

**Aid Activity Name 06B191**

**AidWorks Initiative Number ING918**

**EVALUATION REPORT**

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## Aid Activity Summary

<b>Aid Activity Name</b>	<b>Clinton Foundation HIV/AIDS Initiative</b>		
AidWorks initiative number	Health Program Response to HIV/AIDS ING918		
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Total Australian \$	\$11,080,000.00		
Total other \$			
Delivery organisation(s)	Clinton Foundation		
Implementing Partner(s)	Government of PNG through the National Department of Health		
Country/Region	Papua New Guinea		
Primary Sector	Health		

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The ET would like to thank the Port Moresby AusAID office for the logistical support it has provided, for original sourcing of key documents for review, and facilitating a smooth evaluation exercise. We do not underestimate the demands of this task.

Please note that the views expressed in this report are those of the author and do not necessarily represent the views of AusAID or the Government of Papua New Guinea

## Author's Details

Alison Heywood, Ph.D., is Director of Heywood Public Health Group, an international consulting company established in 2002 providing services ranging from in-country situation analyses/needs assessments, health systems analysis, program/project designs, study designs, to reviews and evaluations. These assignments have been undertaken in Fiji, Tonga, Samoa, Solomon Islands, Kiribati, Vanuatu, Papua New Guinea, East Timor, Philippines, China, Laos, Maldives, Thailand, Cambodia and Indonesia. Technical areas of focus have included health promotion and public health, health systems strengthening, HIV and AIDS, immunisation, other non communicable diseases including mental health, and disabilities. Alison has undertaken consultancies for AusAID, the Commonwealth Department of Health and Ageing, NZAID, WHO and the World Bank, as well as for Australian universities, private companies and NGOs. Alison comes with a behavioural science and research background, and lived in Papua New Guinea for 11 years, and eight of those were spent working in research at the PNG IMR in Madang. She currently serves on the TRP of the Global Fund, and the IRC of the GAVI Alliance.

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## ACRONYMS

AAP	Annual Activity Plans
ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
AMS	Area Medical Store
ANC	Antenatal Care
AoC	Areas of Collaboration
ART	Antiretroviral Treatment
ARV	Antiretroviral
ARV/TK	Antiretroviral drugs and HIV test kits
AusAID	Australian Agency for International Development
CBSC	Capacity Building Service Centre
CF	Clinton Foundation
CHAI	Clinton Foundation HIV/AIDS Initiative
CoC	Continuum of Care
CPHL	Central Public Health Laboratory
DBS	Dried Blood Spot
DNA PCR	DNA Polymerase Chain Reaction
EHP	Eastern Highlands Province
EID	Early Infant Diagnosis
EQAS	External Quality Assurance Scheme
ET	Evaluation Team
FHI	Family Health International
GoPNG	Government of Papua New Guinea
GPH	Goroka Provincial Hospital
HIV	Human Immunodeficiency Virus
HSIP	Health Sector Improvement Program
IMAI	Integrated Management of Adult and Adolescent Illness
IMR	Institute of Medical Research
JTAI	Jane Thomason International & Associates
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
NAC	National AIDS Council
NACS	National Aids Council Secretariat
NCD	National Capital District
NDoH	National Department of Health
NGO	Non-governmental Organisation
NSP	National Strategic Plan
PAC	Provincial Aids Council
PASHIP	PNG-Australia Sexual Health Improvement Program
PICT	Provider-Initiated HIV Counselling and Testing
PLHIV	People Living With HIV
PMGH	Port Moresby General Hospital
PMTCT	Prevention of Mother to Child Transmission
PNG	Papua New Guinea
PPTCT	Prevention of Parent to Child Transmission
QA	Quality Assurance
QASI	Quality Assessment and Standardization for Immunological Measures
QR	Quarterly Progress Reports
RI	Rural Initiative
RUTF	Ready-to-Use Therapeutic Food
SCiPNG	Save the Children PNG
SHP	Southern Highlands Province
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection

TB	Tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCCT	Voluntary confidential counselling and testing
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WHP	Western Highlands Province

## Executive Summary

### Background

At the end of 2008 HIV prevalence in PNG was around 2.03%. Rural prevalence is increasing rapidly, and overtaking that of urban areas. Rural adult prevalence is predicted to reach 5.74% by 2012 (versus the urban estimate of 1.44%).

In 2006 Australia, through AusAID, agreed to fund the Clinton Foundation (CF) to scale up treatment and care for people living with HIV in PNG. A Funding Agreement was signed in August 2006 whereby AusAID agreed to contribute \$10,202,351 to the end of 2009 to support the Clinton Foundation HIV/AIDS Initiative (CHAI). A workplan for the period 1 October 2006 to 31 December 2009 describes nine Areas of Collaboration - later reduced to six technical Program Areas, plus Management. This evaluation addresses these seven Program Areas (Laboratory, Paediatric Care and Treatment, Rural Initiative, Supply Chain Management, Clinical Mentoring, and Patient Information Systems, Management).

### Activity objectives

- (i) Assess and rate CHAI against eleven evaluation criteria (relevance, effectiveness, efficiency, impact and sustainability, monitoring and evaluation, gender equality and analysis and learning);
- (ii) Recommend whether there should be continued support to CHAI under the proposed PNG-Australia Partnership for Development HIV/AIDS Schedule, under negotiation in 2009;
- (iii) Investigate options for other suitable mechanisms for funding for CHAI PNG;
- (iv) Provide a synthesis of lessons learnt and a way forward for AusAID support for HIV/AIDS.

The evaluation methodology had three clear stages: desk study and AusAID Canberra consultations; PNG field study; and reporting.

### Evaluation findings

**Laboratory:** Significant achievements include establishment of an Early Infant Diagnosis (EID) system for HIV using DNA PCR (DNA Polymerase Chain Reaction), allowing diagnosis of infants aged 2-18 months to facilitate early initiation of ART which is expected to lead to significantly better clinical outcomes. CHAI support has included: Central Public Health Laboratory (CPHL) renovations; developing SOPs; developing a testing algorithm; staff training for SOPs, DBS. All positive infants now receive ART.

A validation study has changed the dominant HIV testing strategy to a 2-Rapid HIV Test Algorithm to provide same-day confirmatory testing at the point of testing (eight sites now provide this service), and participate in the External Quality Assurance Scheme (EQAS) program for quality assurance of rapid testing. Working with the National Department of Health (NDoH), World Health Organization (WHO) and Asian Development Bank (ADB) CHAI has improved provincial hospitals/ CPHL capacity to provide CD4 cell count testing to assist in the treatment and care of people living with HIV.

This support means better clinical management of infants. However, significant obstacles include delays in approving training curricula, and lack of leadership/ management capacity at CPHL.

**Paediatrics:** In January 2007 only about 14% of children were being effectively managed. There was no national training of Paediatric ARV prescribers, no national paediatric training curriculum, and no dedicated national coordinating entity for Paediatric HIV in NDoH.

Significant achievements have been made in increasing the number of children on ARV treatment, getting the new National Guidelines for Early Infant Treatment adopted, providing training in the prescription and/or monitoring of Paediatric ARVs, providing Paediatric HIV ARV commodities through UNITAID, establishing the Early Infant Diagnosis System, and establishing/build capacity at the Well Baby Centre at Port Moresby General Hospital (PMGH).

Outstanding leadership by the Medical Director of the Paediatric Division within PMGH has been paramount to the achievements in this program. But the continuing absence of national level leadership (NDoH) for Paediatric HIV could be detrimental to the program. Case management still requires further effort, as does sustained clinical mentoring for paediatricians.

**Rural Initiative (RI):** The 24-month RI pilot commenced in Eastern Highlands Province (EHP) in August 2007 and is systematically being rolled out, so far to provincial and district level. There has been substantial progress in

increasing quality HIV testing, care and treatment services at Goroka Provincial Hospital (GPH); full adult services operate in five district level health facilities; the first phase of PPTCT (prevention of parent to child transmission) is in all eight districts. Expansion has commenced in Southern Highlands Province (SHP).

Between 2007 and 2009 quantitative data show an increase in percentage of people: with advanced HIV infection on ART (46% to 58%), on ART 12 months after initiation (73% to 86%), underweight adults increasing body weight after ART (75% to 87%), 93% survival after ART initiation, women offered who receive ART for PPTCT (26% to 88%).

There has been an increase in uptake of HIV testing through voluntary counselling and testing (VCT) and provider-initiated HIV counselling and testing (PICT), uptake of sexually transmitted infection (STI) testing through PICT in STI patients, and PICT in tuberculosis (TB) out-patients. Loss to follow up of clients who had initiated treatment has decreased. PPTCT is now delivered at 14 district-level sites, with 88% uptake of treatment. Ninety eight percent PPTCT received HIV appropriate supervised deliveries.

Capacity is being increased in district level hospitals, health centres and laboratories through trainings with follow-up, renovations and infrastructure improvements, and a clinical mentorship program is developing confidence and skills of clinicians. A standardised paper-based reporting system is facilitating more effective patient management.

Rollout has been measured to ensure sustainability. Support at every level of the provincial administration and health system is significant. However, there is a notable lack of HIV prevention in the model.

Clinical Mentorship: CHAI has catalysed the creation of PNG's *Minimum Standards for HIV/Care and Treatment* (2007). It has successfully hired one clinical mentor to work in adult HIV, split between Goroka, SHP and Port Moresby. Clinical mentors have spent at least four weeks per site, working at provincial hospital and district level facilities. It is noted that the mentorship program has been problematic, with difficulty retaining recruits.

Patient Information System: CHAI has been pivotal in developing standardized clinical forms for HIV patient care and has piloted a new patient information database application using Microsoft Word, adopted for national implementation at the end of 2008. The system is user friendly and provides reports that are useful for managers.

It was noted that the new database field capturing risk groups did not include a choice of category to capture those who are engaged in transactional sex/sex work. Any revision will need to ensure a full range of responses is included in appropriate fields. Virus protection issues also need to be addressed.

Procurement and Supply Chain Management: CF has significantly helped strengthen the management capacity of the procurement and supply chain for HIV ARVs and kits, funding a logistics manager position. Needs forecasting has been improved, and CHAI has been able to gap-fill as issues arise that impede smooth operation of the chain. Assistance is being given to the development of a new database to assist inventory management. There have been no stock-outs at the facility level since CHAI assistance commenced.

Project Management: The current in-country CF team is highly motivated and responsive to the PNG environment, and strong leadership is demonstrated in the Country Director. This has very clearly enabled the good outcomes to date. Agreements have been developed between CHAI and GPH, Mendi Hospital, Jane Thomason International and Associates (JTAI) for NDoH supported positions, and Catholic Health Services in Tari, SHP to clearly articulate responsibilities. At the national (Port Moresby) level coordination and management are occur informally. At the provincial level in the EHP the RI has its own management structure with a four-person Steering Committee that meets regularly. This committee acts as a sub committee of the Provincial Aids Council (PAC).

Some management weaknesses were noted, with human resource management, the absence of readily available and useful budget information showing exactly how funds are spent, and project monitoring.

Monitoring and evaluation (M&E): The absence of an M&E framework and reporting matrix has been detrimental to the overall rating of the project.

Sustainability: Evidence of likely sustainability is seen in local ownership of the project largely due to the Government of PNG (GoPNG) vision of health system reform, building capacity of health service providers for both leadership and health service provision, and CHAI's readiness to unreservedly commit to and support this vision. At the provincial level, the initiative will be supported with the new provincial health administration reforms, and the ability for the province to direct how its funds will be spent. Their vision is to establish at the GPH a centre of HIV excellence. There are however key systems factors that will be ongoing challenges toward achieving sustainability.

## Conclusion

It is the view of the ET that the project is progressing well, and toward a sustainable situation. At this stage it is too early to know how successful sustainability will be, and donor funding will be required for some years yet. Given the excellent progress that is being made, and the obvious commitment of GoPNG to make this work, it would be unfortunate if funding were not continued.

### **Lessons Learned**

Many lessons have been identified from the project, and are presented below. Many of them are not new in PNG (identified with an \*) and have been highlighted in previous evaluations, including of HIV projects/programs.

#### **General**

- (i) Expedient NDoH approval for training curricula facilitates implementation of new, innovative and proven interventions approaches.
- (ii) Introduction of new and innovative approaches is only successful if accompanied by staff training, sound supervision and appropriate facilities.\*
- (iii) Strong local leadership and management capacity are central contributing factors to success in donor supported initiatives.\*
- (iv) Health systems issues impede effective implementation and sustainability: timely release of funds, timely approval of training, support for regular maintenance.\*
- (v) Human resource capacity requires time to be developed.\*

#### **Project design**

- (vi) A project that has a clear design at commencement, that includes a logical framework with outcomes and indicators articulated at every level of the project hierarchy, enhances the likelihood of clear cumulative reporting on progress toward higher level outcomes (monitoring and evaluation).\*
- (vii) Project implementation and monitoring is facilitated when the outline of a M&E Framework and matrix is presented during design stage. This is particularly important if the skills to develop these tools are likely to be underdeveloped in the project management/implementation team.\*

#### **Training**

- (viii) Unless national training capacity can meet the training demands essential to implement programs such as CHAI, capacity building and commitment to donor programs will be threatened.\*

#### **Management**

- (ix) Minimal management and governance arrangements can be effective with the right project personnel in place.
- (x) The importance of selection of an appropriately skilled and committed team is paramount to success.\*

#### **Laboratory**

##### **EID**

- (xi) Emphasis on quality assurance is critical to efficient and accurate diagnostic capability.
- (xii) Quality is compromised if rollout of the program occurs too quickly; time is needed to consolidate and follow up performance and adherence to protocols.\*
- (xiii) Complementary mechanisms for treatment, adherence/retention are critical.

##### **Rapid Test algorithm Development**

- (xiv) Development is limited without donor funding during Phase III analysis and rollout due to limited NDOH resources
- (xv) Will still require gradual exit plan to build capacity and fill gaps as needed

#### **Paediatrics**

- (xvi) It continues to be the case that positive children are largely identified in the inpatient wards rather than in outpatient clinics; counselling and testing training for both outpatient and inpatient paediatric staff supports earlier diagnosis.
- (xvii) Space is needed for clinics that is specific to HIV and not combined with other hospital departments.
- (xviii) Loss-to-follow-up is a serious impediment to PMTCT/paediatric HIV cases; a strong case management system (in the RI), contributes to reduce loss-to-follow-up.
- (xix) Well baby centre
  - Accurate data collection important from start;
  - Coordination and partnership are priorities;
  - Local leadership/initiative needs to drive process;
  - Project-funded systems must complement existing structure and address sustainability and absorption into those systems.

## RI

- (xx) A significant factor in the success of the pilot of the RI is the step-wise, flexible, facility-specific, appropriately paced and tailored approach of the CHAI to its implementation, balanced with the urgent need to increase HIV services in rural areas.
- (xxi) Factors that contribute to successful implementation of the RI:
  - strong commitment of the provincial government and hospital administration to reforming the health sector;\*
  - placing improved access to quality health services at the community level as a central plank of that reform;
  - uniform articulation of a vision for reform by every level of the provincial government and the health administration;
  - a solid understanding of where donor assistance can contribute to that vision.
- (xxii) Greater synergy is achieved if partners implementing similar programs are aligned with GoPNG priorities and demonstrate resourcing that will build capacity and contribute to long term sustainability.\*
- (xxiii) Building capacity at the provincial level to provide paediatric treatment and care beyond the provincial level depends upon a strong mentoring program being in place.

## Recommendations

**Recommendation 1:** In Phase 2 of the project HIV prevention is mainstreamed into all service components.

**Recommendation 2:** A new phase of CHAI is guided by a design that includes a logical framework, uses recognized project terminology and clearly identifies the project purpose, component/program areas and their objectives, and activities that will contribute to achievement of each of the component objectives. The design should be preceded by a concise needs assessment that clearly justifies the project content.

**Recommendation 3:** To support implementation of a new phase AusAID articulates a new agreement that is more specific about reporting against all elements of the logical framework.

**Recommendation 4:** Areas of potential conflict are articulated in a risk management plan and GoPNG ensures that all parties working in similar areas are collaborating and coordinating their activities.

**Recommendation 5:** As a matter of urgency NDoH precipitate the appointment of a permanent head to CPHL.

**Recommendation 6:** Phase 2 of CHAI continues to support strengthening of laboratory services.

**Recommendation 7:** Undertake a detailed assessment and cost-analysis within six months on those components of the RI already in place to inform expansion of the model.

**Recommendation 8:** Establish criteria for selection of further provinces for implementation of the RI.

**Recommendation 9:** Efforts need to be made to maximise integration of HIV, including prevention, into other services such as STIs, TB and maternal and child health.

**Recommendation 10:** AusAID, CHAI, Save the Children (and other relevant PASHIP implementing organisations), FHI and GoPNG need to ensure that cooperation and synergies between projects are maximised. GoPNG must lead this effort.

**Recommendation 11:** Leading into Phase 2 explore the feasibility of and alternative options for expanding paediatric HIV services beyond the provincial hospitals.

**Recommendation 12:** At the national level institute strategies to improve training capacity to meet demand for staff training.

**Recommendation 13:** Review all fields in the patient information database and ensure that a full range of response categories are included.

**Recommendation 14:** Patient information database: develop a system for monitoring/controlling for virus threats to the system.

**Recommendation 15:** The CF improves its recruitment processes to ensure continuing placement of credible and appropriate personnel to key CHAI positions.

**Recommendation 16:** A detailed budget breakdown of spending is provided prior to the design of new phase.

**Recommendation 17:** CHAI Phase 2 design includes the development of a comprehensive risk management plan.

**Recommendation 18:** A video version of the step-by-step manual for the Rural Initiative is made in tok pisin.

**Recommendation 19:** As a matter of urgency NDoH identify key senior staff to support the Principal Technical Adviser, HIV/AIDS/STI, (Communicable Diseases Branch) in the GoPNG oversight/support of CHAI.

**Recommendation 20:** in preparation for the next phase of CHAI must:

- seek the support of a gender specialist to better understand the requirements of the project;
- ensure gender issues specific to HIV and its treatment, care and prevention are documented and project responses are identified, including indicators for their measurement;
- include indicators to measure the project's response to all dimensions of gender equity in the M&E framework and matrix under the "Management" component when the design is developed for the next phase.

**Recommendation 21:** A new phase of the project develops a design document, a logical framework, an M&E plan and matrix, and templates for reporting that reflect the project outline; indicators are identified at the goal/purpose and component (Program Area) level.

**Recommendation 22:** A new phase (five years) should be designed, with NDoH and Clinton Foundation leading that design process, and AusAID supporting the inclusion of a Design/M&E Specialist to be part of the team.

