited commodities and training to the Regional AIDS Education Unit of the South Pacific Commission to improve HIV/AIDS prevention and control through AIDS education in the South Pacific Region. The project will develop and disseminate AIDS messages through private and community organizations. Educational messages and approaches will be developed and assessed on the basis of health data collection, analysis, and planning.

B. Evaluation of Environmental Impact

The project activities are expected to have no adverse impact on the natural or physical environment.

C. Recommendation:

A categorical exclusion from A.I.D.'s Initial Environmental Examination, Environmental Assessment and Environmental Impact Summary requirements is recommended.

This recommendation corresponds to A.I.D. Regulation 16, Section 216.2, which stipulates categorical exclusion for a number of "classes of actions" including: : "Education, technical assistance, or training programs except to the extent such programs include activities directly affecting the environment..." [ Section 216.2(c)(2)(i) ]; and " Programs involving nutrition, health care, or population and family planning services, except to the extent designed to include activities directly affecting the environment..."[ Section 216.2(c)(2)(viii) ].

EQUIPMENT PRIORITY LIST FOR USAID/SPC AIDS PROJECT\*  
Listed for each of the three media units

QTY	DESCRIPTION	MAKE/MODEL	APPROX. COST
2	VHS Duplicating Recorder (HTSC)	JVC-BR-7030	US\$ 5,000
1	Multi-System Monitor 27" PAL/HTSC/SECAM 240VAC	SONY KX-27HG2	5,000
1	S-VHS editing recorder PAL 240VAC	JVC-BRS611E	4,500
1	Oscilloscope 240VAC	Leader LB0-315	2,250
1	S-VHS Dockable recorder PAL	JVC-BR-S411	5,000
1	Camcorder Flight case to house JVC camcorder	JVC CB-P400U	800
1	Time Base Corrector PAL 240VAC	I.DEN IVT-9SP	6,000
1	Multi-System VHS VCR 240VAC	JVC BR-6400TR	2,000
1	Edit Controller S-VHS PAL 240VAC	JVC RM-6810U	2,500
1	Tripod Dolly	JVC TP-P205U	250
1	Borderline Generator for Grass Valley 100 Video Switcher	GVG 100-60	1,500
TOTAL AMOUNT FOR VIDEO UNIT			<u>US\$32,800</u>

\*Note: This equipment list is illustrative and represents the maximum amount of equipment needed by the Media Center. There is a possibility that JICA or other donors might finance some of this equipment.

5	Portable Cassette Recorders	SONY TC-D5 PROLI	7,500
5	Electro-voice cardioid Micro	EV RE-15	2,500
1	High Speed cassette copier reel master and 8 slaves	HELEX 6120	5,000
2	Wireless microphone systems Vega "Reporter" system	Vega HIRLU 1-BH	2,000
1	Portable Microphone mixer Hono mini mic mixer	Shure FP-51	700
1	Facsim studio Mixer console	TASCAM 216	4,000
1	IRT Talkback system 6 x 6 matrix for studio to studio communication (6 rooms)	AA-331D	6,000
2	Toshiba laptop computers w/carrying case w/1 MB RAM upgrade cards	T1003E	4,000
1	Kodak portable printer	Diconix 150	600
1	Computer software	MICROSOFT WORD	500
	TOTAL AMOUNT FOR RADIO UNIT		<u>US\$34,200</u>

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1	Macintosh computer w/8 MB Ram upgrade	MAC SE/30	4,200
1	Macintosh Laser printer	Apple LINK	6,000
1	Macintosh Hard disk	Apple 8050	2,000
1	Scanner	Apple or Sharp	3,600
1	Gillette automatic Paper cutter	Ideal Fortematic 525E	4,500
1	Electronic Slide duplicating Machine	Beseler Dual-Node	1,200
1	Photographic copystand with 4 lights	Bogen TC-2 & TL-3	750
1	Darkroom automatic processor for processing RC colour and B&W papers	Durst RCP20	1,000
1	AE Prism Finder S for Bronica Zenza SQ-A 6 X 6 camera		500
1	Zenza non 250 mm F5.6 Tele- lens for Bronica SQ-A	Zenza	500
1	Aluminum case for Nikon F3 and accessories	Nikon	250
2	Halogen/quartz photo studio lighting unit w/shutters & stands	Sunpak	500
1	Complete set of graphic tools, instruments	Rotring	3,000
1	Photocopier	Nashua	5,000

TOTAL FOR GRAPHIC ARTS UNIT US\$33,000

TOTAL FOR MEDIA CENTRE US\$100,000

Plus an estimated amount for consumable supplies 30,000  
for training courses and production of project materials

Total US\$130,000

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ANNEX L: COUNTRY PROFILES\*

\* The information provided in this Annex is in summary form. Complete country health profiles, including a listing of NGOs recognized in each country is available from the HPN Office.

COUNTRY PROFILE  
THE COOK ISLANDS

Population (87)	19,000
Population Growth Rate (80-85)	0.3%
% Urban Population	27%
% Population under 15 years of age	43%
Land Area	240 sq. km.
Sea Area	2,176,000 sq. km.
Population Density	75 per sq. km.
GDP/Capita (86)	US\$1,239
Literacy Rate	87%
Fertility Rate	4.2
Infant Mortality Rate/1000	21.6
Life Expectancy	N/A
Major Diseases	Malignant Neoplasm, Nephritis, pneumonia, cerebrovascular, cir- culatory.
Number of HIVs	0
Number of AIDS cases identified	0
Laboratory Testing Available	Yes
Number of Doctors	15
Number of Nurses/midwives	57
Number of Hospitals	3
Number of Languages Spoken	2
Major Ethnic Groups	Polynesian (Maori), New Zealand
Total Donor Assistance (86)	US\$20,757,000
Total A.I.D. Assistance(89)	US\$586,900
Member of SPC	Yes
MTP Completed	Yes
NAC Functional	Yes

COUNTRY PROFILE

FIJI

Population (87)	715,000
Population Growth Rate (80-85)	1.9%
% Urban Population	39%
% Population under 15 years of age	38%
Land Area	18,272 Sq. Km.
Sea Area	1,290,000 Sq. Km.
Population Density	39 per Sq. Km.
GDP/Capita (86)	US\$ 1,662
Literacy Rate	79%
Fertility Rate	3.4
Infant Mortality Rate (84)	22.5
Life Expectancy	62.5
Major Diseases	TB, Cardiovascular
Number of HIVs	6
Number of AIDS cases identified	1
Laboratory Testing Available	Yes
Number of Doctors	300
Number of Nurses/Midwives	750
Number of Hospitals	25 Gov., 2 Prv.
Number of Languages Spoken	4
Major Ethnic Groups	Fijian (45%), Indian (50%), European (4%), Chinese, Polynesian.
Total Donor Assistance (86)	US \$27,245,000
Total A.I.D. Assistance (89)	US \$390,000
Member of SPC	YES
MTP Completed	YES
NAC Functional	YES

