Australian Agency for International Development

MID TERM REVIEW

16-30 July 2007

Tibet Health Sector Support Program

Final Report

4 October 2007

The findings and recommendations presented in this report are those of the review team and do not necessarily represent the views of the Governments of the People's Republic of China or Australia. The review team expresses its gratitude for the cooperation received from all agencies in the Tibet Autonomous Region, THSSP and individuals consulted during the course of the review.

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Project Data Sheet

Tibet Health Sector Support Program

Location: Regional level in Lhasa, Lhasa City and Lhasa Municipality Counties of Damxung, Nimu, Qushui and Linzhou, Tibet Autonomous Region, China

Australian Managing Contractor: Australian Red Cross with the Burnet Institute

Key Implementing Agencies: TAR Regional Health Bureau and Lhasa Municipal Health Bureau

Offices: TAR Regional CDC, Lhasa; Lhasa Municipal Health Bureau, Lhasa

Key Dates:

- Feasibility Design Studies 1999 & 2000
- PDD 2001
- Tendered 2003
- Start 22 March 2004
- Inception Phase 22 March 2004 – 15 May 2005 (extended from 21 March 2005 to 15 May 2005 through Contract Variations Nos. 2.0 and 4.0)
- Implementation Phase 16 May 2005 – 21 March 2009
- Extension Phase CON 12484 Schedule 1 allows an extension at AusAID's sole discretion: no extension envisaged
- Expected End 21 March 2009

Australian contribution: A$17.3million

Currency Equivalent

A$ 1.00 = ~ 6.66 Yuan (July 2007)

THSSP Framework:

Goal: To improve the health of the people of the Tibet Autonomous Region (TAR), particularly those who have the greatest need, through strengthening health services.

Purpose: To strengthen health systems in the TAR.

Components and their Objectives:

Component 1: Health System Development

Objective: Improved health system effectiveness in TAR at the strategic and operational levels.

Outputs:

1.1 Improved management practices applied by senior health managers

1.2 Improved training practices

1.3 Sustainable safe blood supply

1.4 Improved clinical infection control ("…and waste management practices" deleted)

1.5 (Strengthening affordable access to health care) (deleted)

1.6 Strengthened health emergency preparedness and response

Component 2: Primary Health Care Support

Objective: Improved effectiveness, and quality of, and access to, integrated rural health services in four PHC Program counties.

Outputs:

2.1 Improved practices applied by county and township health managers to manage integrated health services

2.2 Improved clinical care of maternal, infant, child and family health

2.3 Improved access to health services at all levels of the system

2.4 Effective health promotion

Component 3: HIV and AIDS Support

Objective: Improved effectiveness of the TAR response to HIV and AIDS.

Outputs:

3.1 Effective key stakeholder response to HIV and AIDS

3.2 Expanded program of HIV and AIDS and STI surveillance

3.3 Reduced risk behaviours among groups vulnerable to HIV infection

3.4 Improved awareness and knowledge of HIV and AIDS and STI prevention and control among the general population

3.5 Improved access to quality condoms

Acronyms

ACWF	All China Women's Federation
AIDS	Acquired Immune Deficiency Syndrome
AMC	Australian Managing Contractor
AP	Annual Plan
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drugs
ATL	Australian Team Leader
AYA	Australian Youth Ambassador
BCC	Behavioural Change Communication
CDC	Centre for Disease Control
CLTA	Chinese Long Term Advisor
CMS	Cooperative Medical Scheme
CPD	Chinese Project Director
CSM	Condom Social Marketing
CSTA	Chinese Short Term Advisor
CTL	Chinese Team Leader
CUP	Condom Use Program
DOFCOM	Department of Finance and Commerce (TAR)
DOHA	Department of Health and Ageing (Australian)
EE	Entertainment Establishments
EMNC	Essential Maternal and Neonatal Care
EW	Entertainment Worker
GOA	Government of Australia
GOTAR	Government of the Tibet Autonomous Region
GOPRC	Government of the People's Republic of China
HIV	Human Immunodeficiency Virus
IDD	Iodine Deficiency Disease
IDU	Injecting Drug User
IMCI	Integrated Management of Childhood Illness
IEC	Information, Education, Communication
LMHB	Lhasa Municipal Bureau of Health
LTA	Long Term Advisor
MARPs	Most At Risk Populations
M&E	Monitoring and Evaluation
MDGs	Millenium Development Goals
MOE	Ministry of Education
MOH	Ministry of Health
MSM	Men who have Sex with Men
MTR	Mid Term Review
NAP	National AIDS Program
NHSHR	Non Health Sector HIV Response
PCC	Program Coordinating Committee
PTD	Project & Technical Director
PDD	Program Design Document

PHC	Primary Health Care
PM	Program Manager
PMO	Program Management Office
PWG	Program Working Group
RBC	Regional Blood Centre
RCDC	Regional Centre for Disease Control
RHB	Regional Health Bureau
SHA	Senior Health Advisor
STA	Short Term Advisor
SOS	Scope of Services (specifying the activities to be completed by the AMC)
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group
TAR	Tibet Autonomous Region
TOT	Training of Trainers
TRHB	Tibet Regional Health Bureau
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Fund
VTC	Voluntary Testing and Counselling
WAD	World AIDS Day
WHO	World Health Organization

Executive Summary

A. Background to the MTR

THSSP resulted from several pre- and feasibility and design missions from 1997-2001, was tendered in 2003, and commenced on 22 March 2004. The original concept of two separate project, HIV/AIDS and rural primary health care, was integrated into one Program design which include health system strengthening. The Inception Period finished on 15 May 2005 following a short extension. The four-year Implementation Phase completes on 21 March 2009. There was a mid-2006 TAG. A proposed MTR for Year 3 was incorporated in CON 12484 Schedule 1.

The TORs of the Mid Term Review (MTR) (16-31 July 2007) were, inter alia, to assess Program progress and provides recommendations to enhance implementation and outcomes over the remaining twenty months. The draft MTR Report was submitted to AusAID on 6 August 2007, AMC and AusAID comments were received on 25 September 2007, reviewed by the MTR team, this final report prepared and sent to AusAID on 4 October 2007.

B. Contextual Changes

A different and more enabling policy environment in China and Australia has developed during THSSP.

Australia's changed policy context includes the White Paper, Australian Aid: Promoting Growth and Stability (2006), AusAID Health Policy (2006) and Gender Policy (2007) which emphasise health systems, women and children's health, gender equality, and leadership on HIV/AIDS; (ii) AusAID's China Country Strategy; (iii) Australia's International HIV/AIDS Strategy (2004); (iv) commitments under UN HIV/AIDS Declarations (2001 and 2006); (vi) the "Three Ones" principles[1]; and (vii) recommendations of the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (2005).

China's changed policy context includes GOPRC's global commitments to improve health; the establishment of China's National AIDS Committee in 2004; the State Council issued China's AIDS Regulations, effective 1 March 2006; China's second five year *Action Plan for the Containment and Control of HIV/AIDS in China (2006-2010); and the increase in GOPRC budget allocation to* HIV/AIDS prevention and care from 390 million RMB (~US$ 48.75 million) in 2004 to 800 million RMB (~US$ 100 million) in 2005, with steady increases continuing.

GOTAR has responded to national requirements with a series of policies which THSSP 's work is supporting including the *11th Five Year Development Plan (2006-2010), t*he 2006 GOTAR 11th Five Year Plan of Human Resource Development, TAR Guidelines for Women and Children Development 2001-2010, GOTAR's 2004-2010 Strategic Framework for Preventing and Controlling HIV/AIDS, Members and Responsibilities of the TAR HIV/AIDS Prevention Working Committee and the 11th 5 year Plan of TAR to Prevent and Control HV/AIDS (not yet officially endorsed)

C. Program Progress

Goal level progress is measurable through one Key Indicator: improved maternal and infant mortality rates (in the four official THSSP counties of Lhasa Municipality: Damxung, Nimu, Qushui and Linzhou). There may be difficulties in measuring the three other goal-level key indicators.

Overall progress in Components 1 and 2 is highly satisfactory to good in all Outputs. There have also been some good achievements in Output 3.2 (Component 3, surveillance). Component 3 in general lacks an agreed strategic and integrated approach between THSSP and counterparts, and there is consequent slow progress in the majority of Outputs.

Cross-cutting activities in Component 1, and particularly Output 1.1 (senior management development) and increasingly Output 2.2 (middle management development) are facilitating synergy and progress through all

[1] UNAIDS Three Ones: one national AIDS coordinating authority; one national AIDS plan; one national M&E framework

Components. The new Health Promotion Strategy is cross-cutting and satisfactory; the aim is stronger impact of THSSP HP support.

Component 1 successes include the senior management development programs and consequent organisational and system changes, supported by strong CPD leadership; TUMC strengthening institutionalisation of improved teaching and research practices; the RBC receiving national accreditation during the MTR; infection control support now gaining strong traction; and progress in the new Output 1.6 on pandemic preparedness.

Component 2 enjoys strong counterpart leadership and overall progress is highly satisfactory (while there is a watching brief on recurrent funding sustainability and utilisation of ambulances, Output 2.3), there is an increase in the number of women delivering at hospital and the reduction in maternal and infant mortality reported above.

Component 3 is achieving well in Output 3.2 (surveillance et al) but needs a shared vision between counterparts and the AMC, and fresh joint planning is required and recommended. New approaches appear to be assisting non-heath sector engagement, where have been some challenges. Review of progress of the NHSHRP is recommended, led by counterparts with THSSP support, by end-2007 to guide future direction.

Program Management was impacted by perceived ambiguities in some Chinese counterpart THSSP responsibilities. These have been clarified and, MTR hopes, this will significantly strengthen overall communication, counterpart ownership, coordination and progress in Component 3 in particular. CPD leadership is strong. The key relevant GOTAR policies, guidelines and targets to which THSSP is contributing should be transparently linked to THSSP documentation (e.g. logframe, M&E table) and translated copies available to all advisors. A final AP is recommended from March 2008-March 2009, with an exit strategy, and a TAG for Component 3 only in March 2008. The AMC should re-assess whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 through the current Component 1 training coordinator. This would be in line with the AMC's stated demand response approach.

Underspending is probable. The degree of underspending is difficult to predict given Component 3 progress may improve, possible pre-payment (as one option to be explored) for the public health management program which will finish after THSSP completes, and system change progress possibly creating new opportunities for THSSP support.

Outputs remain satisfactory – the AMC may request some minor word changes in two Outputs.

M&E has been revised and the structure is sound, if a little complex in part. MTR recommends the AMC consider some changes to key indicators, for greater ease of internal and external assessment of successes and delays, and that GOTAR targets be documented within the M&E Table at least. No changes are recommended to the M&E structure.

THSSP success stories are many. The AMC's focus on improving what is not going so well, e.g. aspects of Component 3, has perhaps distracted them from promulgating some considerable achievements and this should be rectified.

Sustainability probability is high in many Outputs, and low in most Component 3 Outputs – whilst there is hope that rapid progress may be possible under the clarified Chinese counterpart arrangements and fresh joint planning.

D Conclusion

THSSP is on track in Components 1 and 2 and Output 3.2 in Component 3, and there are some significant GOTAR successes with THSSP support. There is strong counterpart leadership and some critical other counterpart responsibilities have been clarified. New joint planning is recommended for Component 3. The structures of the revised M&E Framework and Table are satisfactory while suggestions are made to strengthen some Key Indicators. A review of NHSRG is recommended by end December 2007 to determine future direction. The final AP is recommended for March 2008, which should include an accurate assessment of underspend and the Exit Strategy. A further TAG mission is also recommended for March 2008.

E Recommendations

Output 1.6

1. *Counterparts, the AMC and AusAID discuss options for, and agree on, support to the Shandong University public health management program after THSSP finishes (21 March 2009)*

2. *The AMC and counterparts consider implications of expanding other training to township level, including the feasibility and risks of expanding epidemiological training to township level and advise AusAID*

Output 2.3

3. *The AMC and counterparts include assessment of sustainability (e.g. operating costs such as petrol and maintenance, and availability of latter) when assessing ambulance use later in 2007*

Output 2.4

4. *The AMC and counterparts ensure that the proposed arrangements for managing, monitoring and evaluating the new cross-cutting Health Promotion Strategy do not detract from Component 2 needs continuing to be met*

Component 3 overall

5. *The AMC strengthen management of Component 3 by ensuring during recruitment that the new Component 3 Team Leader is a 'best fit' for progressing Component 3*

6. *The AMC and counterparts jointly develop a stronger strategic and operational workplan for Component 3 for the next 20 months, which incorporates strengthened engagement of the Regional CDC to support the planning and implementation of component 3 (for example through mobilizing RCDC expertise in training activities)*

7. *TRHB and THSSP in partnership, ensure that the focus of implementation efforts is on strengthening the surveillance system and intensifying targeted interventions among most at-risk populations to prevent the sexual transmission of HIV*

Output 3.1

8. *Counterparts, with THSSP support,*
   (i) consider appropriate NHSHR grant applications from regional level agencies and, where appropriate, other centres where interest is self initiated to strengthen response to demand and increase impact
   (ii) ensure efficient and timely NHSHR approval processes

9. *Counterparts, and THSSP support, a review of progress of non-health sector engagement and NHSHR-funded activities by the end of 2007, to determine future*

direction of the NHSHR grants scheme and its budget allocation and advise AusAID of its recommendations

Output 3.2

10. *Counterparts consider THSSP supporting*
    - *(i) further improvement of current surveillance practices through adaptation of serological and behavioural surveillance to the TAR context*
    - *(ii) strengthened data collection methods and data use and*
    - *(iii) THSSP maintain a focus on building capacity for HIV testing, while exploring opportunities with counterparts to strengthen the regional HIV surveillance system*

11. *RCDC request THSSP support to establish reasonable referrals between the model STI clinic and on-going outreach interventions among entertainment workers (this should be a win-win arrangement to meet health care needs among entertainment workers and to increase the use of the existing clinic services)*

Output 3.3

12. *Counterparts and THSSP collaborate to document and promulgate the Shannan experience, including the planning processes, implementation approaches, and progress to date to assist expansion of similar interventions to other places*

13. *TRHB, with technical support from THSSP, lead relevant interventions among vulnerable populations including emerging high risk populations such as IDUs and MSM groups*

Output 3.4

14. *TRHB lead awareness raising campaigns with a focus on mobile populations and at county level (e.g. Linzhou) when mobile populations return home from Lhasa and request THSSP technical assistance*

15. *As previously requested by TRHB and LMBH, THSSP support expansion of the number of HIV/AIDS billboards to include billboards on buses and in bus stations, on trains and in train stations, along highways and at and in the airport*

Output 3.5

16. *For condom use, in line with China's AIDS Regulations effective 1 March 2006,*
    - *i. counterparts, with THSSP support, consider a rapid assessment to have better understanding about condom availability and accessibility by MARPs*

ii. *TRHB lead condom use strategies at prefecture level engaging PSB, Tourism, Culture and FP departments, as well as entertainment establishment managers*

iii. *THSSP advocate and plan (with TRCDC and Lhasa Health Bureau) for targeted interventions among most-at-risk populations in Lhasa, such as condom use by entertainment workers and their clients, and peer education*

iv. *THSSP support TRHB for key non-health sector agencies' study tours on successful condom use at relevant sites within China for lessons learned for adaptation to Tibet*

v. *counterparts and THSSP reassess possibilities to speed up delayed proposals on condom promotion to be funded under the NHSHR grants*

Program Management

17. *Counterparts and THSSP strengthen mechanisms for management and coordination and in doing so consider, and build on, the following and report on progress in the next Six Monthly Report*

(i) Strategy development and monitoring
- *quarterly meetings of THSSP and the CPD (Xi Le)*
- *PWG*

(ii) Management and coordination
- *monthly meetings of THSSP and the Chinese Coordinator (Li Jiang)*
- *early consultation by THSSP of the Chinese Coordinator (Li Jiang) on all high-level coordination matters*
- *regular ad hoc communication between ATL and Chinese Coordinator*
- *AMC re-assessment of whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 as above*

(iii) Component 3 leadership and management
- *possibly similar arrangements to Component 2 (weekly counterpart and THSSP meetings)*
- *and consider also replication of the decision-making arrangement of Component 1 (e.g. CPD, ATL, and Chinese and Australian Component 3 Team Leader)*

(iv) More frequent communication
- *continuation of THSSP/counterpart ad hoc meetings (daily, weekly) and communications as required*

(v) Implementation
- *Counterparts focus on implementation and THSSP on support*

18. *The AMC re-assess whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 through the current Component 1 training coordinator, to strengthen communication and progress, and counterpart satisfaction with THSSP's responsiveness to requests*

19. *The AMC ensure that leadership accountability for Component 3 is clear, consider the PTD spending additional time in-country to add additional strength to Component 3, and, if agreed, AusAID consider agreeing to funding this additional PTD time through unallocated STA budget*

20. *The AMC request and GOTAR provide all relevant current policies, strategies and guidelines and THSSP*
    i. *document specific linkages between these and THSSP-supported activities (e.g. in the log frame and M&E Table) and*
    ii. *ensure all planning, advisor support and M&E is linked to them*

21. *The AMC re-assess whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 through the current Component 1 training coordinator, to strengthen communication and progress, and counterpart satisfaction with THSSP's responsiveness to requests*

22. *The AMC arranges for translation of the full MTR and provides copies to counterparts and all THSSP staff*

23. *For advisor recruitment,*
    (i) the AMC and counterparts consider the merits of C/STA inputs where C/LTA recruitment is problematic
    (ii) the AMC consider further strategies for overall LTA and STA recruitment, such as recruiting from untapped institutions in Inland China and reviewing its executive search processes for opportunities for strengthening, including assessing strategies used by professional executive search firms for ideas to achieve strengthened outcomes

24. *The AMC request and GOTAR provide all relevant current policies, strategies and guidelines and THSSP*
    (i) document specific linkages between these and THSSP-supported activities (e.g. in the log frame and M&E Table) and
    (ii) ensure all planning, advisor support and M&E is linked to them

25. *AusAID consider that the final THSSP annual plan should be the 12 months from March 2008 to (i) enable a clear sense of strategies and sustainability (ii) the degree of underspend by end-THSSP and (iii) that an exit strategy be included*

26. *AusAID, counterparts and the AMC agree timelines for (i) the Activity Completion report and (ii) the Independent Completion Report and any other Program completion processes, as part of the recommended 2008-2009 planning process*

27. *The AMC, in consultation with counterparts,*

(i) revise certain aspects of the M&E Table as discussed during the MTR, including outcome indicators at Purpose and Component 1 level for the next Six Monthly Report

(ii) include available and relevant GOTAR indicators in the M&E Table, to which THSSP support is contributing

28. AusAID consider a TAG in March 2008 to review Component 3 progress only and the Component 3 aspects of the 2008-2009 annual plan (as recommended above) and the TAG report be an input to the AMC's Activity Completion Report and the Independent Completion Report; AusAID consider by January 2008 whether a TAG for Components 2 and 3 and Program Management would add value or not

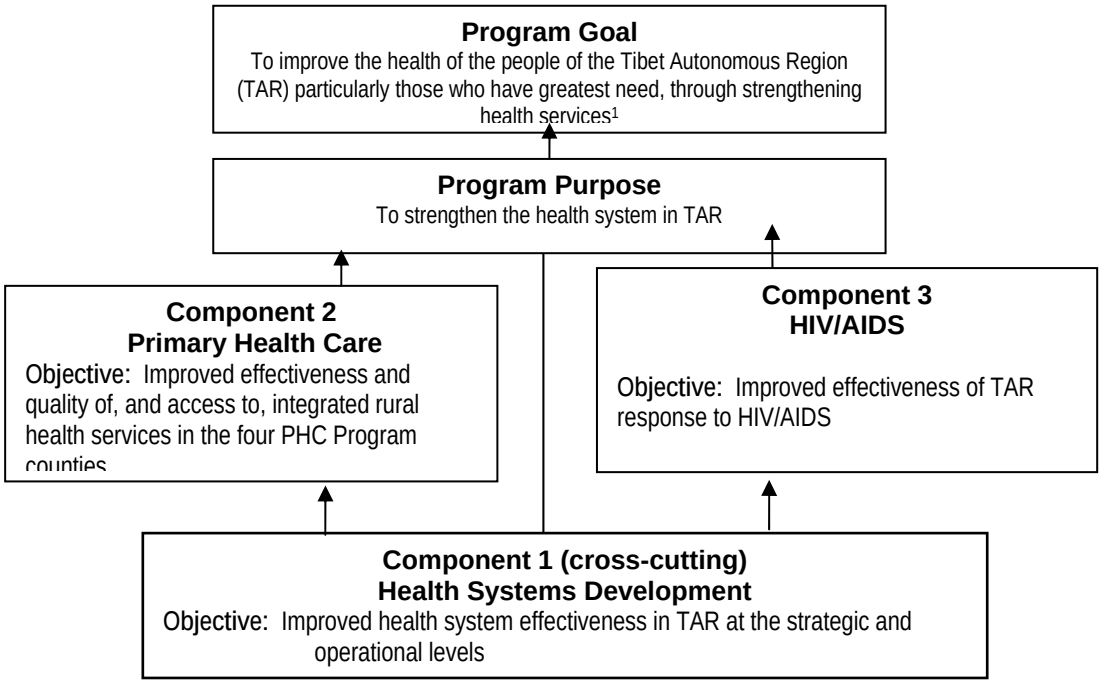
1 INTRODUCTION

1.1 Background

THSSP resulted from several feasibility and design missions from 1998-2001. The initial focus was two separate projects, HIV AIDS and rural primary health care. Given AusAID's then aim of using a program approach, and given then weaknesses in TARs health system, a joint 2001 mission (September) was charged with integrating the two pre-tender projects' foci into a program approach and with incorporating health systems strengthening. There was then a lengthy period before tendering generating some counterpart frustration, which was compounded by characteristics of the Inception Phase which included tender and contractual specification of further analysis and research, not implementation support. This was not a feature of the original PDD, was commented on in the 2006 TAG Report and the TAG made recommendations to AusAID. The CPD stated to the MTR that the Inception Period "…did not aid progress or achieve any change".