- A new design should reflect new thinking within the NDoH (corporate plan, partnership and the new national health plan).
- Extend the current project for up to a one year, depending on likely duration of the above exercise.
- A fuller review of the RI is undertaken, possibly in six months time (not waiting until it is fully rolled out) to use in preparation for expansion elsewhere; whether this is led by an external consultant or CF would be determined in due course.
- Plan for the Rural Initiative costing study.
- The timing of these activities needs to be further explored with key stakeholders to ensure appropriate sequencing/timing.
- Continuation of the RI needs to continue to be within the context of a broader health system strengthening approach and should consider:
  - The potential for increasing linkages between HIV and other services to develop one-stop-shop services for HIV, tuberculosis, STI, family planning and nutritional support, linked to home-based care and community support.
  - Involvement of people living with HIV (PLHIV) in counselling and support.
  - Increased focus on district level laboratory services to enable basic level point of care diagnostics, including confirmatory HIV testing.
  - Prevention should be strengthened within the model, particularly to integrate condom distribution into all aspects of health service delivery, including mobile clinics to improve the availability of condoms at the community level.

- The need to disaggregate data by sex
- Consider adding health system strengthening to the model.
- Include a Social Mobilisation component.

## Evaluation Criteria Ratings

<b>Evaluation Criteria</b>	<b>Rating (1-6)</b>
Relevance	5
Effectiveness	5
Efficiency	5
Sustainability	4
Gender Equality	2
Monitoring & Evaluation	2
Analysis & Learning	5

*Rating scale: 6 = very high quality; 1 = very low quality. Below 4 is less than satisfactory.*

# 1. INTRODUCTION

## 1.1 Activity Background

### 1.1.1 Country context

Papua New Guinea (PNG) is at a critical point with HIV with adult prevalence of around 2.03% at the end of 2008, and increasing. Estimates indicate that HIV is entering a period of unprecedented growth in rural PNG where 85% of the country's population live and where, by 2007, HIV prevalence had overtaken urban prevalence (1.65% and 1.38% respectively). Predictions are alarming. Without significantly increased HIV prevention efforts, it is predicted there will be a dramatic increase, with more than one in 20 adults living with HIV by 2012, mostly in rural locations (where it is difficult to reach people with services). Rural adult prevalence is predicted to be 5.74% by 2012 compared to an urban estimate of 1.44%.<sup>1 2</sup>

While there are roughly equal numbers of men and women living with HIV in PNG, there are a disproportionate number of young women affected, with prevalence more than twice as high in women aged 15 to 29 years as men in the same age group. Conversely, the majority of men diagnosed with HIV are between 30 and 34 years of age. More than three in every hundred women attending antenatal clinics in Enga and Western Highlands Provinces were HIV positive in 2007.

Voluntary confidential counselling and testing (VCCT) services have expanded significantly in recent years with 93,168 people tested in 2008, up from 48,126 in 2007 and 2,000 in 2005.

It is estimated that in 2007, 954 children (0 to 14 years) were newly infected with HIV in PNG, up from 353 four years earlier. Most of this could have been prevented if prevention of parent to child transmission (PPTCT) strategies were more widely available to parents.

PPTCT services declined in reported coverage between 2006 and 2007 to 2.32% (84 mothers). In the first half of 2008 there was a slight increase in the number receiving PPTCT (124 mothers). This is despite the increasing availability of rapid testing and national policies to support provider initiated counselling and testing (PICT) and its implementation in many hospitals in PNG.

By the end of 2008, there were a total of 50 antiretroviral treatment (ART) sites located in all provinces; except in Manus and New Ireland services have extended to regional and provincial hospitals; however these are largely inaccessible by remote communities. ART services have reached a total of 5,195 people (4,866 adults and 329 children), which is estimated to be 67% of services required.<sup>3</sup>

### 1.1.2 Process for CHAI commencing in PNG

In the course of discussions with the Australian Foreign Minister in 2006 Australia, through AusAID, agreed to support funding to the Clinton Foundation (CF) to scale up treatment and care for people living with HIV in China, Vietnam and PNG. Indonesia was included later. A Memorandum of Understanding (MoU) between the Australian Government and CF was signed in February 2006 stating the Australian Government, through AusAID, would provide funding of up to \$25 million over four years, to be complemented by funding from the Clinton Foundation HIV/AIDS Initiative (CHAI). The MoU established the goals of the program as:

- providing support in implementation of integrated care, treatment and prevention programs in accordance with national plans;
- using these as a basis for discussion with other development partners in order to mobilise resources for the sustainable implementation through nationally owned development plans;
- developing quality management and information sharing that will allow quality treatment and care programs to rapidly scale-up; and
- participating with other stakeholders to coordinate complementary strategies between expanded HIV and health sector support.

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<sup>1</sup> 2007 Estimation Report on the HIV Epidemic in Papua New Guinea

<sup>2</sup> AusAID HIV Annual Sector Performance Report 2009

<sup>3</sup> IRG 2009. Independent Review Group on HIV/AIDS. Report from an assessment visit. 23 April – 6 May 2009.

A Funding Agreement between CF and the PNG Government states CF will complement AusAID funding. CF has contributed paediatric ARVs, paediatric OI drugs, commodities for the Early Infant Diagnosis Program (e.g. reagents, equipment including PCR machine) totalling US\$417,622 USD as of June 2009.

In August 2006 a Funding Agreement was signed where AusAID agreed to contribute \$10,202,351 up to the end of 2009 to support the CHAI initiative in PNG.

In the absence of a design document for the project, the second milestone under the Agreement was to provide a workplan for the period 1 October 2006 to 31 December 2009, developed in collaboration with, and approved by the PNG National Department of Health (NDoH), AusAID and other relevant stakeholders in PNG. This was to be supplemented by Annual Activity Plans (AAP), Annual Progress Reports against the Annual Plan (including expenditure against budget), quarterly progress reports (QR), and an annual expenditure certificate.

## 1.2 Evaluation Objectives and Questions

The overall objectives of the evaluation were to:

- (i) Assess and rate CHAI against AusAID's eight evaluation criteria defined in *AusAID's Guideline: Manage the Independent Evaluation of an Aid Activity* which include the five OECD/DAC criteria of relevance, effectiveness, efficiency, impact and sustainability, and the three additional AusAID criteria of monitoring and evaluation, gender equality and analysis and learning;
- (ii) Recommend whether AusAID should continue to support CHAI under the proposed PNG-Australia Partnership for Development HIV/AIDS Schedule, under negotiation in 2009;
- (iii) Investigate options for other suitable mechanisms for funding for CHAI PNG including integration into existing systems and programs on HIV treatment to minimise fragmentation; and
- (iv) Provide a synthesis of lessons learnt and a way forward for AusAID support for HIV/AIDS. If continuation of initiatives is to be recommended, develop an outline of a design concept paper listing key considerations and requirements, for internal AusAID discussion.

Detailed Terms of Reference are found in Annex 1.

## 1.3 Evaluation Scope and Methods

### 1.3.1 Scope of the evaluation

The evaluation was undertaken in May/June 2009 and examined activities over the 3½ years since the project's commencement. These activities were initially described within nine Areas of Collaboration (AoC), and subsequently six technical Program Areas plus Project Management (see Annex 2). The evaluation has examined progress toward achieving primarily activities of the project, although this is constrained by a number of factors noted in Section 3.2 below.

### 1.3.2 Evaluation methodology

The evaluation had three clear stages: desk study and AusAID Canberra consultations; PNG field study; and reporting.

(1) *Desk study and AusAID consultations:* The desk study was conducted in Australia prior to the in-country visit to review available project, AusAID and Government of PNG (GoPNG) documentation, to identify key informants and potential field sites, and to plan the field work component of the study. Meetings were undertaken with AusAID's PNG Branch in Canberra. Relevant documents were examined. Further documents were requested. A full list of documents consulted is found at Annex 3.

(2) *PNG field study:* Meetings and discussions were undertaken with AusAID Port Moresby (Health Program and the Australia-PNG HIV Program), counterpart and stakeholder agencies, staff and management of the CHAI and key development partners actively supporting the GoPNG response to the HIV/AIDS epidemic.

In NDoH the Evaluation Team (ET) met with the Health Secretary, staff in the Disease Control Branch and the Health Economist.

At the Port Moresby General Hospital (PMGH), the team visited the Well Baby Centre to tour the facility and meet key staff. There was an excellent opportunity to sit with mothers, fathers and babies/children attending a weekly

group run by the Friends Foundation, and listen to some of the women and men relate stories of their experience with HIV and the value of that group for them.

CHAI and government staff were met at the Central Public Health Laboratory (CPHL), which presented an opportunity to view the facility and equipment in use. A visit was also made to the Heduru Clinic and to the Are Medical Store (AMS).

Various partners were met including Family Health International (FHI), World Health Organisation (WHO), Save the Children PNG (SCiPNG), UNICEF, AT Projects, Asian Development Bank (ADB), and the Capacity Building Service Centre (CBSC).

A field trip was undertaken to Goroka, Eastern Highlands Province (EHP). The ET met with the Governor of the EHP, Provincial Administration, and key people at the Goroka Provincial Hospital (GPH). Field visits were undertaken to Asaro Health Centre, Kainantu Rural Hospital and Henganofi Health Centre.

A list of people consulted is found in Annex 4.

The in country meeting schedule is found at Annex 5.

(3) *Reporting:* Analysis and reporting was undertaken prior to, during and following the field visits. An Aide Memoire was presented in NDoH on 5<sup>th</sup> June outlining initial findings of the evaluation. This meeting provided opportunity for government and stakeholders to comment on preliminary findings and offer further information. A draft report was distributed to AusAID on 17<sup>th</sup> July and put out to peer review. Based on feedback from that process, a final report was submitted to AusAID on (date to be determined).

### 1.3.3 Methods of analysis

A large amount of data was collected from reports, face-to-face and telephone interviews. While the project reports focus largely on outputs, the evaluation sought to report not only on the quantity of outputs but on the quality of those outputs from the perspective of the key stakeholders.

Quantitative and qualitative data were examined systematically, permitting triangulation of data and verification of information particularly where discrepancies occurred. Quantitative data are presented where possible in the report.

### 1.3.4 Limitations of the methodology

The evaluation is limited by a number of factors. The amount of time allocated for the in-country field work was limited given the amount of information to be collected, and the paucity of information in documents available for initial review. Three days were available for the visit to the Eastern Highlands Province (EHP) to assess progress with the Rural Initiative (RI). This allowed for visits to three districts alone, and to locations that were close to the main highway. More remote locations were not visited. Consequently, issues of access could not be explored with beneficiaries.

No meetings were scheduled with people living with HIV (PLHIV), the ultimate beneficiaries of the project, and it was only by chance that the ET met with PLHIV at the Well Baby Centre at Port Moresby General Hospital (PMGH).

The ability to undertake a detailed assessment of value for money to include making comparisons with other similar activities has not been possible due to insufficient financial information in project reporting required for such an assessment. There are other similar programs in the region, and had this information been available comparisons could have been made.

The inadequacy of project documentation has quite significantly affected the ability to undertake a systematic evaluation of the project. Project documentation lacks cohesiveness, consistency and inadequate outcome indicators against one consistent set of objectives limits the extent to which there can be an acceptable discussion about effectiveness.

## 1.4 Evaluation Team

The evaluation team included:

Dr Alison Heywood	Team Leader and Health Systems Strengthening Specialist
Dr Robyn Biti	HIV Adviser, AusAID Canberra
Ms Lydia Butut-Dori	Senior Program Officer, AusAID Port Moresby

Dr Heywood is an independent consultant with a long history in the health sector in PNG, including in design and evaluation of HIV/AIDS projects. Dr Heywood has in-depth knowledge of the health service delivery environment in

the country. Dr Biti is currently HIV Advisor in AusAID, Canberra, and was First Secretary Health for two years in AusAID Port Moresby (2005-2007). Ms Butut-Dori is the Activity Manager of CHAI for AusAID in Port Moresby. The skills sets of each of these people were complementary.

## 2. The CHAI Project

The project was first articulated in the Clinton Foundation HIV/AIDS Initiative Workplan of 2006, in which nine *Areas of Collaboration* were articulated. At the time of the evaluation, there are six major *Program Areas*, underpinned by a Management Program. The components of the two program outlines (2007, 2009) are presented below:

2007 – Areas of Collaboration	2009 – Program Areas
<ol style="list-style-type: none"> <li>1. Laboratory infrastructure,</li> <li>2. Procurement and supply management</li> <li>3. Paediatric care and support</li> <li>4. The rural initiative</li> <li>5. Monitoring and evaluation system</li> <li>6. Training</li> <li>7. Clinical support</li> <li>8. Hospital administration initiative</li> <li>9. Program management and coordination</li> </ol>	<ol style="list-style-type: none"> <li>1. Laboratory</li> <li>2. Paediatric Care and Treatment</li> <li>3. Rural Initiative</li> <li>4. Supply Chain Management</li> <li>5. Clinical Mentoring</li> <li>6. Patient Information Systems</li> <li>7. Program Management</li> </ol>

At the time of the evaluation there was no documentation of the reasons for this transition from nine Areas of Collaboration to six Program Areas. Explanations were provided by the CHAI Program Director during the evaluation: "Training" was folded into program areas and not undertaken as a national program; "Clinical Support" became "Clinical Mentoring", and was undertaken at key project sites; and the "Hospital administration initiative" was never initiated.

The ET uses the term **Program Areas** in its report. Each Program Area has a number of Sub-Programs:

Program Area	Sub-programs
1. Laboratory	<ol style="list-style-type: none"> <li>1.1 Early Infant Diagnosis (EID)</li> <li>1.2 Rapid Test algorithm development</li> <li>1.3 CD4 Testing</li> <li>1.4 Infrastructure, HR, mentoring and research</li> </ol>
2. Paediatric Care and Treatment	<ol style="list-style-type: none"> <li>2.1 Provider Initiated Counselling and Testing (PICT)</li> <li>2.2 Early Infant Initiation</li> <li>2.3 Retention and Case Management (Well Baby Centre at PMGH)</li> </ol>
3. Rural Initiative (RI)	<ol style="list-style-type: none"> <li>3.1 Adult Care and Treatment</li> <li>3.2 Paediatric Care and Treatment</li> <li>3.3 Prevention of Parent to Child Transmission</li> </ol>
4. Supply Chain Management	<ol style="list-style-type: none"> <li>4.1 Support to NDoH Logistics Unit</li> </ol>
5. Clinical Mentoring	<ol style="list-style-type: none"> <li>5.1 Support to ART Sites</li> </ol>
6. Patient Information Systems	<ol style="list-style-type: none"> <li>6.1 National HIV Database Development</li> </ol>
7. Program Management	<ol style="list-style-type: none"> <li>7.1 Support and Coordination of All Major Program Areas.</li> <li>7.2 Budget Oversight</li> <li>7.3 Safety and Security</li> <li>7.4 Strategic Planning</li> <li>7.5 Reporting</li> </ol>

### 3. Evaluation findings against AusAID's eight evaluation criteria

This section of the report assesses CHAI against the following eight evaluation criteria: relevance, effectiveness, efficiency, impact, sustainability, monitoring and evaluation, gender equality and analysis and learning, and rates them using a rating scale developed by AusAID.

#### 3.1 Relevance

*Key questions:* Were the objectives relevant to Australian Government and partner government priorities? Were the objectives relevant to the context/needs of beneficiaries? If not, what changes should have been made to the activity or its objectives to ensure continued relevance?

##### 3.1.1 Consistency with Australian Aid Strategy

The CHAI is consistent with priorities of the Australian government development program, in which PNG is a priority, and a particular priority for the HIV program. One of four pillars of Australia's Development Partnership with Papua New Guinea 2006-2010 is a strengthened, coordinated, and effective response to the HIV/AIDS epidemic. The approach taken by the CHAI to work within existing systems and to strengthen them in a way that is responsive to country-led priorities and decisions is highly consistent with the Paris Declaration on Aid Effectiveness and Accra Agenda for Action.

It is also largely consistent with Australia's international development strategy for HIV, and in particular with two of the six priorities: *to strengthen capacity to scale up by supporting countries to strengthen systems to overcome barriers to universal access to treatment* and *to optimise the role of health services within HIV responses* including through supporting PNG to improve HIV treatment and care.

The strategy places HIV prevention as the cornerstone of Australia's program. However, it is noted that prevention is almost totally absent in this initiative. The initiative does not use opportunities to strengthen broader preventive health services. It is generally very focused on HIV, and even while the RI (a major intervention in the project) is focused on testing it could be more linked into STI and preventive services (e.g. including through mobile, outreach activities).

**Recommendation 1:** *In Phase 2 of the project HIV prevention is mainstreamed into all service components.*

##### 3.1.2 Consistency with PNG's priorities and strategies

The National AIDS Council (NAC) and its Secretariat are mandated by the PNG Government to coordinate and facilitate the delivery of the national response. The range of implementing partners are guided by the *National Strategic Plan (NSP) 2006-2010* and its seven focus areas, which ideally provide the basis for all programming decisions in PNG. This initiative supports implementation of the strategy and in particular support to Focus Area 1 *to improve HIV treatment, counselling, care and support*.

This initiative also supports the *PNG National HIV, AIDS and STI Surveillance Plan 2007-2010* which guides implementation of all serological and behavioural surveillance activities related to HIV infection.

The *NDOH Corporate Plan 2009-2013* integrates the various responsibilities of the NDoH into one plan through three themes: healthier communities, improved support for service delivery, better management – all of which are consistent with the CHAI approach.

##### 3.1.3 Overall relevance of project design

At the time of the evaluation, CHAI has six major technical program areas: Laboratory, Paediatric Care and Treatment, Rural Initiative, Supply Chain Management, Clinical Mentoring, and Patient Information Systems.

There was no project design at the commencement of the project. The usual steps that lead to the development of a project design were not undertaken, largely as a result of the way in which the decision to fund CHAI was made (see Section 1.1.2 above). The project commenced with a workplan that articulated nine Areas of (potential) Collaboration (AoC). These AoC were based on Clinton Foundation experience in Cambodia and Vietnam, and two assessments of the status of HIV/AIDS care and treatment in PNG undertaken in February and April 2006, respectively. The results of these assessments are not included in the workplan, nor could reports of the assessments be provided to the ET by the current CHAI management. One assumes that these would provide justification for the proposed project workplan. Strictly speaking it is difficult to say that an appropriate response was evident in a proposed project design, as the evidence for it is missing. In addition, the elements of the project have changed over time and while

there is no documentation to explain the changes, the ET was informed by the CHAI management why these changes were effected (see Section 2 above).

The evidence base for the project has not been presented in a systematic way, nor were key issues or gaps clearly articulated. The 2006 Funding Milestone Report presents some discussion on needs but does not do this systematically for each of the Program Areas. The second Milestone Report for 2006 describes further investigations that have informed project activities. The weakness is in the absence of a systematic approach to developing an evidence-based rationale for the project. Problems were not identified that would naturally lead to a presentation of project responses. The consequences of this have been the absence of a *justified* logical project, presentation of indicators to measure effectiveness, and the development of an M&E framework to assist both implementer and donor to monitor achievements.