COUNTRY PROFILE  
THE REPUBLIC OF KIRIBATI

Population (87)	61,000
Population Growth Rate (80-85)	2.0%
% Urban Population	33%
% Population under 15 years of age	39%
Land Area	690 Sq. Km.
Sea Area	3,500,000 Sq. Km.
Population Density	88/Sq. Km.
GDP/Capita (86)	US \$333
Literacy Rate	90%
Fertility Rate	3.2
Infant Mortality Rate	82/1000
Major Diseases	Intestinal, cerebravascular, Cirrhosis, TB, Meningitis.
Number of HIVs	0
Number of AIDS cases identified	0
Laboratory Testing Available	Limited
Number of Doctors	15
Number of Hospitals	2
Number of Nurses/Midwives	128
Number of Languages Spoken	2
Major Ethnic Groups	Micronesian, European
Total Donor Assistance (86)	US \$8,891,000
Total A.I.D. Assistance(89)	US \$1,957,700
Member of SPC	YES
MTP Completed	YES
NAC Functional	YES

COUNTRY PROFILE

NIUE

Population (87)	2,000
Population Growth Rate (80-85)	4.7%
% Urban Population	21%
% Population under 15 years of age	46%
Land Area	259 Sq. Km.
Sea Area	390,000 Sq. Km.
Population Density	8/Sq. Km.
GDP/Capita (83)	US \$1,364
Literacy Rate	N/A
Fertility Rate	4.3
Infant Mortality Rate	11/1000
Life Expectancy	77
Major Diseases	Respiratory
Number of HIVs	0
Number of AIDS cases identified	0
Laboratory Testing Available	Limited
Number of Doctors	4
Number of Nurses/Midwives	128
Number of Hospitals	1
Number of Languages Spoken	2
Major Ethnic Groups	Polynesian
Total Donor Assistance	US \$9,043,000
Total A.I.D. Assistance	US\$ 407,100
Member of SPC	YES
MTP Completed	NO
NAC Functional	NO

COUNTRY PROFILE  
PAPUA NEW GUINEA

Population (87)	3,480,000
Population Growth Rate (80-85)	2.1%
% Urban Population	13%
% Population under 15 years of age	43%
Land Area	462,840 Sq. Km.
Sea Area	3,120,000 Sq. Km.
Population Density	8/sq. Km.
GDP/Capita (86)	US \$ 773
Literacy Rate	32%
Fertility Rate	5.4/1000
Infant Mortality Rate	72/1000
Life Expectancy	49.9
Major Diseases	Pneumonia, perinatal, intestinal, TB, Meningitis, Malaria
Number of HIVs identified	14
Number of AIDS cases identified	46
Laboratory Testing Available	YES
Number of Doctors	269
Number of Nurses/Midwives	3,941
Number of Hospitals	50
Number of Languages Spoken	700+
Major Ethnic Groups	Melanesian
Total Donor Assistance(86)	US \$373,835,000
Total A.I.D. Assistance (89)	US \$9,297,100
Member of SPC	YES
MTP Completed	YES
NAC Functional	YES

COUNTRY PROFILE  
THE SOLOMON ISLANDS

Population (86)	286,000
Population Growth Rate (80-85)	3.5%
% Urban Population	14%
% Population under 15 years of age	47%
Land Area	28,369 Sq. Km.
Sea Area	1,340,000 Sq. Km.
Population Density	9/Sq. Km.
GDP/Capita (86)	US \$542
Literacy Rate	13%
Fertility Rate	7.3
Infant Mortality Rate	52/1000
Life Expectancy	60
Major Diseases	Malaria, TB
Number of HIVs	0
Number of AIDS cases identified	0
Laboratory Testing Available	YES
Number of Doctors	48
Number of Hospitals	8
Number of Languages Spoken	87
Major Ethnic Groups	Melanesian, Polynesian, Gilbertese, European, Chinese.
Total Donor Assistance (86)	US \$19,266,000
Total A.I.D. Assistance	US \$604,700
Member of SPC	YES
MTP Completed	YES
NAC Functional	YES

COUNTRY PROFILE  
THE KINGDOM OF TONGA

Population (87)	106,000
Population Growth Rate (80-85)	0.2%
% Urban Population	26%
% Population under 15 years of age	44%
Land Area	699 Sq. Km.
Sea Area	700,000 Sq. Km.
Population Density	152/Sq. Km.
GDP/Capita (85)	US \$623
Literacy Rate	93%
Fertility Rate	4.9
Infant Mortality Rate	41/1000
Life Expectancy	63
Major Diseases	Influenze, Cardiovascular, cerebravascular
Number of HIVs	3
Number of AIDS cases identified	3
Laboratory Testing Available	YES
Number of Doctors	32
Number of Nurses/Midwives	207
Number of Hospitals	1
Number of Languages Spoken	2
Major Ethnic Groups	Polynesian
Total Donor Assistance (86)	US \$10,288,000
Total A.I.D. Assistance (89)	US \$1,555,100
Member of SPC	YES
MTP Completed	YES
NAC Functional	YES

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COUNTRY PROFILE

TUVALU

Population (87)	8,000
Population Growth Rate (80-85)	1.8%
% Urban Population	30%
% Population under 15 years of age	32%
Land Area	26 Sq. Km.
Sea Area	900,000 Sq. Km.
Population Density	308/Sq. Km.
GDP/Capita (85)	US \$307
Literacy Rate	98%
Fertility Rate	2.8
Infant Mortality Rate	43/1000
Life Expectancy	58
Major Diseases	TB, Leprosy, Filariasis, Cerebrovascular, Cardiovascular.
Number of HIVs	0
Number of AIDS cases identified	0
Laboratory Testing Available	YES
Number of Doctors	3
Number of Nurse/Midwives	26
Number of Hospitals	1
Number of Languages Spoken	2
Major Ethnic Groups	Polynesian
Total Donor Assistance	US \$14,053,000
Total A.I.D. Assistance	US \$ 558,100
Member of SPC	YES
MTP Completed	YES
NAC Functional	YES

COUNTRY PROFILE  
THE REPUBLIC OF VANUATU

Population (87)	145,000
Population Growth Rate (80-85)	3.3%
% Urban Population	18%
% Population under 15 years of age	46%
Land Area	11,800 Sq. Km.
Sea Area	680,000 Sq. Km.
Population Density	12/Sq. Km.
GDP/Capita (86)	US \$ 861
Literacy Rate	N/A
Fertility Rate	6.5
Infant Mortality Rate	94/1000
Life Expectancy	60
Major Diseases	Gastrointestinal, Malaria, cardiovascular.
Number of HIVs	0
Number of AIDS cases identified	0
Laboratory Testing Available	YES
Number of Doctors	20
Number of Nurses/Midwives	237
Number of Hospitals	7
Number of Languages Spoken	100+
Major Ethnic Groups	Melanisian, European
Total Donor Assistance(86)	US \$18,616,000
Total A.I.D. Assistance (89)	US\$ 930,000
Member of SPC	YES
MTP Completed	YES
NAC Functional	YES