THSSP was tendered in late 2003 and mobilised on 22 March 2004. The Inception Period completed on 15 May 2005[2]. The Implementation Phase completes on 21 March 2009. A proposed MTR for Year 3 was incorporated in CON 12484 Schedule 1. The June 2006 TAG made several recommendations[3], which it summarised as THSSP needing to improve (i) Program Planning to better reflect the program approach, enhance strategic thinking, improve the focus of the Program and aid in a more analytical approach to reporting and (ii) the design and delivery of the Program's monitoring and evaluation systems.

Figure 1: Tibet Health Sector Support Program Framework



[2] Following two Contract Variations (CON 12484) Nos. 2.0 and 4.0 extending the end-Inception date from 21 March to 15 May 2005

[3] See 2006 TAG recommendations at Annex 1 and the MTRs assessment of AMC response and progress

1.2 Purpose and Method of Review

The purpose of the Mid Term Review (MTR) (16-31 July 2007) was to, inter alia, assess whether THSSP's progress to date is satisfactory, and make recommendations to enhance implementation and outcomes over THSSP's remaining twenty months[4].

The MTR methodology included consultation at the AusAID Beijing Post and with key stakeholders in Tibet[5], document analysis[6], and synthesis and analysis of data jointly by the MTR team[7]. The THSSP team, CPD and key counterparts were kept informed of progress in thinking during the MTR and their feedback sought. Consultation processes in Tibet included with individuals, groups and teams and a workshop with the AMC on Component 3 issues. Where there were different perspectives these were discussed either at the time or at a later date. Requests for additional THSSP documents were readily provided and revealed a depth and breadth of information highly useful to MTR's thinking and conclusions. Relevant GOTAR policies, strategies and guidelines were unavailable through THSSP and were provided by counterparts; their not being used as guiding documents by THSSP needs to be rectified. To cover all consultations across all Components the MTR team split when necessary. Daily MTR meetings were held at the end of each day to share information gained, to discuss and assess strategic and operational implications, and to form a shared view against the MTR TORs. An Aide Memoire[8] was presented in TAR to key TAR counterparts and THSSP on 27 July in Lhasa. The MTR emphasised that the Aide Memoire was based on key issues, that the MTR report would expand on these, and alerted counterparts and the AMC that during the writing of the report further thinking may emerge.

A draft MTR Report was sent to AusAID on 13 August 2007. Comments from AusAID and the AMC, which had consulted with counterparts in Tibet (on the Executive Summary only), were received on 25 September 2007. The comments were reviewed by the MTR team to arrive at this final report, submitted on 4 October 2007 in line with AusAID's request fro submission by 5 October.

1.3 Report Structure

This Report has been prepared on the basis that the reader is familiar with the THSSP. The structure of the Report is

- a situational analysis of the changed policy context in Australia and China since THSSP began
- analysis of progress against each of THSSP's principles, and then Components and Outputs, including for sustainability; Program management issues are then discussed; THSSP Outcome Key Indicators (from Goal to Output levels) are used to focus the analysis
- lessons learned

[4] MTR TORs are at Annex 2; all recommendations are listed at Annex 3, are within the body of the Report at relevant points, and are also within the Executive Summary to enable it to be a stand alone document

[5] See Annex 4 for list of people consulted

[6] See Annex 5 for documents analysed

[7] The MTR team was Gillian Biscoe (Team Leader), Professor Zhao Pengfei, and John Godwin (15-22 July)

[8] The MTR Aide Memoire is at Annex 6; a translated Power Point presentation and translated Aide Memoire were used at the exit briefing; Dr. Pengfei presented the MTR finding to counterparts in Mandarin to ensure clarity of communication

- summary conclusions conclude the Report
- recommendations are made at each relevant part of the Report, and are summarised at Annex 3
- response to TAG recommendations is at Annex 1

2 Situation Analysis: Policy and Program Context

There are significant changes in the GOA and GOPRC contextual environment since THSSP commenced.

2.1 Australian policy and program context

Changes in the GOA contextual environment include (i) the *White Paper, Australian Aid: Promoting Growth and Stability (2006)*, AusAID *Health Policy (2006)* and *Gender Policy (2007)* which emphasise health systems, women and children's health, gender equality, and leadership on HIV/AIDS; (ii) AusAID's *China Country Strategy*; (iii) Australia's *International HIV/AIDS Strategy (2004)*; (iv) commitments under *UN HIV/AIDS Declarations (2001 and 2006)*; (vi) the "Three Ones" principles[9]; and (vii) recommendations of the *Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (2005)*.

The White Paper[10] on the Australian government's Overseas Aid Program, released in 2006, provides a comprehensive outline of the approach to doubling Australia's aid budget to around $4 billion by 2010. Health, along with education, is a focus of one of the White Paper's four themes 'Investing in People'. A key objective of Australia's development assistance in health is to strengthen health systems to deliver sustained improvements in the health outcomes of those most in need, particularly women and children, as well as gender equality and leadership on HIV/AIDS. To facilitate achieving the Government of Australia's aims, the AusAID policy document, *Helping health systems deliver, Aug 2006,* emphasizes harmonization with other donors and alignment with local priorities, policies and systems.

In addition to the White Paper, Australia's changing focus takes into account directions outlined in *AusAID 2010: The Director General's blueprint*[11] in particular the commitment that by 2010

(i) dependency on contractor-delivered stand along projects will have decreased
(ii) (ii) sectoral and thematic programs expanded
(iii) working through host government and with other donors strengthened and
(iv) complexity of support increased strategic dialogue with host governments and impact increased

Australia's international leadership role in HIV now includes GOA's

(i) board memberships of UNAIDS and the GFATM
(ii) initiation of the pre-eminent leadership group on HIV in the region (the Asia Pacific Leadership Forum on HIV/AIDS)
(iii) work with the business community to establish the Asia-Pacific Business Coalition on HIV/AIDS and

[9] UNAIDS Three Ones: one national AIDS coordinating authority; one national AIDS plan; one national M&E framework.
[10] Australian Aid: Promoting Growth and Stability, April 2006
[11] AusAID 2010: The Director General's Blueprint, AusAID February 2007 p.4.

(iv) a five-year agreement with the Clinton Foundation to provide technical assistance in the health sector to support HIV treatment access in Asia and the Pacific, which in China is being provided in Xinjiang

In April 2006, Australia appointed an Ambassador for HIV/AIDS[12]. The focus of this position is to encourage political, business and community leaders in the Asia Pacific region to provide the direction and support needed to meet the HIV/AIDS threat. Australia has earmarked a total of $1 billion over ten years (2000 – 2010) to global HIV/AIDS initiatives.

AusAID is also developing new monitoring and evaluation frameworks and tools, which in turn require robust and clear program/project M&E frameworks, performance measures and reporting. AusAID's new Quality Reporting System is the framework for monitoring and rating whether activities have clearly stated objectives that contribute to higher level objectives, effectively measure progress towards meeting objectives, continually manage risks, appropriately address sustainability and whether the activities are based on sound technical analysis and ongoing learning.

AusAID support to health and HIV response in China

AusAID has funded support to health and HIV in China over many years including through THSSP, the Bazhong Rural Health Improvement Project, the Xinjiang Autonomous Region HIIVAIDS Prevention and Care Project, the Asia-Regional HIV AIDS Program, the Xianyang Integrated Rural Health Project, and the new China Australia Integrated Health and HIV/AIDS Program which commences shortly. Other Australian support includes scholarships, conference support and study tours.

AusAID's new China Country Strategy focuses on health systems strengthening, emerging infectious diseases (including HIV/AIDS and pandemic preparedness), and child and maternal health. These elements are also integral to the design and implementation of THSSP, in response to TAR's priority health needs. GOTAR confirmed during the MTR that these priority health needs remain current.

All AusAID's health and HIV activities in China including THSSP are now structured within a single national program framework (*China Australia Integrated Health and HIV Program*) and new national oversight mechanisms are being established in 2007. The rationale for this approach is that Australia's assistance is more likely to contribute to national level change through a coordinated program of activities operating within a single framework than through discrete activities operating at provincial/regional or local levels. Under the strategic oversight of AusAID and the Ministry of Finance and Commerce, a Program Management Committee (PMC) – comprising senior representatives from China (MOH, MOFCOM) and Australia (DOHA, AusAID) – meet at least twice per year. As a result there is a clear emphasis on ensuring activities at regional level align well with national policy and are well coordinated with development partners.

GOA priorities under the China Australia Integrated Health and HIV Program are, as the framework for its technical focus,

(i) aligning more closely with partner government systems
(ii) facilitating stronger government-to-government linkages and
(iii) central-level policy engagement

[12] Ms Annmaree O'Keefe

In 2007 AusAID engaged a Senior Health Adviser based in Beijing to further strengthen Australia's support to China who will work in partnership with a Chinese Senior Health Adviser. These new Advisers are intended to provide the focal point for implementing partners' joint strategies in health and HIV. The SHAs will coordinate various elements of the Program strategy, provide technical advice (or access to any more specialised technical advice required), and ensure that linkages and coherence are maximised.

2.2 China's policy context

National

Better health is an important part of China's effort to reduce poverty and inequality and underpins sound economic and social development. China has entered a critical development stage. Industrialization and urbanization are accelerating, as is economic restructuring. Since reform and opening to the outside world over the last several decades, China has enhanced the health of its people and improved its capacity for providing health services. China's health system still requires reform to ensure that all citizens who require health services can access these services.

The Government's approaches to development are contained in its Scientific Development View and its Five Balanced Developments. These set out the Government's method of analysis and broad plan to reach its goals. The concept of a *xiaokang* society (which may be translated as a "well-rounded society with broad prosperity") captures the large-scale goals that the Government has set to reach by 2020.

GOPRC has made global commitments to improve health including commitment to the *United Nations' Millennium Development Goals* (MDGs). Six of the eight MDGs are specifically about health or are health-related. There is some progress towards their achievement in China. China's challenges to achieve the MDGs include child and maternal mortality, HIV/AIDS and tuberculosis, and basic water and sanitation needs.

HIV/AIDS control efforts have intensified across China in recent years. In December 2003, China announced a new national AIDS control policy, *Four Frees and One Care* (free treatment, free Voluntary Counselling and Testing (VCT), free Prevention of Mother to Child Transmission, free schooling for AIDS orphans, and provision of social relief for HIV patients). China's National AIDS Committee was established in 2004 directly under the State Council and led by Vice Premier Madame Wu Yi. Similar committees at provincial, prefecture and county levels have, or are being, established. Key stakeholders in harm reduction include the health, public security, justice, education and labour and social security sectors, and also the Women' Federation and Youth League. Relationships between these key stakeholders vary substantially from area to area. The various AIDS Committees play a key role in coordinating these sectors, a role that was codified in the State Council issued China's *AIDS Regulations*, effective 1 March 2006.

China's second five year *Action Plan for the Containment and Control of HIV/AIDS in China (2006-2010)* is now in effect and resourced for implementation. The national budget for HIV/AIDS prevention and care has risen from 390 million RMB (~US$ 48.75 million) in 2004 to 800 million RMB (~US$ 100 million) in 2005. Local government investment has risen from less

than 100 million RMB (US$12.5 million) in 2003 to 280 million RMB (US$ 34.7 million) in 2005. The level of funding from 2006 onward will be sustained at the central level and steadily increased at provincial level.

TAR

In response to national requirements, GOTAR's efforts to improve overall health status in TAR are through its Health Development Framework, attached to the *11th Five Year Development Plan (2006-2010)*. Tibet's primary health care system is beginning to strengthen. There are improvements in rural health insurance and affordable access.

Key policies and strategies to which THSSP is contributing, all of which have various targets and performance measures, include

- The 2006 GOTAR *11th Five Year Plan of Human Resource Development*
- TAR *Guidelines for Women and Children Development 2001-2010*
- GOTAR's *2004-2010 Strategic Framework for Preventing and Controlling HIV/AIDS*
- *Members and Responsibilities of the TAR HIV/AIDS Prevention Working Committee*
- The *11th 5 year Plan of TAR to Prevent and Control HV/AIDS*

Since THSS was designed there are new indications that Lhasa in particular is at risk of an HIV epidemic that is likely to be at a low level but expanding and highly concentrated among injecting drug users, sex workers and their clients, and possibly also men who have sex with men.[13]

3 Progress Overview

3.1 Progress at Goal and Purpose Levels

THSSP provides support to GOTAR's implementation of its policies, guidelines etc. THSSP does not deliver on GOTAR's policies, it contributes to their successful achievement. In the Updated Logframe of the THSSP Annual Plan 2007-2008, for THSSP Goal-level Key Indicators the AMC states *"Whilst these measures will be interesting to monitor…they will not necessarily reflect impact of THSSP."* MTR agrees with this statement in part only. MTR's view is that contribution analysis enables some assessment of the aggregate impact of THSSP activities at outcome level.

MTR has assessed that THSSP has been, and should continue to be, a key contributor to the measurable improvement in one goal-level Key Indicator, maternal and infant mortality rates.[14] This is also the view of counterparts (e.g. LMHB). THSSP's contribution to this Key Indicator has been particularly through all Component 2 Outputs, Output 1.1 (improved management practices) and Output 1.2 (improved training practices).

[13] See Annex 8
[14] In the four official THSSP counties of Lhasa Municipality: Damxung, Nimu, Qushui and Linzhou

Figure 2: LMHB figures at THSSP Goal level in THSSP Lhasa Municipality Counties of Damxung, Nimu, Qushui and Linzhou

Key Indicators Goal-level impact	2004	2006
Maternal mortality (THSSP Indicator)	321	223
Infant mortality (THSSP Indicator)	49.31	32.2
Neonatal Mortality (GOTAR Indicator)	30.5	26.1

Figures supplied to MTR by LMHB from MCH surveillance system, assessed as accurate by LMHB since at least 2002

For the second goal-level Key Indicators, *rates of HIV infection and STIs*, some relevant data is regarded as sensitive by GOTAR and is unavailable to the AMC, making assessment of progress different. As well,

(i) the introduction of systematic and more skilled testing, will paradoxically make assessment of progress difficult even if data were available and

(ii) there is uneven progress in Component 3 raising questions about THSSP's ability to significantly contribute to this Key Indicator in the remaining 20 months of the Program.

For the third Goal-level Key Indicator, *rates of other diseases targeted by RHB*[15], accurate data may not be available given not all people will present for diagnosis and treatment, making assessment of THSSP's contribution problematic. MTR encourages revision of this Key Indicator.

There is currently no Key Indicator at Purpose level.[16] MTR has recommended to the AMC that Key Indicator(s) are developed, based on being able to measure health system strengthening for those elements of, or organisations within, the health system to which THSSP support has significantly contributed. (See recommendation at Principles below re the AMC further refining or augmenting some Key Indicators).

3.2 Overall Progress at Component Level

Overall progress in Components 1 and 2 is highly satisfactory to good in all Outputs. There have also been some good achievements in Component 3. However Component 3 lacks an agreed strategic and integrated approach between THSSP and counterparts, and there is consequent slow progress in the majority of Outputs.

[15] Particularly those affecting family health, such as pneumonia, diarrhoeal disease and vaccine-preventable diseases

[16] The Purpose of THSSP is *"To strengthen the health system in TAR"*

3.3 Examples of Significant Progress at Output Level

GOTAR has achieved some significant results with a high probability of sustainability since THSSP implementation began, to which THSSP has directly contributed. These include, but are not limited to,

(i) system change underway in several key institutions (e.g. Shannan Hospital) linked to the THSSP-supported leadership and management development including its seminars and study tours (Outputs 1.1 and 2.1, which are cross cutting through all Components)
(ii) improved maternal and infant mortality improvements in THSSP geographic areas (noted above)
(iii) participatory teaching methods improving student/participant learning at TUMC (Output 2.1 and now cross-cutting through many Outputs e.g. management development through Outputs 1.1 and 2.1; THSSP-supported obstetric training, Output 2.2; infection control, Output 1.4; health promotion, Output 2.4)
(iv) national accreditation of the Regional Blood Centre (during the MTR) providing evidence of safe blood supply (Output 1.3)
(v) strengthened laboratory skills in STI and HIV diagnosis and the
(vi) establishment of a Model STI Clinic (Output 3.2)

3.4 Examples of Improving Progress in Other Outputs

Work-in-progress which has potential for achieving significant, sustainable progress includes

(i) infection control (Output 1.4)
(ii) improved access (Output 2.3)
(iii) health promotion (Output 2.4 which is now cross-cutting with a new strategy) and
(iv) improved HIV and STI surveillance (output 3.2).

3.5 Particular Challenges to Progress for next 20 Months

Challenges include developing a shared counterpart/AMC vision and joint planning agreement for Component 3 including

(i) which HIV-vulnerable groups are to be targeted and how (Outputs 3.3 and 3.5) and
(ii) strengthening HIV-awareness strategies targeting the general population (Output 3.4)

There has been recent progress in strategies to strengthen non-health sector engagement (Output 3.1) after protracted difficulties resulting in some key-stakeholder ill-will and their, counterpart and AMC frustration.

3.6 Sustainability

Counterparts, the AMC and the MTR Team have a combined view, expressed in different ways, that THSSP's next 20 months should be characterised by

- flexibility
- innovation
- practicality of activities
- sustainability of activities

Counterparts stated to the MTR Team that they want mechanisms established during THSSP which will ensure sustainability in all Components. Counterparts were clear on the role of THSSP: to contribute to counterpart implementation of the various GOTAR policies and plans through providing support. Counterparts were specific in not wishing THSSP to directly implement but to provide them instead with the appropriate support to assist locally-led effective implementation. The AMC also wishes this, while accepting that on occasion they have directly implemented, due to challenges in engaging counterpart implementation.