However, overall it is the view of the ET that the program design presents a relevant response to addressing commonly known problems in the HIV/AIDS care and treatment program of PNG.

### 3.1.4 Clarity of objectives, indicators and targets

The project is briefly outlined in Section 2 above. The only defining project document is the Clinton Foundation HIV/AIDS Initiative Workplan for 2006-2009. In this document there is no statement of project goal or purpose, thus no indicators at that level, no clear Program Area objectives (with indicators) and no targets. If this is indeed the equivalent of a design document there are serious weaknesses in the overall logic, statement of objectives to be achieved and indicators that will measure their achievement. The absence of a logical framework (or equivalent), particularly with respect to the distinction between outputs and outcomes, and articulation of indicators and means of verification, may have almost certainly contributed to identified weaknesses with ongoing project monitoring and evaluation, discussed further in Section 3.7.

One finds that project terminology changes throughout quarterly reporting and AAPs, which only further contributes to confusion. The ET has, with assistance from the CHAI management, put together what is probably now the accepted Program Area objectives (see Annex 6). They still lack indicators and targets.

**Recommendation 2:** *A new phase of CHAI is guided by a design that includes a logical framework, uses recognized project terminology and clearly identifies the project purpose, component/program areas and their objectives, and activities that will contribute to achievement of each of the component objectives. The design should be preceded by a concise needs assessment that clearly justifies the project content.*

### 3.1.5 Appropriateness of management and institutional arrangements

A Funding Agreement was signed in July 2006 between the government of Australia and CHAI. This outlined the terms and conditions of the arrangement between AusAID and CHAI for the implementation of CHAI in PNG. This agreement states that *"the parties agree to monitor the Program against the Program Milestones and evaluate it against the Program Outcomes."* The defining document against which this occurs is the Program Workplan 2006-2009. As noted above there is no stated objective/outcome in this document (or any documents subsequent to this) for the whole project (and associated indicators). Outcomes or objectives for each of the AoC are not articulated (thus no indicators provided). It is therefore impossible for this part of the agreement to be adhered to. The elements of the project have also changed over time, and these changes have not been documented systematically. Had there been a monitoring matrix developed at the start of the project these problems could have been avoided. With such a document in place it would have been very easy to document changes so that donor and partners (and evaluators) were abreast of any changes to the project profile.

The Funding Agreement is further compromised by the description of the reporting requirements (Attachment B) which at no time specifies that the project must report *systematically against all activities* that are part of each of the AoC (or subsequent Program Areas), or on any indicators of outcomes (even though it states it must report on progress of the Program against the Annual Plan).

**Recommendation 3:** *To support implementation of a new phase AusAID articulates a new agreement that is more specific about reporting against all elements of the logical framework.*

Agreements have been developed between CHAI and Goroka Hospital, Mendi Hospital, JTAI (for NDoH Supported Positions), and Catholic Health Services in Tari, Southern Highlands Province (SHP) to clearly articulate respective responsibilities.

At the national (Port Moresby) level there is no joint coordination or management mechanism for the project; institutional management is achieved successfully on an informal basis, driven by the Country Director. At the

provincial level in the EHP the RI has its own management structure with a four-person Steering Committee (SC) that meets regularly. Meetings are minuted. This committee acts as a sub committee of the PAC. Feedback to the ET from EHP indicated that this worked extremely well, and contributed to a strong collegial arrangement.

Feedback to the ET suggested that both the formal and informal arrangements were effective, and partners generally seemed comfortable with the communications channels. It was evident though that there was potential for collaboration to not be fully realised in some areas, the most notable being between the CHAI and FHI and the proposed initiatives for home based care and urban clinic models, as well as AusAID's PASHIP. All groups appear to have a commitment to this in the EHP, but there is a real risk that there may be duplication of activities and confusion (for both beneficiaries and implementers) if different models are implemented, possibly in the same locations. Senior EHP health personnel must ensure this does not happen and intervene if necessary.

**Recommendation 4:** *Areas of potential conflict are articulated in a risk management plan and GoPNG ensures that all parties working in similar areas are collaborating and coordinating their activities.*

The ET was struck by the high level of ownership of the initiative by PNG. This occurs without exception at the (EHP) provincial level. At the national level, the exception to this was at the CPHL where an absence of permanent leadership was seriously impeding progress with local ownership.

**Recommendation 5:** *As a matter of urgency NDoH precipitate the appointment of a permanent head to CPHL.*

## 3.2 Effectiveness

The evaluation is using the latest structure of the program and reporting on effectiveness of each of the Program Areas, including Program Management

Key questions: Were the objectives achieved? To what extent has the activity contributed to achievement of objectives?

*"Effectiveness is a measure of the extent to which an aid activity attains its objectives".<sup>4</sup>* As already stated the overarching goal/purpose/objective of the CHAI was never clearly articulated, and thus no indicators to measure its achievement have been presented in any project documentation. The ET consulted with the CHAI team to arrive at possible indicators that might be used in the remaining six months of the program to indicate effectiveness of the whole program.

In the absence of a clear statement of objectives at the overall project level, and objective statements without indicators at the Program Area level it is not possible to say with any degree of confidence whether CHAI has been effective. The only reports on progress are the Quarterly Reports (QRs) (and minimal reporting in the AAPs) and these are limited to describing activities and outputs for each Program Area, and are not linked to indicators for the Program Area.

Reporting on this is compromised by the lack of clear and consistent program logic that has indicators attached to every level of the program. The overall objectives (not originally articulated) that are now stated for each Program Area have been arrived at after discussion between the ET and the CHAI Country Director.

Six key programmatic areas are identified, and achievements against each of these are presented.

### 3.2.1 Laboratory infrastructure

**Overall Objective:** To support the government in the design and implementation of a rationalized laboratory system for HIV care and treatment.

#### Major achievements to date

The CHAI has led the establishment of an **Early Infant Diagnosis (EID)** system for HIV using DNA Polymerase Chain Reaction (DNA PCR), allowing diagnosis of infants aged 2-18 months to facilitate early initiation of ART which is expected to lead to significantly better clinical outcomes. This was possible through leadership and oversight of the

<sup>4</sup> OECD (2000). *Glossary of Evaluation and Results Based Management (RBM) Terms*

CHAI team, particularly the Laboratory Adviser, and included: renovations in CPHL and equipping it to house a high quality HIV PCR testing laboratory; laboratory staff training; developing Standard Operating Procedures (SOP), forms and training manuals; developing the testing algorithm; and working within the CPHL to support staff and management. Six clinical sites have been trained in dried blood spot (DBS) specimen collection from infants that are sent to CPHL for testing. Plans are also underway to fully refurbish and equip a HIV PCR testing laboratory at GPH to help meet the expected high demand for EID services. CPHL currently tests around 8-10 infants each week (362 infants tested to date). All positive infants are now receiving ART.

CHAI has been actively involved in all three phases of the validation study to change the dominant HIV testing strategy in PNG to a **2-Rapid HIV Test Algorithm** that provides same-day confirmatory testing at the point of testing. Eight sites currently provide this service and are participating in the External Quality Assurance Scheme (EQAS) program (through Australia) for quality assurance (QA) of rapid testing. The CHAI is currently helping establish a national EQAS within the CPHL. The Table below summarises results of 2007-2008 in QASI EQAS for CD4 testing.\*

No	Rounds (Survey) Months Panel	1		2		3		4	
		Feb 07		Jun 07		Oct 07		Feb 08	
		1	2	1	2	1	2	1	2
1	CPHL	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
2	Nonga Hospital	Pass	Pass	Pass	Pass	Pass	Pass	NM	NM
3	Mt Hagen Hospital	Pass	Pass	Pass	Pass	NM	NM	NM	NM
4	Angau Hospital	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
5	St Joseph Hospital	NP	NP	Pass	Fail	Fail	Fail	NP	NP
6	Goroka Hospital	NM	NM	NM	NM	Pass	Pass	NM	NM
7	Modilon Hospital	NM	NM	NM	NM	Pass	Pass	Pass	Pass
8	St Mary's Med Centre	NM	NM	NM	NM	NM	NM	NM	NM

\* NP=non participatory. NM=No functional CD4 machine.

CHAI is working with NDoH, WHO and ADB to help improve the capacity of provincial hospitals and CPHL to provide **CD4 cell count testing** to assist in the treatment and care of people living with HIV. CD4 operators have been retrained and a new CD4 machine has been purchased by CHAI for Mendi to complement the six government-funded machines (CPHL and provincial hospitals) and six ABD-funded machines soon to be in place in Rural Enclaves locations. An external Canadian program of quality assurance for CD4 called QASI has been established, demonstrating consistently excellent results in the PNG laboratories. CHAI has arranged repairs to CD4 machines from an Australian technician and has recently identified two local candidates (Goroka, Port Moresby) to be trained in Australia to provide regular maintenance to machines.

CHAI has made an assessment of laboratory/hospital capability now and planned for the future, with CHAI support. This is found at Annex 7.

## Discussion

In the absence of ART infants with HIV in PNG have a very short life expectancy (<1 year). Early diagnosis and treatment is therefore critical. HIV positive infants were only able to be diagnosed at 18 months with the previous test. The new PCR testing capability is therefore an important step in clinical management of infants.

Numerous centres are prepared to commence DBS collection, but unexplained delays in NDoH approving the training curriculum is severely hampering efforts to rollout this service to other sites.

CD4 cell counts are an important tool in managing ART. Maintenance of CD4 machines is the major obstacle, with machines regularly breaking down due to poor routine maintenance and power surges. Immediately prior to the ET mission, just three of the seven government-owned machines were in working order. CHAI has been instrumental in arranging their repair and is actively working to put in place a mechanism for their ongoing maintenance and repair.

PCR requires intensive laboratory staff training and QA, supported through strong supervision, as well as specialised laboratory facilities which CHAI is supporting well. CHAI support at CPHL is therefore likely to be required for the foreseeable future. In addition CHAI is in the process of establishing similar facilities at GPH to ensure the demand for services is able to be met as more sites are able to provide DBS specimens.

**Recommendation 6:** *Phase 2 of CHAI continues to support strengthening of laboratory services.*

Results from low HIV prevalence sites such as ANC (antenatal care) are proving to be less reliable than others (a documented phenomenon elsewhere) and CHAI therefore reports that it is unlikely that the 2-rapid test algorithm will be able to replace confirmatory testing by CPHL at all sites.

Efforts to strengthen laboratory capacity (and therefore to support quality diagnosis, treatment and care of both adults and children) in PNG largely hinge on the ability of CPHL to take on increasing responsibility. Management capacity and lack of leadership within the CPHL is a significant obstacle. Unless the vacant position of CPHL Director is suitably filled by Port Moresby General Hospital in the immediate future, the CPHL will be unable to make the sustainable improvements in capacity that is required (see Recommendation 5).

### 3.2.2 Paediatric Care and Support

*Objective:* Expand quality HIV care, treatment and support including antiretroviral therapy to children in new and existing paediatric treatment sites

#### Major achievements to date

In January 2007, 27 children nationally were on ART at one site. Loss-to-follow-up rates of 8% at ANC, 38% at Labour and Postnatal wards, and 40% at the Paediatric clinic result in only about 14% of children being effectively managed. There was no national training of paediatric ARV prescribers, no national paediatric training curriculum, and no dedicated national coordinating entity for paediatric HIV in NDoH.

Key achievements are now noted:

- By January 2009 179 children were on ARV treatment at six government sites and two Catholic Health Service sites
- CHAI successfully catalysed the adoption of new National Guidelines for Early Infant Treatment
- Five trainings have been conducted of Medical Officers, Nurses, and HEOs from both government and faith-based organizations in the prescription and/or monitoring of paediatric ARVs
- Paediatric HIV ARV commodities are being provided through UNITAID (through to 2010)
- The Early Infant Diagnosis System has been established
- Well Baby Centre PMGH established with significant CHAI support (staff, medicines, equipment) has been an outstanding success: the centre integrates Maternal and Well Baby services including Pediatric HIV services; case management teams are fully staffed; new database system adopted; support and partnership from key clinicians and division heads is evident; Friends Foundation and Susu Mamas involvement; monthly meetings of the teams; monthly meetings with teams and related services; and support from the case management program in EHP.

#### Discussion

The outstanding leadership shown by the Medical Director of the Paediatric Division within PMGH has been paramount to the achievements in the Paediatric Treatment and Care program.

However, a significant issue for this program is the lack of national level leadership (NDoH) for paediatric HIV to address training, mentoring, and paediatric treatment and commodities. NDoH are currently trying to identify where in the department the focal point should be and the responsibility for coordination and leadership for this program should reside.

Loss-to-follow-up rates are 40% or higher in many programs, indicating that case management needs continued effort.

Sustained clinical mentoring for paediatricians is critical. Paediatric HIV treatment is challenging and many clinicians are reluctant to initiate given previous negative experiences. The project has found it difficult to attract and retain paediatric mentors, essential to building up confidence of clinicians. It is now looking at alternative approaches that may overcome this difficulty.

Paediatricians form a critical link to the scale-up of PPTCT services, forging crucial systemic links to both PPTCT and adult HIV care and treatment programs. In addition case management provides the conduit to link PPTCT and paediatrics. These areas require further strengthening.

While there are differing views on PICT, it is the NDoH policy, and the global evidence is that it is working to increase access to testing and treatment numbers. Uptake is still weak in paediatric wards and outpatients, and requires

continued support. There needs to be further examination of the development of a national curriculum for paediatric HIV.

### 3.2.3 The Rural Initiative

**Overall Objective:** To design and implement a replicable model for HIV & AIDS testing, care and treatment for the rural majority in Eastern Highlands Province (EHP) and Southern Highlands Province (SHP).

#### Major achievements to date

The 24-month Rural Initiative pilot commenced in EHP in August 2007 and is gradually and systematically being rolled out, so far reaching the provincial and district level only. There has been substantial progress in increasing quality HIV testing, care and treatment services at GPH. Capacity to provide full adult services (adult testing, care and treatment services) at the district level is now operating at five district level (government) health facilities (Michael Alpers Clinic GPH, Kainantu District Hospital, Henganofi Health Centre, Nupuru Health Sub-Centre, and Asaro Health Centre) and the first phase of PPTCT (the basic antenatal testing package and full referral up to the continuum of care for positive mothers) is in all eight districts. Some PPTCT sites and VCT/PICT within the four pillars sites are operated by faith-based organisations (e.g. Openga Aid Post in Daulo District, Kassam Health Centre in Obura-Wonenara District, Tafeto Health Sub-Centre in Daulo District).

June 2009 will see the completion of the of adult testing care and treatment for Phase I with one adult ART clinic per District (Lufa will have two): Lufa District - Lufa Health Centre, Unggai-Bena District - Sighere Health Centre, Okapa District: Okapa District Hospital, and Obura-Wonenara District - Marawaka Health Centre. All are government run centres.

The RI commenced expansion to Southern Highlands Province (SHP) at the request of the provincial government in October 2008. The ET was unable to assess this aspect of the initiative due to time constraints.

Data on five key indicators against which the design identifies impact will be measured are presented below:

Key Indicators		Jan 07	Apr 09
1	Percentage of people with advanced HIV infection on ART	46%	58%
2	Percentage of people still on ART 12 months after initiation	73%	86%
3	Percentage of adults presenting with weight loss who gain at least 10% body weight at six months after ART initiation	75%	87%
4	Percentage of people who initiate ART alive at 6,12, 24 months after initiation	NA	93%*
5	Percentage of women offered who receive ART for PPTCT	26%	88%**

\* This data set remains incomplete since 24 months has not been completed

\*\* Would be 98% but for PICT in the labour ward (e.g. late entry into care)

During the pilot period other significant achievements have included:

- Increase in uptake of HIV testing through VCT and PICT from 7,358 in 2007 to 13,662 in 2008.
- Uptake of STI testing through PICT in STI patients increased from 10% January 2007 to 90% April 2009.
- PICT in TB out-patients increased from none to 90% of clients over the same period.
- Loss-to-follow-up of clients initiating treatment decreased from 65% January 2007 to 15% April 2009.
- PPTCT is delivered at 14 district-level sites in EHP by April 2009, with 88% uptake of treatment.
- 98% PPTCT received HIV appropriate supervised deliveries

The four clinics visited by the ET (Michael Alpers Clinic, Kainantu District Hospital, Henganofi Health Centre, Asaro Health Centre) are at various stages of capacity to independently deliver services. Many staff have been funded by CHAI to attend the national Integrated Management of Adult and Adolescent Illness (IMAI) prescriber training. Effective roll-out is made possible by the capacity of clinical and laboratory staff at GPH, including a HIV specialist mentor to provide ongoing on-site support to staff, with gradual withdrawal as the confidence and skill level of staff allows. Local staff funded by CHAI are contracted directly by GPH.

Renovations and infrastructure improvements (water, toilets, medical waste incinerators) are also a key part of building capacity of facilities, and impact positively on staff morale.

Laboratory services are being strengthened through staff training, laboratory upgrades, and supply of essential laboratory equipment and some consumable reagents, and introduction of the 2-rapid test algorithm which is allowing same-day confirmatory testing at the site of service (although some sites still require confirmatory testing at GPH). The most significant improvements are at GPH where the speed from automated testing results not only aids better patient management but is increasing staff morale. However, laboratory services remain patchy at the district level with most having limited capacity.

The pilot has developed a sound and standardised paper-based reporting system that ensures transfer of information between the facility and GPH and vice versa, and is facilitating more effective patient management. The new patient information database is expected to be rolled out to EHP in the coming months at the provincial level.

A more recent element of the RI has been the introduction of the Micro Credit Livelihood Enhancement program. So far 29 loans have been provided, of which five have defaulted. The remainder are all in the repayment stage thus it is too early to know how sustained this intervention has been. The main difficulty encountered has been landowner dispute/ownership of kakruk. There have been few instances of theft (borrower robbed of money to repay).

More detail on RI achievements is found in Annex 8.

## **Discussion**

Full implementation of the model in EHP is a considerable way from completion and it is therefore premature to meaningfully assess its full effectiveness. However, results are very promising so far, suggesting improved access to quality HIV health services at the community level, a good chance of sustainability, and potential for expansion into other provinces. It is therefore recommended that the Rural Initiative be continued to enable it to be fully implemented.

There is strong support for continuing the roll-out of the Rural Initiative across the EHP as well as into other high prevalence provinces from the national and provincial levels of government and service providers. Significant funding support for expansion into several other provinces is being sought through Global Fund Round 9. The role the Government of PNG is seeking from CHAI in this is not yet clear. However, it is clear that a significant factor in the success of the pilot to date has been as a result of the step-wise, flexible, facility-specific tailored approach of the CHAI. Proceeding too rapidly with expansion risks jeopardising success of the initiative. This needs to be balanced with the urgent need to increase HIV services in rural areas.