COUNTRY PROFILE

WESTERN SAMOA

Population (87)	159,000
Population Growth Rate (80-85)	0.6%
% Urban Population	21%
% Population under 15 years of age	45%
Land Area	2,831 Sq. Km.
Sea Area	120,000 Sq. Km.
Population Density	56/Sq. Km.
GDP/Capita (86)	US \$613
Literacy Rate	90%
Fertility Rate	4.9
Infant Mortality Rate	33/1000
Major Diseases	Cardiovascular
Number of HIVs	0
Number of AIDS cases identified	1
Laboratory Testing Available	YES
Number of Doctors	32
Number of Nurses/Midwives	283
Number of Hospitals	8
Number of Languages Spoken	2
Major Ethnic Groups	Samoan, Polynesian, European.
Total Donor Assistance	US \$ 21,062,000
Total A.I.D. Assistance	US \$ 875,000
Member of SPC	YES
MTP Completed	YES
NAC Functional	YES

## PROFILES OF SEVERAL NGOS IN PNG AND FIJI

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2. PNG Family Planning Association - page 4
3. Chevron Niugini (PNG) - page 7
4. Fiji Red Cross Society - page 9

PNG YWCA

The YWCA organization consists of the National office based in Port Moresby and four provincial/local offices based in: Port Moresby, Lae, Goroka and Tabubil.

Legal and Financial Status: The PNG YWCA is an official, legal member of the worldwide network of YWCA's. It is recognized by the GPNG as an NGO. The GPNG gives the National YWCA and annual budget which varies from approximately five to eight thousand Kina. In 1990, the YWCA received six thousand Kina. The remaining budget is derived from the following: Kina 53,000 from the International, worldwide YWCA for administrative expenses; US \$ 3,000 from the United States YWCA; Kina 2,000 annually from the four local YWCA organizations (total K8,000).

Local YWCA's receive revenue from projects: preschools, child care centers, hostels for girls, vocational centers and crafts sales centers. Local organizations are autonomous and control their own financial/budget matters.

CUSO offered two years of technical assistance to the National YWCA in budget and accounting. Under the leadership of the current Executive Director, Ms. Au Doko, the organization has concentrated on developing its own internal institutional capacities. This consisted of staff training in the fields of budgeting, management and administration. Ms. Doko has successfully completed several audits, beginning in 1986. She is well-versed in budget, including how it drives project inputs and is reflected in project outputs.

Organizational Pattern: PNG YWCA is obligated to follow the policies, mandates and guidelines of the worldwide YWCA. The National office is responsible for monitoring and overseeing compliance to these policies by the four provincial offices. This year, the National and four local "Y's" will convene to draft a mission statement and define country goals and objectives. This important process, will help move the organization in a unified and cohesive way.

YWCA employs a standard organizational structure. The National "Y" is headed by a board of directors and local offices by their own boards of directors. An executive director heads the national office and a general Secretary the local offices. Each office is directly responsible to their respective Boards. National and local staff are composed of program officers and assistants. The executive Director is the chief national overseer, assigned to monitor policy and guideline compliance of the four local offices.

The YWCA has determined priority sectors and liases with appropriate Government Departments in the following sectors: women's health, law and order, youth and environment. They are also active in the community on matters pertaining to priority sectors. They serve on committees and boards such as the Department of Home Affairs and Youth, The Children's Welfare Council, etc.

The YWCA organizational structure is congruent with PNG's model of decentralization. The government determines policy and basic programming while provinces decide on all matters of implementation and subsequent budget distribution. While local YWCA organizations are autonomous, they remain answerable to the National office in programming and budget. The national office will have more influence over programming when the mission statement and other organizational infrastructure is drafted and agreed upon.

There are fifty (50) paid staff throughout the YWCA system. The National YWCA employs three staff: an executive director, a secretary and a program officer. Remaining staff are divided among the four local offices. There are from 200-300 volunteers including Board members. There are 1,500 members who contribute five (5) Kina per year in membership fees.

National Management: Ms. Doko believes the YWCA organization must continue its internal strengthening, both technically and institutionally, to ensure its sustainability as well as viability prior to expansion to other provinces. Ms. Doko had headed the National "Y" for five years. Under her leadership, national staff have been hired and trained and the central office established. Her next step is to determine, in cooperation with the local organizations, the mission and goals of the PNG YWCA. This critical organizational process may serve to unify and strengthen the programming capability of the organization. Ms. Doko's decision to undertake this exercise is an example of her knowledge of and skill in management. Rather than deciding unilaterally, she has chosen a democratic, egalitarian approach which will include all members of YWCA management in the decision making process.

Each local YWCA has written a four year revolving program plan (1990-94) and submitted these to the national office for discussion and approval.

Ms. Doko has clear, practical management skills. She evaluated and defined organizational needs; then took the necessary sequential steps to build a viable institution. She possesses good foresight, recognizing that expansion should not take place until the system is strengthened. She discusses the importance of mission statements, goals and measureable objectives. She realizes that donor and governmental financial support is dependent on strong organizational infrastructure and performance.

Administratively, she delegates tasks, giving both authority and responsibility by first properly defining her expectations and standards.

Regarding AIDS, Ms. Doko does not feel there will be any conflict with the community, staff or her board. AIDS is seen as a health matter concerning all members of a family and the society. She sees no problem in promoting safer sex practices, condoms, monogamy, etc. The YWCA is not a practical condom sales outlet, lacking expertise, experience and staff. However, the PNG Family Planning Association, another NGO, has a comparative advantage in this sector, with both organizational and distribution experience. In some countries, these two organizations may not be able to work together due to different philosophies and mandates. This, however, is not the case in PNG.

Constraints: The YWCA has strong and committed leadership. They are a small, growing organization which lacks consistent funding and manpower. If the "Y" can maintain quality and consistency of leadership as well as clarity of direction, the organization will become increasingly viable. Their proposal to SPC for AIDS prevention, requests training for three women. We suggest that five - one health programmer for each province and one national program officer - would ensure the sustainability of the system.

Feasibility: There is no reason SPC or RDO/SP can not work with the YWCA. The YWCA is limited by size and experience. The small staff work with numerous program demands. To add AIDS Prevention to their portfolios may be a stretch. However, they are certainly competent, committed and enthusiastic. If SPC offers technical support for a period of a few years, to encourage growth and continuation of the project, it might be useful. However, Ms. Doko is fully capable of defining the needs of her staff and organization.