Ambiguities and misunderstandings on Chinese counterpart THSSP management arrangements were clarified during the MTR. This should assist further THSSP progress in the next 20 months and sustainability. For most Outputs in Component 3 the extent of risks to sustainability will not be clear until, say, after the next six months.[17]

4 Progress against Principles

4.1 THSSP Principle 1: THSSP links to and supports GOPRC and GOTAR policies and reform initiatives

THSSP is supporting relevant GOPRC and GOTAR policies, including new policies as they emerge (see section 2.2 above). However, it is not always easy to discern this from THSSP documentation and, given THSSP was unable to provide to MTR translated policies, muddies the waters. MTR believes THSSP documentation should show the precise linkages with the GOPRC and GOTAR policies and targets to which it is contributing, as a matter of good practice anyway, and to demonstrate AusAID's requirement for alignment with local priorities, policies and systems, and to assist communication, joint planning and M&E (internal and external). For this, translated copies are required. Counterparts readily provided to MTR the key polices which THSSP is supporting[18], the key points of which MTR had translated.

Specific policy linkages should be documented at least in the logframe and GOTAR targets at least in the THSSP M&E Table. (The M&E Framework and Table are discussed further at Principle 6 below.)

For example, documentation on Outputs 1.1 and 1.2 should specifically link to *The 2006 GOTAR 11th Five Year Plan of Human Resource Development*, to which THSSP is strongly responding but which the THSSP documentation does not highlight at a useful level of specificity for analysis. Component Two Outputs and their measurement should be linked to relevant aspects in the *TAR Guidelines for Women and Children Development 2001-2010*, for example, the GOTAR targets of *"30% of hospital deliveries in agriculture and grazing areas and 60% among high risk women"* (p. 20). In this example, THSSP is making a strong contribution but it is not documented as such.

[17] See further discussion at Component 3 at section 5.3

[18] GOTAR policies provided to MTR were (i) *The 2006 GOTAR 11th Five Year Plan of Human Resource Development; (ii) TAR Guidelines for Women and Children Development 2001-2010; (iii)* GOTAR's *2004-2010 Plan for Preventing and Controlling HIV/AIDS; (iv) Members and Responsibilities of the TAR HIV/AIDS Prevention Working Committee; (v) The 11th 5 year Plan of TAR to Prevent and Control HV/AIDS*

Component 3 documentation should show the direct relationship of THSSP support TAR's *HIV/AIDS Strategic Framework (2004-2010).* Strategies and action measures in this Framework to which THSSP is contributing, include to

- carry out comprehensive communication and education activities on HIV prevention and treatment and free blood donation
- establish a supportive social environment for HIV/AIDS prevention and treatment and for caring for people living with HIV/AIDS
- implement and scale up effective intervention measures among MARPs
- strengthen blood safety, especially in blood collection centers and institutions where blood transfusions are performed
- improve the quality of HIV care services: fully implement AIDS treatment measures, and develop care services for HIV-positive individuals, AIDS patients and their families
- build up and improve the HIV surveillance system
- strengthen STI prevention and management
- strengthen operational research and international cooperation in HIV prevention and treatment

Outputs 3.3 and 3.4 directly relate to the GOTAR target of *"By 2005 the awareness rate of HIV/AIDS and STD knowledge should be over 75% in urban areas, over 30% in rural and grazing areas and 85% in high risks groups."* Output 3.4 could also have strategies supporting *"Starting from 2004, the main regional city newspaper, radio, and TV stations should regularly broadcast programs or articles on HIV/AIDS and STD",* for example, by THSSP possibly supporting the training of journalists and editors on how to report HIV/AIDS correctly. For the non-health sector, transparent linkages to their mandated activities as described in the *Members and Responsibilities of the TAR HIV/AIDS Prevention Working Committee* may assist strategy development, relationships and progress. Similarly transparent linkages to *The 11th 5 year Plan of TAR to Prevent and Control HV/AIDS* may assist Component 3 progress. For example, the requirement that "*by 2010 95% of local recreational sites will be covered by effective intervention methods"* could assist THSSP and counterparts' joint planning on a stronger strategic focus in Component 3. (See recommendation under Program Management, section 6 below.)

4.2 THSSP Principle 2: THSSP responds to current and emerging priority needs in the TAR

Counterparts confirmed during the MTR that THSSP continues to target, and respond to, TAR's health and illness priorities. MTR's assessment is that THSSP is achieving this in Components 1 and 2. There are challenges in THSSP effectively responding in Component 3, which are addressed at Component 3 discussions below.

THSSP is pursuing what it terms a 'demand' approach. This language can be interpreted as a passive approach, responding when asked. MTR is satisfied that this is neither the intent nor reality. Rather, MTR's assessment is that THSSP is engaging with counterparts in a continuous process to seek areas of demand to which they can respond and provide support. There are communication challenges, however, some possibly through translation misunderstandings. The 'demand approach' would be strengthened by the AMC using GOTAR's own policies and plans as the basis for discussions, and utilising well the now clarified Chinee Coordination and Component 3 Chinese leadership arrangements. As well, counterparts have requested the Output 1.1 training coordinator to also coordinate training in

Component 3, because of his effective communication and technical skills, which the AMC has rejected on the basis of workload and risks to progress of Output 1.1. This view should be reassessed (see recommendation under Program Management, section 6 below). The AMC, in the counterparts' view, has also not responded to their request for additional billboards etc. This appears to be based on technical differences in the messages they should promulgate (see recommendation under Output 3 below).

4.3 THSSP Principle 3: There is ownership and leadership of THSSP activities by GOTAR partners

Relevant level Chinese coordination arrangements have been clarified (Mr. Li Jiang). Chinese leadership and ownership of, and satisfaction in, Component 1 (through the CPD) and Component 2 (Mr. Gerlic) are strong and there are many successes. For Component 3, the strong contribution of Dr. Jiang Zugang since THSSP Inception is noted. Some perceived ambiguities about which counterpart is responsible for what has contributed to some communication and joint planning challenges, particularly for Component 3. This was clarified during the MTR and hopefully there will now be better progress. Management and coordination issues are discussed further under Program Management, section 6 below.

4.4 THSPP Principle 4: THSSP takes an integrated approach to gender awareness and cultural sensitivity.

This is satisfactory and is reported in the 2007-2008 Annual Plan.

4.5 THSSP Principle 5: THSSP outputs are designed to be sustainable in the TAR.

Outputs are appropriate to TAR's needs and many have potential for sustainability (assessment of the sustainability of each Output is within each Component discussion below). Outputs were reviewed by the MTR with THSSP and remain appropriate. The AMC may approach AusAID with some requests for changes (e.g. Output 3.2) to accommodate better work on clinical care of HIV patients. This is addressed at Output 3.2, section 5.3 below.

4.6 THSSP Principle 6: THSSP works within existing GOTAR information systems and plans wherever possible.

The need for greater documented clarity on THSSP's support to GOTAR's policies, plans and targets is addressed above at Principle 1 (section 4.1).

MTR notes that GOTAR regards some of its information as sensitive, making it unavailable to THSSP. THSSP uses, and the M&E Table largely reflects that it will continue to use, information from existing GOTAR systems wherever possible. The degree to which this could be further strengthened should be assessed by the AMC when further reviewing the M&E Table.

The M&E Table has been revised and reflects the considerable effort of the AMC to successfully respond to the mid-2006 TAG recommendations. The structure and approach of the M&E Framework and Table is a little complex but satisfactory. The inclusion of GOTAR indicators in the M&E Table for areas which THSSP is supporting would further, and strongly,

assist easier assessment of THSSP's activities for their strategic focus on, and contribution to, GOTAR's targets. The MTR discussed with the AMC some changes to Key Indicators (see discussion below at Component-level discussions and recommendation under Program Management, section 6). Together these would strengthen internal and external M&E and perhaps assist the AMC to highlight better its achievements as well as challenges. Counterpart involvement in further strengthening the M&E Table will provide further M&E capacity building.

4.7 THSSP Principle 7: Technical advisor inputs are used across components wherever possible to create synergy and linkages between outputs.

The 2006 TAG found that this was satisfactory as does the MTR. Synergy and linkages across outputs is a continuous process, a reflection of the system changes THSSP is supporting.

4.8 THSSP Principle 8: THSSP collaborates with other development projects, particularly those working in or near TAR.

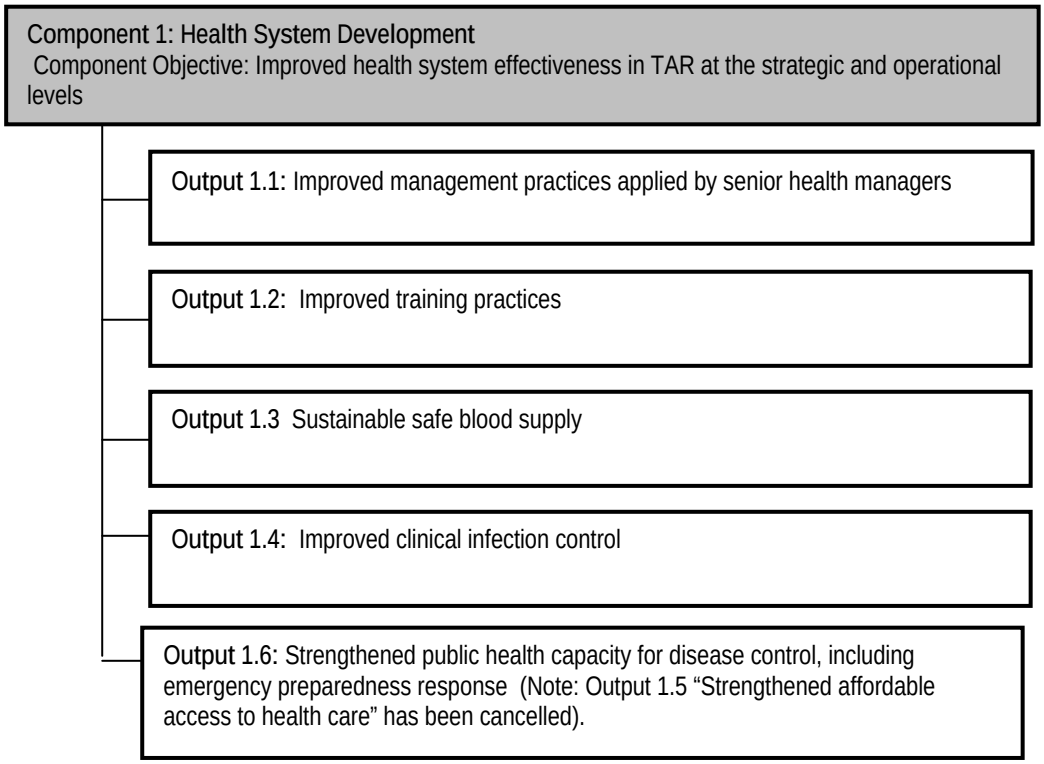
Regular meetings are held with other relevant development projects in TAR, there has been engagement with AusAID's HIV AIDS Project in Xinjiang Uygur Autonomous Region and with other development activities in Inland China and overseas (e.g. through study tours). The majority of these exchanges have added value to THSSP's work in TAR. The replication of the Xinjiang project's approach to health sector engagement was, however, not successful. Counterparts found it complex and cumbersome. It has been abandoned in favour of a simplified approach, which it is hoped, will enable better responsiveness to local needs (see Component 3, section 5.3 below).

5 Progress in Components

5.1 Component 1: Health System Development

Figure 3

Tibet Health Sector Support Program Component 1 Structure



5.1.1 Overall Assessment

Overall progress in Component 1 is highly satisfactory, while noting Output 1.4 gains are recent and Output 1.6 is new, but progress in both is sound. There is no outcome Key Indicator for Component 1. MTR recommended to the AMC that this should be rectified and that the outcome Key Indicator(s) should give evidence of development supported by THSSP, which has led to, or should lead to by the end of THSSP, improved effectiveness (see recommendation at program Management, section 6). MTR assesses that satisfactory progress in Component 1 will continue for THSSP's remaining 20 months.

5.1.2 Output 1.1: Improved management practices applied by senior health managers

(a) M&E

The outcome Key Indicator is "*Senior health managers report a change in management skills and practice*". MTR suggested to the AMC that a further Indicator would strengthen M&E of Output 1.1: the intent being evidence of system, organisational or sub-organisational change led and managed by participants of THSSP-supported management development, and other cross-cutting, activities (e.g. through Component 2). Some evidence is already available. MTR recognises that improved management practices may not result in large scale change but may result in iterative improvements, which could also provide evidence.

(b) Progress

Progress is significant. Further success is anticipated based on current and proposed activities. Outputs 1.1 and 1.2 activities are increasingly merging, a reflection of the strengthened synergy being achieved across all levels of GOTAR, to which both Outputs have contributed. There is high counterpart satisfaction with Output 1.1 management and coordination.

Study tours. Study tours have had a strong impact on key stakeholders, health and non-health participants. This impact includes strengthened understanding of good practice approaches in health structures, health management, primary health care and HIV. Counterparts report that action on return from study tours has included increased emphasis at high GOTAR levels on, and interest in, HIV prevention. Partly as a result of the study tours, there is increased GOTAR budget support to the health sector where good feasibility studies have been provided.

Management development seminars. A second, critical success is the impact of the 150 person day series of management development seminars. While only 20% of participants attended more than three seminars there is nonetheless the beginning of system change, generated through the theoretical learning and subsequent operational research required of participants (an 'action learning' approach). Application of knowledge is assisted by THSSP advisors who provide coaching and support. The major organisational change and development initiatives are:

- Shannan Prefecture Hospital: Cost Management and Culture Building (and this is generating a multiplier effect with other hospitals in TAR visiting Shannan Hospital, as

recommended by the TRHB, which is generating discussions on THSSP and Shannon hospital staff providing support to other hospitals)
- Linzhi Prefecture Hospital: Five Year Planning, Cost Management and Culture Building
- Linzhi CDC: Learning Organisation and Culture Building
- Lhasa CDC: TB survey, MIS building

Synergy between Outputs 1.1 and 1.2. There is cross-fertilisation between this Output (1.1) and Output 2.1 e.g. visiting experts such as a Chinese health economist (Professor Meng) work within both Outputs. Outputs 1.1 and 2.1 are therefore progressively being merged, which is also a reflection of greater synergy between bureaucratic level in TAR's health system, reflected in combined participation from different levels in development programs. This is a pleasing result and one which will enable even stronger impact on the health system

(i) directly from the observable major change management and iterative organisational development initiatives and

(ii) indirectly through the less easily observed strengthened, and sometimes new, relationships and communications between all levels which assists any systems' effectiveness

Improved training practises assisting. Output 1.2 (improved training practices) is credited by counterparts with significantly assisting the impact of both Outputs 1.1 and 2.1.

Hospital management program. The impact of the current intensive hospital management program at Shandong University (1.5 months; 21 participants from regional, prefecture and county levels) will not be apparent for some months but the strategy is sound. All county level participants have previously been on the middle management programs (Output 2.1) thus effectively building their knowledge base and THSSP showing skill and good strategic thinking by leveraging activities for a compound return-on-investment impact.

Shandong University relationship. Shandong University is an increasingly important part of THSSP-supported education initiatives, as is its relationship with TUMC. The two universities recently signed an agreement for cooperation. The THSSP's aim of Shandong University and TUMC presenting joint views to THSSP is now beginning.

Jinziang Hospital relationship. There is also an increasingly close relationship with Jinziang Hospital one of China's model county hospitals, which THSSP is supporting. Jinziang Hospital will provide ongoing free technical training for a month at a time, with its experts also visiting TAR (at this stage MTR understand this will be to Shannan Hospital).

Promulgate successes. Counterparts and the AMC should more strongly promulgate successes in Output 1.1 within TAR, in Inland China and overseas: this is true for all THSSP Outputs where there is significant success/progress (see recommendation under Program Management, section 6 below). No other recommendations are required for Output 1.1.

(c) Sustainability. Current progress and plans for the next 12 to 20 months are supported by MTR, and should facilitate continued success. The intent is that relationships between Shandong University and Jinziang Hospital will continue beyond THSSP, a portent for sustainability. Leadership for change is strong in some key areas (e.g. TRHB, LMHB,

Linhzhou, Shannan Hospital) and the momentum observed by the MTR, and its organisational and system impacts, appears sustainable.

5.1.3 Output 1.2: Improved training practices

(a) M&E

The outcome Key Indicator is *"TUMC deliver Department of Education curriculum using participatory methods".* TUMC is already meeting this indicator. MTR has discussed with THSSP that this outcome indicator does not reflect (i) the extent of TUMC's participatory methods or its impact nor (ii) the broader outcome being achieved through Output 1.2 beyond TUMC (e.g. in infection control, Output 1.3; EMNC, Output 2.2). THSSP has agreed to its revision (see recommendation under Program management, section 6).

(b) Progress

In this Output there has been significant success to date and further success is anticipated. TUMC reports their systematic and integrated implementation of new participatory teaching methods, new research approaches, and new curricula content, as a result of THSSP support through this Output.

TUMC changes. TUMC credits THSSP's support with their strengthened understanding of health and health system challenges in Tibet and TUMC has implemented curricula changes accordingly. These curricula changes include community development, health system development and health economics. THSSP-supported HIV training has also generated clearer understanding and HIV/AIDS is now part of the medical curriculum.

The Dean of TUMC also reports that implementing the new participatory teaching methods, new research methods and new content has strengthened the quality of teaching, with five publications in Inland China journals resulting and some faculty promotions. Strengthened research methodologies include designs that can be generalised and applied across different areas. Strengthened teaching methods means students no longer learn only from text books: their courses include practical examinations and more emphasis on social aspects of medicine and health and health system improvements, and how students, on graduation, can contribute to these.

While TUMC does not directly contribute to policy, it believes that its indirect contribution through its faculty and students will continue to strengthen into the future. For example, TUMC is the key contributor to the official GOTAR response to GOPRC MOE on the 2005-2020 Tibet Health System Personnel Development Policy.

Cross-cutting impacts. Cross-cutting synergies and linkages with other THSSP Outputs include with Outputs 1.1 and 2.1 (senior and middle management development including links with Shandong University and Jinziang Hospital), maternal and child health curriculum changes (reported on in Component 2 below), and HIV and AIDS being incorporated into curricula, underpinned by on-campus peer-led research (see Component 3 below).

Participatory teaching methods are also taught in EMNC, with participants saying that they are incorporating them into their training responsibilities, and that their impact is high. MCH training

has increased their understanding of rural conditions to improve their teaching and training of doctors and other health workers.

The participatory teaching methods used in Output 1.4 (infection control) were commented on positively at length by recipients, as was the content and the commitment and interest of the responsible THSSP member, during the MTR consultations (see Output 1.4 below).

(c) Sustainability. The systematised changes within TUMC, continued cross-cutting support to TUMC by THSSP, the twinning relationships with Shandong University and Jinziang Hospital, and other cross-cutting THSSP activities give a high probability of sustainability in improved training practices.

5.1.4 Output 1.3: Sustainable safe blood supply

(a) M&E

The outcome Key Indicators are *"Voluntary non-remunerated blood donor recruitment system established"* and *"Number of voluntary blood donations"*. MTR discussed with THSSP that the 2nd outcome Indicator could be regarded as means of verification of the first outcome Indicator, and that inclusion of something similar to "*RBC accredited as achieving national standards*" may be appropriate, particularly given the Output objective of *National standards for blood safety (collection, screening, storage, supply/distribution and utilisation) institutionalised at selected facilities*. A Key Indicator reflecting "*supply/distribution and utilisation…"* should also be developed (see recommendation under Program Management, section 6).