In the meantime, a detailed assessment and cost-analysis needs to be undertaken in around six months on those components already in place to inform expansion of the model. Ideally, this would be undertaken once the full model has been rolled out. However, noting the urgency of scale-up, the potential for additional Global Fund resources by the end of 2010, and the significant time taken to fully rollout the model in each province, this should be done quickly on at least the initial steps to facilitate commencement in other priority provinces. There are three features of the Rural Initiative that are as yet at too early a stage for the ET to comment on, but which warrant close scrutiny at the earliest opportunity: wasman/wasmeri, livelihoods initiative and protein supplementation.

**Recommendation 7:** *Undertake a detailed assessment and cost-analysis within six months on those components of the RI already in place to inform expansion of the model.*

A significant factor in the selection of EHP to trial the Rural Initiative model was the strong commitment of the provincial government and hospital administration to reform the health sector, placing improved access to quality health services at the community level as a central plank of that reform. The uniform articulation of vision for reform by the Governor, Provincial Health Office and hospital CEO, matched with a solid understanding of where the assistance from CHAI fitted into that vision are significant elements for success. There exists a risk in expansion to other provinces that the context may not always be as favourable as in EHP.

**Recommendation 8:** *Establish criteria for participation of further provinces in implementation of the RI.*

HIV prevention is under-served within the model, beyond condom provision at treatment monitoring appointments, and positive counselling. Prevention should be strengthened within the model, particularly to integrate condom distribution into all aspects of health service delivery, including mobile clinics to improve the availability of condoms at the community level.

While HIV services being supported and strengthened by CHAI were being integrated into health facilities, and synergies were being explored with TB and antenatal clinic services, significant effectiveness and efficiency gains could be made through a greater focus in this area. Efforts need to be made to maximise integration of HIV into other services such as STIs, TB and maternal and child health. In particular, there appeared to be a disturbing

dissonance in resourcing and prioritising between CHAI approaches and PASHIP (implemented by Save the Children PNG) at one district centre visited. AusAID, CHAI, Save the Children (and other relevant PASHIP implementing organisations) and GoPNG should ensure that cooperation and synergies between the two projects are maximised.

**Recommendation 9:** *Efforts need to be made to maximise integration of HIV, including prevention, into other services such as STIs, TB and maternal and child health.*

**Recommendation 10:** *AusAID, CHAI, Save the Children (and other relevant PASHIP implementing organisations), FHI and GoPNG need to ensure that cooperation and synergies between projects are maximised. GoPNG must lead this effort.*

Paediatric HIV services remain limited to the GPH with district-level staff reporting a lack of confidence to manage infants and children on ART. Despite significant efforts CHAI has been unable to recruit a suitable paediatric HIV specialist mentor to be located at GPH. The lack of a mentor is significantly hampering efforts to provide paediatric treatment and care beyond the provincial level. The feasibility of expanding paediatric HIV services beyond the provincial hospital level needs to be explored.

**Recommendation 11:** *Leading into Phase 2 explore the feasibility of and alternative options for expanding paediatric HIV services beyond the provincial hospitals.*

Further expansion of the initiative required IMAI trained health care providers and thus relies heavily upon the IMAI training requirements being fulfilled by the national IMAI training schedule. This has proved to be a substantial obstacle, with the need for trained staff outstripping capacity to train.

**Recommendation 12:** *At the national level institute strategies to improve training capacity to meet demand for staff training.*

### 3.2.4 Procurement and Supply Management

**Overall Objective:** To continue to serve the commodity and equipment needs of the national HIV program, particularly in regards to paediatric care and treatment, and to encourage superior management of the distribution system in-country through ongoing support to the HIV Logistics Unit

#### Major achievements to date

A significant contribution of the CHAI to HIV treatment and care in PNG is the agreement with UNITAID, which until the end of 2010, will provide PNG with free HIV test kits, free paediatric ARVs, free reagents and cheaper adult ARVs (which are purchased from Global Fund grants). Prior to this, no paediatric ARVs were available in PNG and carers therefore had responsibility for breaking up adult formulations to the required dose. Funding for items currently free through this mechanism has been included in the Global Fund Round 9 application.

CHAI has significantly helped strengthen the management capacity of the procurement and supply chain for HIV ARVs and kits, including through funding a logistics manager position. They have improved needs forecasting including through developing and supporting a monthly inventory report, and supporting the logistics staff in a change of approach to realise the importance of smooth operation of this system. A key aspect of CHAI's support has also been to gap-fill as issues arise that would otherwise impede smooth operation of the chain, such as occasional use of a CHAI car and driver to transport supplies within Port Moresby (note that a dedicated vehicle will shortly be procured with the existing Global Fund grant). This is particularly necessary to overcome slow funds disbursement from the Global Fund and the Health Sector Improvement Program (HSIP) trust account.

The CHAI is currently helping to develop a new database to assist inventory management and to develop SOPs to standardise procedures.

#### Discussion

Management by NDoH of a reliable and continuous medical supply procurement and distribution has been a long-term problem, but is absolutely essential for the successful clinical management of HIV, and the provision of health services in general. As a consequence, there now exist separate national systems for tuberculosis, malaria and HIV. All PNG HIV ARVs, kits and drugs for the treatment of opportunistic infections are distributed through a single system (albeit separate from other medical supplies). The importance of good management of this process has become even more critical as the volume of supplies through the HIV procurement and supply chain have increased

four-fold over the past two years, and is expected to increase further as HIV testing, treatment and care services are expanded across PNG.

There have been no stock-outs at the facility level (although there was one at the Area Medical Store (AMS) for approximately two weeks) since CHAI has been assisting to strengthen procurement and supply chain management, although Global Fund procurement processes have repeatedly delayed procurement of adult ARVs and other supplies.

Despite significant strengthening of systems to facilitate reliable and systematic management of HIV pharmaceuticals and medical supplies, resulting in minimal issues with stock-outs, sustainability remains fragile due to the lack of timely release of funds through government systems to ensure smooth operation of the procurement and distribution system. Likewise, procurement and distribution of other medical supplies remains perilously unreliable.

### 3.2.5 Clinical Mentoring

**Overall Objective:** To ensure a high level of quality of care at key ART treatment facilities and to build capacity of local clinicians to manage HIV testing, care and treatment.

#### Major achievements to date

Prior to CHAI, WHO had provided short-term clinical mentorship at major treatment sites in concert with the IMAI training practicum. There was no sustained program at the district level. Despite consensus to the concept of a National Clinical Mentorship Program, it has not developed across major sites.

Major achievements by CHAI in this program area include:

- CHAI catalysed the creation of PNG's *Minimum Standards for HIV/Care and Treatment* (2007);
- CHAI has successfully hired one clinical mentor to work in the adult HIV – split between Goroka, SHP and Port Moresby and scheduled to work in two other provinces in the next two months (Western Highlands, Central);
- Clinical mentors have spent at least four weeks per site, helping out at provincial hospital and district level facilities with a particular emphasis on the implementation of PICT and improving the quality of HIV care.

#### Discussion

The mentorship program has been problematic, with difficulty retaining mentors e.g. in paediatrics. The CHAI is exploring alternative approaches to keeping this program in place.

Where it is working, the clinical mentors stay a minimum of four weeks per site, with programs well planned to ensure optimal use of the mentor and adequate preparation of the staff. Follow up is essential and is occurring. Overall satisfaction by staff was very high and was translating into self reported improved quality of care.

### 3.2.6 Patient Information Systems

**Overall Objective:** To guide the development of a robust patient information management system which serves the needs of patients, health workers and the national HIV program.

#### Major achievements to date

At the commencement of CHAI there were no standardized clinical forms for HIV patient care, and the patient database application in use (Epi Info) suffered from many shortcomings, including lack of user friendliness, and being a difficult system from which to extract reports. Achievements have included:

- (i) In consultation with key stakeholders, partners and users of the forms, CHAI was pivotal in developing standardized clinical forms for HIV patient care.
- (ii) CHAI sourced and piloted a new patient database application using Microsoft Word which was adopted for national implementation at the end of 2008.

#### Discussion

The CHAI Global Unit identified and assessed an application in use in Tanzania, and took that model and customised it for PNG, working with expertise at University of PNG's Math, Statistics and Computer Science Department, to develop a data base in Microsoft Word. CHAI undertook a needs assessment with those who had worked with the original Epi Info data base, developed the new system, trained users and piloted it, over a six-month period. They

then did a review in August 2008. Using the results of that review, NDoH including PMGH are driving the rollout of the system.

The old system was not able to be used by the providers at all; its sole function was to send data back to NDoH. The new system on the other hand is clearly superior as it allows clinicians to extract patient information and helps to manage patients. It appears to be a user friendly system. Data entry staff demonstrated to the ET their ability to use it and the types of reports it could produce, which appeared to be useful reports for managers.

The ET noted that the new database field capturing risk groups did not include a choice of category to capture those who are engaged in transactional sex/sex work (although it does include such categories as anal sex, heterosexual sex, homosexual, etc). Any revision will need to ensure a full range of responses is included in appropriate fields.

During the rollout of the system five NDoH and CHAI staff are involved in training new users. They spend a week on site providing tailored training to data entry staff one-on-one and observing them using the data base. A program for the training has been developed that identifies elements within the training. The training program is very applied and occurs at the computer (as opposed to didactic teaching) and responds to individual needs.

Some staff indicated they would like other staff to be trained so there is backup if someone is away, rather than having the skills reside in one or two people. Clinical staff were interested in having computers in each consultation room (linked to the main computers) so that the clinician could enter patient information during the consultation. One issue that was noted was the risk of virus infecting computers and the need to put in place a virus protection strategy.

**Recommendation 13:** *Review all fields in the patient information database and ensure that a full range of response categories are included.*

**Recommendation 14:** *Patient information database: develop a system for monitoring/controlling for virus threats to the system.*

### 3.2.7 Program Management and Coordination

**Overall Objective:** To support and coordinate major program areas while providing strategic direction for the Foundation's activities in-country.

#### Overall management by CHAI

At the national (Port Moresby) level there is no joint **coordination or management mechanism** for the project; it is achieved successfully on an informal basis, driven by the CHAI Country Director. At the Provincial level in the EHB the RI has its own management structure with a four-person SC that meets regularly. This committee acts as a sub-committee of the Provincial Aids Council (PAC).

**Agreements** have been developed between CHAI and Goroka Hospital, Mendi Hospital, JTAI (for NDoH supported positions), and Catholic Health Services in Tari, SHP to clearly articulate responsibilities.

The current in-country CHAI team is clearly highly motivated and responsive to the PNG environment, and strong leadership is demonstrated in the Country Director. This has very clearly enabled the good outcomes that are seen in the project to date. The team was rated very positively by everyone consulted by the ET, without exception. Their **communications** with key partners and stakeholders has clearly been welcomed. This is in contrast to the first management team which was reported to be quite problematic.

However, **human resource** issues have challenged the project from the start. There was unusually high staff turnover in the program during the initial two years 2006-2008, including some key positions. Between 2006 and the end of 2007, five of seven original staff transitioned out of the program (see Annex 9). Since the beginning of 2008, there has been program stability though a recent departure of the second Clinical Director has prompted CHAI (at the direction of Principal Technical Adviser, HIV/AIDS/STI, Communicable Diseases Branch and the Health Secretary) to recruit for this position from within PNG going forward. Recruitment of some members of the in-country team appears to have not been thoroughly explored, resulting in appointment of people not suited to the PNG environment, project management roles, and not acceptable to the GoPNG.

**Recommendation 15:** *The CF improves its recruitment processes to ensure continuing placement of credible and appropriate personnel to key CHAI positions.*

There continue to be difficulties attracting and retaining appropriate candidates for the clinical mentor positions. This has led to significant delays in filling these critical positions (see Section 3.2.5 Clinical Mentoring discussion). In

response to these difficulties the CHAI team with its government of partners is exploring alternatives to recruitment of international people in these roles.

An additional weakness includes readily available and useful budget information broken down to a level of detail that shows exactly how funds are spent. Reporting on spending on commodities is needed. Detailed budgetary information will be required to inform the design for the next phase. Budgets were often not appended to the APs, and budgetary information provided to the ET in country, while showing percentage spent in broad categories/cost centres, did not give the detailed breakdown within those necessary to make judgements about reasonable allocation of funding across sub items.

**Recommendation 16:** *A detailed budget breakdown of spending is provided prior to the design of new phase.*

Project reporting is done primarily through quarterly reports, but reporting on achievements annually does not occur systematically or completely. The absence of an M&E framework and reporting matrix is a serious limitation that has not been resolved despite ongoing discussions with AusAID.

### **Joint coordination and management mechanisms**

At the **national level** there is no joint coordination or management mechanism for the project. Communications appears to occur on a semi-formal basis as the need arises and when QRs become available. Despite this, key NDoH stakeholders and partners seem comfortable with how this is working.

However, at the **provincial level** in the EHB the RI has its own management structure. The CHAI Program Officer manages the implementation of the program with provincial partners and collaborators. She has established a four-person SC composed of the CEO Goroka Hospital [Chair], Director Medical Services, Deputy Director District Health EHP Administration, CHAI Program Officer Rural Initiative. The SC meets monthly, and keeps minutes of these meetings. There is also a CHAI-EHPA MOU which outlines responsibilities of both parties

This committee acts as a sub-committee in the PAC, and is essentially the only sub-committee of the PAC.

### **Coordination with other activities**

CHAI is clearly attuned to national and provincial health initiatives, priorities and agendas, and engages successfully to keep informed of developments on these fronts. This engagement occurs both formally and informally.

There appears to be reasonable communication between CHAI and other health sector donors/partners. CHAI participates in HIV donor coordination meetings and Global Fund CCM meetings. However, there are two organisations where there is significant need for improved coordination and formal communication: Save the Children PNG (PASHIP) and FHI (home based care). Evidence of collaboration and coordination is lacking in both cases, and these groups appear to be working in isolation with little indication of being prepared to work together with CHAI (see Recommendation 10).

### **Partner government fulfilment of responsibilities**

Partner government responsibilities were never articulated in initial agreements for CHAI. GoPNG supports access to inexpensive drugs, but this was a responsibility identified in the agreement between the CF and PNG that preceded CHAI. NDoH sign off on CHAI AAPs. The GoPNG is also now supporting new staff to support implementation of CHAI interventions.

### **CHAI's response to a changing environment**

The CHAI has maintained a flexible, responsive, problem-solving approach which has lent itself well to responding to changes in the environment. The CHAI team has responded to a number of significant changes including the request by the SHP provincial government and NDoH to expand into the SHP which has involved a shift in resources to work in a difficult environment.

However, while the ET did not have the ability within the timeframe to look closely at this issue, it appeared that there was room from both sides for more coordination with the AusAID-funded PNG-Australia Sexual Health Improvement Program (PASHIP) being implemented at Kainantu by Save the Children PNG.

Likewise, FHI is implementing a continuum of care and treatment model in urban clinics in Port Moresby and earlier this year commenced a community based continuum of care and treatment program in rural EHP. The ET is concerned that there is a risk of developing multiple models of care at different facilities which could create confusion, overlap and conflicting efforts. The NDoH needs to facilitate coordination between implementing organisations when requesting and agreeing to new areas of work.

There has been no Director at the CPHL since February 2008, with the Acting Director not receiving payment since mid-2008 and on leave without pay since January 2009. The absence of a Director is having a significant impact on staff discipline, morale and work quality. If this remains unresolved it risks the ability to adequately manage the expected demands from EID. Therefore while CHAI will continue to provide constant support at CPHL to keep services there functioning, CHAI is responding by establishing an additional PCR laboratory at GPH.

In response to delays in the release of funds from the HSIP trust account for ongoing costs such as reagents, kits and transport, CHAI has stepped in to fill the gaps and ensure continuation of this program.

There are a number of potentially substantial changes in the operating environment over the next few years of which any new phase of this initiative will need to be cognisant. These include:

***(i) Health Sector Structure, Management and Planning***

- The health sector wide approach, lead by the NDoH, is scheduled to undergo a review and redesign over the coming year.
- NDoH Diseases Control Branch is discussing a new management and reporting structure that is hoped will integrate donor projects and staff more fully into the health system structure.
- Both a new HIV NSP and a new health sector NSP in planned for 2010 which could see a shift in priorities and approaches.
- The planned streamlining of provincial health services, starting with the signing of a partnership agreement between the Minister for Health and the Governor of EHP in June 2009 that will see the Provincial Health Office and GPH brought under one board.
- The Secretary of Health is considering a shift to a flatter provincial health facility structure of community health posts. This concept is yet to be fully defined.

***(ii) Funding Environment***

- The NDoH has recently undertaken a case study of district and facility service delivery funding flows through which it has been proposed that the national government gives direct grants to facilities.
- The Government of PNG has applied for a substantial Global Fund grant in Round 9 of approximately US\$100 million (up from the current grant of approximately US\$25 million). It includes funding to roll-out the Rural Initiative model to around seven provinces.
- Discussions are currently underway to consider the feasibility of introducing a HIV Function Grant.

***(iii) Leadership***

- NDoH is considering options within the Department's structure for placing responsibility for paediatric HIV and PPTCT, which has so far been largely lacking leadership at the national level.
- The National Aids Council Secretariat (NACS) is currently working with provinces to promote strengthening sub-national initiatives to increase provincial ownership of HIV responses, including shifting responsibility for PACS from NACS to Provincial Health Offices.

**Risk Management**

By AusAID: AusAID's standard approach with respect to security risks (for AusAID staff, CHAI staff visiting consultants) has been applied and managed well. Contractual risks are managed through regular milestone reporting articulated in the Funding Agreement, which includes reporting on use of funds.

By CHAI: The CF headquarters and the in-country management team appear to have managed security risks effectively, and have detailed security guidelines for the CHAI in PNG. Project implementation risks, including those related to changes in personnel occupying key positions, appear to have been eventually managed effectively particularly in latter years with the current strong leadership. Despite the weaknesses that have been identified in relation to the absence of a logical framework that would clearly articulate inputs, activities and outputs, the current Country Director is effectively monitoring delivery of inputs, and a sound financial system seems to protect potential for misuse of funds.

However, it should be noted that a risk management plan that included risks associated with project management and implementation was never developed. Indeed it is the view of the ET that this concept is not well understood by CF or CHAI.

**Recommendation 17:** *CHAI Phase 2 design includes the development of a comprehensive risk management plan.*

**Exit Strategy**

There is no formally documented exit strategy for this initiative. However, it is difficult to have a truly effective exit strategy for most of this initiative, and the Rural Initiative in particular, because the ET is of the opinion that it is too early to withdraw support. Funding for limited aspects of the work currently funded by CHAI is believed to be incorporated into Global Fund Round 9 application although there is no contingency plan if this grant application is unsuccessful. Funding for Round 9 is unlikely to be received until the end of 2010.