YWCA-Goroko has an established literacy program. Since 1988, they have trained one hundred women, who are now functionally literate. It is feasible that USAID could support such a successful program by helping establish similar programs in the remaining three provinces. Use of this arena for AIDS health programming could reach a critical target population. PNG/UNICEF is funding women's literacy. An AIDS prevention component could be easily added as part of a joint SPC/UNICEF effort.

The YWCA proposal for STD/AIDS is within the range of existing skills and management capability. The training of trainers is appropriate for continued institutional building. The YWCA currently writes, publishes and distributes their own materials and are willing to collaborate with the DOH in the development of appropriate content for women's AIDS prevention materials. Their proposal was drawn from Dr. Glen Mola's studies, an excellent and well respected PNG resource in women's health.

#### PNG FAMILY PLANNING ASSOCIATION

Legal Status: FPA is an NGO. Ms. Jane Kesno has been the Executive Director for one year, seconded from The Department of Youth and Home Affairs for a three year period. The FPA is redrafting their constitution, revising their scope of work to include family health - an integrated approach to family planning. This approach has eased the impact of family planning, a sensitive topic in some sectors of PNG society, steadily increasing numbers of acceptors, and building community trust and confidence.

The organization has no formal limitations but remains in compliance with The Department of Health (DOH) in family planning policy and guidelines, including the types of contraceptives offered in PNG. This cooperative working relationship with DOH is a wise starting point for organizational acceptance. In the future, as their reputation grows, they might afford more independence and play a more central policy making role. In addition, the GPNG is encouraging private sector development, another positive governmental action in favor of FPA evolution.

Financial Status: PNG/FPA receives the majority of its funding from outside sources: IPPF US \$ 191,000/yr.; UNDP, Kina 58,000/yr. and contraceptive sales of Kina 5,000/yr. The GPNG provides no financial assistance. There are one hundred voluntary members who pay five Kina/year in membership fees.

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The Executive Director submits six month reports to UNDP and IPPF. These are prepared by a professional international accounting firm in Port Moresby. The organization had fallen into disarray prior to the secondment of Ms. Kesno. She was presented with a six month mandate to bring the FPA into compliance and rectify/justify financial matters. She has managed to do this and IPPF has resumed funding.

The provincial branches of FPA submit budget requests to the Executive Director, who then determines budget allocations based on the national FPA yearly budget.

Organizational Pattern: The Executive Director is responsible to a management board. There are branch offices in NCD, Morobe, East Sepik and Manus, headed by provincial organizers. There are sixteen employees, eight of whom staff the NCD office.

The Manus Branch is opening on August 20, having expressed an interest in establishing their own organization. Interested communities are first required to socially mobilize and when a list of basic requirements are met, FPA will assist the community to establish a base of operations.

Management: The new executive Director has proven her management ability by preventing the closure of FPA. As with many NGO's, FPA has too much to do and is understaffed to efficiently achieve its established goals.

However, this is an appropriate organization for condom distribution, although PNG/FPA is evaluating methods to increase condom sales since women are the primary FP acceptors. It is also appropriate for STD/HIV/AIDS counselling.

FPA has mobile clinics staffed with trained FP nurses, which take contraceptives to private and public sector offices (PTT, GPNG and others) and the settlements. FPA has established community based distribution services, with regular weekly schedules.

FPA sells 144 condoms for Kina Five. Oral contraceptives sell for one kina per cycle. In villages where there is insufficient cash economy, FPA allows sliding scale payments. Products are donated through IPPF, Schering and AG. They receive microlut, microgynon, deprovera, IUD's and condoms. Vaginal spermicides do not sell. Village women prefer deprovera. UNDP has discussed NORPLANT with DOH, but FPA was not party to the discussions.

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In assessing FPA needs, the Executive Director believes staff must acquire basic training in FP, especially IEC. RDO/SP/PNG has supported FPA's training efforts by fellowships offered through AID/W sources (S&T Population), developing FP materials for illiterates, recognizing the urgent need for information aimed at the country's majority of illiterate women. FPA is committed to hiring experts to train staff in order to strengthen institutional capabilities and work toward eventual organizational autonomy.

Feasibility and Constraints: With support from the Department of Education, FPA is launching FP education in trade and high schools. With urbanization, increased mobility, unemployment and the need for cash economy, FPA recognizes social/familial changes which cause an increase in STD/AIDS and teen pregnancy. They are aware of similar problems arising in the mining and petroleum communities. FPA recognizes the potential role they play in the current social climate.

Ms. Kesno is willing to work with organizations such as the YWCA in cooperative STD/AIDS planning and project implementation. She perceives YWCA as a viable resource for materials production (especially since YWCA has a successful literacy project in Goroka). She recognizes FPA's comparative advantage in counselling and condom distribution. FPA counsellors are trained and practicing. As such, FPA feels that additional AIDS counselling is within the scope of existing skills. FPA is committed to integrated primary health care and general family health, thus STD/AIDS falls well within the organizational mission.

National FPA is purchasing their headquarters, located just across the road from National YWCA in Port Moresby.

Under the excellent leadership of the National Executive Director, FPA is recovering from near extinction. They have the leadership necessary to continue healthy institutional strengthening. RDO/SP/PNG has been impressed with the nurses and health workers employed at FPA. There is no formal FP training in PNG for health workers, including medical school students, leaving a large gap in trained personnel. While admittedly needing training, FPA staff is competent, interested and committed.

As FPA continues to build technical and institutional capacity, some TA in the areas of social marketing and cost retrieval maybe useful. FPA can eventually learn more about sales and profits, focussing on urban economies as well as rural, non-cash sectors.

CHEVRON NIUGINI

Dr. Bill Chapman is the manager of Chevron Niugini Medical Services. He arrived in PNG on July 2nd, 1990. Chevron Niugini opened office in Port Moresby three years ago, under the direction of Mr. Ollie Ollinger. Explorations in PNG have proved promising. As a result, Chevron hired a physician who is in charge of the implementation of secondary medical services for its contractors, subcontractors and field staff totalling some 3,000.

Chevron must acquire the approval of the GPNG for all expatriate hires, in compliance with regulations from the Department of Foreign Affairs. It adheres to the same regulations as all bi-and multilateral donors and private companies in hiring and operations. It is obligated to hire at least equal if not greater numbers of Papua New Guinean as expatriate staff.

The main base of operation is South of Mendi at Lake Kutubu, a twenty five minute helicopter ride from Mendi. Villages are hired as local staff. As operations are successful, other bases may open along the pipeline, which runs from Mendi into the Gulf of Papua.

The role of the medical management is to deliver secondary health services, i.e., the care and treatment of all company illnesses, accidents and/or injuries. Employees requiring hospital are referred to the Mendi hospital. Small clinics will be located at Lake Kutubu and in three to four satellites. Health Extension Officers (HEO's) and nurses will be hired in PNG and the staffing completed by American physician's assistants.