(b) Progress

There is significant success in Output 1.3, culminating in the RBC achieving national accreditation during the MTR, an excellent achievement. The senior accreditor reported to the MTR that RBC standards, including the management of RBC, exceeded that found in some Inland China blood centres. This links to the two foci of THSSP support

(i) technical standards and
(ii) managerial standards for sustainability. T

Voluntary blood supply achieved. The GOTAR policy of moving from paid to volunteer blood supply has been implemented quickly and smoothly over the last three years. All blood donations in Lhasa City are now from low-risk volunteers. Volunteers have health assessments before their blood is accepted, including HIV testing. The proportion of blood donors where initial rapid testing resulted in blood samples being sent to the Regional CDC for Western Block testing is said to be extremely low (data is regarded by GOTAR as sensitive and could not be provided to the MTR). Since the opening of the RBC in June 2005, there have been 6,786 volunteer donations (84% from Han Chinese, 16% Tibetans, and 3% 'other').

THSSP support to date. THSSP support included workshops, a conference with participants from regional to prefecture level, advertising bill boards to assist the move to voluntary blood donations, and lengthy short term advisor support working directly with RBC staff. THSSP also procured blood storage refrigerators, highly valued as a key element of ensuring safe blood supply.

THSSP support was applauded by all consulted. Over 3 visits the CSTA delivered training at prefecture, hospital and RBC levels, and ensured GOPRC laws, regulations and standards

were able to be operationally implemented (and culminated in RBC's national accreditation). The THSSP STA is credited by the RBC with motivating and inspiring RBC staff through her role modelling of hard work, technical knowledge, commitment and high standards. RBC staff now discern what is 'nice to have' versus what is needed.

THSSP future support. RBC requests further laboratory technical support to ensure safe blood supply to prefecture level. For safe blood transfusion, RBC and the CSTA are clear that the technical advisor for safe blood transfusion should be a Chinese clinician with broad technical experience, not just blood transfusion experience. The CSTA's report and recommendation were not completed when the MTR was in-country: her recommendations will and should guide future THSSP support (about which the THSSP 2007-2008 Annual Plan is vague). Unfortunately the current CSTA is unable to return. She will assist sourcing other CSTA support through the China Society of Blood Transfusion.

(c) Sustainability. RBC assert they now have the technical and managerial capacity to *assist* sustainability, while being clear that further THSSP support is needed over the next 20 months to *ensure* sustainability, with which MTR concurs. Sustainability appears probable assuming

(i) the CSTA recommendations will provide a sound future strategic direction which THSSP will support
(ii) the CSTA's intention of facilitating of an ongoing relationship between RBC and the China Society of Blood Transfusion
(iii) the three year national re-accreditation requirement, which gives a continual goal for maintaining standards
(iv) Lhasa Hospital No. 2 effectively implements its plan to train all medical staff in safe blood transfusion indicating system change at service delivery level is commencing

5.1.5 Output 1.4: Improved clinical infection control

(a) M&E

The outcome Key Indicator is *"Infection control and universal precautions standards operating procedures are drafted and adopted."* Specificity is needed on 'adopted by whom'.

(b) Progress

There has been significant recent progress. There were THSSP-supported study tours of key stakeholders at Lahsa No. 2 Hospital to Inland China, and there is effective THSSP support. The most recent study tour resulted in significant counterpart conceptual and operational understanding of the complexities of infection control, and strategies and actions required for its achievement.

Leadership commitment. Management and staff at Lhasa No. 2 hospital are highly receptive to the strengthened infection control program. Potentially, the Hospital may become a model site for replication of good infection control practices across TAR, and this should be encouraged. Lhasa Hospital No. 2 is the appropriate entity as it is Lhasa's infectious diseases hospital.

Two year work program. There is now a two year THSSP work program for support to Lhasa Hospital No. 2 for

(i) infection control, based on pre-testing to define the specific challenges and using participatory methodology for training and
(ii) clinical management of HIV including infection control (and see Output 3.2 below)

Base line work and capacity building. As well as study tours and national training for four infection control staff, THSSP support for Lhasa Number 2 hospital includes an infection control audit based on a methodology used by the NSW health system, a knowledge survey of health care workers; and seven educational sessions for the infectious diseases ward staff.

Organisational change initiatives. Changes resulting from the base line work and national and local capacity building include establishment of the hospital's first infection control committee, chaired by the Hospital President; finalising of hospital infection control standards; hand hygiene with new hand washing procedures developed, implemented and monitored; strengthening medical disposals; protocols for the protection of health workers from infection (occupational safety); regular cultures in hospital wards and monitoring of post-operative infection rates.

Waste management. Waste management was removed from this Output at the AMC's request. Waste management is an integral element of infection control; its removal from the Output descriptor in no way changes this. There are local waste management efforts e.g. counterparts have requested THHSP to replace their Sharps disposal/crushing unit. Counterparts now also understand the importance of overall disposal of infected, or possibly infected, waste, including high temperature incinerators. In response to a draft MTR recommendation that the AMC consider advocacy for effective management of infected waste in Lhasa City, the AMC advised that the "…GOTAR regional government has recently made a decision to purchase a Lhasa-wide incinerator to support correct waste disposal process' and also noted this was unlikely to become operational during THSSP.

(c) Sustainability. Principals at Lhasa Hospital No. 2 are happy to be an infection control pilot site or test site but say they are not yet ready to be regarded as a 'model' site for assisting replication: they feel they are only just beginning. The Hospital's Deputy Director General noted to MTR that the THSSP-supported management development program had assisted his management of infection control progress. At Lhasa Hospital No. 2 there is pre-operative testing of all patients for HIV and TB. MTR was impressed with progress and initiatives and assesses sustainability as probable, assuming continued momentum.

5.1.6 Output 1.5: Strengthening affordable access to health care

Output 1.5 was cancelled: GOTAR is successfully strengthening rural health insurance provisions which are providing an enabling environment for THSSP, particularly in Component 2.

5.1.7 Output 1.6: Strengthened health emergency preparedness and response

(a) M&E

The outcome Key Indicator is *"Improved application of CDC guidelines for epidemic response".* MTR discussed with the AMC, whether, if there was no epidemic against which this outcome was tested, or if there was no 'practice run', could this outcome be measured? THSSP has agreed to reconsider the outcome measure.

(b) Progress

This is a new Output and progress is satisfactory against the strategic framework for support (in THSSP 2007-2008 Annual Plan).

Public Health Management Program Shandong University. Negotiations are nearing completion for a two-year Public Health Management program at Shandong University. On current time lines, graduation will be after THSSP finishes on 21 March 2009, perhaps by up to four months (details were anticipated in the next few weeks following MTR when negotiations are completed). The aim of GOTAR is that all 700 CDC staff will, over time, complete this Program (well beyond THSSP time lines).

Epidemiological training. Participant feed back on THSSP-supported epidemiological training is that the training was a welcome mixture of theoretical training and site practice, including surveys and samples, and some procurement. There is now basic understanding of pandemic diseases and contingency planning to respond to pandemics. As in other parts of the world, there will need be regular 'practise runs' to maintain skills, especially given there have been no recent pandemics in TAR. Prior to THSSP support, clinical diagnosis was the focus with capacity for diagnosing some diseases such as measles. Now there is increasing capacity and desire to understand aetiology, predict impact and respond appropriately. Training within TAR is appreciated. Study tours or placements in Inland China may also assist. Training is currently to county level, and counterparts would like this extended to township level. The AMC advise that a lesson learned from previous training (in Linzhi and Shannan) includes that some participants had learning difficulties because Mandarin was used by teachers. AusAID's position is that language barriers can be overcome. The AMC also believes that epidemiology training at township level will only be possible if Tibet Regional CDC (TRCDC) take on responsibility for developing and delivering this course. The MTR has not explored the feasibility of this, or of the degree of difficulty in overcoming language barriers, but believes township level training should be pursued, in line with THSSP's stated demand response approach.

Further THHSP support. Continued THSSP support is needed, and is planned, for

(i) improved epidemiological knowledge, including in laboratories and
(ii) capacity to process data using modern technology – computer skills are currently at basic level only (and have been supported by THSSP)

(c) Sustainability. This is a new Output and sustainability could not be expected in the time available until THSSP ends. Ongoing capacity building and operational budget support would probably be needed: this may be provided through GOPRC and GOTAR support given the high global, and GOPRC, interest in emergency preparedness.

Sustainability potential is supported by there being four staff regarded as sufficiently prepared to conduct local training. There are also strong efforts to establish systematised mechanisms for reporting on, and responding to, emerging diseases within the GOPRC framework (funding is provided through Government Treasury Bonds). To date this has involved six prefectures and 50 counties, with one more prefecture and 25 counties to be incorporated. The aim is an integrated system by end-2007. However, there may be insufficient GOTAR recurrent budget to give confidence in sustainability even assuming skills are sufficiently upgraded e.g. the budget for reagents is limited.

Sustainability is therefore dependent on

(i) greater in-depth knowledge of emergency preparedness issues and responses – i.e. more capacity building is needed through applied training
(ii) strengthened GOTAR emergency preparedness mechanisms particularly at county and township levels
(iii) upgraded computer analysis skills (including using the new version of EpiData aimed to be in Chinese)
(iv) sufficient recurrent budget
(v) time and consistent effort, beyond THSSP

Recommendations

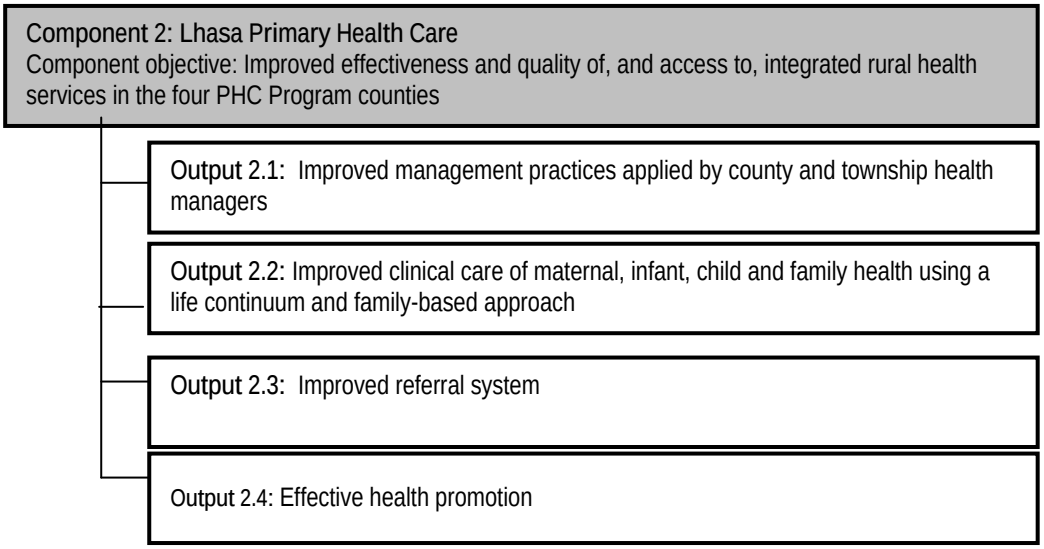
1. Counterparts, the AMC and AusAID discuss options for, and agree on, support to the Shandong University public health management program after THSSP finishes (21 March 2009)

2. The AMC and counterparts consider implications of expanding other training to township level, including the feasibility and risks of expanding epidemiological training to township level and advise AusAID

5.2 Component 2: Primary Health Care

Figure 4

Tibet Health Sector Support Program Component 2 Structure



The outcome indicator for Component 2 is *Quality of services improved, which may result in:*

- *Service utilisation and care seeking improved*
- *Reduced case-fatality rates*

5.2.1 Overall Assessment

In this Component overall progress is highly satisfactory (while there sustainability and utilisation of ambulances, Output 2.3 is still to be assessed). Continued success is anticipated.

The enabling environment has strengthened during THSSP through the policy framework detailed at section 2.2 above and also through

(i) strengthened GOTAR rural health insurance and therefore more affordable access
(ii) improvements in, and increases in the number of, health facilities
(iii) further GOPRC support for equipment

There is strong Component 2 counterpart leadership and well planned and appropriate Component 2 activities in all Outputs.

THSSP has been attributed by counterparts and others consulted (e.g. LMHB, TUMC) as being a key contributor to the increase in the number of women delivering in hospitals (see Figure 5 below) and to the reduction in maternal, neonatal and infant mortality rates in the four official THSSP counties through Component 2 and through the cross-cutting Outputs 1.1 and 1.2 in particular (see Figure 1 re THSSP Goal-level measures at section 3 above).

Counterparts regard Component 2 as 'very practical', focused and its implementation methodologies highly suited to Tibet's needs. The various protocols are also regarded as practical, easily understood, easily used and are 'highly' valued including their ease of replication to parts of Tibet beyond the four THSSP counties[19] on which Component 2 is largely focused. The clear orientation in Component 2 includes to grass-roots levels, where the technical tools provided and ambulance transport are regarded as key influences on achieving the improvements in maternal, neonatal and infant mortality. EMNC training is also a resounding success and is credited by counterparts as a significant influence on morbidity and mortality improvements.

Output 2.4 (health promotion) is now a cross cutting strategy and issues and risks around this for Component 2 are discussed below at Output 2.4.

Figure 5
Deliveries at hospital 2004-2006 in Lhasa Municipality counties of Damxung, Nimu, Qushui and Linzhou

Key Indicator Service utilisation and care seeking improved	2004	2006
Deliveries at hospital (in the four THSSP official counties)	43.9%	69.1%

Data supplied to MTR by LMHB

3.2.2 Output 2.1: Improved practices applied by county and township health managers to manage integrated health services

[19] The four official THSSP counties of Lhasa Municipality are Damxung, Nimu, Qushui and Linzhou

(a) M&E

The outcome Key Indicator is *"Improved management of health services at Municipal and county levels".* MTR discussed with THSSP whether, similar to Output 1.1, this should be revised with the intent of better reflecting evidence of system, organisational or sub-organisational change.

(b) Progress

Output 2.1 is complementary to, and increasingly integrated with, Output 1.1, with both now cross cutting through all Components. The increasing integration is a reflection of the health system's increasing synergy as change increases, which is enabling different levels of participants in the same program.

Middle management development. The focus of Output 2.1 has been on 'middle level' management. There was a five-day HIV/AIDS workshop for 18 key CDC staff including from six remote counties. Trainers are from the national level, bringing with them a wealth of knowledge and, importantly, ability to communicate that knowledge in Mandarin to participants. LMHB would like local staff to be directly exposed to the national level through study tours and training opportunities. The MTR was unable to assess the relative merits of this suggestion and draws it to the AMC's attention.

Management skills improved. Officials and participants spoke to MTR (in various settings) of management skills prior to THSSP-supported programs, with the constant theme that management approaches had previously been fairly non-strategic. Participants consulted, and their supervisors, stated to MTR that they now know how to plan and do so, are focused on implementation and results, and are better able to monitor and evaluate what they do and how they do it, and what is achieved or not. For several of the participants consulted, self confidence to more effectively lead and manage was a key outcome, laying a foundation for ongoing development and confident management.

Cross-cutting issues. The two-year Shandong University Masters Program in Public Health Management is managed through Outputs 1.1 and 2.1 (see discussion at Output 1.6 above). The current intensive hospital management program at Shandong University is discussed at Output 1.1. Output 1.1 and 2.1 have generated significant synergy and change cross cutting through all Components.

(c) Sustainability. See discussion at Output 1.1 above.

3.2.3 Output 2.2: Improved clinical care of maternal, infant, child and family health

(a) M&E

The outcome Key Indicators are

- *Increased proportion of births with skilled attendant and increased use of health facilities for maternal and neonatal care, especially for pregnancy and childcare complications*
- *Increased number of health facilities with staff trained in maternal and neonatal care, especially for pregnancy and childbirth complications*
- *Implementation of standard treatment protocols*
- *Increased diagnosis and treatment of childhood illnesses*

There are no changes suggested to the Key Indicators.

(b) Progress

There is significant progress and success.

EMNC training. The EMNC training of all obstetricians is resulting in improved practices. Participants are now passing on skills including through their training of lower level health workers. Participatory training is encouraged (Output 1.2). Participants are carefully selected and include younger people, with the aim of succession planning and longer term sustainability. Training covers all seven counties in Lhasa, not just the official four counties. LMHB is monitoring recipients of the training and advised MTR that practice had improved significantly. This is reflected in the improvement in the Goal and Output-levels outcome Key Indicators (see Figure 2, section 2 above).

EMNC text book. The development and publication, supported by THSSP, of a new, practically oriented text book, based on EMNC training, is regarded by counterparts as a helpful and practical contribution to sustainability. The LMHB originally thought training materials and the text book would need national experts. Instead, with THSSP support, training materials and the text book were developed by the local EMNC Committee as well as national and THSSP experts. The key differences in the EMNC text book to others text books are that it

(i) is practical rather than theoretical - important given theory is often well-understood by Tibetan doctors but not always practiced
(ii) targets county and lower level staff
(iii) is authorised by the Regional Bureau of Health for in-service training
(iv) may be used by TUMC as a practically-oriented student reference book to complement their theoretically-based text books

TUMC changes. TUMC reports that, resulting from THSSP activities including EMNC, their previous MCH obstetric focus has been expanded to a more integrated life-continuum and health system approach including

- pre-natal care (including pre-natal hypertension or eclampsia) to care of the child to 28 weeks
- prevention of infant mortality
- quality of the services provided
- health education

Procured equipment. Counterparts report that the THSSP-procured neonatal resuscitation equipment and the training provided for its use, and other procurement, have been instrumental in contributing to the decrease in neonatal mortality rate.

Training extended beyond THSSP's four counties. MTR believes THSSP strategies and approaches are such in Component 2 that extending the training to the other three Lhasa Municipal counties poses no risks. If risks should emerge (e.g. THSSP being spread too thinly) the counterpart/AMC relationships in Component 2 are such that MTR believes risks would be identified early and satisfactorily negotiated.

(c) Sustainability. Sustainability appears probable based on the stronger enabling environment in Tibet, successes to date in the field, changes to TUMC curricula, and THSSP plans for the next 12 months and beyond, including the strengthening focus on townships and village levels. There are two main areas of risk

(i) the number of obstetricians available for outreach training work (e.g. numbers are small and e.g. one obstetrician is on maternity leave) and
(ii) payment of their travel/per diems when THSSP finishes

For (i), counterparts and the AMC are aware and discussions are ongoing and a resolution will hopefully be found. For (ii), it appears that a healthier budget situation exists in Lhasa then when THSSP began, and this risk may therefore be illusory.

3.2.4 Output 2.3: Improved access to health services at all levels of the system

(a) M&E

The outcome Key Indicators are

- r*educed fatality cases for conditions which depend on timely referral*
- *improved community preparedness for medical emergencies and attitudes to and use of referral services, classified by type and location of community*
- *healthcare system able to provide transport for medical emergencies from isolated or difficult access communities*

The means of verification could be expanded to include TAR data. The Goal-level data (see Figure 5 earlier) indicate that aspects of Output 2.3 are being achieved.

(b) Progress

There is satisfactory progress.

Ambulances procured. Ambulances have been procured, counterparts are satisfied that their locations are in areas of greatest need where there is capacity (e.g. availability of drivers). THSSP has budgeted for further ambulance procurement.

Ambulance utilisation. Getting the ambulances on the road has been slowed by lengthy local procedures involving government registration requirements (that assist minimising or eliminating expensive road taxes). These were completed immediately prior to the MTR. Log books have been issued and the importance of their use emphasised. Criteria will be developed to assess ambulance use to guide further procurement decisions. Assessment will need to be after some months of the ambulances being fully registered for use i.e. perhaps later in 2007.

(c) Sustainability. Availability of operational budgets for running costs and which level of the health system is responsible (e.g. petrol, maintenance), is still being negotiated within TAR's health system. Sustainability is therefore difficult to assess and will be included in the proposed ambulance utilisation assessment later in 2007, the results of which will guide further ambulance procurement.