Evidence of moving toward an exit strategy is the development of a step-by-step manual for the Rural Initiative by end 2009, and is intended to guide roll-out to additional provinces, although this would remain difficult without the support that the CHAI currently provides. Whilst the manual is a very important development, it needs to be available using communication other than pictures and words, e.g. video.

**Recommendation 18:** *A video version of the step-by-step manual for the Rural Initiative is made in tok pisin.*

The strong focus on building capacity in local service providers/clinicians participating in this project is clearly directed at achieving self sufficiency so that eventually many, preferably most elements of the project can be delivered within the GoPNG system. Further evidence of working toward an exit strategy is demonstrated commitment by CHAI to work within the GoPNG system.

### **Management by AusAID**

Following signing of the Funding Agreement responsibility for project management/oversight (including monitoring contract management) was fully devolved to the Post in Port Moresby. One AusAID officer (the Activity Manager) is responsible for managing the CHAI contract and liaising with local stakeholders on behalf of AusAID. The ET is of the view that the AusAID Post has provided fairly effective support to project implementation, given that there are limited resources for this task and that there has been some considerable change to staff with responsibility for CHAI. The Activity Manager has been successful in establishing effective working relationships with project stakeholders. The only area where AusAID appears to have been ineffective is in achieving a response by CHAI to implement an M&E framework/matrix

### **3.3 Efficiency**

*Key questions:* Did the implementation of the activity make effective use of time and resources to achieve the outcomes? Was a risk management approach applied to management of the activity (including anti-corruption)? What were the risks to achievement of objectives? Were the risks managed appropriately?

The total budget for CHAI 2006-2009 is \$11.08 million. All but one tranche has been paid to CHAI on time (see Table below). The delay in payment of the fourth tranche was due to a lengthy discussion process on the AAP, focusing on M&E weaknesses, and some issues that were raised by the NDoH. The issues were raised with CF Director for Asia/Pacific in a meeting in Canberra. It must be noted that to date the M&E issues have not been addressed by CHAI.

Tranche	Date released
First tranche payment (Aug to Sept 2006)	14 Aug 2006
Second tranche (Oct to Dec 2006)	1 Oct 2006
Third tranche (Jan to Dec 2007)	1 Jan 2007
Fourth tranche (Jan to Dec 2008)	19 May 2008
Fifth tranche (Jan to Dec 2009)	16 February 2009

Detailed budgets are needed to assess efficiency adequately. Financial documentation available for the review for the years 2007-2008 is found at Annex 10. Based on consultations and the information found in Section 3.1 of this report it is the opinion of the ET that the model of having CHAI technical assistance (TA) that directly supports capacity building in the Program Areas that have been identified as GoPNG priorities is working well, and constitutes value for money. The model uses the CHAI TA to provide the continuing capacity building and mentoring that is so necessary if ownership, confidence and skills are to be supported. Consultations with key stakeholders and ET observations confirmed that this was being achieved in a way not often seen in PNG donor supported projects in the health sector.

The CHAI is also working in Indonesia and Cambodia, and the ET considered comparing these programs with the CHAI in PNG to arrive at some conclusion about efficiency and value for money. However, the Indonesian and Cambodian programs are engaged in different types of activities and on smaller budgets. Even if they had been like-for-like comparisons the data to make these comparisons was not available to the ET.

Significant goodwill and altruism has been created by the project, resulting in substantial support/contribution that is external to the donor resource envelope. Within the Laboratory Program and the Rural Initiative CHAI in PNG has been able to leverage over 1 million Kina in donations and collaborative funding towards project efforts. In the Rural Initiative this has come from: UNICEF, the Governor EHP, Asian Development Bank, AT Projects, Provincial Health Services, Provincial Department of Education, Community-Based Organizations, Goroka General Hospital, New Chapter, Inc; National Volunteer Service, Highlands, Mercy Works, Evangelical Brotherhood Church, Anglican Church, Pastors Fraternal of Eastern Highlands, University of Goroka.

For laboratories this includes: the ADB, WHO, NACS, CBSC, Catholic Health Services, CDC Thailand, and PNG IMR. These have been significant achievements.

Overall, such contributions should not be underestimated, and will be a significant factor in terms of long-term sustainability of the elements of the project.

### 3.4 Impact

Impact examines the *"long-term effects produced by a development intervention, directly or indirectly, intended or unintended"*.<sup>5</sup> To do this the project would need to provide a statement of likely impact, with indicators to measure this, and this has not been done. However, it is too early in the project to measure impact and will not be commented upon in this evaluation.

### 3.5 Sustainability

Key questions: To what extent will the benefits of the project continue after donor funding ceases? What are the major factors which might influence the achievement or non-achievement of sustainability of the project?

In the context of donor-funded development programs and projects, sustainability can be defined as measuring the likelihood that there will be *"continuation of benefits from a development intervention after major development assistance has been completed"*.<sup>6</sup>

This section of the report assesses the commitment and capacity of GoPNG to continue to implement each program area, and should answer the question: To what extent are NDoH and EHP government able to take responsibility for this work?

An important element of sustainability of the project is local ownership. This has been achieved in some (though not all) key areas of CHAI nationally. At the national level there is outstanding individual leadership that persists and achieves progress despite the absence of a "home" for some elements of the project in NDoH.

At the provincial level there is very clear evidence of local ownership and commitment to the RI. This is evident in letters from key stakeholders, funding to facilities and staff positions, and has been confirmed through the ET's consultations. It has been evident from the top level of government (Governor), down through the provincial administration to the leadership and health staff in the hospital and lower level health services.

At the request of the ET the project has provided an analysis of sustainability issues related to the overall program and each Program Area specifically. The discussion below reflects the combined discussions of the ET and the CHAI team. There are some key factors that will affect the sustainability of the overall program:

It is the view of the ET that the project is progressing well toward a sustainable situation. This is very largely due to the GoPNG vision of health system reform, ownership, building capacity of health service providers for both leadership and health service provision, and CHAI's readiness to commit to this vision and provide support without compromise. Long-term capacity building goes beyond simple training and must include close follow-up and

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<sup>5</sup> OECD (2000). *Glossary of Evaluation and Results Based Management (RBM) Terms*

<sup>6</sup> Ibid.

mentoring, and support at a pace that is comfortable for the beneficiaries. At the provincial level this will be supported with the new provincial health administration reforms, and the ability for the province to direct how its funds will be spent. Their vision is to establish at the GPH a centre of HIV excellence.

At this stage it is too early to know how successful sustainability will be, and donor funding will be required for some years yet. Given the excellent progress that is being made, and the obvious commitment of GoPNG to make this work, it would be unfortunate if funding were not continued.

There are however key health systems factors that will be ongoing challenges and risks to achieving sustainability. These include: weak leadership and management in some key areas; timely release of funds, delays in NDoH approvals for training; delays in approving new positions; absence of funding commitment to key health priorities including salaries and consumables; absence of responsibility for maintenance and servicing of infrastructure including equipment. Currently in NDoH responsibility for all elements of CHAI reside in one person. It will be important to split out the areas of responsibility if they are to each get the attention and support that is needed. To continue to provide training and follow-up support intensive training of staff (train-the-trainer) will be required to build a cadre of trainers beyond 2010 (e.g. Laboratory and DBS). It is noted that without funding for the Global Fund Round 9 proposal, many aspects of the CHAI project will be seriously compromised. Until these issues are addressed this project is not sustainable and dependence on donor funding will continue.

**Recommendation 19:** *As a matter of urgency NDoH identify key senior staff to support the Principal Technical Adviser, HIV/AIDS/STI, (Communicable Diseases Branch) in the GoPNG oversight/support of CHAI.*

The factors that contribute to the likelihood of effectiveness and sustainability of this project are:

- GoPNG (EHP government in particular) has a clear vision of reform for the health sector to increase access to quality services at the community level;
- The work of CHAI is aligned with this vision and is working to progress government priorities and not their own, and has firmly integrated its activities into the government system;
- Working within national systems;
- Building capacity of organisations, not just individuals;
- Current CHAI team has good credibility and has established strong relationships with partners and stakeholders.

### 3.6 Gender Equality

**Key Question:** To what extent has the project (i) advanced gender equality and (ii) promoted women, using the four dimensions of access, decision-making, women's rights and capacity building.

The CHAI AAPs describe the project approach to gender, and CHAI management reiterated to the ET that CHAI in PNG is built upon the goal of equal access to treatment and care that need it. Within this broad vision are substantive focal areas of work that at their core promote equity in HIV services, whether it is to ensure ARV supplies are available throughout the country at all ART sites through supply chain management, provide women-appropriate PPTCT services at ANC through the Rural Initiative, or implement integrated services for HIV positive mothers and their babies at the Well Baby Centre through paediatrics.

However, there is no reporting in any QRs on achievement by CHAI describing what the project has actually done to address gender issues, in particular those that are significant in HIV. Some training data made available to the ET while in country was sex disaggregated, but most of it was not. A summary table provided to the ET as a result of joint discussions during the evaluation process provided the following sex disaggregated training data, showing that women dominate in training opportunities and thus opportunities for capacity building:

TRAINING	TOTAL #	WOMEN	%	MEN	%
VCT	124	98	79%	26	21%
Introduction to HIV	69	22	32%	47	68%
PPTCT	19	13	68%	6	32%
Paediatric HIV Prescribers	54	29	54%	25	46%
CD4	4	2	50%	2	50%
Wasmeri DOTS	8	8	100%	0	0%
IMAI	35	22	63%	13	37%
DBS	14	11	79%	3	21%

From a programmatic standpoint, CHAI management informed the ET that access and women's rights dimensions were evident when one examined the direct and indirect recipients of the project:

- In the RI 63% of adult patients at the end of 2008 were female (cumulative from the beginning of the HIV registry in the EHP);
- this increased to 74% when the 92 PPTCT women the program has cared for to date were included;
- the microcredit project has focused its efforts on gender equity: 61% of all loans to date to women;
- key program areas are intrinsically focused on access to care and treatment for women – PPTCT programming in the RI, PPTCT and paediatric services in paediatrics.

Fifty percent of the eighteen national staff supported through the Foundation are women. Three of the nine international staff are women; all of these women are in significant management roles (Director of Rural Initiative, Laboratory Advisor, and Business Service Manager). CHAI also works closely with Care Partners, with three of the five partnerships headed by women (Diocese of Bereina, Diocese of Mendi, and Friends Foundation).

However, sex disaggregated data is only one aspect of considering gender in a project of this kind. The HIV epidemic in PNG is very much driven by gender issues that include violence against women, and transactional unprotected sex.

The gender analysis and strategies to address gender-related issues in CHAI programming is weak, and places a significant risk to the effectiveness of HIV services that the project supports. CHAI must go beyond collection of sex disaggregated data for training participants and CHAI staff. In addition to collecting sex disaggregated data, the work should consider the differences between men, women and people of diverse gender identities and sexualities related to:

- their different needs;
- implications of HIV status and treatment;
- constraints restricting participation and access to services; and
- trends, successes and lessons that relate to service provision.

Gender-related issues need to be mainstreamed into all training, programming and reporting including skills development around gender-sensitive issues and needs, including violence. CHAI would do well to seek the support of a gender specialist to better understand the issues and implications for future work, and to better meet the needs of marginalised communities. The ET sensed that providers thought more about these issues than CHAI personnel.

The project is seriously compromised by the absence of ongoing data monitoring or thorough data assessment of its gender equity activities, or its effectiveness towards meeting stated objectives in its AAPs.

**Recommendation 20:** *in preparation for the next phase of CHAI must:*

- *seek the support of a gender specialist to better understand the requirements of the project;*
- *ensure gender issues specific to HIV and its treatment, care and prevention are documented and project responses are identified, including indicators for their measurement;*
- *indicators to measure the project's response to all dimensions of gender equity are included in the M&E framework and matrix under the "Management" component when the design is developed for the next phase.*

### 3.7 Monitoring and Evaluation (M&E)

This section of the report assesses whether the M&E framework effectively measures progress towards meeting project objectives. It therefore assumes that there is an M&E framework for the project with clearly stated objectives and indicators to use for measuring their achievement. This was not the case with CHAI.

Monitoring is a "*continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds*".<sup>7</sup>

For CHAI monitoring is achieved through quarterly reporting and Annual Activity Plans. Whilst much of this is informative there is no systematic approach to reporting against each element of each Program Area. From one

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<sup>7</sup> OECD (2000). *Glossary of Evaluation and Results Based Management (RBM) Terms*.

document to another the number of technical Program Areas varies from year to year, and even in the most recent AAP only five are listed (there are now six). AAPs sometimes list achievements of the previous year, and sometimes they do not. Key achievements of the previous year are never listed against each Program Area. This is key information that should then inform the planning for the next year.

Evaluation is the "systematic and objective assessment of an on-going or completed project ..., its design, implementation and results." <sup>8</sup> Evaluation is undertaken to determine the achievement of project objectives and outcomes, among other things.

Evaluation requires that objectives and outcomes are clearly stated at the overall project (goal) and component (Program Area) level, and indicators for measuring achievement of those goals and objectives are stated. There is no overarching project goal statement. In the 2006 workplan (the first definitive description of the project) no objectives were stated for each of the AoCs (later Program Areas). Only in the 2008 AAP do Program Area objectives become evident for *some* Program Areas, but these are interchangeably objectives for the duration of the project or for the year of that AAP. At this point in time no indicators are provided to measure their achievement.

Systematic M&E is integral to effective project management. For CHAI an M&E framework has never been developed, despite frequent requests by AusAID for one. The problems identified above would have almost certainly been overcome had there been a project monitoring matrix developed at inception. This could be a "living" document that evolves as new elements to the project are introduced in response to government needs.

The ultimate beneficiaries of this project are people living with HIV. There is no indication CHAI will measure the outcome of the project on them. There is a significant body of published literature on measuring the outcome of treatment and care programs for PLHIV using Quality of Life indicators. There are opportunities to collect "significant stories" (as distinct from using the "Significant Change" methodology) as evidence of the effect of this project on PLHIV, particularly to do with the Micro Credit Livelihood Enhancement and participation in activities such as those available through the Well Baby Centre. Literature is available on the measurement of stigma. To date CHAI does not appear to have considered any of these.

**Recommendation 21:** *A new phase of the project develops a design document, a logical framework, an M&E plan and matrix, and templates for reporting that reflect the project outline; indicators are identified at the goal/purpose and component (Program Area) level.*

### 3.8 Analysis and Learning

While the original evidence indicating the activity was based on sound technical analysis is weak (see Section 3.1.3 above) documentation of continuing analysis and learning has been weak, and not systematic. However, the ET consultations with CHAI management indicated that the rollout of the initiative is based on continuous learning, and can be summarised as follows:

#### 3.8.1 Rural Initiative

- November 2006-April 2007: Extensive consultation and focus groups with key stakeholders including Eastern Highlands Provincial Health, Goroka Hospital, other NGOs, Faith Based Organizations, and District level partners during program design period;
- March 2008: Mid-term presentation of Rural Initiative progress to key partners including FHI, ADB, WHO, UNAIDS, and NDOH for feedback and adjustment of Rural Initiative strategy;
- February 2009: Sharing of Rural Initiative strategy and progress with Mendi Hospital and Southern Highlands Provincial Health management by Eastern Highlands Steering Committee;
- March 2009: Presentation of Rural Initiative progress to Technical Working Group writing the Global Fund Round 9 Proposal.

#### 3.8.2 Laboratory

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<sup>8</sup> OECD (2000). *Glossary of Evaluation and Results Based Management (RBM) Terms*.

## EID

- Ongoing TWG Feedback on materials;
- Peer review presentation of EID program at September 2008 PNG Medical Symposium;
- Curriculum approval of program materials pending (SOP have been approved by NDOH);
- January 2009: DBS six month review meeting with all pilot participants (nurses, etc) feedback session and improvements to program based on learning;
- Ongoing mentoring and feedback from participants on a regular basis (regular bimonthly check in meetings with nurses in PMGH paediatric ward on their progress and participation in the EID program-issues encountered;
- Ongoing laboratory quality assessments:
  - EQAS provided by US-CDC quarterly (result: 100 % in all assessments)
  - Internal quality control
  - Monthly proficiency testing
  - Daily QC activity of all laboratory technicians results by laboratory advisor
  - Weekly laboratory meeting for testing team facilitated by CHAI Laboratory Advisor.

## Rapid Testing Algorithm

- Analysis of results from Phase II and III at VCT sites by retesting of serum and DBS at CPHL;
- Quality Assurance of test results in Phase III by:
  - EQAS
  - Internal Quality Assurance Controls (run weekly at each site)
  - Blinded rechecking of 5% of test results
- Ongoing supervision by both the CPHL team and provincial laboratory and feedback on regular basis as needed and regular phone calls to check progress, needs and to guide participants at VCT sites.

## CD4 Testing

- Assessment of down time of machines;
- External quality assessment of all CD4 testing sites four times a year;
- Feedback session in TWG and refresher training from all CD4 operators nationally.

## General

- Safety Committee meetings at CPHL facilitated by CHAI.

### 3.8.3 Paediatrics

- April 2008: Shared reflections and presented case management model to PMGH management and key staff findings from Eastern Highlands to gauge feasibility for replication in Paediatrics and PPTCT at PMGH;
- June 2008: Presentation and sharing of information on Ready to Use Therapeutic Formula (RUTF) at the Paediatric Symposium;
- Monthly Well Baby Centre Team meetings with case managers, social workers, other clinic staff;
- Monthly report to all hospital key staff affected or linked to paediatric HIV.

It is also evident that interventions put in place have been based on sound analysis of best practice nationally and internationally. Some examples include:

- Detailed analysis of testing protocols in HIV/AIDS programs internationally;
- Researching SOPs for appropriate models for PNG;
- Sourcing of Australian laboratory expertise for quality assurance programs;
- University of Michigan Ross School of Business study into the supply management system for ARVs and test kits;
- University of San Diego (CF care partner) contribution to sharing international practices in paediatric HIV;
- Identification of a Tanzanian patient information database to provide the basis for a PNG customised database;
- Piloting implementation of the Ready-to-Use Therapeutic Food (RUTF) for malnourished and HIV-positive children in PMGH and GPH;
- Assessment for establishing a model of Continuum of Prevention to Care to Treatment.