Primary health care (PHC) and IEC/prevention services are not offered - except the immunization of field staff and people in the villages where staff resides. Chevron employs a safety officer who is in charge of food handling and hygiene to bed nets, etc.

Dr. Chapman knows of two AIDS posters which hang in their offices. There are no planned AIDS or other IEC activities nor does Chevron distribute condoms. I asked about possible five year future plans for such activities. Dr. Chapman suggested this would be a management decision rather than his. Using local hospital services, the company has no special provisions for securing its blood supply beyond current GPNG/DOH practices. I would not have asked if expatriate or National Staff are screened for HIV, but it is an interesting question.

Chevron is directed by the Managing Director, under him are an Operations Manager, Exploration Manager and the Medical Manager (and possibly others).

Private mining and petroleum companies often manage and direct their own health services. In PNG, such companies have also been interested in public relations and carried out a number of health-related activities. It would seem feasible for an AIDS program to be developed then implemented through existing services. Important populations, often with high incidence of STDs, are easily accessed. Mining and petroleum companies may be amenable to IEC/AIDS prevention activities. Perhaps Chevron, if approached through its management with project descriptions and serious intentions, might be amenable to STD/AIDS prevention projects. It is equally possible these companies would not be interested due to the sensitivity of the subject. However, as more and more information is reported on increasing STD's in mining/petroleum communities, it could eventually be advantageous for the mining companies to address these issues before too much controversy arises.

It was difficult to assess Chevron's amenability to AIDS activities. They do not deliver PHC and/or prevention/IEC services, nor did Dr. Chapman seem interested or uninterested. To assess attitudes and the amenability of other petroleum and mining companies will require extensive interviewing. Clearly, they have organizational infrastructure, financial stability and service capability.

An official visit to Mr Ollinger, the Managing Director, to determine Chevron's future plans and their potential interest in STD/AIDS IEC activities will be necessary. The reluctant attitude characterized in the subsequent interview does not mean that Chevron Niugini should be dismissed from consideration as a potential participant in the AIDS prevention activities.

As an organization concerned with the health and welfare of the people of Fiji, FRCS recognizes that it can contribute to the efforts of the Ministry of Health in improving health conditions in areas not adequately served by government health personnel. In Fiji, as in many developing nations, the most common health problems are preventable and occur largely due to ignorance of basic health practices. In addition, many health problems experienced in Fiji are the result of change from rural to urban lifestyles. With this in mind, the FRCS, in close discussion with the Ministry of Health, began initial efforts toward an educational program based on the community health worker model as early as 1979.

The CHW program is an on-going project within the FRCS's National Health and Welfare Program. It began with 17 CHWs in 1983, and now supports 33 active CHWs throughout Fiji. These volunteer CHWs are chosen by the communities in which they live and are accepted into the week-long CHW introductory training program based on their abilities, enthusiasm, dependability, and locale. Further in-service training in the form of five-day workshops focusing on one or more topics are conducted twice a year. Although some are based in urban areas, the majority work in rural and often geographically isolated areas. When possible, they work in close collaboration with health care professionals to coordinate clinical care with health prevention and promotion activities.

The CHWs conduct health or community awareness sessions for groups or individuals, the topic of which is chosen by the participants. CHWs are trained to provide sessions on a variety of issues which include but are not limited to: nutrition counselling, common health problems, women's health, family planning, water supply and sanitation, breastfeeding, sexually transmitted diseases and AIDS awareness. Sessions are conducted in locations convenient for the recipients and in the language common to all involved. The approach is low-key and informal with emphasis placed on group involvement and discussion. In 1989 a total of 2873 health sessions were provided to 63,989 participants. Although only six of the currently active CHWs are male, a progressive increase in male attendance has been noted, with approximately 30% of the session participants being men.

CHWs are provided an honorarium of F\$3 per session up to a maximum of F\$80 a month. In addition, travel expenses (bus, taxi, boat fares) are reimbursed by FRCS. Monthly report forms are collected by the program coordinator, based in Suva, who serves as the primary liaison between FRCS headquarters and Branch offices, the Ministry of Health, and other government and NGOs involved in health care. The program coordinator is also responsible for the recruitment and initial training of new CHWs and the provision of two in-service training seminars per year.

The CHW Program is currently subsidized by a grant from the Australian Red Cross Society which in 1990 amounts to F\$10,000. In addition, the New Zealand Red Cross Society contributes F\$10,000 towards the Program. Finally, a grant of F\$2,222 per year is received from the Ministry of Health towards the overall FRCS National Health Program budget, some of which incorporates the CHW Program. With these minimal resources, the CHW Program has made an impressive start and has established a demand for expansion of services that it can not meet without additional resources.

Management:

(a) The Blood Program

The Society continued to maintain all donor recruitment activities and organization of mobile collections in the Central Division while Ra, Tavua and Labasa Branches promoted ad hoc mobile collections for their respective Divisional Blood Banks.

A full staff member hold responsibility for coordinating national activities and maintaining Central Division services. While mobile collection levels were maintained in 1988, donor numbers continued to decline that year requiring intensified motivation efforts and increased mobile collections. As part of these efforts, new recruitment and donor incentive items (posters, certificates, stickers) were designed and produced locally in 1988 while a new pamphlet was printed in 1989. These were also distributed to the Lautoka and Labasa Blood Banks and concerned Branches to augment their recruitment activities.

During the period, the Society also successfully sought assistance from sister Societies and aid sources to overcome acute shortages of essential items (blood packs, test kits, etc.), that threatened disruption of collection activities. This also includes disposable items to facilitate the establishment of a donor register for the Tavua/Vatukoula area.

The Society also submitted a request for Australian Government funding consideration for new and/or replacement equipment to enable upgrading of blood banking facilities in Suva and other centers. We understand the request was met in full and that the Ministry of Health took delivery of this valuable consignment in August, 1989.

In July, 1989, the Society took delivery of a new multi-purpose van to replace the old one used for mobile collections in the Central Divisions. This was made possible by a generous donation by the States of Jersey Trust and the British Red Cross supplemented by a grant from the Fiji Sixes Charity Committee.

In April, 1988, the Program Coordinator undertook a six-week study visit in New Zealand, sponsored by the New Zealand Red Cross Society and the Pacific Paramedical Training Center. League support later in the year enabled our participation in the 7th Asian and Pacific Regional Seminar on Red Cross Blood Programs, hosted by the Red Cross Society of China and the three-day Symposium on Blood Derivatives hosted by Thailand Red Cross. These provided an invaluable overview of regional activities, an opportunity to exchange information and to discuss common issues.

The Society continued to seek formal recognition of its role and a clear delineation of duties from the Ministry of Health during the period. While a proposal was received in early September 1989, clarification had not been received at the end of the year.

(b) Disaster Services:

Disaster Preparedness:

The Society has continued to promote disaster awareness and preparedness among both members and the general public, primarily through its Youth Program and Community Health Workers' outreach.