Recommendation

3. The AMC and counterparts include assessment of sustainability (e.g. operating costs such as petrol and maintenance, and availability of latter) when assessing ambulance use later in 2007

3.2.5 Output 2.4: Effective health promotion (cross-cutting with particular links to Outputs 1.1, 2.1, 2.2, 2.3, 3.1 [non-health sector agencies], 3.3 [e.g. Model STI Clinic] and 3.4)

(a) M&E

The outcome Key Indicator is *"Health staff and community agencies (such as Women's Federation) are active in health promotion including counselling during clinical work".* In MTR's view, at outcome level, behaviour change could perhaps be incorporated within the Key Indicators.

(b) Progress

The impact at grass roots level is strong.

Increase in rural women delivering their babies at hospitals. The education of rural women, together with initiatives under all other Component 2 Outputs, has contributed to an increased number of rural women delivering their babies in hospitals rather than in their village-level traditional birthing places. Indeed, overcrowding is now a problem in some centres (e.g. Linzhou County Hospital, where a new maternity wing is under construction). Prenatal checks were not previously part of routine care and now are. Component 2 TOT has been a significant strategy as are

(i) GOTAR's establishment of an expert committee to monitor and sustain good practice and
(ii) an 'incentives policy' for women to deliver in hospital.

Parent and family education not just mothers? An aim of the THSSP design was families, particularly both parents, being included in health education given that many maternal, infant and child diseases have the same aetiology as those experienced by all members of the family (e.g. diarrhoea {and hygiene implications], chest infections, nutritional issues) and to encourage joint parenting responsibility. This has not yet eventuated, with women being mainly engaged in health promotion and education. There is a possibility that THSSP may be able to broaden its 'catchment group' to include at least some fathers.

Output 2.4 now cross-cutting. Output 2.4 is now a cross-cutting Output, as reflected in the new, revised Health Promotion Strategy within the THSSP 2007-2008 Annual Plan (Annex 10). The AMC requests that Output 2.4 is not moved to Component 1(the cross-cutting Component) mainly because of budget line changes which would be required. The MTR has no problem with this. The new cross-cutting Strategy is being led by the Component 3 team leader. There is potential, therefore, that the success achieved to date for Component 2 may be dissipated, not because of intent but because the emphasis may inadvertently shift away from Component 2's needs. New management and monitoring arrangement are documented in the 2007-2008 AP but the MTR was unconvinced they were working strongly yet. It is important that there is active involvement of Component 2 Australian and Chinese team leaders in developing technical approaches which support Component 2 progress, and Component 2 advisors/counterparts for monitoring and evaluation of the implementation and impact. Component 3 HP is discussed in section 5.3.

(c) Sustainability. The new cross-cutting Health Promotion Strategy is satisfactory whilst there are many challenges to its effective implementation. These include weak GOTAR health

promotion infrastructure (human resources, knowledge and budgets). Sustainable BCC is a high risk in the THSSP 2007-2008 AP. Progress has improved, however, and is good at grass roots level in Component 2. Counterparts are not keen on social marketing or its contracting out. The new Strategy and renewed effort may assist sustainability. Further comment is at Component 3 below.

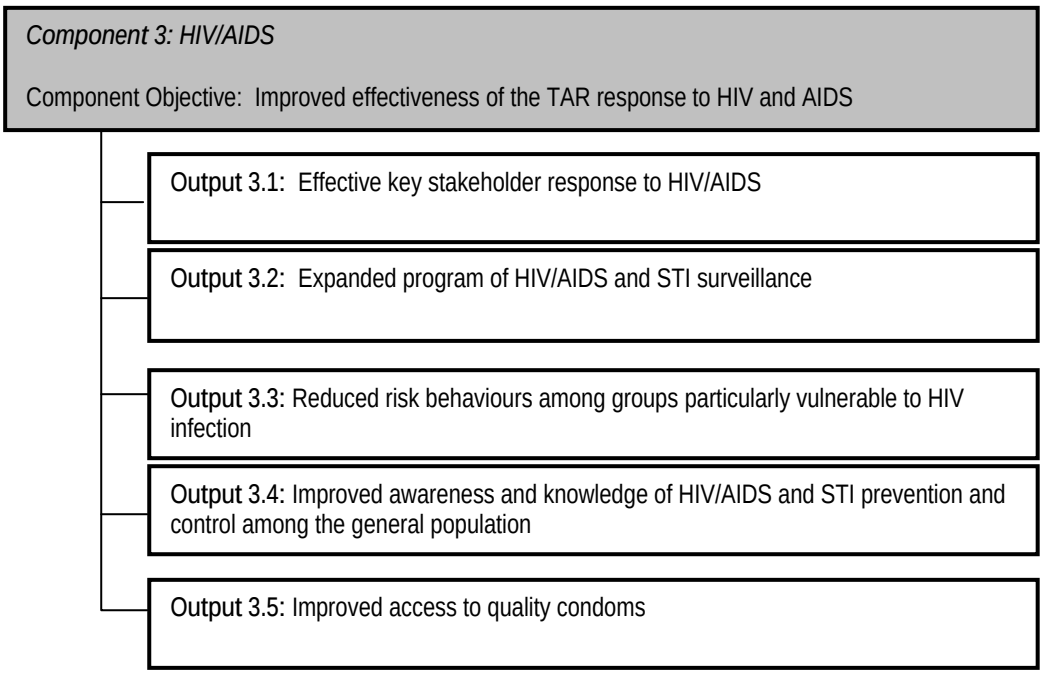
Recommendation

4. *The AMC and counterparts ensure that the proposed arrangements for managing, monitoring and evaluating the new cross-cutting Health Promotion Strategy do not detract from Component 2 needs continuing to be met*

5.3 Component 3: Improved effectiveness of the TAR response to HIV & AIDS

Figure 6

Tibet Health Sector Support Program Component 3 Structure



5.3.1 Overall Assessment

Outcome Key Indicators are

(i) c*hanges in community awareness and decrease in risk behaviours*
(ii) h*ealth sector with increased capacity to lead, plan and implement HIV responses in line with national policy and international good practice*

There has been relatively slow progress in Component 3, other than in Output 3.2 (surveillance including HIV laboratory testing and model STI clinic) and some increased progress in health promotion. However, many necessary activities (particularly in Lhasa) have been undertaken as appropriate to the epidemic level (very low HIV prevalence, <0.01%). There has been little

attention targeting men who have sex with men (MSM) or IDU. Annex 7 shows a summary matrix of WHO/UNAIDS recommended priority HIV interventions by epidemic stage and target population. This indicates the need to implement targeted prevention through outreach to sex workers, MSM and IDUs prior to developing broader media campaigns and youth awareness activities.

The slower rate of progress is also influenced by some local cultural sensitivities in addressing HIV/AIDS, a lack of RCDC engagement and some ambiguity around counterpart leadership and management accountability for Component 3. For the latter, clarity was reached during the MTR and is discussed at Program Management (section 6) below. This, and the recommended new joint planning, should more strongly assist progress. The MTR disagrees with the AMC's statement in the 2007-2008 THSSP Annual Plan that the regional level's role in coordination is limited (p. 88) and believes that strong regional-level engagement is vital to sustainable success. This should not preclude the AMC continuing to engage at other levels.

In recent years, GOTAR has paid greater attention to fostering a multi-sectoral response to HIV to keep HIV prevalence below 0.01% by 2010. The keys to success lie in targeting the right groups, identifying and applying appropriate evidence based approaches, and ensuring the effectiveness, coverage, intensity and continuation of relevant preventive and medical interventions.

Counterpart priorities include support for

- the Tibet Regional HIV and AIDS Coordinating Group
- further development / implementation of TAR HIV strategies
- strengthening of HIV surveillance
- health promotion
- voluntary testing and counselling (VCT)
- piloting HIV prevention projects in Cheng Guan Qu sub-municipality of Lhasa (CGQ)
- condom promotion and distribution among MARPs

The AMC intended to apply a three-pronged approach in order for THSSP to

(1) strengthen cooperation with, and capacity of, the Tibet Regional AIDS Coordinating Group (renamed as the AIDS Working Committee since 2005) and its executive office, located in the Tibet Regional Health Department – there have been problems in achieving this
(2) assist counterparts to develop a realistic, effective and achievable HIV/AIDS Strategic Plan for Tibet – counterparts have developed a plan which is currently under consideration
(3) respond to local needs by supporting the China CARES pilot programme in Lhasa, involving multiple sectors such as TRHB, LMHB, PFPC, ACWF and CYLC – issues are addressed at each Output below

During the next 20 months of THSSP, a jointly agreed integrated strategic focus is required based on a shared vision, shared understanding, and joint agreement on key result areas and activities and processes for their achievement. The strategic focus needs to be on the core, priority areas of work, including surveillance, targeted interventions among most-at-risk groups (entertainment workers and their clients, IDU and MSM), and raising awareness of HIV among vulnerable groups and the general population. Engagement at regional level is critical for impact and sustainability.

Recommendations

5. *The AMC strengthen management of Component 3 by ensuring during recruitment that the new Component 3 Team Leader is a 'best fit' for progressing Component 3*

6. *The AMC and counterparts jointly develop a stronger strategic and operational workplan for Component 3 for the next 20 months, which incorporates strengthened engagement of the Regional CDC to support the planning and implementation of component 3 (for example through mobilizing RCDC expertise in training activities)*

7. *TRHB and THSSP in partnership, ensure that the focus of implementation efforts is on strengthening the surveillance system and intensifying targeted interventions among most at-risk populations to prevent the sexual transmission of HIV*

5.3.2 Output 3.1: Effective stakeholder response

(a) M&E

The outcome Key Indicator is *HIV responses implemented in health and other relevant sectors*.

(b) Progress

There is limited progress towards this outcome and engagement of the non-health sector has met with difficulties. Strategies over the last few months have given some hope for progress and this is discussed further below. Counterparts want to revitalise this Output, have more flexibility and innovation and simplified administration and procedures, which the AMC is progressing.

Enhancing the non-health sector response to HIV in the Tibet Autonomous Region. There has been slow progress in engaging the non-health sector and under-disbursement (6.4% only, A$32,171.70) of the $500,000 small grant facility, the aim of which is to incentivise and support the non-health sector response to HIV/AIDS. Two seminars were conducted using the coordination mechanism of the Office of Tibet Regional AIDS Working Committee to promote the effective use of the NHSRG and increase the involvement of the non-health sector. Ten baseline surveys were conducted between June and September 2006 (Phase 1) by the Regional Transport Bureau, the Regional Tourism Bureau, the Regional Narcotics Control Division, the Regional Traffic Police Unit, the Regional Youth League, Tibet University Medical College, the Regional Entry-Exit Inspection and Quarantine Bureau (Customs), the Tibet Army Hospital, and the Regional Women's Federation. The slow progress and under-disbursement have been partially due to the original complex application process (including development of guidelines) and limited implementation capacity of the non-health sector, as well as insufficient mutual understanding between THSSP and the various local implementers. This resulted in a diminution in some non-health sector partners' enthusiasm and engagement in the NHSHR processes, some ill will and frustration for all parties (the non health sector, the AMC and counterparts).

Problem solving. To address these problems, the TRHB, DOFCOM and the AMC agreed upon a set of revised guidelines in March 2007. These new guidelines include a new, simplified activity proposal format within the Manual of Operations for the NHSHR, a simplified disbursement format and acquittal process for recipient agencies, and were endorsed by counterparts. The AMC also recruited a new CLTA for NHSHR who is working with non-health sector agencies to develop appropriate activities. These initiatives have brought new progress. As of July 2007, a new round of 7 proposals had been received and review of these proposals is underway (known as Phase 2 proposals).

World AIDS Day activities. The AMC provided technical support to the TRHB in identifying several potential activities for World AIDS Day 2006 (WAD). Though few of these activities were taken up, several well attended stalls in five locations around Lhasa distributed leaflets, posters and condoms. In addition, a seminar on raising awareness and fostering multi-sectoral response to HIV/AIDS was held for government agencies. Besides providing technical support, THSSP provided financial support to the TRHB for the procurement of IEC materials from the Burnet Institute NGO project based in Lhasa; the production of television programmes and billboards; and the delivery of prefecture level seminars on government HIV/AIDS policies. In addition to supporting WAD activities in Lhasa municipality, THSSP supported the design of WAD activities targeting community members at the county, township and village levels in Linzhou county, which is under the jurisdiction of Lhasa Municipality.

TUMC and HIV & AIDS in medical curricula (and see Output 1.2, Improved Training Practices). TUMC's interest is high, HIV and AIDS has been incorporated into TUMC's medical curriculum in a systematised way, and sustainability appears probable.

TUMC has a two phase approach to strengthening HIV & AIDS knowledge among its students.

The First Phase (2005-2007) was

- Increased faculty knowledge of HIV and AIDS in order to teach students effectively
- Base line survey of students
    - 521 medical students: their knowledge of HIV was low, mostly gained from text books and the media; an HIV counsellor from Lhasa No. 1 hospital was invited to speak with students with improved knowledge resulting
- Inclusion of HIV & AIDS in the medical curriculum.
- Students now know about HIV participatory research and other research methodologies

TUMC hopes they will receive support from THSSP for the Second Phase (from mid-2007). They have not yet submitted a proposal which may encompass

- Publishing an HIV and AIDS text book consolidating the various learning packages from Phase 1
    - TUMC states that this can easily be completed before THSSP finishes given that the material for it has already been developed
- Continuing teacher and student education on HIV and AIDS
- Establishing a peer education program on campus (not approved under Output 3.1 but TUMC hopes that it will be)

(c) Sustainability. Given that momentum in the non-health sector is only just returning, other than TUMC, and there is limited time left for (i) development of projects that will result in sustainable system change and (ii) disbursement of funds through NHSRP, an internal review of progress is recommended by the end of 2007, led by counterparts and supported by THSSP, and advice provided to AusAID on progress and issues.

Recommendations

8. *Counterparts, with THSSP support,*
   (iii) consider appropriate NHSHR grant applications from regional level agencies and, where appropriate, other centres where interest is self initiated to strengthen response to demand and increase impact
   (iv) ensure efficient and timely NHSHR approval processes

9. *Counterparts lead, and THSSP support, a review of progress of non-health sector engagement and NHSHR-funded activities by the end of 2007, to determine future direction of the NHSHR grants scheme and its budget allocation and advise AusAID of its recommendations*

5.3.3 Output 3.2: Expanded program of HIV and AIDS and STI surveillance

(a) M&E

The outcome Key Indicator is *comprehensive surveillance data on HIV and STIs, including passive surveillance and sentinel surveys, are used in HIV policy, planning and evaluation*. This is satisfactory.

(b) Progress

There has been strong progress in Output 3.2. The AMC has requested an adjustment to the descriptor of Output 3.2 to include "…and response." MTR has no objection to this while it cautions against emphasising clinical treatment of HIV over strengthening surveillance at this stage of the epidemic.

Building laboratory capacity for HIV testing. The TRHB intends for all prefectures to have capacity to test for HIV by using ELISA equipment. Most of the equipment has been supplied by MOH, but there is still room for THSSP to supply complementary equipment to ensure smooth operation to prefecture level CDCs, and to activate and enhance the testing network and surveillance system led by RCDC. So far support has been provided to two labs in RCDC and Lhasa Municipal CDC. Similar support will be extended to other prefectures in the next 20 months.

Staff capacity building. THSSP supported the head of the RCDC HIV confirmatory Laboratory to attend a national training workshop on standardization of the management of HIV laboratories and bio-safety, and supported another lab staff member to attend a one month training on flow cytometry operations management and troubleshooting. In addition, THSSP, in collaboration with the RCDC HIV laboratory, held a training workshop on HIV laboratory testing. Both THSSP and RCDC counterparts felt that this training was very

successful. A CSTA played a key role in this exercise, and is expected to continue providing technical support in the coming 6 months. Since the training, HIV testing quality has been enhanced significantly with the next step a networked system of laboratories at the prefecture level (at least covering Lhasa, Linzhi and Changdu) led by RCDC. THSSP will support training of regional and prefecture level staff for laboratory testing and surveillance to 2008. The RCDC HIV confirmatory laboratory is reportedly operating well and has been accredited by the national laboratory quality assurance program.

Infection control and HIV in clinical settings. See Output 1.4 above.

HIV screening. THSSP has been supporting HIV screening activities among entertainment workers since early 2007. So far, 491 entertainment workers have been tested for HIV; the target is to test 1200 entertainment workers in Lhasa municipality.

Sentinel surveillance. With support from China CDC National AIDS Centre (NCAIDS), RCDC has set up 3 sentinel surveillance sites covering 6 groups, including entertainment workers, IDUS, STI clinic attendees, pregnant women, and long-distance truck drivers. The surveillance system is in its infancy and work is required to develop a systematic approach to consolidating and expanding sentinel surveillance for both HIV and STIs including annual plans and clarity as to how data is informing policy and planning of HIV and STI prevention and treatment services.

Establishing a model STI clinic to strengthen STI surveillance. From April to June 2007, the China CDC National STI Centre (NCSTD) worked with local counterparts to establish a model STI clinic with THSSP support. RCDC was responsible for the refurbishment of the clinic, and THSSP provided essential equipment and supported on-going monitoring to ensure that the model clinic functions according to national standards. The MTR team observed a well renovated STI clinic with a special VCT room. Unfortunately, the clinic is not sufficiently used at the present time, with only 1-2 new STI clients per day. Staff skills in general are good, although counselling skills need to be improved. There is a concern about over-diagnosis (MDI for non-specific mycoplasma) and over-treatment (anyone with urethral/vaginal discharge is given one week of azithromycin plus injections of other antibiotics). Much of this has to do with the fact that STI services are driven by income generation. HIV testing among STI clients is promoted but pre- and post-test counselling is rather weak and condoms are only given if requested, as distinct from being automatically offered/provided. There is a need for monitoring and on-the-job support to ensure that standards of practice are met.

Quality assurance in HIV and STI laboratories. The AMC is currently advertising for a CLTA with skills to support quality assurance in HIV and STI laboratories, together with the present CSTA.

RCDC requests for THSSP support include

- mobilizing the capacity, and maximizing the use, of locally existing staff in supporting THSSP activities
- involving RCDC as key partner trainer (rather than trainee) in all THSSP funded activities
- coordinating the THSSP workplan with the Regional HIV/AIDS implementation plan

- seconding 1-2 national experts to work closely with the Regional HIV Unit on essential techniques, particularly surveillance and targeted interventions
- ensuring the role of the newly seconded staff member from the HIV unit to THSSP

(c) Sustainability. Stronger engagement with RCDC is the overall key to sustainability. Progress on RCDC engagement will be clear within six months: if it has not happened by then under the new Chinese Coordinator arrangements it is doubtful it will, and sustainability risks increase.

Recommendations

10. *Counterparts consider THSSP supporting*
    - *(i) further improvement of current surveillance practices through adaptation of serological and behavioural surveillance to the TAR context*
    - *(ii) strengthened data collection methods and data use and*
    - *(iii) THSSP maintain a focus on building capacity for HIV testing, while exploring opportunities with counterparts to strengthen the regional HIV surveillance system*

11. *RCDC request THSSP support to establish reasonable referrals between the model STI clinic and on-going outreach interventions among entertainment workers (this should be a win-win arrangement to meet health care needs among entertainment workers and to increase the use of the existing clinic services)*

5.3.4 Output 3.3: Reduced risk behaviours among groups vulnerable to HIV & AIDS

(a) M&E

The outcome indicator is *changes in risk behaviour targeted by RHB and RCDC*.

(b) Progress

There is some progress. More is needed starting with the earlier recommendation for a new joint planning and agreement on the strategic focus for THSSP's remaining 20 months for Component 3.

Base line work. In December 2006 and July 2007, rapid assessment workshops were conducted in Shannan prefecture, with support from the Burnet Institute NGO project targeting entertainment workers. After the workshops, 2 HIV/AIDS knowledge, attitudes and practices (KAP) surveys were conducted in conjunction with CDC staff from 12 counties in Shannan prefecture. A total of 156 entertainment workers were surveyed. STI rates are high. Screening conducted by the Shannan CDC and verified by RCDC has revealed high syphilis prevalence among entertainment workers (13.5% among Han entertainment workers; and 21.3% among Tibetan entertainment workers), and KAP surveys have revealed low condom use rates (<60% among Han women, and <40% among Tibetan women).