### 3.9 Evaluation Criteria Ratings

Evaluation Criteria	Rating (1-6)
1. Relevance	5
2. Effectiveness	5
3. Efficiency	4
4. Sustainability	5
5. Gender Equality	2
6. Monitoring & Evaluation	2
7. Analysis & Learning	5

#### Rating scale:

Satisfactory		Less than satisfactory	
6	Very high quality	3	Less than adequate quality
5	Good quality	2	Poor quality
4	Adequate quality	1	Very poor quality

Justification for the scores against each criterion is as follows:

- Relevance: CHAI does not use opportunities to strengthen the broader health services; it is very focused on HIV, whereas it could be more linked into STI services and preventive services (e.g. mobile, outreach).
- Effectiveness: while CHAI is considered to have been effective, the score is compromised by weaknesses in measuring and reporting.
- Efficiency: difficult to assess because of lack of detailed budget information required for an assessment of efficiency. It could be considered quite expensive. Efficiency in the RI could be increased by ensuring better integration with other health services (STI, TB, OIs, MCH, mobile clinics, PASHIP, etc).
- Sustainability: the project is demonstrating that it is working reasonably well toward a sustainable situation and identifies where it falls short; it is very much about strengthening the systems and long-term capacity building that includes continuous follow-up and mentoring, and being integrated into GoPNG's reform priorities. It is too early yet to know how successful it will be.
- Gender equality: Reporting on gender equality is weak, and there is little evidence in the reporting that CHAI has understood or incorporated gender into the project. CHAI is not collecting adequate data. Gender analysis must go much further to include HIV issues affecting women. CHAI needs to incorporate strategies for doing this into its project.
- Monitoring and evaluation: this is not considered satisfactory, given the absence of a logical framework with clearly stated objectives and indicators at each level of the project, and the absence of an M&E framework and matrix. It is possible that a lot of data is being collected but it is being reported to CF head office rather than to the GoPNG or the donor.
- Analysis and learning: while the project is guided by considerable analysis and learning, it is not well reported.

## 4. Conclusion and Recommendations

It is the view of the ET that this has been on the whole a well managed project that has created enthusiasm and ownership in many areas. It has been exemplary in the way it has carefully considered the pace of rollout of all program areas, and has taken time to reflect and analyse many elements of it. Its commitment to building local capacity has been outstanding.

The factors that contribute to the likelihood of effectiveness and sustainability of this project are:

- GoPNG (EHP government in particular) has a clear vision of reform for the health sector to increase access to quality services at the community level;
- The work of CHAI is aligned with this vision and is working to progress government priorities and not its own, and has firmly integrated its activities into the government system;
- Working within national systems;
- Building capacity of organisations, not just individuals;
- Current CHAI team has good credibility and has established strong relationships with partners and stakeholders.

Barriers persist to effective delivery of the program and in particular as threats to its sustainability. Many of these are health systems issues that are repeatedly identified from one evaluation to another of donor funded projects in PNG. In particular these relate to delays in appointments to key positions, lack of national training capacity for health and HIV in particular, tardy approval for training curricula, government health system support for/commitment to regular maintenance.

The CHAI approach to capacity building is outstanding, and should be a model to other projects and programs in the country.

A key factor in the successful delivery of this project is the current CHAI team that supports highly motivated and visionary GoPNG counterparts. We can only hope for their continued association with the project.

**Recommendation 22:** *A new phase (5 years) should be designed for CHAI, with NDoH and Clinton Foundation leading that design process, and AusAID supporting the inclusion of a design/M&E specialist to be part of the team.*

- *A new design should reflect new thinking within the NDoH (corporate plan, partnership and the new national health plan).*
- *Extend the current project for up to a one year, depending on likely duration of the above exercise.*
- *A fuller review of the RI is undertaken, possibly in six months time (not waiting until it is fully rolled out) to use in preparation for expansion elsewhere; whether this is led by an external consultant or CF would be determined in due course.*
- *Plan for the Rural Initiative costing study.*
- *The timing of these activities needs to be further explored with key stakeholders to ensure appropriate sequencing/timing.*
- *Continuation of the RI needs to continue to be within the context of a broader health system strengthening approach and should consider:*
  - *The potential for increasing linkages between HIV and other services to develop one-stop-shop services for HIV, TB, STI, family planning and nutritional support, linked to home-based care and community support.*
  - *Involvement of PLHIV in counselling and support.*
  - *Increased focus on district level laboratory services to enable basic level point of care diagnostics, including confirmatory HIV testing.*
  - *Prevention should be strengthened within the model, particularly to integrate condom distribution into all aspects of health service delivery, including mobile clinics to improve the availability of condoms at the community level.*
  - *The need to disaggregate data by sex*
  - *Consider adding health system strengthening to the model.*
  - *Include a Social Mobilisation component*

Options for other suitable mechanisms for funding CHAI PNG have been examined. It is the ET's view that at this point in time the continuing rollout of the CHAI would be put at risk by changing the current arrangements. However, it would be prudent during the extension phase to identify elements of the project that are soundly embedded into the system, and have clear support and leadership at a senior level that might lend themselves to funding through, for example, the Function Grants, or other mechanisms that are under discussion. At the provincial level there may be opportunities that emerge as a result of the provincial health reforms. In the foreseeable future, however, it is likely that the current arrangements will need to be in place for some years until the interventions are firmly in place, and GoPNG is confident to take them forward. Discussions should continue between AusAID, CHAI and GoPNG to ascertain the approach that will best suit all elements of the initiative, and not jeopardise the success that has been seen so far. The ET cautions against doing this premature early.

## 4.1 Lessons Learned

Many lessons have been identified from the project, and are presented below. Many of them are not new in PNG (identified with an \*) and have been highlighted in previous evaluations, including of HIV projects/programs.

### General

- (i) Expedient NDoH approval for training curricula facilitates implementation of new, innovative and proven interventions approaches.
- (ii) Introduction of new and innovative approaches is only successful if accompanied by staff training, sound supervision and appropriate facilities.\*
- (iii) Strong local leadership and management capacity are central contributing factors to success in donor supported initiatives.\*
- (iv) Health systems issues impede effective implementation and sustainability: timely release of funds, timely approval of training, support for regular maintenance.\*
- (v) Human resource capacity requires time to be developed.\*

### Project design

- (vi) A project that has a clear design at commencement, that includes a logical framework with outcomes and indicators articulated at every level of the project hierarchy, enhances the likelihood of clear cumulative reporting on progress toward higher level outcomes (monitoring and evaluation).\*
- (vii) Project implementation and monitoring is facilitated when the outline of a M&E Framework and matrix is presented during design stage. This is particularly important if the skills to develop these tools are likely to be underdeveloped in the project management/implementation team.\*

### Training

- (viii) Unless national training capacity can meet the training demands essential to implement programs such as CHAI, capacity building and commitment to donor programs will be threatened.\*

### Management

- (ix) Minimal management and governance arrangements can be effective with the right project personnel in place.
- (x) The importance of selection of an appropriately skilled and committed team is paramount to success.\*

### Laboratory

#### EID

- (xi) Emphasis on quality assurance is critical to efficient and accurate diagnostic capability.
- (xii) Quality is compromised if rollout of the program occurs too quickly; time is needed to consolidate and follow up performance and adherence to protocols.\*
- (xiii) Complementary mechanisms for treatment, adherence/retention are critical.

#### Rapid Test algorithm Development

- (xiv) Development is limited without donor funding during Phase III analysis and rollout due to limited NDOH resources
- (xv) Will still require gradual exit plan to build capacity and fill gaps as needed

### Paediatrics

- (xvi) It continues to be the case that positive children are largely identified in the inpatient wards rather than in outpatient clinics; counselling and testing training for both outpatient and inpatient paediatric staff supports earlier diagnosis.
- (xvii) Space is needed for clinics that is specific to HIV and not combined with other hospital departments.
- (xviii) Loss-to-follow-up is a serious impediment to PMTCT/paediatric HIV cases; a strong case management system (in the RI), contributes to reduce loss-to-follow-up.

- (xix) Well baby centre
- Accurate data collection important from start;
  - Coordination and partnership are priorities;
  - Local leadership/initiative needs to drive process;
  - Project-funded systems must complement existing structure and address sustainability and absorption into those systems.

## RI

- (xx) A significant factor in the success of the pilot of the RI is the step-wise, flexible, facility-specific, appropriately paced and tailored approach of the CHAI to its implementation, balanced with the urgent need to increase HIV services in rural areas.
- (xxi) Factors that contribute to successful implementation of the RI:
- strong commitment of the provincial government and hospital administration to reforming the health sector;\*
  - placing improved access to quality health services at the community level as a central plank of that reform;
  - uniform articulation of a vision for reform by every level of the provincial government and the health administration;
  - a solid understanding of where donor assistance can contribute to that vision.
- (xxii) Greater synergy is achieved if partners implementing similar programs are aligned with GoPNG priorities and demonstrate resourcing that will build capacity and contribute to long term sustainability.\*
- (xxiii) Building capacity at the provincial level to provide paediatric treatment and care beyond the provincial level depends upon a strong mentoring program being in place.

## 4.2 Recommendations

**Recommendation 1:** *In Phase 2 of the project HIV prevention is mainstreamed into all service components.*

**Recommendation 2:** *A new phase of CHAI is guided by a design that includes a logical framework, uses recognized project terminology and clearly identifies the project purpose, component/program areas and their objectives, and activities that will contribute to achievement of each of the component objectives. The design should be preceded by a concise needs assessment that clearly justifies the project content.*

**Recommendation 3:** *To support implementation of a new phase AusAID articulates a new agreement that is more specific about reporting against all elements of the logical framework.*

**Recommendation 4:** *Areas of potential conflict are articulated in a risk management plan and GoPNG ensures that all parties working in similar areas are collaborating and coordinating their activities.*

**Recommendation 5:** *As a matter of urgency NDoH precipitate the appointment of a permanent head to CPHL.*

**Recommendation 6:** *Phase 2 of CHAI continues to support strengthening of laboratory services.*

**Recommendation 7:** *Undertake a detailed assessment and cost-analysis within six months on those components of the RI already in place to inform expansion of the model.*

**Recommendation 8:** *Establish criteria for selection of further provinces for implementation of the RI.*

**Recommendation 9:** *Efforts need to be made to maximise integration of HIV, including prevention, into other services such as STIs, TB and maternal and child health.*

**Recommendation 10:** *AusAID, CHAI, Save the Children (and other relevant PASHIP implementing organisations), FHI and GoPNG need to ensure that cooperation and synergies between projects are maximised. GoPNG must lead this effort.*

**Recommendation 11:** *Leading into Phase 2 explore the feasibility of and alternative options for expanding paediatric HIV services beyond the provincial hospitals.*

**Recommendation 12:** *At the national level institute strategies to improve training capacity to meet demand for staff training.*

**Recommendation 13:** *Review all fields in the patient information database and ensure that a full range of response categories are included.*

**Recommendation 14:** *Patient information database: develop a system for monitoring/controlling for virus threats to the system.*

**Recommendation 15:** *The CF improves its recruitment processes to ensure continuing placement of credible and appropriate personnel to key CHAI positions.*

**Recommendation 16:** *A detailed budget breakdown of spending is provided prior to the design of new phase.*

**Recommendation 17:** *CHAI Phase 2 design includes the development of a comprehensive risk management plan.*

**Recommendation 18:** *A video version of the step-by-step manual for the Rural Initiative is made in tok pisin.*

**Recommendation 19:** *As a matter of urgency NDoH identify key senior staff to support the Principal Technical Adviser, HIV/AIDS/STI, (Communicable Diseases Branch) in the GoPNG oversight/support of CHAI.*

**Recommendation 20:** *in preparation for the next phase of CHAI must:*

- *seek the support of a gender specialist to better understand the requirements of the project;*
- *ensure gender issues specific to HIV and its treatment, care and prevention are documented and project responses are identified, including indicators for their measurement;*
- *include indicators to measure the project's response to all dimensions of gender equity in the M&E framework and matrix under the "Management" component when the design is developed for the next phase.*

**Recommendation 21:** *A new phase of the project develops a design document, a logical framework, an M&E plan and matrix, and templates for reporting that reflect the project outline; indicators are identified at the goal/purpose and component (Program Area) level.*

**Recommendation 22:** *A new phase (five years) should be designed, with NDoH and Clinton Foundation leading that design process, and AusAID supporting the inclusion of a design/M&E specialist to be part of the team.*

- *A new design should reflect new thinking within the NDoH (corporate plan, partnership and the new national health plan).*
- *Extend the current project for up to a one year, depending on likely duration of the above exercise.*
- *A fuller review of the RI is undertaken, possibly in six months time (not waiting until it is fully rolled out) to use in preparation for expansion elsewhere; whether this is led by an external consultant or CF would be determined in due course.*
- *Plan for the Rural Initiative costing study.*
- *The timing of these activities needs to be further explored with key stakeholders to ensure appropriate sequencing/timing.*
- *Continuation of the RI needs to continue to be within the context of a broader health system strengthening approach and should consider:*
  - *The potential for increasing linkages between HIV and other services to develop one-stop-shop services for HIV, TB, STI, family planning and nutritional support, linked to home-based care and community support.*
  - *Involvement of people living with HIV (PLHIV) in counselling and support.*
  - *Increased focus on district level laboratory services to enable basic level point of care diagnostics, including confirmatory HIV testing.*
  - *Prevention should be strengthened within the model, particularly to integrate condom distribution into all aspects of health service delivery, including mobile clinics to improve the availability of condoms at the community level.*
  - *The need to disaggregate data by sex.*
  - *Consider adding health system strengthening to the model.*
  - *Include a Social Mobilisation component.*

## ANNEX 1: TERMS OF REFERENCE

### 1. Purpose

The Independent Completion Report (ICR) of the Clinton Foundation HIV/AIDS Initiative (CHAI) will provide important lessons to AusAID on aid program management and development effectiveness. It will contribute to the evidence-base for HIV/AIDS program planning and strategy development. It will also inform PNG-Australia negotiations on the new PNG-Australia Partnership for Development HIV/AIDS Schedule.

### 2. Objectives

The objectives of the ICR the CHAI are to:

- a. Assess and rate CHAI against AusAID's eight evaluation criteria defined in *AusAID's Guideline: Manage the Independent Evaluation of an Aid Activity*;
- b. Recommend whether AusAID should continue to support CHAI under the proposed PNG-Australia Partnership for Development HIV/AIDS Schedule, under negotiation in 2009.
- c. Investigate options for other suitable mechanisms for funding for CHAI PNG including integration into existing systems and programs on HIV treatment to minimise fragmentation;
- d. Provide a synthesis of lessons learnt and a way forward for AusAID support for HIV/AIDS. If continuation of initiatives is recommended, develop an outline of a design concept paper listing key considerations and requirements, for internal AusAID discussion.

### 3. Scope

As required under *AusAID's Guideline: Manage the Independent Evaluation of an Aid Activity*, the CHAI will be assessed and rated against eight criteria: the five OECD/DAC criteria of relevance, effectiveness, efficiency, impact and sustainability, and the three additional AusAID criteria of monitoring and evaluation, gender equality and analysis and learning. The rating scale used is 1 – 6, with 6 indicating very high quality and 1 indicating very low quality. A rating below 4 indicates that an activity has been rated as less than satisfactory against a criterion. The evaluation team should draw upon the attached evaluation questions to assist them rate CHAI against the eight criteria.

In addition, the evaluation team will address the following:

- a. Assess changes (or impending changes) in the project external environment that could have implications for project implementation and/or achievement of project goal, purpose or objectives.
- b. Recommend changes in strategic direction and/or refinements in project design/approach to strengthen project implementation and increase sustainability if required, including increasing synergy with the national program.
- c. Identify and highlight lessons/achievements that may have wider implications/interest for the PNG National Department of Health or the Australian Government.
- e. Assess measurable contribution of the CHAI project in PNG to achievement of objectives under PNG National HIV/AIDS strategy.
- f. Recommend whether AusAID's support to this project should continue to be provided beyond December 2009, leading to its inclusion in the PNG-Australia Partnership for Development HIV/AIDS Schedule and describe any risks/implications of not continuing funding.
- g. The program supports NDoH activities in rapidly scaling up its response to HIV and AIDS. There has been an increase in the number of people accessing ART. Support is also provided to clinical facilities at the district level and national clinicians trained in various aspects of the program. Assess the commitment from GoPNG on the sustainability of CHAI activities.
- h. Although the agreement is between NDOH and CHAI, some of the components of the assistance are implemented at the district level. Assess how the support has impacted at the district level including an assessment of impact made, suggestions for sustainable approaches and how this assistance could be continued as a recurrent priority program.
- i. The CHAI does not have a monitoring and evaluation framework which clearly links program targets to higher level outcomes (i.e. number of people trained in PPTCT compared to number of women accessing PPTCT services). Assess current M&E process and recommendations for improvement.

- j. Assess CHAI's exit strategy.
- k. Localisation – GoPNG ownership, capacity and sustainability: CHAI's principal collaborating partner within GoPNG is the National Department of Health and the Eastern Highlands Provincial Government (EHPG). The effectiveness of this collaboration is critical for the sustainability of CHAI outputs across all components of its program. Assess the extent to which NDoH and EHPG are willing and able to take up this work after the completion of CHAI.

#### **4. Background**

- a. The William J. Clinton Foundation is a charitable organisation established by President Clinton to construct the Clinton President Centre and to pursue four Missions; Health Security, Economic Empowerment, Leadership Development and Citizen Service and Racial, Ethnic and Religious Reconstruction.
- b. In February 2006, the Australian Government and the CHAI signed a Memorandum of Understanding. Under the agreement, the Australian Government through AusAID is to provide funding up to \$25 million over four years, complemented by funding from the Clinton HIV/AIDS Initiative.
- c. Under the MOU, AusAID agreed to fund CHAI to work with public health authorities in three countries including Papua New Guinea to scale-up treatment and care for people living with HIV and AIDS. The other countries were Vietnam and China, with an option to extend the initiative to other countries. Indonesia is the fourth country to be included.
- d. In PNG, AusAID is supporting the CHAI to improve access to HIV and AIDS treatment. Total agreed funding is \$11,080,000 for the period 2006-2009. The goal of the CHAI in PNG is to work with the National Department of Health (NDoH) to improve clinical, laboratory and management capacity in Papua New Guinea to enable an expansion of access to antiretroviral treatment for HIV positive people. The NDOH and the CHAI identified nine areas of collaboration (Attachment 1 2007 Workplan) to help support the scaling up of care and treatment, and support the objectives of NDOH. These are: Laboratory Infrastructure; Procurement and Supply Management; Pediatric Care and Support; The Rural Initiative; Monitoring And Evaluation System; Training; Clinical Support; Hospital Administration Initiative; Program Management And Coordination
- e. The CHAI program is due to reach completion on 30 December 2009. While no formal request for extension has been received from CHAI, such a request would not be unexpected.
- f. AusAID Strategic Directions AusAID launched a new HIV Strategy on 7 April 2009. The new strategy recognises that Australia's role in supporting the HIV response in PNG needs to be broader than for most other countries. As such, Australia is willing to help implement and expand a comprehensive response in PNG that includes treatment and care in addition to prevention.
- g. During 2009, the Australian and PNG governments plan to negotiate a schedule for future Australian assistance for HIV, under the PNG-Australia Partnership for Development. This new schedule will cover all Australian assistance for HIV in PNG until 2015.
- h. The new 2009-2013 NDoH Corporate Plan and the PNG HIV Strategic Plan (2008 – 2010) should also guide any future support to the CHAI. The goal of the plan is to improve the health of people of PNG through development of a health system that is responsive, effective, affordable, acceptable and accessible to the majority of people. Any future funding for HIV and AIDS prevention and treatment must be justifiable against this goal.