The Society prepared and released over 300,000 copies of three locally designed and produced disaster game-sheets featuring the basic 'do's and don'ts relating to cyclones, earthquakes and floods. These were distributed during the Week, through the newspapers, to all schools and to Youth members and received a positive response. Interest has since been shown by several sister Societies and other overseas bodies in adapting and reproducing them to meet their local needs.

Preliminary work was initiated on plans to revise and reprint the Red Cross Disaster Preparedness Lessons Kit for primary schools.

The Society continued efforts to rebuild its national relief stock to acceptable levels. Preparation of pre-packed emergency family packs ("black packs") was somewhat erratic during the period owing to chronic shortages of some clothing items and the increased demands on Branches for welfare assistance particularly in drought-affected areas during the first part of 1988. Pre-packed stock to cater for 3,100 families and other items in place at twelve different centers around Fiji by December, 1989.

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Stock shortages were generously overcome by donations of clothing by the Japanese and New Zealand Red Cross Societies and an individual donor during the period while the very generous donation of a second pre-stocked shipping container from the Japanese Red Cross Society has enabled us to further strengthen storage facilities for those Branches which do not have their own premises. The Society now has five such containers deployed for disaster storage purposes.

A financial grant from the Ministry of Home Affairs in December, 1988, sufficiently boosted funds held by the Society to enable it to activate plans for a national disaster storage facility in Suva. Work commenced on the Gorie Street site in February, 1989, and was completed in June.

Following discussions with the Japanese Red Cross Society the same month, the Society subsequently announced a grant to fully cover the cost of Stage II of the new national complex, enabling completion of the disaster bulk store facilities. Work on this commenced in November, 1989.

Disaster awareness sessions were held for over 6,700 members of the public during 1988 - 1989 (excluding contact through public displays and the media), while twenty-three Red Cross personnel attended a training course in September, 1989. The Society also presented sessions at several training courses organized by other bodies, including EMSEC.

#### Relief Activities:

The Society assisted approximately 300 disadvantaged families in drought-affected areas with rations early in 1988. This had been progressively phased out by mid-April as casual seasonal work became available. No other major relief activities were undertaken in the period.

Substantial financial assistance from sister Societies for drought relief activities was received as ration assistance was being phased out. Reviewing the situation it was established that the prolonged drought had severely affected the water supplies. Following discussion with district officials, the Society agreed to help fund the re-establishment or location of alternate water supplies at nine sites. These projects will benefit approximately 2,000 individuals.

The Society also funded the purchase of planting materials in 1988 for a crop rehabilitation program in a drought-affected area, benefitting over 1,000 subsistence and cash crop farmers and their families. This project had to be delayed until the beginning of the wet season in September of that year.

Following discussions with the New Zealand Embassy regarding a large grant for drought relief work received in August, it was agreed this be redirected for the purchase of relief stock.

(c) Dissemination Program:

This program was established late in 1987 to promote increase awareness of International Humanitarian Law (I.H.L.) and the role of the Red Cross.

During 1988 - 1989, training for the Armed Forces continued on a rotational basis reaching over 3,000 Army, Naval and Police personnel. In August, 1988, the I.C.R.C. conducted a course for officers of the Armed Forces.

An Instructor's Manual has now been drafted to be tested for use by Armed Forces personnel. A component covering I.H.L. and the role of the Red Cross is now included in all instructor and Branch volunteer training. Dissemination to members and the general public reached over 1,300 individuals during the year while over 9,000 members of the public received a broader introduction when attending health and safety education sessions.

Early in 1988 a new information brochure on the Society was produced for general distribution. This was later reproduced in Fijian.

(d) The Health Program:

The Red Cross Community Health Workers (C.H.W.s') continue to demonstrate that this program provides a viable and valuable community outreach for the promotion and encouragement of primary health care.

Session subjects essentially continue to be determined by the audience, except when specifically targetted as with ante-natal sessions. This is indicated in the fluctuating demands for some subjects, as reflected in the statistical summary.

The C.H.W.s' enjoy cordial relationship with the Ministry of Health personnel within their respective districts and often work as part of teams in field activities. Liaison at the national level with other statutory and non-governmental bodies ensures coordination and cooperation at all levels. The Program Coordinator represents the Society on the National Food and Nutrition Committee and liases with the Family Planning Association of Fiji. In October, 1988, the Coordinator attended that 18th National Training Course on Diabetes which has reduced our need to call upon staff of the National Diabetes Center for in-service training.

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Program personnel participated in World Food Day activities in 1988 and 1989, World Consumer Rights Day in 1989 and have participated in numerous displays at trade shows and festivals. In August, 1988, C.H.W.s' from ten districts took part in an Interaid Workshop on Intellectual Handicaps and subsequently one Community Health Worker was instrumental in establishing a facility for intellectually handicapped children in her area.

Regular health sessions were presented by the National Coordinator during 1988 until March 1989 on Radio Fiji. This was phased out as other special interest groups began conducting their own sessions.

C.H.W. numbers fluctuated during the period with some losses primarily to migration and/or the economic necessity. An introductory training course was conducted for fourteen recruits in 1988, In-service workshops were held on Maternal and child Health (1988), Family Planning and Sexually Transmitted Diseases including AIDS (1989). This regular in-service training was made possible by generous sponsorship of the Workshops by the Hans-Siedel Foundation and strengthens field supervision and liaison.

(e) Medical Welfare Services:

The past two years have seen the progressive rationalization of the Society's activities in this field.

In March, 1988, responsibility for coordination of medical welfare activities was removed from those of the Director General and the separate post of Medical Welfare Coordinator established. This has allowed for greater coordination, follow-up and the implementation of regular training for field personnel.

Airfare assistance from national funds for medical cases requiring urgent specialist assistance overseas was phased out by January, 1989, as part of the rationalization process although some Branches have continued to contribute to cases from their districts from their own funds. The Society, as a whole, could not financially cope with the number of legitimate requests for such assistance. Funding has been redirected to the provision of ambulatory aids and other home nursing items for free loan to economically disadvantaged families coping with chronic, terminally ill or mobility handicapped members (including the elderly infirm, stroke cases, Parkinsons disease patients, etc.).

In mid-1989 the Society held the first re-orientation workshop for branch welfare officers. This basic introductory workshop provided an understanding of common disabilities and debilitating diseases, home management and home help skills, care of the elderly and basic social work principles and skills. This was followed by an in-service workshop in late November which provided more in-depth training (including practical work) on the management of stroke cases and care of the aging. The workshops were sponsored by the Hans-Siedel Foundation and resource personnel drawn from the Department of Social Welfare, Ministry of Health (particularly the Tamavua Rehabilitation Unit/Samabula Old Peoples Home staff), the Fiji Disabled Peoples Association, Counterstroke Fiji and other concerned voluntary bodies.