Entertainment establishments. These are generally small, with between 5 and 10 workers per establishment. Two massage parlours were visited, and each massage parlour had between 5 and 10 entertainment workers, mostly from Sichuan and Hunan provinces. Depending on the season, each entertainment worker has between 0 and 10 male clients per day. Condom use remains low (<60% at last sex) though the intention to use condoms is high. Entertainment workers indicated a need for support in handling uncooperative customers, either through training on negotiating condom use and/or provision of female condoms.

Behavioural interventions. Following the rapid assessment workshops and surveys, behavioural interventions among people at higher risk of HIV were launched in Shannan prefecture. The Shannan CDC developed a four month workplan (July to October 2007) for behaviour change communication and health promotion. The plan includes targeting 26 entertainment establishments, covering ~25% of the estimated 600 female entertainment workers in Tse Dang Town, Shannan municipality. Similar activities are planned for Shigatze and Linzhi prefectures. In Shannan, three trained Tibetan outreach workers from Shannan CDC are dedicated to doing outreach work in entertainment establishments. It seems there is good relationship between establishment managers and outreach workers, though more efforts are needed to ensure consistent application of the "no condom, no sex" principle during paid entertainment work.

100% CUP. In December 2006, THSSP met with WHO staff based in Beijing to discuss the possible implementation of 100% CUP in targeted areas of Lhasa municipality. After briefing relevant counterparts, including the RCDC and LMHB, and receiving their support to move forward, the aim was piloting 100% CUP from July 2007 in Lhasa and other selected sites. However, approval from TRHB is still needed. THSSP advise that experts who have engaged with THSSP consider 100% CUP to be too complex for TAR, including given (i) THSSP time frame and (ii) prevailing counterpart perspective/ government mandates on condom programming. The AMC's view is that a less ambitious program of activities is more appropriate.

Condom availability. Condoms are readily available in pharmacies and kiosks, and both women and men are able to buy condoms at a reasonable price (2-15 RMB per pack, with each pack containing 10 or 12 condoms). The MTR was unable to locate female condoms in Lhasa.

Health Promotion and BCC training. The Shandong University School of Public Health has been contracted to deliver a certified, modular course on Health Promotion and BCC techniques. The objectives of the training are to increase skills, stimulate activities and raise the status of prevention activities. Participants are drawn from the TRHB, TRCDC, LMHB, LMCDC and Linzhi, Shannan and Shigatse prefecture CDCs. The course design is 5 modules of 1-2 weeks each according to the topic over a period of around 6 months. So far two modules (Module 1, an overview of health promotion; and Module 2, an overview of health promotion in China and Tibet's HIV and STI epidemics) have been delivered (with 18 and 10 participants, respectively). Modules 3 and 4 (with an anticipated 13-14 participants) will be from 20-29 August 2007 in Lhasa. The final module will be at Shandong University in late September/early October 2007.

Shannan CDC requests. Over the coming 20 months, the Shannan CDC requests support for

- outdoor billboards to increase awareness and promote safer sex in the general population
- capacity building on outreach, behaviour change communication (BCC) skills, and effective strategies to target MARPs; capacity building can take different forms, including study tours or other training opportunities
- follow up support to women who test HIV positive
- supplies for condom demonstrations, including penis models, lubricant, and a reliable supply of condoms and IEC materials

Lhasa municipality needs. The MTR suggests that counterparts and the AMC consider activities over the next 20 months that support

- condom use in Lhasa
- intensified health education among vulnerable groups
- expanded sentinel surveillance to cover groups such as truck drivers, in addition to sex workers and IDU

(c) Sustainability: Sustainability is at risk unless there is fresh joint planning, an agreed and integrated strategic focus, and strong implementation. The need for this was discussed and agreed by counterparts at the MTR exit brief.

Recommendations

12 Counterparts and THSSP collaborate to document and promulgate the Shannan experience, including the planning processes, implementation approaches, and progress to date to assist expansion of similar interventions to other places

13. TRHB, with technical support from THSSP, lead relevant interventions among vulnerable populations including emerging high risk populations such as IDUs and MSM groups

5.3.5 Output 3.4: Improved awareness and knowledge of HIV and STIs and how to prevent them

(a) M&E

The outcome indicator is *community knowledge of HIV and STIs and how to prevent them is increased.*

(b) Progress

There is some progress but more is needed.

Dissemination of information. THSSP supported activities linked to WAD and posting of billboards. Counterparts very much appreciated these activities. The AMC collaborated with TRHB and LMHB to design materials for WAD activities and general information dissemination within Lhasa municipality. At the request of LMHB, THSSP participated in the vetting of messages and images for the production of HIV/AIDS awareness and prevention billboards.

THSSP also provided financial support for the production and installation of ten double-sided and illuminated billboards in Lhasa. Billboards are bilingual (both Chinese and Tibetan), and installed at high traffic sites in Lhasa. Billboards were installed in time for WAD on 1 December 2006 and will remain on display for one year. During the one year period, images and messages will be changed twice. LMBH indicated disappointment at the stalled proposal to implement messages on bus handles. A difficulty is that the type of message needed is not always agreed between the AMC and counterparts.

LMBH request for further support. LMBH indicated to the MTR that they want more and higher profile billboards installed and replaced at the Lhasa airport, along highways, and within bus and train stations. This would link with the national effort to improve HIV/AIDS awareness among migrant populations.

(c) Sustainability. A much stronger strategy is needed to achieve sustainability.

Recommendations

14. *TRHB lead awareness raising campaigns with a focus on mobile populations and at county level (e.g. Linzhou) when mobile populations return home from Lhasa and request THSSP technical assistance*

15. *As previously requested by TRHB and LMBH, THSSP support expansion of the number of HIV/AIDS billboards to include billboards on buses and in bus stations, on trains and in train stations, along highways and at and in the airport*

5.3.5 Output 3.5: Improve access to quality condoms

(a) M&E

The outcome indicators are

- *increased availability of quality condoms at selected sites*
- *increased demand for condoms at selected sites.*

(b) Progress

There is little progress and little agreement between counterparts and the AMC on the way forward. It is hoped that the recommended new joint planning may achieve progress.

Condom availability. There are conflicting indications of condom availability and accessibility in Tibet. In some places, condoms are readily available, while in others, particularly in some remote counties, condoms are difficult to obtain.

100% CUP & CSM (and see Output 3.3 above). The AMC has explored different approaches to achieve the Outcome of this Output, including implementation of 100% condom use programmes (100% CUP) and condom social marketing (CSM). As well as the Beijing meeting with WHO in December 2006 (see Output 3.3 above), meetings were held in Chengdu with the Futures Group on a pilot CSM project in Lhasa and Shannan prefecture. The TRHB, LMHB and Shannan CDC were briefed on these meetings with WHO and the Futures Group, and the processes of implementing both 100% CUP and CSM were explained. All groups were supportive of the introduction of both 100% condom use and CSM

programmes, though so far implementation has not yet commenced. There is a LMBH proposal funding a pilot CSM project after a rapid needs assessment exercise by Futures Group. Another proposal has been submitted by TUMC for NHSHR funded condom promotion activities on the Tibet University campus. Neither proposal has yet been approved. And see AMC's current views on 100% CUP at Output 3.3 above.

Vending machines. LMHB expressed disappointment that their request for a condom vending machine at a target group site was unable to be met by the AMC. It may be strategic to revisit this proposal, drawing on lessons learned from the Shanghai card machines, or other examples and ideas.

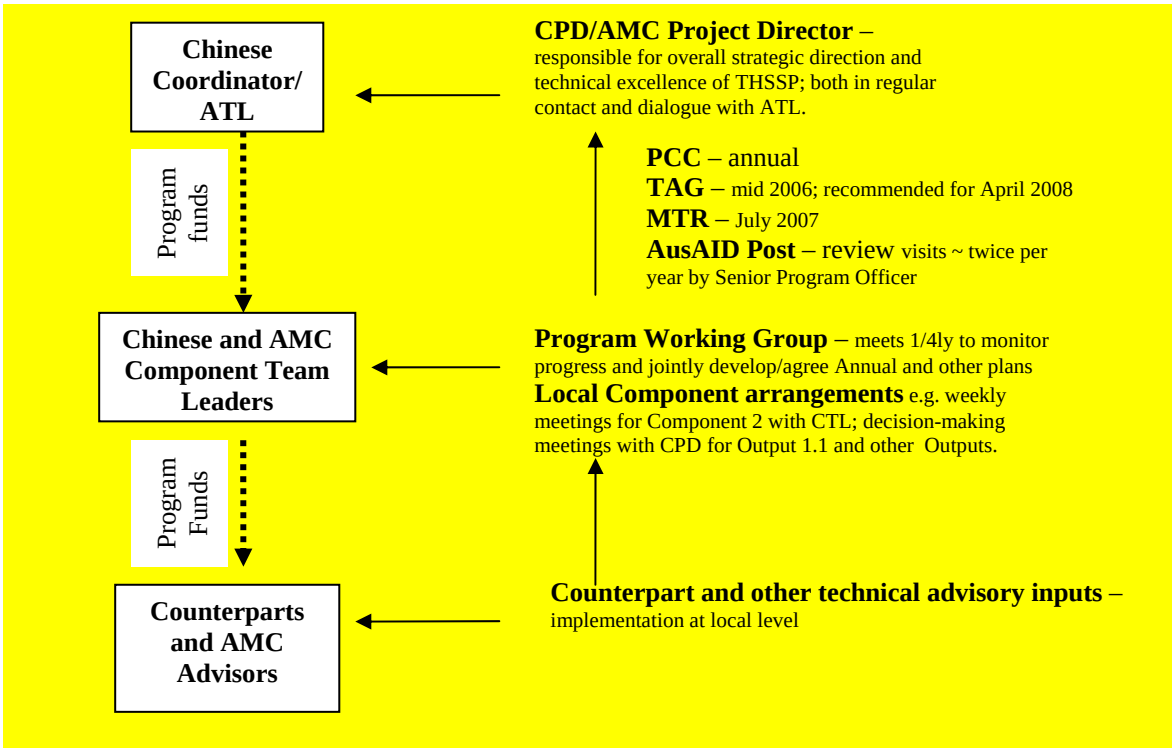
(c) Sustainability. On present indications the Outcome of this Output will not be met.

Recommendations

16. *For condom use, in line with China's AIDS Regulations effective 1 March 2006,*
    - *(i) counterparts, with THSSP support, consider a rapid assessment to have better understanding about condom availability and accessibility by MARPs*
    - *(ii) TRHB lead condom use strategies at prefecture level engaging PSB, Tourism, Culture and FP departments, as well as entertainment establishment managers*
    - *(iii) THSSP advocate and plan (with TRCDC and Lhasa Health Bureau) for targeted interventions among most-at-risk populations in Lhasa, such as condom use by entertainment workers and their clients, and peer education*
    - *(iv) THSSP support TRHB for key non-health sector agencies' study tours on successful condom use at relevant sites within China for lessons learned for adaptation to Tibet*
    - *(v) counterparts and THSSP reassess possibilities to speed up delayed proposals on condom promotion to be funded under the NHSHR grants*

6. Program Management

Figure 7
Schematic overview of THSSP communication, management, coordination and monitoring mechanisms



6.1 Counterparts and the AMC

There are some challenges with aspects of Progam Management.

First, for the AMC, there have been ambiguities around counterpart responsibilities. These ambiguities were clarified during the MTR, but counterparts felt that they had already explained clearly who was responsible for what. There are also some challenges with THSSP engagement at Regional CDC level. MTR hopes that the clarification of counterpart roles, the recommended joint planning for Component 3, the new Component 3 Team Leader, and the new PTD, may collectively assist engagement with the Regional CDC.

The clarified Chinese counterpart arrangements are:

- Chinese Project Director: Mr. Xi Le
- Chinese Team Leader: Mr Bai, with Mr Li Jiang deputising
- Chinese Coordinator for Components 1, 2 and 3: Mr. Li Jiang
- Chinese Component 1 Team Leader: Mr Bai (Mr Li Jiang deputising)
- Chinese Component 2 Team Leader: Mr. Gerlic
- Chinese Component 3 Team Leader: Mr Li Jiang

Recommendation

17. *<u>Counterparts and THSSP</u> strengthen mechanisms for management and coordination and in doing so consider, and build on, the following and report on progress in the next Six Monthly Report*
    - *(i) <u>Strategy development and monitoring</u>*
        - *quarterly meetings of THSSP and the CPD (Xi Le)*
        - *PWG*
    - *(ii) <u>Management and coordination</u>*
        - *monthly meetings of THSSP and the Chinese Coordinator (Li Jiang)*
        - *early consultation by THSSP of the Chinese Coordinator (Li Jiang) on all high-level coordination matters*
        - *regular ad hoc communication between ATL and Chinese Coordinator*
        - *AMC re-assessment of whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 as above*
    - *(iii) <u>Component 3 leadership and management</u>*
        - *possibly similar arrangements to Component 2 (weekly counterpart and THSSP meetings)*
        - *and consider also replication of the decision-making arrangement of Component 1 (e.g. CPD, ATL, and Chinese and Australian Component 3 Team Leader)*
    - *(iv) <u>More frequent communication</u>*
        - *continuation of THSSP/counterpart ad hoc meetings (daily, weekly) and communications as required*
    - *(v) <u>Implementation</u>*
        - *Counterparts focus on implementation and THSSP on support*

Second, counterparts expressed dissatisfaction with some aspects of THSSP management, including

(ii) not always using formal coordination channels (e.g. an Inland China visit; aspects of the MTR visit arrangements)

(iii) lack of clarity in some communication (perhaps related to translation issues) citing the gap between the effectiveness of communication through Output 1.1 and some other THSSP areas, and requesting the Output 1.1. training coordinator also coordinate Component 3 training – with which the AMC has not agreed (and see earlier discussions on this)

(iv) perceived lack of responsiveness and appropriate action in some Component 3 areas raising their concern about THSSP capacity to be effective across Component 3 (e.g. messages on bus handles; the condom vending machine request; the initial arrangements for non-health sector engagement and grants; (joint) disappointment in the relationships between THSSP and some of the non-health sector key stakeholders)

In its response to the draft MTR Report, the AMC invited the MTR team to include, as appropriate, any strategic reflections or insight gained which could assist the AMC's continuing efforts to support locally led implementation of THSSP. As a principle MTR believes this is best

addressed by direct discussions between the AMC and counterparts, to arrive at agreed expectations, with a process for feedback on progress and issues. From the MTR's perspective, the AMC may like to consider the following points:

- Advisors recruited whom the counterparts respect professionally and personally (Outputs 1.1 and Component 2 are examples)
- Understanding by THSSP of how government and its bureaucratic arms work and how this either limits or enables communication and action on the part of counterparts
- Discerning key interests and "the vision" of counterparts and responding well to them e.g. non-health sector engagement and disappointment at its progress – and understanding the difficulties this may cause counterparts within their bureaucratic and government environment
- Understanding the subtleties and nuances of spoken Chinese communication – by ensuring translators provide this
- THSSP actively using GOPRC and GOTAR policies etc. as the basis for strategy and technical discussions, actively demonstrating a demand response approach
- A genuine partnership approach in technical and other exchanges; paying attention to symbolic partnership issues e.g. there are no counterparts in the various photos of the "THSSP team" mounted in the office as well as THSSP team
- THSSP ensuring they follow formally required protocols at ell times e.g. the issue of travel to Inland China; some MTR visit arrangements; a key counterpart stating he did not know about advisors coming sometimes until he was asked to arrange visas – ensuring protocols are followed demonstrates not only understanding of the system but also respect for it and the people within it
- Early enthusiasm, 'embracing' and wise strategic use of counterpart placements in the THSSP office
- Genuine commitment by THSSP staff to operationalise the stated demand response within the design parameters of THSSP e.g. the request for more billboards; working with counterparts to achieve, however long it takes, an agreed message for bus straps within the symbolism of Chinese and Tibetan language; providing explanations that are clearly understood when something cannot be done e.g. vending machines where the explanation given to the MTR was this could not be agreed because there were no coins in Tibet but counterparts believing that there are non-coin vending machines used elsewhere in China – therefore the reason for not responding to the request is seen as curious and perhaps spurious
- High level coaching by THSSP staff to assist counterparts in understanding implementation skills
- Clarity on who is responsible for what – both counterparts and THSSP

The AMC

(i) now has clarity on counterpart responsibilities which MTR hopes will greatly assist communication and progress, particularly in overall coordination and for Component 3

(ii) has simplified the non-health sector grant proposals and there is some progress

(iii) is supporting many of its advisors with further education including translators

(iv) continues to have difficulties recruiting suitable Chinese LTAs and STAs, notwithstanding using its networks to source possible candidates

(v) has responding to changing management and technical input needs (see Annual Plan pp. 88 & 89) while some aspects are still being bedded down

(vi) is recruiting a Component 3 team leader where the requirements emphasise health promotion, the AP states that the ATL will manage the higher level policy aspects, and where there is a new PTD with HIV experience

a. MTR believes that Component 3 needs a high level LTA who can command the respect of senior counterparts, supported by the PTD and ATL
b. with perhaps the PTD spending longer in country during regular visits enabling her to add strength to Component 3 without this being detrimental to the overall program (and perhaps funded through unallocated STA, whilst she would remain in the PTD role) and
c. where there are clear lines of accountability within the AMC on who is responsible for what for Component 3 i.e. will the new Component 3 LTA be the team leader for Component 3? MTR's view is that this should be their role, similar to Component 2

Recommendations

18. The AMC re-assess whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 through the current Component 1 training coordinator, to strengthen communication and progress, and counterpart satisfaction with THSSP's responsiveness to requests

19. The AMC ensure that leadership accountability for Component 3 is clear, consider the PTD spending additional time in-country to add additional strength to Component 3, and, if agreed, AusAID consider agreeing to funding this additional PTD time through unallocated STA budget

20. The AMC request and GOTAR provide all relevant current policies, strategies and guidelines and THSSP

i. document specific linkages between these and THSSP-supported activities (e.g. in the log frame and M&E Table) and
ii. ensure all planning, advisor support and M&E is linked to them

21. The AMC re-assess whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 through the current Component 1 training coordinator, to strengthen communication and progress, and counterpart satisfaction with THSSP's responsiveness to requests

6.2 Communication

Communication is frequent between the AMC and CPD on both an ad hoc and structured basis (daily, weekly etc.), there is a quarterly PWG and annual PCC, a TAG and the MTR, and twice yearly review visits by AusAID's senior program officers. Despite this there have been some miscommunications between the AMC and counterparts e.g. the importance counterparts are placing on the newly seconded RCDC staff member to facilitate linkages with

RCDC and for Output 3.1 progress; and that the CPD feeling he had communicated clearly to the AMC the clarified Chinese Coordination arrangements but that these were still not understood. Conversely, AMC 'constraints' on the in-country team e.g. the NHSHR procurement issues, are also not always appreciated by counterparts. Opportunities for replication the effectiveness of the communication through Output 1.1 should be analysed by the AMC

There is no clear solution to achieving 100% effective communication between the AMC and counterparts, but in general there appear to be good relationships, despite some frustrations, and good will. This always assists. The AMC will continue to strengthen its interpreter support through support for their continuing education, will maintain and continually strengthen relationships with counterparts, and needs to keep a strategic eye out for what may be being indicated if not explicitly stated. The reality of working in government and bureaucracies, of course, also influences what and how counterparts communicate; it is not always possible for counterparts to keep an AMC fully informed where government deliberations are in progress.

There was variability in the effectiveness of AMC communication with AusAID from the Inception Phase. AusAID's satisfaction has increased since the appointment of the then new PM – who is now leaving. Orientation of the incoming PM to AusAID's preferred communication approach will be important and was briefly discussed with the AMC during the MTR.