#### **5. Evaluation method**

- a. The team will initially undertake a thorough review of documentation as listed at Section 10 - Reading List. In country, the team will hold meetings and discussions with AusAID Port Moresby, counterpart and stakeholder agencies, staff and management of the CHAI in PNG and key development partners actively supporting the GoPNG's response to the HIV/AIDS epidemic.
- b. Individual members of the team will provide advice and written inputs to the Team Leader, as instructed by the Team Leader, in order for the Objectives and Reporting Requirements of the Review to be met. Responsibilities of each review team members are set out below are flexible and may be further refined.
- c. Inputs
  - Desk review relevant background documents including those listed Section 10 (Team Leader and team members).
  - Consult with various partners on the performance of the CHAI including:

- initial consultation with AusAID PNG (Health, PNG-Australia HIV and AIDS Program (Sanap Wantaim) and Sub-National Team in Goroka)
- Secretary, National Department of Health
- NDoH Disease Control Branch
- Other Development Partners – WHO, UNICEF, ADB, NZAID
- National AIDS Council and Secretariat
- Port Moresby General Hospital's Director Medical Services
- Director Central Public Health Laboratory, Port Moresby Hospital
- CHAI's Country Director and staff (Port Moresby and Goroka)
- private sector service providers actively supporting the NDoH in responding to the HIV/AIDS epidemic with a view to identifying the successes and lessons learned from the program.

Undertake field visits to 3 districts in EHP (Team Leader and team).

- Consult with Government counterparts associated with the program, including: EHP Provincial Administrator, Provincial Director of Health Services, Goroka Hospital Director Medical Services and clinical staff, Asaro Health Centre OIC and staff, and staff of health facilities included in the ART outreach program;
- Consult with non-Government counterparts associated or affected by the program, including: Susu Mamas, Save the Children in PNG on patient referral system and links with PASHIP, AT Projects on practical approach to infrastructure development for people living with HIV and AIDS at the District level and UNICEF.
- Provide an overall assessment of the performance of CHAI against the requirements of the funding agreement (Team Leader and team);
- Provide an overall strategic assessment of the project relevance within the context of the evolving environment in PNG and internationally and with regard to relevant AusAID policies (AusAID HIV Advisor);
- Provide an overall assessment of the effectiveness of the CHAI and issues of GoPNG ownership and sustainability of project outcomes (NDoH HIV/AIDS specialist and provincial health representative);
- Identify, assess and highlight lessons/achievements that may have broader relevance (Team Leader and team);
- Assess the success, suitability and replicability of the Rural Initiative as a model for expansion of HIV and AIDS services into rural areas in PNG; (Team Leader and team)
- Make recommendations to AusAID on future support or otherwise to CHAI in PNG. (Team Leader and team)

## 6. Reports

The Review Team is required to provide the following reports to AusAID:

- a An Aide Memoire for the review debriefing session in PNG maximum of 10 pages (Team Leader and team) following the attached AusAID template;
- b A first-draft ICR report following the attached AusAID template, submitted electronically to AusAID by 17 July 2009, in a format compatible to AusAID's IT system (Team Leader and team);
- c A second-draft report, submitted electronically to AusAID by 21 August 2009 which will consist of a review of the report against the terms of reference, for distribution to GoPNG agencies and to other relevant stakeholders for their comments (Team Leader and team);
- d A final report submitted electronically within 2 days of receiving consolidated AusAID and GoPNG and other stakeholder comments, collated by AusAID and based on a technical review and a peer review. This report will be a maximum of 25 pages in length in the format provided by AusAID.

## 7. Review Team Composition

- a AusAID's guideline for independent evaluations, including ICRs, requires that the team leader be an external evaluation expert. The Guideline also states that all team members should be independent of the aid activity, and should not have had past involvement in the activity, including in an advisory role.
- b The review team will comprise of an independent Health Systems Strengthening Specialist (Team Leader), a senior NDoH PNG HIV/AIDS expert (Deputy Team Leader), a GoPNG provincial health representative and a Canberra based AusAID officer. The team will be assisted by the AusAID Health and HIV teams; contact person Lydia Butut-Dori. The team collectively will have the following skills and qualifications:

- i Expertise in one of the nominated specialties as stipulated under the review;
  - ii Demonstrated knowledge of the health service delivery in PNG;
  - iii Demonstrated knowledge of HIV and AIDS issues in PNG and globally;
  - iv Demonstrated knowledge of health service delivery at the provincial level;
  - v Strong analytical skills, cross cultural communication and interpersonal skills and the ability to present information logically and concisely.
- c Team Leader and Health Systems Strengthening Specialist
- i. Act as the Team Leader for the review mission for the management of team inputs, liaison and production of an Aide Memoire and Review report following AusAID's Guideline and templates;
  - ii. assess how well CHAI is working to improve health systems and build capacity within existing PNG structures.
- d Senior NDoH HIV/AIDS Specialist
- i. To act as Deputy Team leader and assist the Team Leader in the management of team inputs, liaison and production of an Aide Memoir and Review report;
  - ii. To assess the impacts of the changing external environment in PNG in terms of the effectiveness of the CHAI in PNG;
  - iii. To assess the ability of the key local stakeholder within the GOPNG to sustain CHAI outcomes once the project is completed;
  - iv. To liaise with other PNG stakeholders in the HIV/AIDS area in terms of providing information and perspectives relevant to the Review.
- e GoPNG provincial health representative (a Provincial Health Advisor)
- i. To provide an assessment on the challenges of implementing HIV program at the service level.
- f HIV/AIDS Advisor, AusAID Canberra
- i. To provide an input on the CHAI program in PNG in light of AusAID's new HIV Strategy
  - ii. To provide an input on challenges and achievements of CHAI PNG in comparison to other CHAI programs under the 2006 agreement between the Australian Government and the Clinton Foundation.
- g The team will be assisted by the AusAID Activity Manager – PNG Health Response to HIV/AIDS, to provide background information on the project implementation process, content and oversight to the review team through regular feedback during the review process.

## **8. Duration and Phasing**

A two-week in-country mission will commence on 24 May 2009 and conclude on 5 June 2009. An additional 14 days on either side of the mission for preparation and report writing. The attached AusAID Guideline explains the steps AusAID will follow to assess the draft. AusAID requires a three week period between receiving the draft ICR and providing comments to the team leader. This is in part because AusAID will submit the ICR to an independent team for technical review, and then will hold a peer review to examine and contest the findings.

Team members	Duration in Australia	Duration in PNG	Duration of mission
Team Leader	2 days pre and post briefing in Canberra 14 working days prior to coming to PNG AusAID will require 3 weeks to provide feedback to the team leader on the first draft 14 working days to writing and collating feedback and submitting final report	25 May – 5 June 2009 including travel days  NOTE: We are required to submit all draft ICRs for technical review and then peer review before on the first draft	43 days
NDoH HIV/AIDS specialist (in charge of operational and functionality of review)		2 working days for reading 25 May – 5 June 2009 including travel days 5 days report writing	15 days
Provincial health representative (focus on challenges at service delivery level)		2 working days for reading 25 May – 5 June 2009 including travel days 5 days report writing	15 days
HIV/AIDS Advisor, AusAID Canberra	2 days reading  5 working days for reporting writing	24 April – 5 June May 2009	15 days

## 9. Reading materials

- a Responding to HIV/AIDS in PNG – Australia's PNG specific HIV strategy
- b Independent Review Group Reports 07 and 08
- c AusAID/Clinton Foundation Agreement
- d CF Workplans – 2007, 2008 and 2009
- e AusAID's new HIV Strategy (2009)
- f NDoH 2009 – 2013 Corporate plan
- g NDoH Strategic Plan (2006 – 2008)
- h CF activity reports (2007, 2008 and 2009)
- i PNG HIV/AIDS Strategic Plan 2008 – 2010
- j PNG HIV Surveillance Plan 2008 – 2010

## ANNEX 2: COMPONENTS OF THE PROJECT

2007 – Areas of Collaboration	2009 – Program Areas
<ol style="list-style-type: none"><li>1. Laboratory infrastructure,</li><li>2. Procurement and supply management</li><li>3. Paediatric care and support</li><li>4. The rural initiative</li><li>5. Monitoring and evaluation system</li><li>6. Training</li><li>7. Clinical support</li><li>8. Hospital administration initiative</li><li>9. Program management and coordination</li></ol>	<ol style="list-style-type: none"><li>1. Laboratory</li><li>2. Paediatric Care and Treatment</li><li>3. Rural Initiative</li><li>4. Supply Chain Management</li><li>5. Clinical Mentoring</li><li>6. Patient Information Systems</li><li>7. Program Management</li></ol>

### **ANNEX 3: DOCUMENTS CONSULTED**

- AusAID 2006. AusAID HIV Annual Sector Performance Report 2009
- AusAID 2006. AusAID/Clinton Foundation Agreement, 2006
- AusAID 2007. Papua New Guinea – Australia Development Cooperation Strategy 2006-2010
- AusAID 2008. Partnership for Development between the Government of Australia and the Government of Papua New Guinea
- CHAI (undated). A model for HIV/AIDS care and treatment in rural Papua New Guinea. Pilot Project - HIV/AIDS Rural Initiative
- CHAI 2006. SE Asia Papua New Guinea Program Budget
- CHAI 2006. The William J. Clinton Foundation HIV/AIDS Funding Milestone Report July-September 2006.
- CHAI 2006. The William J. Clinton Foundation HIV/AIDS Funding Milestone Report October-December 2006.
- CHAI 2006. The William J. Clinton Foundation HIV/AIDS Initiative Work Plan for the Independent State of Papua New Guinea, 2006-2009.
- CHAI 2006. The William J. Clinton Foundation HIV/AIDS Initiative 2006 Annual Plan for the Independent State of Papua New Guinea
- CHAI 2007. The William J. Clinton Foundation HIV/AIDS Initiative Quarterly Report Q1 2007
- CHAI 2007. The William J. Clinton Foundation HIV/AIDS Initiative Quarterly Report Q2 2007
- CHAI 2007. The William J. Clinton Foundation HIV/AIDS Initiative Quarterly Report Q3 2007
- CHAI 2007. The William J. Clinton Foundation HIV/AIDS Initiative Quarterly Report Q4 2007
- CHAI 2007. The William J. Clinton Foundation HIV/AIDS Initiative 2007 Annual Plan for the Independent State of Papua New Guinea
- CHAI 2008. 2008 Annual Planning Template
- CHAI 2008. The William J. Clinton Foundation HIV/AIDS Initiative Quarterly Report Q1 2008
- CHAI 2008. The William J. Clinton Foundation HIV/AIDS Initiative Quarterly Report Q2 2008
- CHAI 2008. The William J. Clinton Foundation HIV/AIDS Initiative Quarterly Report Q3 2008
- CHAI 2008. The William J. Clinton Foundation HIV/AIDS Initiative Quarterly Report Q4 2008
- CHAI 2008. The William J. Clinton Foundation HIV/AIDS Initiative 2008 Annual Plan for the Independent State of Papua New Guinea
- CHAI 2009. Budget FY2009
- CHAI 2009. The William J. Clinton Foundation HIV/AIDS Initiative 2009 Annual Plan for the Independent State of Papua New Guinea
- GoPNG 2006. Review of Provincial Function Grants in 2005 Prepared for the National Economic & Fiscal Commission. September 2006
- GoPNG 2009. HIV Annual Sector Performance Report – April 2009
- IRG 2007. Independent Review Group on HIV/AIDS. Report from an assessment visit 31 August–13 September 2007
- IRG 2008. Independent Review Group on HIV/AIDS. Report from an assessment visit 27 August–9 September 2008
- IRG 2008. Independent Review Group on HIV/AIDS. Report from an assessment visit 12-25 April 2008
- IRG 2009. Independent Review Group on HIV/AIDS. Report from an assessment visit. 23 April – 6 May 2009.

Joint team, 2007. Continuum of Prevention to Care and Treatment (CoPCT). Site assessment: Findings and recommendations 18-29 November 2007.

Laura Chin, Divyesh Modi, Amit Nangalia, Purvi Ravani, Emily Reyna, Stephen M. Ross School of Business. 2007. Distribution of Antiretroviral Drugs & HIV Test Kits in Papua New Guinea

National AIDS Council of PNG 2006. National Gender Policy and Plan on HIV and AIDS 2006-2010

NDoH 2005. Memorandum of Understanding between the Government of Papua New Guinea and the Clinton Foundation HIV/AIDS Initiative

NDoH 2007. Estimation Report on the HIV Epidemic in Papua New Guinea

NDoH 2007. Health Sector Strategic Plan 2007 – 2010

NDoH 2008. Corporate Plan 2009 – 2013 – Our Way Forward.

NDoH 2008. PNG Health Sector Performance report for 2008

NDoH 2008. PNG Health Sector Strategic Plan for STI, HIV and AIDS 2008 – 2010.

NDoH 2008. PNG HIV Surveillance Plan 2008 – 2010

NEFC 2007. Improving service delivery outcomes through provincial budgeting and expenditure management: Some ideas from the National Economic and Fiscal Commission. June 2007

## ANNEX 4: PEOPLE MET

### AusAID Canberra

Janet Donnelly  
Jennifer Lean  
Kirsty Dudgeon  
Mukii Gachugu  
Sofia Erikson

Manager, Evaluation and Reviews, PQR, PNG Group  
Manager, PNG Branch  
Program Manager, Program Quality & Review Section, PNG Branch  
Manager - Design Support, Program Quality & Review Section, PNG Branch

### AusAID Port Moresby

Anne Malcolm  
Lydia Butut-Dori  
Katherine Yuave  
Brian Dowling  
Gaye Moore

Program Manager, Australia-PNG HIV Program (by phone)  
Senior Program Officer  
Program Officer  
2<sup>nd</sup> Secretary Health  
A/1<sup>st</sup> Secretary, Australia-PNG HIV Program

### AusAID Goroka

Moale Vagikapi

Team Leader & Senior Program Officer

### Clinton HIV/AIDS Initiative

Sarthak Das  
Prescott Chow  
Dr Jessica Markby  
Andy Carmone  
Dr Prithi Panditharatne  
Michael Schaultz

Country Director  
Deputy Country Director  
Laboratory Adviser  
Program Officer, Rural Initiative  
CHAI Clinical Mentor  
Country Analyst

### NDoH

Dr Clement Malau  
Dr Esorom Daoni

Secretary  
Principal Technical Adviser, HIV/AIDS/STI, CDB

### NACS

Dr Romanus Pakure

A/Director

### FHI PNG

Nayer Kaviani  
Tess Prombuth

Country Director  
Senior Technical Officer

### EHP Provincial Government

Mr Malcolm Smith

Governor

### EHP Provincial Administration

John Jiminsavi  
Ben Haili  
Ken Wai

Deputy Provincial Administrator  
Director, Health Services  
Deputy Director – District Health

### Goroka Hospital

Dr Joe Apa  
Dr Frank Dale  
Theresa Palau  
Dr Paul Wari  
Simon Pekon  
Sr Ulato Gebaro-Imara  
Mr Jani Wano  
Mary Drua

CEO  
Director Medical Services  
Laboratory Manager  
Paediatric Registrar  
Case Manager, Adult Care & Treatment  
Sister-in-Charge, Michael Alpers Clinic  
2<sup>nd</sup> OIC, Michael Alpers Clinic  
Case Manager, PPTC/Paediatric HIV, Michael Alpers Clinic

### Asaro Health Centre

Kum Topma

Health Extension Officer

### Kainantu Rural Hospital

Dr Thomas Koimbu

Chief Medical Administrator

Rhoda Eliab Haggai Joshua	OIC STI/HIV Clinic Laboratory Technician, PASHIP
<b>Henganofi Health Centre</b> Jonas Tevesabo Sr Jenny Kemeya Pop Siwi Akome Mananu Bernard Nondosi Roy Uzetto Formai Meneme Sharron Hitio	OIC Family Health District Health Officer VCT TB DOTS ACSM VCT VCT
<b>AT Projects</b> Miriam Layton Steve Layton	Co-Director Co-Director
<b>Save the Children PNG</b> Peter Raynes Rosario Sam Erwin Korarome Larry Wadiri Steve Willie Sam Ghanshyam Jethwa Rhoda Tavoro Priscilla Yabio	HIV & AIDS Program Manager Program Support SPO, Tingim Laip Volunteer, Tingim Laip Volunteer, Tingim Laip Project Manager, PASHIP JPO-AF, Poro Sapot Project JPO-AF, Poro Sapot Project
<b>UNICEF</b> Carlos Baraka Cristi Morf Hamish Young	Assistant Programme Officer, Goroka HIV/AIDS Specialist, Port Moresby Country Representative, Port Moresby
<b>WHO</b> Dr Fabian Ndenzako	HIV/AIDS Country Officer
<b>AMS</b> Cathy Kemben Willie Aloitch	Logistic Officer CHAI Cadet, Career & Development Program
<b>Well Baby Centre, PMGH</b> Dr Mobumo Kiroamat Tessie Soi OBE Sr. Rambai, Well Baby Centre Sr. Poli Yaueib, Nursing Sr. Wendy Kunal Aiwa, Sr. Kulu Kaltia, Sr. Veronica Kalebe, Sr. Kaye Aimari, Mr. Rory Sitapai, Ms. Etu Azavu, Mr. Julius Piku,	Medical Director, Paediatric Division Director/Founder Friend Foundation Inc Sister in Charge, Paediatric Nurse Counsellor and PPTCT Coordinator, ANC Case Manager, PPTCT Nursing Officer, PPTCT Case Manager, Paediatrics Nursing Officer, Paediatrics Manager, Friends Foundation Social Worker, O&G Division Data Clerk, PPTCT and Paediatrics
<b>Friends Foundation Inc</b> Asi Nauna Ceslyn Hetabu Kila Buro Elizabeth Loko Group of 17 mothers, 2 fathers, 2 grandmothers, 14 children	Administrative Assistant Coordinator PPTCT Site visit volunteer Assistant to PPTCT Coordinator
<b>CPHL</b> Dr Evelyn Lavu	a/Director