The training is providing an effective outreach and referral service in many areas improving liaison and coordination. This is of particular importance for those services which have been or are still primarily institution-based and are therefore not readily accessible to those who can not afford to travel to them.

The Society continues to be the primary supplier of mobility aids particularly for adults. These are available for sale, hire or hire-purchase or free according to ability to pay. Income from sales and hire charges does not offset free loans or allow for regular re-stocking. In 1988, the rapid escalation of wheelchair costs from traditional suppliers forced the Society to look elsewhere for stock. An alternate supplier was located who also manufactured other mobility aids capable of meeting increasing local requests for such items.

The maintenance and provision of stock for free loan is only possible through the funding support provided each year by the Annual Bed Races. The Annual Red Cross - Hot Bread Kitchen Bed Race Championships have become an established institution. In 1988, these were boosted by the establishment of the Red Cross - Tropic Western Division Bed Races. The generous support provided by the primary sponsors and the small but dedicated organizing committees involved merits special acknowledgment .

In 1988, the Fiji Sixes Charity Committee provided a grant to enable purchase of spare parts for wheelchairs distributed by the Committee over the past decade or so. This enabled the Society to repair a number of these wheelchairs which it was unable to do previously owing to differing parts from those stocked by the Society for its own stock. The Society maintains its own loan stock and also undertakes repair work for various hospitals, institutions and private individuals.

Branches continue to provide ad hoc assistance with rations, clothing, purchase of drugs during the period (including assistance to fire victims).

Miscellaneous assistance has also been provided for the provision and/or repair of artificial limbs, with the generous support of New Zealand Red Cross who provide rubber feet for many of those fitted with artificial legs.

The Coordinator attended a number of interagency Workshops over the period and represents the Society on Counterstroke Fiji.

Tracing is an integral part of Red Cross services both in conflict and disaster situations. In 1988, the Coordinator attended the 1st Tracing Workshop for Asian and Pacific Red Cross & Red Crescent Societies organized by the I.C.R.C. in Singapore. This has enabled the subsequent establishment of a standardized procedure within the Society and incorporation of this in training for branch welfare personnel. The few tracing requests received over the period were welfare-orientated and all successfully completed.

The Coordinator promoted services within her program at a number of public displays and on several radio sessions during the period.

(f) The Safety Programs

The Society continued to promote and encourage safety education over the period and 1989, in particular, showed a reversal of the declining numbers attending certificated first aid and C.P.R. courses experienced during the post-coups period.

It is, however, disturbing that the bulk of the participants at these courses are those sponsored by their employers and that few individual members of the public are prepared to attend at their own expense. Course fees have been set at minimal rates over the years and are now inadequate to offset the basic costs involved providing such training (manuals, maintenance of training equipment, transport, etc.). This has to be weighed against the progressive increase in the number of adults attending non-certificated Basic Aid Training sessions which are conducted free of charge and do not require qualified instruction.

First aid personnel provided support services at various public events and have promoted safety awareness at trade displays and local festivals. Support services for the C.W.M. hospital relating to the Sunday ban were maintained for the first two months of 1988 allowing the Hospital adequate time to make alternative arrangements to meet outpatient and patient discharge transport needs.

The Society continues to pack and sell first aid kits at cost to maximize availability. In spite of this, the rapid escalation of bulk purchase cost for stock has necessitated price increases, a deterrent to many potential individual purchasers. Our market remains primarily the industrial sector and sports bodies.

#### Water Safety:

The strength of the Water Safety Program has continued to fluctuate over the past two years.

While a relatively high number of instructors were trained over the period a number were police personnel and fifteen were Duke of Edinburgh Award Scheme participants. While the latter have not to our knowledge followed through or utilized this training, the police instructors actively utilize their skills in preparing recruits for Royal Life Saving Society examinations. Two instructor's Courses scheduled for the Western Division in 1988 were cancelled owing to lack of interest. This was disappointing as there are both adults and schools in the Division who would like to either learn to swim or improve their swimming skills.

Suva-based instructors did conduct one course for Lautoka Primary School students in 1988 and also continued to meet pool and beach guard training for Western Division hotels over the period however it is impractical to consider such Suva-based help if, for example, Western Division schools wish to incorporate learn to swim classes in their normal weekly period allocated for sports activities.

The statistics for Learn to Swim classes for 1988 - 1989 do not include those participants who attended private classes. These classes were conducted by qualified Water Safety Instructors who would, in most instances, have been regarded as "unemployed school leavers." For a small fee these instructors ran weekly classes over school terms for a number of primary schools in the Suva area, one high school, a pre-school and for children in need of special attention.

Radio programs on basic Water Safety tips were prepared and broadcast in both Fijian and English over four months in early 1989 and Program personnel also promoted basic water safety principles at a number of trade and public displays. Staff also initiated and prepared the text for the Small Craft Safety pamphlet produced by EMSEC during the National Disaster Awareness Week.

The National Program Coordinator took part in an Olympic Regional Solidarity Swimming Course in Suva in mid-1988 which while geared to competitive swimming provided some valuable teaching skills and provided a broader perspective.

A substantial grant from the Spanish Red Cross in 1989 both ensured continuity of the Program during the year and has provided the necessary funding to enable the Society initiate action on the long deferred proposal to prepare a basic Water Safety teaching kit for primary school use.

(g) The Youth Program:

Youth activities have for many years been conducted as an extra-curricula "club" activity in primary schools.

During 1988 national efforts focused on "holding" efforts to support and encourage the 208 Youth groups still operational. The Society has, however, continued to lose Youth Leaders owing to migration while teacher transfers affecting Leaders over the two year period affected continuity where no willing replacements could be found. A Youth Leadership Workshop in 1989 for new volunteers was not fully subscribed and the year saw further resignations of Leaders.

Despite these setbacks, those Youth Leaders still in place put a lot of effort into maintaining activities and encouraging new members. The Society also saw the establishment of the first high school Youth Groups, a positive move that will reduce the gap in membership that currently exists for this age group.

Youth members participate in a balanced range of civic orientated activities that include basic health and safety education, community service and exchange programs with fellow groups in sister Societies. The latter focuses on the exchange of friendship cards, topical albums on lifestyles, culture and Red Cross activities undertaken by the individual groups.

In late 1988 two teenage members joined others from the Asia Pacific region in a Youth Exchange Program organized by the Japanese Red Cross in recognition of the 40th anniversary of the reorganization of their Youth Section. Our participants thoroughly enjoyed the program organized by the Japanese Red Cross Youth and found it a positive means for learning and exchange.

The National Youth Coordinator was also fortunate to visit the Japanese Red Cross in 1988 under a Fellowship Program for Youth Leaders Abroad sponsored by the Japanese National Assembly for Youth Development. Her extensive program enabled her to view a wide range of both Red Cross and other Youth related activities and provided some new ideas that could be incorporated into the local Program.