Given that counterparts have only seen the Aide Memoire and the draft Executive Summary of this MTR, and given their and THSSP advisors input to this report, and to assist transparency and communication, copies of the full MTR report should be provided to counterparts and all THSSP staff.

Recommendation

22. The AMC arranges for translation of the full MTR and provides copies to counterparts and all THSSP staff

6.3 Advisor recruitment

There have been occasional counterpart dissatisfactions with advisors (both Chinese and International) which largely mirror the AMC's dissatisfactions. Counterparts find effective Chinese advisors very helpful, because of language and familiarity with the Chinese context, if not the Tibetan context (until learned). Most, though not all, Chinese advisors have been effective.

Recruitment of effective and appropriate Chinese and some other advisors remains challenging, despite the AMC using its China and international networks, including institutions, to source possible candidates. The AMC advises that

> *"…securing staff to work in Tibet – long or short term – is problematic. To date, the majority of CSTAs who have worked on the Program are engaged elsewhere in full time employment – in universities, government health departments or other health institutions – and are not usually able to complete inputs longer than 10 days. Complicating this further is the usual situation*

where these advisers cannot commit to completing inputs until 2 weeks before the input is due to take place."[20]

Two ideas may assist:

(i) where there are difficulties in attracting and recruiting Chinese or international long term advisers then consider substituting with regular short term advisor inputs (as in Output 3.4 for blood safety) given potentially easier recruitment; this may also assist the counterparts' wishes that the AMC advisors provide support to their implementing, rather than the AMC directly implementing

(ii) the AMC consider reviewing its current executive search procedures to see where there may be possibilities for strengthening

The MTR raised with the Chinese Coordinator the possibility of his active involvement in the selection of advisors. The TAG raised a similar issue with counterparts. The Chinese Coordinator advised the MTR that he does not wish this level of involvement, while expressing concerns that he is sometimes unaware of selections made until notified of visa requirements. MTR suggests that early advice to the Chinese Coordinator on the selected candidate would assist ownership and better enable the Chinese Coordinator's role. Given the new clarity in Chinese counterpart arrangements this should no longer be a problem. Ideally, counterparts should be an integral part of all selection processes and the AMC should encourage the Chinese Coordinator to actively participate in the selection process.

The MTR reviewed the advisor position descriptions and, in general, they contain sufficient role specificity to give clarity, and a sufficient strategic approach to enable flexibility and responsiveness to the changing needs in TAR and system change progresses.

There is a new seconded Chinese counterpart to facilitate progress in the non-health sector response (Output 3.1) within the AMC's THSSP office. This reflects the importance counterparts place on stronger progress with engagement of the non-health sector, with which they have been disappointed (and see discussion at Output 3.1 above). The AMC's strategic and effective engagement of this new Chinese counterpart is therefore important, and will hopefully be progressed well.

Recommendations

23. For advisor recruitment,

(i) the AMC and counterparts consider the merits of C/STA inputs where C/LTA recruitment is problematic

(ii) the AMC consider further strategies for overall LTA and STA recruitment, such as recruiting from untapped institutions in Inland China and reviewing its executive search processes for opportunities for strengthening, including assessing strategies used by professional executive search firms for ideas to achieve strengthened outcomes

6.4 Documentation and other promulgation

GOTAR policies, strategies and guidelines. AMC documentation largely does not specifically link to GOPRC and GOTAR policies, strategies and the majority of advisors

[20] AMC written response to draft MTR report 130807

consulted did not have knowledge of which policies etc. their activities were supporting, nor of the GOTAR targets to which their support was contributing, with THSSP M&E therefore not specifically linked to the various GOTAR targets. A basic tenet, indeed THSSP Principle 1, is that THSSP is supporting GOTAR priorities, and translated copies of relevant GOTAR priorities would also seem to be important to know that this is so. The relevant GOTAR policies etc. were readily supplied to the MTR by counterparts when requested, and were important reference tools in its deliberations (e.g. see discussions at Principle 1, section 4.1 for examples of the many areas where explicit strategic links would benefit the AMC's planning, management and M&E and AusAID's ability to support and monitor THSSP).

24. The AMC request and GOTAR provide all relevant current policies, strategies and guidelines and THSSP
- *(i) document specific linkages between these and THSSP-supported activities (e.g. in the log frame and M&E Table) and*
- *(ii) ensure all planning, advisor support and M&E is linked to them*

AMC documentation. The AMC provided sound, detailed documentation on most Output activities when requested (e.g. the two-year infection control action plan; MCH plans; management development program participants; study tour details; safe blood supply planning; draft strategic plan for Shannan-based activities etc.). This provided the MTR with the information needed to be satisfied that there is good detailed planning reflecting good strategic thinking across Components 1 and 2 and aspects of Component 3. The robustness of these is not always reflected in the AMC's reporting documentation to AusAID.

THSSP successes. In the MTR's view, the AMC needs to more effective in conveying THSSP successes, particularly in Components 1 and 2 and aspects of Component 3. Relying only on AMC reporting documentation, many of THSSP's significant successes are somewhat obscured. The relatively recent publication of newsletters (two now published) is a good step. The MTR suggests that THSSP should further encourage and support counterparts for

(i) Inland China publications (TUMC has published five papers to date in Inland China) and conference presentations
(ii) publications in international journals and on the Web (e.g. the AMC web site)
(iii) the AMC, and counterparts, presenting at international conferences (using simultaneous translation where needed).
(iv) story writing (such as Shannan Hospital and Linzhou life saving programme) using a contracted information communication expert (e.g. a journalist)

6.5 Underspend and 2008-2009 activities

It is unlikely THSSP will be able to expend its budget. However, if Component 3 strategies are developed and implemented strongly, under the guidance of the CPD and newly (formally) designated Chinese Component 3 then underspending will be reduced. The MTR is reluctant to put a figure on the likely underspend by end-THSSP because of the uncertainties around

(i) Component 3 activities
(ii) the public health management program time-overrun and perhaps possibilities of pre-paying costs before THSSP ends
(iii) further opportunities in most Outputs as system change continues and new opportunities present

(iv) the possibility (not probability) that a significant project may emerge from NHSHR

For these reasons, the MTR recommends a March 2008-March 2009 annual plan, which would clearly lay out the final year's work enabling GOTAR planning for post-THSSP, the AMC to focus on key strategies for sustainability and exiting in March 2009, and AusAID to assess likely achievements and underspend.

While there is a *Sustainability and phase out matrix* annexed to the THSSP 2007-2008 AP, and clearer Exit Strategy will be required. This is difficult to do when planning for the final year is not yet known. An Exit Strategy is a usual AusAID requirement with greater specificity than in the current matrix and encompassing two aspects: (i) operational issues such as handover of equipment, cars, dates for closing down of bank accounts, closing the office etc., usually finalised, say, three months before completion and (ii) strategic issues related to the handover of full responsibility to counterparts for each specific THSSP-supported activity to maximise sustainability, accompanied by assessment of sustainability risks. A matrix approach would be usual with the current matrix providing a foundation.

This would also enable programming timelines for the Activity and Independent Completion reports.

Recommendations

25. AusAID consider that the final THSSP annual plan should be the 12 months from March 2008 to (i) enable a clear sense of strategies and sustainability (ii) the degree of underspend by end-THSSP and (iii) that an exit strategy be included

26. AusAID, counterparts and the AMC agree timelines for (i) the Activity Completion report and (ii) the Independent Completion Report and any other Program completion processes, as part of the recommended 2008-2009 planning process

6.6 M&E

"Internal". M&E is discussed at Principles (section 4) and at each Component and Output (section 5) and at Annex 1 (TAG recommendations). In summary,

(i) the new M&E Framework and M&E Table (Annex 6 in the 2007-2008 Annual Plan) is a significant improvement

(ii) the MTR discussed with the AMC suggested revisions or augmentations of some Key Indicators and their measures

(iii) these are discussed above at each Goal, Purpose, Component and Output 'outcome level' as relevant

(iv) MTR recommends the inclusion of GOTAR targets in the M&E Table at least, to enable policy and other linkages to be seen and THSSP focus and contribution to be more easily assessed

Recommendation

27. The AMC, in consultation with counterparts,
- *(i) revise certain aspects of the M&E Table as discussed during the MTR, including outcome indicators at Purpose and Component 1 level for the next Six Monthly Report*
- *(ii) include available and relevant GOTAR indicators in the M&E Table, to which THSSP support is contributing*

"External". There was a TAG in mid-2006 and this MTR in July 2007. THSSP finishes in March 2009. Planned monitoring and evaluation over the next 20 months includes

(i) the proposed review of NHSHP by end-2007
(ii) and approximately twice yearly review visits by AusAID's senior program officers from the Beijing Post
(iii) the annual PCC
(iv) the AMC formally reporting each 3 and 6 months to AusAID
(v) Activity Completion Report
(vi) Independent Completion Report (assumed)

Given the intent for a new strategic plan for Component 3, MTR recommends that this be reviewed by desk analysis, and that there is a TAG for Component 3 only in March 2008. A TAG for other Components could also be considered depending on progress.

Recommendation

28. AusAID consider a TAG in March 2008 to review Component 3 progress only and the Component 3 aspects of the 2008-2009 annual plan (as recommended above) and the TAG report be an input to the AMC's Activity Completion Report and the Independent Completion Report; AusAID consider by January 2008 whether a TAG for Components 2 and 3 and Program Management would add value or not

7. LESSONS LEARNED

- Counterpart role clarity is essential for communication and progress
- Local policies, strategies and guidelines need to be translated, available to all and transparently linked to Program planning and M&E
- Strong counterpart leadership, together with shared understanding and clear strategic and implementation foci are keys to success
- Language barriers can be overcome by good translation while the cultural subtleties of Chinese communication need also to be learned and understood
- Well planned study tours can act as catalysts for change
- Engagement with other development projects can be significantly helpful while their experiences need to be adapted for the different contextual reality

- Whether advisors should be international non-Chinese speaking or Chinese speaking (local or international) is dependent on the task required and the calibre/competency and personal attributes of the advisor; where calibre/competency and personal attributes are equal, local experts can add significant value because of cultural understanding and language
- Clear documentation showing successes and challenges enables funders and other key stakeholders, including internal Program staff, to distinguish between successes and areas of concern, avoiding the whole Program being perceived as not progressing rather than a specific part or parts
- Well designed and delivered action learning programs can be a significant catalyst for system and organisational change
- Local success and innovation should be accessible to a wider audience: other local audiences (visits, local conferences), nationally (publication of papers, presentation of papers at conferences), and internationally (internet, international publications, international conferences using simultaneous translation if needed)
- Twinning arrangements which are well thought through and implemented can contribute well to sustainability

8. CONCLUSION

There are new, more enabling policy environments in China and Australia since THSSP commenced, to which THSSP is responding. Relevant GOPRC and/or GOTAR policies, strategies and plans require translation and should be available to all THSSP advisors, be part of their orientation, and the salient points and GOTAR targets included in THSSP documentation as appropriate (e.g. the M&E Table, updated logframe).

GOTAR counterparts confirm THSSP continues to target TAR's health priorities. GOTAR is achieving success with THSSP support across Components 1 (Health System Development) and 2 (Primary Health Care). Management development through Outputs 1.1 and 2.1 is having a strong cross-cutting impact on system and organisational change and development.

There have been challenges with some aspects of Program coordination related to Component 3 progress. The MTR hopes these will be overcome with the new clarity around counterpart responsibilities and new joint planning proposed for Component 3. There is a new AMC PTD and there will be a new AMC PM. MTR anticipates the AMC will manage the transition well.

THSSP is achieving well in Components 1 and 2, and in aspects only of Component 3. There is (i) strong counterpart leadership, (ii) new clarity on counterpart roles which will assist progress, (iii) anticipation of continued progress in Components 1 and 2 and much that has a high probability of sustainability, and (iv) potential for improved progress in Component 3, which should be closely monitored. The final annual plan is recommended for March 2008-March 2009, including an exit strategy and estimate of the predicted underspend. A TAG is recommended for Component 3 in March 2008 and revision of some aspects of the M&E matrix.

ATTACHMENT 1

Assessment of response to TAG recommendations

Recommendations from 2006 THSSP TAG Report

Overview

The following list, at first glance may appear arduous. However, there are really on two major recommendations that several of these more detailed recommendations are linked to.

Primarily, the THSSP implementation team will need to address improved Program Planning to better reflect the Program-Approach, enhance strategic thinking, improve the focus of the Program and aid in a more analytical approach to reporting. Secondly, the team are required to improve the design and delivery of the Program's Monitoring and Evaluation systems.

Pace of Program Inception and Implementation

Recommendations for AusAID Post and Contracts

1. Implementation teams need to be in place early to learn about the context, location of decision-making within the counterpart structures, prioritise counterpart needs especially after lengthy design periods, and to develop a modest series of interventions that result in the early demonstration of outcomes that clearly benefit counterparts and beneficiaries. There is a need to create time and opportunity for the team to engage with counterparts during inception. The best engagement is partnering in activities that are seen to be beneficial to counterparts. This allows learning through the process of joint action rather than undertaking consultations for the preparation of reports (such as technical or situation analyses);

2. Requirements for further analysis and consultation need to be balanced with early demonstration of selected outcomes;

3. When preparing RFT design documents, contractors should not required to name and contract Short-Term Advisers (STAs), and produce adviser reports to meet milestones until they have had the opportunity to re-evaluate the situation, identify local need and absorptive capacity;

4. Preliminary Monitoring and Evaluation systems need to be developed within three months of Program mobilisation, in the first instance, to identify and then demonstrate a small selection of intermediate outcomes to develop increasing engagement by stakeholders. Further development of M&E systems can be carried out over the whole period of inception.

MTR Response: Agree

Sustainability

Recommendations for THSSP

1. Define short-term and intermediate outcomes expected at the end of the program with counterparts as part of the Annual Planning Process;

MTR Response:

The AMC has revised its M&E Framework and included an M&E Table in the 2007-2008 AP. The structure of the M&E approach is now at three levels: process, capacity and outcome, for each Output. This creates some complexities on occasion but is satisfactory.

Recommendations are made in the report re some strengthening of key indicators at outcome level in particular, and at Goal and Purpose levels, and for Key Indicators for Component 1.

MTR also recommends the specific linkages of THSSP M&E key indicators to GOTAR policies and targets.

2. Develop an Exit Strategy during the next Annual Planning Process (discussion to inform this Strategy can begin as soon as possible);

MTR Response:

A phase out matrix has been developed, which needs to be progressed to an Exit Strategy. MTR recommends this is done with counterparts as part of the 2008-2009 'annual' plan development and is an annex to that plan.

3. Clear analyses of approaches to sustainability and progress against the Exit strategy should be included in each Annual Report/Plan.

MTR Response:

As above

Capacity Building

Recommendations for THSSP

1. As part of the next annual planning process, specific capacities expected to be developed and sustained by the end of program need to be defined as part of the process to identify intermediate outcomes. These outcomes should be clearly linked to the M&E framework, be reported on quarterly or annually as required, and supported by credible evidence.

MTR Response:

The AMC has made significant progress

2. The Annual Report/Plan can: show how the Capacity Building Strategy has been reflected in programming; identify successes in Strategy implementation; identify challenges encountered; and describe responses taken to address challenges; and provide credible evidence of the results of adjustments made;

MTR Response:

The AMC has made significant progress

3. The approach taken to build capacity can be reflected in activity planning (eg. consideration given to what will be required beyond training to sustain behaviour change, such as the existence of appropriate equipment, or management support for new ways of working). Where these approaches are documented with respect to activity planning can be determined by the implementation team. At a minimum, adviser reports should include how they have addressed the breadth of Capacity Building Strategy in their work programs, or when developing training plans. International Technical Advisers may need to provide some support to ensure that this is achieved.

MTR Response:

The AMC has made significant progress

4. Definition of the role and expected outcomes for seconded staff requires review, with the development of a targeted professional development program that is realistic for the Program to provide, and within the capacity of the staff to participate. Outcomes of these professional development activities should be reported against in the Annual Report/Plan (though not necessarily in the M&E framework).

MTR Response:

Advisors are supported in their professional development endeavours. Understanding of, and support for, seconded staff's roles appears still to require better understanding. MTR does not agree that a targeted professional development program as such may be the only strategic support that could be provided – experiential experience is also valuable to many. MTR agrees with the AMC that each case needs to be assessed for individual need and context. The clarification of Chinese coordination arrangements and the recommended new joint planning for Component 3 should assist. Leadership and management of the new seconded position for Output 3.1 should be monitored to assess progress.

Gender Strategy

Recommendations for THSSP

1. The next annual plan should include a review of implementation of the Gender Strategy, and an analysis of challenges and successes.

MTR Response:

Progress made with documentation in the annual plan.

2. The Monitoring and Evaluation Framework should include measures of gender mainstreaming where this is deemed relevant.

Health Promotion Strategy

Recommendations for THSSP

1. Health promotion strategies are central to the success of program outcomes and therefore should be closely reviewed over the next year for both Component Two and Three. Critical to success of health promotion in the TAR is the improved capacity of the Health Promotion Units. Outcomes for health promotion capacity building should be realistic and strategies defined should be highly focused on a limited number of key outcomes.

MTR Response:

New cross-cutting health promotion strategy developed and is satisfactory.

2. Since the Regional Health Bureau has given direction to work through the Regional Health Promotion Unit, opportunities exist to move forward. It would be worthwhile to explore health promotion approaches with representatives from the Units and Regional Health Bureaus through an internal study tour of health promotion activities in Sichuan and Yunnan. Hong Kong is another good destination for exposure to health promotion approaches.

MTR Response:

AMC engagement at regional level remains challenging. There is significant progress in strategy development for health promotion; includes engagement with Shandong University and TUMC, which are stronger strategies for sustainability than focusing only on the fairly weak and under-resourced health promotion units, while these are not being neglected.

3. Discussions could be held with the Tibet University Department of Public Health on how to build health promotion capacity in the Department. The objective of these discussions would be to support the Public Health Unit to incorporate health promotion into the curriculum. There is a national health promotion curriculum, and THSSP could consider consultations with Professor Guo from Peking University, and Professor Wu Zen You at the National CDC who has taken health promotion forward in China. THSSP could also provide support to improve counterpart understanding of the impact of new policy on health promotion activities such The Guiding Plan for High Risk Behaviours Interventions.

MTR Response:

TUMC engagement well done.

4. Program plans show that Tibet Academy of Social Science (TASS) is to be used for health promotion research however there is limited evidence in Program documentation of this relationship to date. Although early efforts to engage the TASS did not result in substantial gains, this approach could be reconsidered. To support this work, THSSP could also engage with the Hua Xi University School of Public Health (Sichuan University) to strengthen linkages with TASS and provide additional support for capacity building. If other agencies are working with TASS there may be links that can be forged for cooperative research.

MTR Response:

See above

Partnerships and Linkages

Recommendation for THSSP

1. An analysis of Program partnerships and linkages is required in the next Annual Plan. This analysis would include statements of objectives for establishing relationships, and strategies employed to ensure sustainability of the linkages.

MTR Response:

Analysis of Program partners and linkages is included in 2007-2008 AP (section 3.3.9) which was useful. The ambiguities around Chinese counterpart responsibilities, who are partners, are discussed in the body of the MTR report – and the importance of it being clarified.

Program Planning

Recommendation for AusAID

1. A general format for planning for the Program approach would assist teams to reflect the flexible and responsive programming more effectively, and allow AusAID to demonstrate aid effectiveness.

MTR Response:

MTR believes that an AMC should understand planning, strategic thinking and flexibility and responsiveness. A format may or may not assist this – it may have unintended consequences of limiting strategic thinking, synergy and innovation. The AMC appears to be now doing well with internal synergies and cross-cutting synergy between outputs and components.

Recommendations for THSSP

1. THSSP can take the opportunity to work with counterparts to extend planning horizons. This could be approached by analysing barriers to more long-term planning and working with counterparts to address any factors that are within their control. That is, using a problem-based approach such as those employed in Component One. It may be that THSSP cannot bring about change in this area, but it is reasonable to expect that an issue that has such an effect on Program delivery and achievement of outcomes is analysed, has specific strategies developed to address it, and efforts are reported on formally. This approach is a requirement for good risk management.