Loina Yafin  
Geline Narekine

Logistic Officer  
Medical Laboratory Technician

**CBSC**

Brendon Douglas  
Shane Martin

Facility Manager  
HIV Management Adviser

**Heduru Clinic**

Dr Jimbanao  
Sr Gola Sawiya  
Ns Po'o Mendi

Medical Officer  
Senior Nursing Officer  
Community Health Worker

**ADB Enclaves Project**

Jeremy Syme  
Kel Browne

Project Manager  
Deputy Project Manager – Health Services

## ANNEX 5: IN-COUNTRY MEETING SCHEDULE

Name	Designation	Organisation	Time	Venue
<b>Monday 25 May 2009</b>				
Nayer Kaviani	Director	Family Health International	0830- 1000	FHI Office
Fiona Cornwell/ (and health team)	Counsellor/First Secretary Health	AusAID	1030 - 1130	4 Floor Deloitte Tower
Gaye Moore	First Secretary	AusAID	1300 -1400	PNG HIV/AIDS Program Office, Kumul Building, Waigani
Dr Esorom Daoni (and team)	Technical Advisor	HIV/AIDS/STI	1445 - 1600	3 Floor, NDoH, Aopi Centre
<b>Tuesday 26 May 2009</b>				
Sarthak Das (and staff)	Country Program Director	Clinton Foundation	0830 - 1200	
<b>Travel to Goroka: Tuesday afternoon flight</b>				
<b>Wednesday 27 May 2009</b>				
Moale Vagikapi	Team Leader	AusAID Goroka	0830 -0 930	Provincial Administration Building
John Jiminsavi	Deputy Provincial Administrator	EH provincial administration	0945 -1015	Provincial Administration Building
Ben Haili, Ken Wai, Deputy Director Provincial Health	Provincial Health Advisor	EH provincial administration	1030 -1130	Provincial Administration Building
Meet with CHAI Goroka staff		Clinton Foundation	1145 - 1245	
Peter Raynes/Sam Gethwa	Country Manager	SCiPNG	1330 - 1430	SciPNG Office
Miriam and Steve Layton	Co-Directors	AT Projects	1500 - 1630	AT Projects base
<b>Thursday 28 May 2009</b>				
Dr Apa	CEO	Goroka Provincial Hospital	0830 - 1045	Goroka Provincial Hospital
Dr Frank Dale	Director Medical Services			
Carlos Baraka	Assistant Program Officer	UNICEF Goroka	1100 - 1200	
Field visit Asaro Health Centre, Daulo District			1300 - 1600	
<b>Friday 29 May 2009</b>				
CF Goroka to organise	Site visits to Kainantu ( 1hour drive) and Henganofi		0800 - 1600	
Dr Thomas Koimbo	CEO Chairman, EHP PAC	Kainantu Hospital	9.00 - 1000	Kainantu Hospital
Mr Malcolm Smith	Governor	EHP Provincial Government	1830 -2000	Working dinner
<b>Saturday 30 May 2009 - Return to Port Moresby (morning flight)</b>				
<b>Monday 1 June 2009</b>				
Romanus Pakure (and staff)	A/Director	National AIDS Council Secretariat	0830 - 0930	

Name	Designation	Organisation	Time	Venue
Joint Health DP meeting	UNICEF, WHO		1000 – 1130	AusAID Conference Room, Deloitte Tower
Jeremy Syme	Project Manager	ADB Rural Enclave Project	1300-1400	Aopi Building
<b>Tuesday 2 June 2009</b>				
Dr Evelyn Lavu	a/Director	CPHL	1000 - 1200	PMGH
Dr Kiromat	Medical Director Paediatric Division	Well baby and mothers clinic	1300 - 1430	PMGH
<b>Wednesday 3 June 2009</b>				
Navy Mulou	Health Economist	NDoH	0830 -1030	Aopi
Brendon Douglas	Facility Manager	CBSC	1330 - 1430	Aopi
Shane Martin	HIV Management Adviser			
CF team		Visit to area medical store	1445 - 1600	Badili
<b>Thursday 4 June 2009</b>				
Sarthak Das and CF team			0830 - 1200	NDoH Conference Room
Friends Foundation		Well Baby Centre	1300-1400	PMGH
Anne Malcolm	Program Director	AusAID HIV/AIDS Program	1430-1530	Phone hook-up
<i>Preparation for Aide memoire</i>				<i>rest of the day</i>
<b>Friday 5 June 2009</b>				
Review Team	Aide memoire presentation 9.00 - 1030		NDoH Conference Room	

## ANNEX 6: CHAI PROGRAM LOGIC

**Aim/purpose:** To bring high-quality medical care and treatment to PLWHA & to improve health systems in resource poor countries

**Indicators**

- None provided

**Program Areas**

**Sub-programs**

**1. Laboratory Infrastructure**

*Objective:* To support the government in the design and implementation of a rationalized laboratory system for HIV care and treatment.

*Indicators*

- None provided

- ← 1.1 Early Infant Diagnosis (EID)
- 1.2 Rapid Test algorithm development
- 1.3 CD4 Testing
- 1.4 Infrastructure, HR, mentoring & research

**2. Paediatric Care & Support**

*Objective:* Expand quality HIV care, treatment & support including antiretroviral therapy to children in new & existing paediatric treatment sites

*Indicators*

- None provided

- ← 2.1 Provider Initiated Counselling & Testing (PCT)
- 2.2 Early Infant Initiation
- 2.3 Retention & Case Management (Well Baby Centre at PMGH)

**3. The Rural Initiative**

*Objective:* To design & implement a replicable Model for HIV & AIDS testing care & treatment for the rural majority in EHP & SHP.

*Indicators:*

1. % people with advanced HIV infection on ART
2. % people still on ART 12 months after initiation
3. % adults with initial weight loss, gain =>10% body weight 6 mths after ART initiation
4. % people who initiate ART alive at 6,12, 24 months after initiation
5. % women offered who receive ART for PPTCT

- ← 3.1 Adult Care and Treatment
- 3.2 Paediatric Care and Treatment
- 3.3 Prevention of Parent to child transmission

**4. Procurement & Supply Management**

*Objective:* To continue to serve the commodity & equipment needs of the national HIV program, particularly in regards to paediatric care & treatment, & to encourage superior management of the distribution system in-country through ongoing support to the HIV Logistics Unit.

*Indicators:*

- None provided

- ← 4.1 Support to NDOH Logistics Unit

**5. Clinical Mentoring**

*Objective:* To ensure high level of quality of care at key ART treatment facilities & to build capacity of local clinicians to manage HIV testing, care, & treatment.

*Indicators:*

- None provided

- ← 5.1 Support to ART Sites

**6. Patient Information Systems**

*Objective:* To guide the development of a robust patient information management system which serves the needs of patients, health workers & the national HIV program.

*Indicators:*

- None provided

- ← 6.1 National HIV Database Development

**7. Program Management and Coordination**

*Objective:* To support & coordinate major program areas while providing strategic direction for the Foundation's activities in-country.

*Indicators:*

- None provided

- ← 7.1 Support & Coordination of All Major Program Areas
- 7.2 Budget Oversight
- 7.3 Safety & Security
- 7.4 Strategic Planning
- 7.5 Reporting Support to NDOH Logistics Unit

## ANNEX 7: CURRENT AND EXPECTED LABORATORY CAPABILITY

Capability now	Expected capability (assuming CF will be extended)
<p><b>CPHL</b></p> <ul style="list-style-type: none"> <li>• HIV Serology Confirmatory Testing</li> <li>• (1 month turn around)</li> <li>• CD4 Count (long machine down times, stock outs etc)</li> <li>• EID using DNA PCR (Average less than 10 tests per week)</li> <li>• TB microscopy</li> </ul> <p><b>Pathology PMGH</b></p> <ul style="list-style-type: none"> <li>○ Haematology</li> <li>○ Biochemistry</li> </ul>	<p><b>CPHL</b></p> <ul style="list-style-type: none"> <li>○ IQC for VCT confirmatory testing in NCD/Central</li> <li>○ NEQAS for HIV testing for all of PNG</li> <li>○ CD4 percentage upgrade and continuous CD4 machine running with strengthened service, maintenance of machines</li> <li>○ Enhance capacity of PCR lab</li> <li>○ Viral Load</li> <li>○ ART Resistance genotyping testing</li> <li>○ TB sensitivity testing</li> </ul>
<p><b>Goroka Hospital</b></p> <ul style="list-style-type: none"> <li>• HIV Serology Confirmatory Testing</li> <li>• CD4 Count</li> <li>• Haematology</li> <li>• Biochemistry</li> </ul>	<ul style="list-style-type: none"> <li>• IQC for VCT confirmatory testing in EHP</li> <li>• CD4 percentage upgrade and continuous CD4 machine running with strengthened service, maintenance of machines</li> <li>• Commence PCR testing</li> <li>• Viral Load</li> </ul>
<p><b>Mendi Hospital</b></p> <ul style="list-style-type: none"> <li>• HIV Serology Confirmatory Testing</li> <li>• CD4 Count</li> <li>• Haematology</li> <li>• Biochemistry</li> </ul>	<ul style="list-style-type: none"> <li>• IQC for VCT confirmatory testing in EHP</li> <li>• CD4 percentage upgrade and continuous CD4 machine running with strengthened service, maintenance of machines</li> </ul>
<p><b>Mount Hagen Hospital</b></p> <ul style="list-style-type: none"> <li>• HIV Serology Confirmatory Testing</li> <li>• CD4 Count</li> <li>• Haematology</li> <li>• Biochemistry</li> </ul>	<ul style="list-style-type: none"> <li>• IQC for VCT confirmatory testing in WHP</li> <li>• CD4 percentage upgrade and continuous CD4 machine running with strengthened service, maintenance of machines</li> </ul>
<p><b>Angau Hospital (Lae)</b></p> <ul style="list-style-type: none"> <li>• HIV Serology Confirmatory Testing</li> <li>• CD4 Count</li> <li>• Haematology</li> <li>• Biochemistry</li> </ul>	<ul style="list-style-type: none"> <li>• IQC for VCT confirmatory testing in Morobe</li> <li>• CD4 percentage upgrade and continuous CD4 machine running with strengthened service, maintenance of machines</li> </ul>
<p><b>Modilon Hospital (Madang)</b></p> <ul style="list-style-type: none"> <li>• HIV Serology Confirmatory Testing</li> <li>• CD4 Count</li> <li>• Haematology</li> <li>• Biochemistry</li> </ul>	<ul style="list-style-type: none"> <li>• IQC for VCT confirmatory testing in Madang</li> <li>• CD4 percentage upgrade and continuous CD4 machine running with strengthened service, maintenance of machines</li> </ul>
<p><b>Nonga Hospital (Rabaul)</b></p> <ul style="list-style-type: none"> <li>• HIV Serology Confirmatory Testing</li> <li>• CD4 Count</li> <li>• Haematology</li> <li>• Biochemistry</li> </ul>	<ul style="list-style-type: none"> <li>• IQC for VCT confirmatory testing in ENBP</li> <li>• CD4 percentage upgrade and continuous CD4 machine running with strengthened service, maintenance of machines</li> </ul>

## ANNEX 8: DETAILED RURAL INITIATIVE ACHIEVEMENTS

### Major Achievements: *Quantitative*

- In 2007 a total of **7358** HIV tests were conducted in Eastern Highlands Province.
- In 2008 a total of **13,662** HIV tests were conducted in Eastern Highlands Province (This represents *nearly 40% of the total number of tests in all of PNG for 2009.*)

	HIV Testing	
	January 2007	April 2009
PICT in STI Patients	10% of clients	90% of clients
PICT in TB Out-Patients	none	90%
Rural Outreach VCT	none	3,700

	Adult Care & Treatment	
	January 2007	April 2009
Registered Care/Tx	169/78	946/521
Body Mass Index Increase	75%	87%
Proportion on ART	46%	58%
Lost-to-Follow-Up	65%	15%
12M ART Retention	73%	86%
District Level ART	none	27%
Projected Need Addressed	2%	11%

	PPTCT	
	January 2007	April 2009
HIV Testing Uptake	<50%	88%
Lost-to-Follow-Up	74%	2%
Anti-Retroviral Rx	NVP	4 Protocols
Maternal Follow-Up	none	95%
Newborn Follow-Up	none	95%
District Level Testing	none	14 sites
Projected Need Addressed	10%	39%

	Paediatrics	
	January 2007	April 2009
Registered Care/Tx	1/1	69/19
Lost-to-Follow-Up	34%	5%
Patients from PPTCT	none	59
Projected Need Addressed	1.6%	55%

### Major Achievements: *Qualitative:*

- *Quality services are delivered.*

In HIV patient care, the numbers show a high quality of care for the setting, firstly evidenced by patient retention.

- *This level of collaborative relationship is unprecedented.*

Goroka General Hospital and Provincial Health Services working to design and implement this model of HIV testing, care and treatment for is notable.

- *HIV service delivery is seen as integral to standard patient care* at Goroka General Hospital, as well as in many places in the Province, whereas before Rural Initiative, HIV care was seen as a duty outside of normal patient care.
- *Access to HIV testing has expanded dramatically.* The efforts made in VCT training of Health Care Workers as well as laypeople, followed up with ample opportunity to practice the skills learned, such as bringing newly trained counsellors to Health Fairs featuring VCT to practice under supervision with higher numbers than possible normally, has resulted in much higher numbers of VCT through the Hospital and Outreach, answering a need of the community. Likewise, in-service training in PICT as distinct from VCT has led to far better counselling skills and execution of PICT throughout the Hospital and affiliated clinics, namely the Antenatal Clinic, Children's Medical and Outpatient, Labour Ward, Medical Ward and STI/HIV clinic.
- *expansion has been driven largely by existing Health Care Providers.* The first phase expansion of adult ART to the District level was manned entirely by Provincial Health Services employees who had been trained in ART prescribing but were since idle. Mentoring and supervising them as they undertake this new role has given them greater job satisfaction. This approach also demonstrates how to optimize the existing human resources within a Province through mentorship and supervision.
- *Laboratory improvements have benefitted the people of the entire catchment area.* Laboratory is the backbone of health care service. Upgrades made to the Goroka General Hospital Pathology Lab in order to provide adequate HIV treatment have benefitted the care of every patient.

## ANNEX 9: HR summary

### Overall Proposed Structure for CHAI Program in 2006

- One (1) Full Time Country Director
- One (1) Full Time Program Officer to coordinate CF-NDOH initiatives
- One (1) additional Program Officer to work with NDOH
- One (1) Full time Laboratory Expert
- Two (2) Full time HIV Physicians
- One (1) Full time paediatrician
- Clinicians and technical experts on as needed basis
- Funding for local staff including clinicians, data analysts, and nurses

### 2006 Actual Staff

- One (1) Full Time Country Director
- One (1) Full Time Program Officer for Rural Initiative
- One (1) Analyst to liaise with NDOH
- One (1) Analyst to work with Logistics Unit
- One (1) Full time Laboratory Expert
- One Full Time Clinical Director
- One Full Time HIV Physician (only with program for 3 months)
- One (1) Part Time Nurse Midwife with the Rural Initiative

### *Changes to staff by 2006 Year End: None*

### 2007 Actual Staff

- One (1) Full Time Country Director
- One (1) Full Time Program Officer for Rural Initiative
- One (1) Analyst to liaise with NDOH
- One (1) Analyst to work with Logistics Unit
- One (1) Full time Laboratory Expert
- One (1) Full Time Clinical Director
- One (1) Full Time Nurse Midwife with the Rural Initiative

### *Changes to staff by 2007 Year End:*

- Loss of Country Director
- Loss of Clinical Director
- Loss of Laboratory Expert
- Loss of Adult HV Physician
- Loss of Analyst liaising with NDOH
- (Full Time Paediatrician Remained Vacant)

Out of the original 7 team members 5 remained, both the Rural Initiative staff members.

### 2008 Actual Staff

- One (1) Full Time Country Director
- One (1) Full Time Deputy Country Director
- One (1) Full Time Program Officer for Rural Initiative
- One (1) Analyst to work with Logistics Unit
- One (1) Full time Laboratory Expert
- One (1) Full Time Clinical Director
- One (1) Full Time Patient Support Coordinator

Clinical Mentors arrival delayed by visa/work permit issues

### 2009 Actual Staff

- One (1) Full Time Country Director
- One (1) Full Time Deputy Country Director

- One (1) Full Time Program Officer for Rural Initiative
- One (1) Analyst to work with Logistics Unit
- One (1) Full time Laboratory Expert
- One (1) Full time Clinical Mentor for Adult HIV

### **National Staff Supported**

#### **Port Moresby (14 Positions, managed through JTAI)**

- CF / Administrative Officer
- PMGH / Adult HIV/AIDS Physician
- CPHL / Laboratory Technician – EID
- CPHL / Laboratory Technician – EQAS
- PMGH / Case Manager PPTCT
- PMGH / Nursing Officer PPTCT
- PMGH / Community Health Worker PPTCT
- PMGH / Case Manager Paediatrics
- PMGH / Nursing Officer Paediatrics
- PMGH / Community Health Worker Paediatrics
- PMGH / Data Clerk
- PMGH / Logistics Management Officer
- CF/Drivers
- In addition, the Foundation has one cadet from the Cadets in Development program

#### **Mount Hagen (2 Positions, managed through JTAI)**

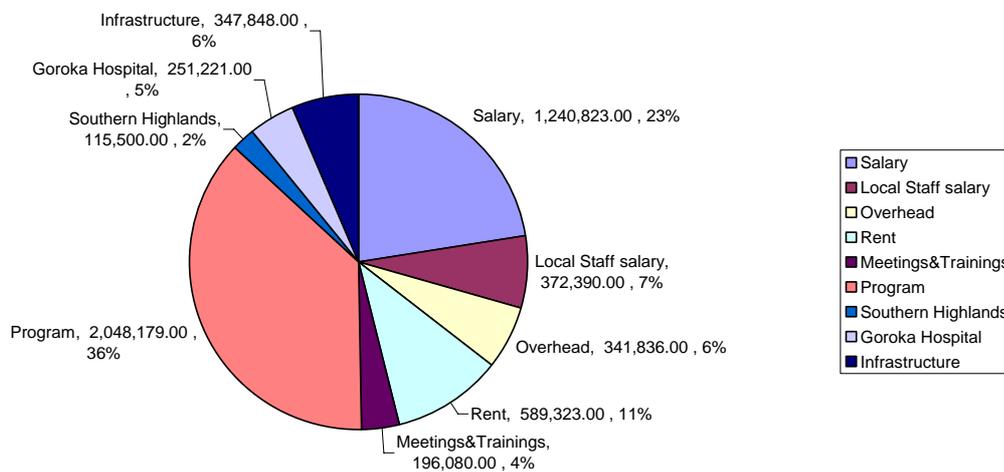
- Nurse Coordinator for HIV
- Adult HIV/AIDS Physician

#### **Goroka (8 Positions based at Goroka Hospital, managed by the Hospital)**

- CF / Administrative Office
- 2 Case Managers (HEO)
- 2 Nursing Officers
- 2 Community Health Workers
- 1 Driver

## ANNEX 10: ALLOCATION OF FUNDS (2007-2009)

Expense allocation 2007-09



Program allocation 2007-08