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In 1989, two Fiji delegates joined 548 others from 131 other National Societies at Super Camp, an event organized to commemorate the 125th Anniversary of the International Red Cross and Red Crescent Movement. Delegates travelled direct to Italy and spent their first week in camp at a site adjacent to Solferino, where the idea for the Movement was initially formed. The following week, participants travelled to Geneva and visited the headquarters of the I.C.R.C., the League and the newly opened Red Cross International Museum.

Late in 1989, at the invitation of the Bulgarian Red Cross, the Society was instrumental in organizing an art competition for local children attending special education schools. The winning entries were sent to the 8th International Arts competition physically and mentally disabled children and attracted several awards.

Constraints: The Fiji Red Cross society has a scope limited to Fiji. However, discussions are underway which may result in the Suva office becoming the South Pacific Regional Head Quarters.

Feasibility: The excellent management of the Society, its network of resources, financial stability, and the success of its CHW program make it a logical choice for project AIDS prevention and condom promotion activities.

Loel Callahan, June, 1990, doc. 0094Y

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FIJI RED CROSS SOCIETY

FACTS AND FIGURES: JUNE 1989 - MAY 1990

SERVICES

Blood Donor Recruitment	3,989 donors
Medical Welfare: (supply of equipment)	
wheelchairs	104 individuals
others (including artificial limb repair)	65 "

COMMUNITY EDUCATION/TRAINING

* Community Health Education (2,873 sessions)	63,989 participants
Community Health Worker training:	
Introductory Course (new trainees)	12 "
In-service (3 course)	66 "
Disaster Preparedness:	
Public Education	672 "
Branch Disaster officers Course	23 "
Dissemination (I.H.L.)	
Armed Forces/Police	671 "
** Members/public	233 "
Medical Social Work:	
Introductory Course (new trainees)	13 "
In-service (1 course)	20 "
*** Safety Education:	
First Aid Talks	497 "
First Aid (B.A.T. adult non-cert.)	6,193 "
First Aid (adult certificated)	381 "
First Aid Instructors Courses (2)	36 "
C.P.R. (adult certificated)	256 "
C.P.R. Instructors Course (1)	21 "
Water Safety (certificated)	887 "
Water Safety Instructors Course (1)	8 "

NOTES:

- \* see overleaf for breakdown
- \*\* excludes sessions "Introduction to Red Cross"
- \*\*\* above statistics exclude public contact via media/displays, general welfare statistics, youth member statistics health/safety training, community service).

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FIJI RED CROSS SOCIETY

STATISTICAL INFORMATION: 1988 -1989

BLOOD SERVICES:

Current donor register (Central Div):	<u>1988</u>	<u>1989</u>
Repeat donors	1473	1545
New donors	1543	2231

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TOTALS	3016	3776
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Donations to Red Cross mobile collections:

Central Division	2158	2510
No. of Red Cross mobile collections	105	122

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DISASTER SERVICES:

Drought Related Projects - 11 Projects	approx. 7000 beneficiaries	
Fires	27	60
Disaster Preparedness Education * (public sessions)	1477	5227
Disaster Officer Training (Red Cross Personnel)-		23

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TOTALS	8504	5310
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\* Excludes public contact through news media, displays,  
distributed games-sheets.

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DISSEMINATION:

I.H.L. and the Role of Red Cross: \*

Armed Forces personnel/police	1718	1457
Members and the public	738	585
Introduction to the Red Cross	3838	5283

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TOTALS	6294	7325
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MEDICAL/WELFARE SERVICES:

Welfare (clothing, rations, etc.)	approx.	700	N.Q.
Wheelchairs: Free Life Loan		141	40
Free Short-term loan		7	-
Short-term hire		7	14
Hire purchase *		3	16
Sales		4	10
Other Medical Equipment loans (walking frames, crutches, bedpans, etc.)		22	36
Medical Airfare assistance (phased out Jan. 1989)		5	-
Tracing		8	-
Miscellaneous		N.Q.	N.Q.

Training:

Medical Welfare Worker Training:			
Introductory Course (1)		-	13 (6)
In-service Workshop (1)		-	21 (7)

Figures in brackets indicate Government Welfare Officers who participated.

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TOTALS		770	150
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\* Exclude wheelchairs taken on hire purchase prior to Jan. 1988 for which payments were/are still being made.

N.Q. Not quantified.

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HEALTH:

Health Education: Subject	<u>1988</u>		<u>1989</u>	
	Sessions	Participants	Sessions	Participants
Ante-natal	470	7774	234	3997
Budgeting/Consumer Education	75	1588	81	1309
Breastfeeding	184	3720	196	3971
Communicable Diseases*183		5317	74	1736
Care of the sick	47	1095	66	1571
Diabetes	198	5534	368	9402
Family Life Education	49	1444	56	1347
Family Planning	412	7440	344	8654
Maternal/Child Health** 289		7453	261	4978
Nutrition	422	10475	392	12575
Puberty	50	795	70	1471
Primary Health Care	135	3361	163	3503
Sexually Transmitted Diseased (incl.AIDS)	233	4619	402	12739
Women's Health	121	1995	214	1021
Water Supply/ Sanitation	91	2392	40	1021
Miscellaneous	32	403	112	2548
<b>TOTALS</b>	<b>2,991</b>	<b>65,405</b>	<b>3,073</b>	<b>75,417</b>

\* Includes Common Health Problems, heart disease, physical disabilities/prevention, men's health problems, drugs, child abuse etc.

\*\* Excludes public contact through radio sessions, public displays, etc.

<u>Community Health Worker Training:</u>	1988	1989
Introductory Course )1)	14	-
In-service Workshops (3)	18	36

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SAFETY EDUCATION: \*

<u>Subject:</u>	<u>1988</u>	<u>1989</u>
Safety Talks	N.Q.	497
Basic Aid Training (adult non-certificated)	5863	7534
Basic First Aid (adult certificated)	276	355
Refresher courses (certificated)	-	32
Cardio-pulmonary Resuscitation (CPR):		
(Adult certificated Heartsaver/Basic)	108	353
Refresher courses (adult certificated)	9	29
Learn to Swim classes (all age groups) **	464	134
Special Water Safety Courses ***	39	16
<u>Instructor Training:</u> (members and public)		
First Aid Instructors	7	21
C.P.R. Instructors	-	8
Water Safety Instructors	27	8
Swimmers Aides	20	-
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TOTALS	6813	8987

\* Excludes public contact through news media, public displays, etc. All stats. marked 'certificated' refer to passes only.

\*\* Certificated. Figures exclude school classes.

\*\*\* Basic Aid Training & Water Safety/Pool and Beach Guard.

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NOTE: The above statistics reflects only those activities recorded by H.Q. and reporting Branches. No estimates have been made for non-reporting Branches. Unless otherwise indicated all above figures relate to either individual beneficiaries or participants.

Loel Callahan: June, 1990: doc. 0094Y

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