MTR Response:

This does not appear to be a problem in Components 1 and 2 where there is plenty of evidence of longer term planning, including for years beyond THSSP (e.g. Shandong

University, long term plans for all 700 staff of CDC to do the public health management program etc.). It is a problem in most of Component 3 Outputs, which the proposed joint planning should, hopefully, overcome.

2. Conduct a review of Program Logic and identify intermediate outcomes leading up to the next Annual Planning process.

MTR Response:

Done and reflected in 2007-2008 AP. Satisfactory.

3. The Annual Plan format requires review. Some suggestions for content can be found in Annex 4, but final negotiations with AusAID are required to agree on a final format.

MTR Response:

Format agreed with AusAID and reflected in 2007-2008 AP. As with all continual improvement, next year's 'annual' plan should show further improvement.

4. The Annual Plan will address intermediate and long-term outcomes where appropriate. It should include only general approaches or strategies to achieve the desired outcomes. Activity reporting will not be required.

MTR Response:

The AMC has done as the TAG recommended.

MTR has chosen to assess THSSP progress against its stated outcomes. Given that the underlying purpose of THSSP is to assist GOTAR achieve its outcomes, then AMC documentation should include specific linkages to GOTAR policies, guidelines etc. and their targets, to enable assessment of its contribution to them.

5. The Annual Report and Annual Plan need to be conducted 12 monthly, and merged into one document. This will also require negotiation with AusAID to ensure that there are no negative impacts on current contractual arrangement.

MTR Response:

The AMC has done this.

6. The Annual Operational Plan should be replaced by an improved quarterly reporting and activity planning. All activity plans should show direct relationships to intermediate outcomes in the Annual Plan. Currently quarterly reporting is required for the PWG report and the AusAID Simplified Monitoring Toolkit (which is currently under review in AusAID). PWG reporting may need to reflect THSSP counterpart needs, but a more analytical approach to reporting is required for AusAID. This would include ensuring that constraints are explored and responses described; that achievements are based on evidence generated from the M&E system; and that achievements are related to outcomes where possible. THSSP will need to negotiate a format for quarterly reporting that meets these needs, ideally linked to current quarterly SMT reporting.

7. It would be more efficient to link PWG and AusAID SMT quarterly reporting cycles to limit time spent by the implementation team preparing reports at different times.

MTR Response:

Progress but this still needs strengthening in light of AusAID's new quality reporting requirements.

Scope and Coverage

Recommendation for THSSP

1. During the next Annual Planning cycle when program logic and intermediate outcomes are reviewed and articulated, the scope of activities under each component of the Program should be reviewed to ensure that there is sufficient effort in each component to achieve sustainable outcomes;

MTR Response:

The AMC has requested reallocation of funding between Components which the MTR endorses subject to close monitoring on progress in Component 3.

2. Clear articulation of the criteria for extension and retraction of program geographical coverage is required in PWG reports and Annual Plans, and with stakeholders;

MTR Response:

The AMC has documented its approach at section 3.3.5 of the 2007-2008 AP. MTR's view is that where there are significant gains for replication and sustainability, and an improved return-on-investment therefore for THSSP efforts, and therefore risks are minimal or non-existent but the converse is true, the extension of retraction of geographical coverage should be based, at the bottom line, on readiness of change.

3. Reduce the emphasis on outputs 1.4 and 1.5.

MTR Response:

Output 1.4 has been (appropriately) cancelled. It was included in the original design as a small input only to see if it could be a catalyst for GOTAR strengthening the enabling environment for Component 2 in particular. GOTAR has strengthened affordable access in rural areas in particular and the Output was no longer required.

For Output 1.5, however, 'waste management' being included in the Output descriptor was tautologous. Waste management is an integral part of infection control, not something separate. The question for THSSP support is the degree to which this element of infection control is supported and this is discussed in the report at Output 1.5.

Technical Assistance

Recommendations for THSSP

1. Review and improve recruitment and selection strategy for Chinese long- and short-term advisers. It may prove to be useful to develop relationships with institutions in mainland China where a Chinese adviser is sent to Tibet for regular short term inputs which, with careful planning may result in sustainable relationships beyond the life of the Program. THSSP and AusAID will need to review current contracting arrangement under the Program to ensure that this approach can move forward effectively. This is another high rated risk identified in the risk management matrix and requires good documentation of planned risk treatments and monitoring of outcomes.

MTR Response:

This remains challenging for the AMC. The relationships established through Outputs 1.1 and 1.2 with Shandong University and Jinziang Hospital are proving useful and the CSTA for sustainable blood supply anticipates assisting with further CSTA recruitment. Given the AMC's extensive networks and there still being problems attracting Chinese long- and short- term advisors, further effort is needed.

2. Engage counterparts more fully in the recruitment and selection process for both Australian and Chinese technical assistance. Although the TAG team recognises the challenges in getting full engagement, it may be useful to identify specifically why counterparts are not as interested in participating in the recruitment of Australian advisers. This may reveal something about how Australian advisers are perceived to be contributing to the Program, or how well Australian advisers are perceived to be integrated into Program counterpart institutions.

MTR Response:

This could still be improved. By this stage of the Program, counterparts should be chairing advisor selection committees and taking joint ownership of who is selected. The ambiguities around Chinee counterpart responsibilities, particularly for Coordination and Component 3 may have created blockages. MTR recommends that there are renewed efforts to engage counterparts more fully in advisor selection.

3. Develop and deliver a modest, but focused professional development program for long-term Chinese advisers.

MTR Response:

See earlier comments above. Also, MTR believes it is not only about professional development programs per se but also about supportive leadership and management, role clarity, and experiential discovery and learning which, of course, can and should be regarded as a significant part of professional development.

4. Develop outcome focused work programs for all technical advisers and include measures of outcome, and report on outcomes under the M&E system.

MTR Response:

The AMC only partly agrees with this recommendation. Nonetheless the revised M&E Framework and Table provide a good framework for this, including having Outcome measures for each Output, as well as capacity and process measures. MTR agrees with the AMC that advisors cannot be responsible for GOTAR outcomes, and it is unlikely that this is what the TAG meant. MTR's view is that advisors can and should be interested in knowing their own outcomes and the GOTAR targets to which they are contributing. MTR does not believe there should be a major revision of existing processes and work program, given there is much momentum in many Outputs, and it is dynamic change environment. MTR does suggest that advisors should all be clear on what their Output performance measures (key indicators) and to what GOTAR targets these outcomes contribute, and therefore to what their work is contributing. This would assist external and internal monitoring of progress, focus, and support motivation as successes are reached.

Monitoring and Evaluation

Recommendations for THSSP

1. The draft Monitoring and Evaluation Framework should include basic requirements of an M&E system. Some suggestions for this can be found in Annex 5. Reporting against the new M&E framework will need to be reflected in the next Annual Planning cycle.

MTR Response:

M&E is revised, structure is satisfactory, some key indicators could be strengthened and these are commented on in the MTR Report. And see earlier comments.

2. The Program will need to recruit an M&E adviser to support the design of the M&E system, and to provide adequate support for data collection, analysis and reporting;

3. Risk Management Reporting needs to be included at a minimum in the Annual Report/Plan, and ideally, reflected in the M&E framework.

MTR Response:

Risk management matrix is an annex of the 2007-2008 AP. Some risks are captured in the M&E Table.

Small Grant Facility

Recommendation for AusAID Post

1. Practical guidelines will be required that improve the performance of the SGF. The provision of guidelines from other successful small grant facilities operated in AusAID programs would provide good direction to the THSSP implementation team, at the same time ensuring that guidelines meet AusAID standards. The upcoming visit by the Xinjiang HIV Project team will provide useful information for the THSSP team.

MTR Response:

New simplified guidelines prepared.

2. A review of resources allocated to the SGF requires review to ensure it can reasonably meet the objectives of the Program.

MTR Response:

There is a new CLTA and a seconded person from regional level – both are to focus on Output 3.1. MTR has recommended a review of progress by end-2007. There now appears to be some better momentum but it is unlikely that complex and substantive and sustainable system-change activities will eventuate. Projects/activities are likely to be smaller and more iterative.

Recommendations for THSSP

1. Review SGF guidelines.

2. Include performance monitoring of SGF in M&E framework.

3. A review of the scope of the 11 proposals is required to ensure that line agencies can reasonably meet stated outcomes.

4. Consideration is required to how the interventions can be expanded to include behaviour change activities. For example, training in strategies and good practice for behaviour change should be identified and incorporated into the projects. Consideration is also required on how to support behavioural change activities with vulnerable groups and build the capacity of TRHB and CDC staff to support these initiatives.

MTR Response to 1-4 above:

1. **Simplified guidelines prepared and operationalised**
2. **SGF (now NHSHR) to be reviewed by end-December 2007**
3. **Proposals reviewed**
4. **Behaviour change unlikely: awareness raising is the initial focus given difficulties with progress**

Attachment 2

MTR Terms of Reference

Terms of Reference
Tibet Health Sector Support Program (THSSP)
Mid-term Review Mission
16-30 July 2007

(Final)

1. BACKGROUND

1.1 The implementation of the Tibet Health Sector Support Program (THSSP) began in March 2004 after a lengthy design process that included a Government of Australia (GOA) Project Identification Mission in 2000, a Feasibility / Design Mission in 2001 and a Field Appraisal Mission in 2002.

1.2 The THSSP builds on GOA support given to the health sector of the Tibet Autonomous Region (TAR) through the bilateral Tibet Primary Health Care and Water Supply Project (1997-2001), the China Australia NGO Scheme (CHANGES), the HIV/AIDS Strategy and Planning Development Project, the Iodine Deficiency Disorder Prevention Project (completed in 2004) and the Polio Eradication Program funded through the World Health Organisation (WHO).

1.3 The PDD acknowledges the GOTAR priorities are to (i) reduce the high maternal, infant and mortality rates; (ii) improve leadership and management capacity; (iii) progress health system reform; (iv) improve health service affordability; (v) prevent an HIV/AIDS epidemic; and (vi) reduce adult chronic illness.

1.4 THSSP is a five year program starting in March 2004 with an Australian contribution of A$17.3million. There was a one year Inception Phase which lasted (with a short extension) from March 2004 until May 2005 and a four year Implementation Phase. The PIP is informally divided into two phases, each lasting two years: Phase one, approximately May 2005 to April 2007 and Phase two, approximately April 2007 to March 2009.

1.5 The first Technical Advisory Group (TAG) review was conducted from 15 to 26 May 2006. The TAG recommended that the THSSP implementation team would need to address improved Program Planning to better reflect the Program-Approach, enhance strategic thinking, improve the focus of the Program and aid in a more analytical approach to reporting. Secondly, the team are required to improve the design and delivery of the Program's Monitoring and Evaluation systems.

2. IMPLEMENTATION AND ISSUES

2.1 Main Implementing Agencies

- Tibet Regional Health Bureau (TRHB)
- Lhasa Municipal Health Bureau (LMHB)
- Ministry of Commerce (MOFCOM)
- Department of Commerce of GOTAR (DOFCOM)

2.2 Objectives

Goal: To improve the health of the people of the Tibet Autonomous Region (TAR), particularly those who have the greatest need, through strengthening health services.

Purpose: To strengthen health systems in TAR. Work towards this purpose is conducted through three components, each with discrete outputs:

Component 1 Health System Development focuses on improved health system effectiveness in TAR at the strategic and operational levels.

Component 2 Primary Health Care Support focuses on improved effectiveness, and quality of, and access to, integrated rural health services in four primary Health Care Program counties.

Component 3 HIV and AIDS Support focuses on improved effectiveness of the TAR response to HIV and AIDS.

The THSSP strategies support: i) TAR's priority health challenges: reducing infant, child and maternal mortality, and preventing an HIV epidemic; and ii) TAR's health system reforms, which aim to improve the management, efficiency and affordability of health services. The aims of THSSP are consistent with the principle of people-oriented development proposed by the Central Committee of the Chinese Communist Party and the State Council. Implementation of the THSSP will support the Government of the People's Republic of China (GOPRC) initiatives in rural health system restructuring and reform, as well as strengthening the disease control system in the country.

2.3 Progress to date (the key achievements are included in the THSSP AP07/08 which will be provided to the MTR mission as background document)

(a) Since May 2005, THSSP entered into the Implementation Phase of the program. The key achievements included support to senior and middle level management development; support to the new Lhasa Regional Blood Service; retraining in basic epidemiology required for diseases control and outbreak response, improved rural health services especially in maternal and neonatal care, and increased capacity for HIV diagnosis and STI management in certain areas.

(b) In addition, some activities were conducted including seminars on introducing modern management theory and practice to health managers and stimulating the operational research activities on upgrading prefecture hospital HIS as well as new performance related bonus scheme adopted at the prefecture CDC.

(c) In response to the emerging needs on EID control and prevention, the Output 1.6 has been included into the Program. The training on field epidemiology was conducted by the Program based on the text book distributed by the National CDC and subsequently followed by filed epidemiology studies with technical assistance provided by the THSSP.

(d) The establishment and operation of Essential Maternal and Neonatal Care Committee (EMNC) has contributed to building capacity of local MCH counterparts in their technical skills in clinical supervision and management. The EMNC materials have been adopted by the Tibet Regional Bureau of Health as a standard for in-services training in obstetrics.

(e) The Health Promotion strategy has been revised in response to the experiences in the early part of Program implementation and recommendations from the TAG review of 2006. The new strategy aims to increase linkages between outputs by working across health promotion for voluntary blood donation, rural health priorities, HIV and STIs.

(f) The establishment of standard operating procedures and essential equipments at the Regional CDC HIV confirmation labs plus the Municipal CDC and the Municipal Hospital HIV screening labs. Support to HIV labs in training in use of diagnosis; the establishment of an infection control committee by the hospital.

(g) Program activities to support the development of a condom promotion strategy were conducted, including production of a survey of condom quality and availability in Lhasa and provision of assistance to the Tibet Regional Health Bureau and the Tibet Population and Family Planning Commission to organise a Condom Social Marketing Conference in Lhasa with participation of officers from various counterpart and other organisations in Tibet.

(h) The Program Working Group, consisting of representatives from Regional Department of Commerce, Regional Bureau of Health, Lhasa Municipality Bureau of Health and the Australian team, was established for jointly planning and managing the program implementation.

2.4 Emerging Dimensions

(a) A new output (Output1.6) namely Strengthening Health Emergency Preparedness and Response has been added into Component 1 considering the epidemic situation of emerging health issues.

(b) Several activities, including management development and EMNC training, are at a natural review point where discussion of how to disseminate current gains and refocus activities are needed.

(c) THSSP has responded to local demand to work on improved HIV and STI control in clinical settings, which includes work on infection control and safe blood transfusion.

(d) An increasingly enabling China policy environment for comprehensive HIV/AIDS responses is emerging, including a stronger GoPRC emphasis on: comprehensive interventions; strengthening and utilising Chinese expertise; detecting more HIV infected individuals (free testing)and scaling up proven interventions. In addition, a new HIV/AIDS Regulation became effective on 1 March 2006.

(e) Increasing requirements from the Chinese government regarding strengthening the public health system, strengthening disease prevention and control system and strengthening diseases treatment system. In addition, improvement of health equity, accessibility and affordability has been highlighted by the central government in health policies and plans.

(f) There is an increase in Chinese managed funds/resource and technical advice being provided through a range of national and international funding sources including the China Cares project, USCDC Global AIDS Program with regard to HIV/AIDS response in surveillance and VCT; UNICEF and other international NGOs have been also working in primary health areas in Tibet. Complementarity and synergy with other donor and government programs is vital.

(g) The new China Country Program Strategy 2006-2010 was endorsed by AusAID and MOFCOM in November 2005. The new strategy emphasises a shift towards program approaches, increase in Chinese expertise utilised in activities and strengthening policy linkages between Central and Provincial Governments on existing projects. At the sub-national level, AusAID will support provincial/regional and, where appropriate, local level governments to translate sound national policies into practice. This may include support for planning, co-ordination and scaling up of prevention-based initiatives, as well as information sharing across provinces and autonomous regions. Aligning more closely with partner government systems and facilitating stronger government-to-government linkages and central-level policy engagement will be a priority. HIV/AIDS and support to other communicable diseases including pandemic preparedness as well as health system strengthening will be the focus for the new China Australia Integrated Health and HIV/AIDS Program.

(h) The TAG was conducted in May 2006 with key findings and recommendations articulated in the TAG report (the MTR background doc list).

(i) There is increasing emphasis on aid effectiveness from AusAID. It is required that the M&E system be capable of monitoring not only progress against initiative-specific objectives, but also their

contribution to higher-level country strategy objectives. The THSSP has reallocated M&E resource to reflect these requirements. A revised M&E Framework for the THSSP is provided for the MTR mission's comments for further improvements if it is needed.

3. OBJECTIVES

The key objectives are to review achievements to date and progress in applying the TAG recommendations. Identify the current issues (including technical, managerial and institutional) in implementation; and make recommendations for the future direction of the remaining life of the Program as well as to improve activity implementation and performance.

4. SCOPE OF SERVICES

4.1 The MTR mission will consult with:

(a) Australian Managing Contractor (ARC)

(b) MOFCOM, MOH (CDC) as appropriate

(c) Tibet Autonomous Region Counterparts

(d) AusAID Beijing Post

4.2 The MTR mission will

(a) Assess progress in delivering outcomes for each component.

(b) Identify problems, issues and optimal solutions.

(c) Assess appropriateness of the M&E Framework of the program and recommend any changes

(d) Assess appropriateness of the program approaches and delivery mechanisms used

(e) Assess strength of Partner Government support and provision of inputs to the activity

(f) Assess the Program performance in delivering expected outcomes and outputs

(g) Assess sustainability of outcomes and appropriateness of sustainability strategy

(h) Assess identification and management of risks

(i) Assess the appropriateness and usefulness of contracting out some activities under Component 3 and the Health Promotion as proposed by the THSSP team

(j) Assess the appropriateness of level of focus in terms of the THSSP Component outcomes which link to the output level outcomes referring to the revised M&E Framework. In addition, assess the appropriateness of the Capacity Objectives and the Specific Intermediate Outcomes referring to the Annual Plan.

(k) Review the current outcomes and outputs statements with the consideration of the dimension and changes as noted in the Section 2.4 of the TOR.

(l) Assess the appropriateness and implementation of the gender strategy

(m) Assess the key elements and lessons that can be shared with other health projects in China and utilised in AusAID's new China Australia Integrated Health and HIV/AIDS Program.

(n) Recommend any required changes to the current outputs including recommendations on new outputs or combination of the relevant outputs, and changes in emphases of the Components if necessary.

5. TEAM COMPOSITION

5.1 The MTR mission will comprise one Australian team leader/primary health care expert who also has HIV/AIDS and M&E experience, one WHO China Office HIV specialist. The team will also be accompanied by representatives from AusAID Beijing Post and AusAID's Canberra-based HIV/AIDS Advisor.

5.2 The combined skills required of the team include:

(a) team leadership;

(b) project design and assessment expertise;

(c) demonstrated capacity to assess project monitoring requirements;

(d) expertise in international and national health and HIV/AIDS issues and approaches, health policy and public health;

(e) experience assessing institutional capacity in a developing country context

(f) experience assessing sustainability of development projects

(g) awareness of relevant AusAID's and GOPRC's policies and development objectives;

(h) development experience in China, and TAR in particular

(i) experience working with senior government officials.

5.3 Responsibilities within the team are to be negotiated between the team leader and the team members. The terms of reference however, should provide an indicative guide to individual team member inputs/ outputs. The team leader should confirm primary responsibilities of individual team members with the AusAID desk prior to departure.

5.4 Team members

(a) Team Leader and Primary Health/Health System Management Specialist (Gillian Biscoe)

The Team Leader will be responsible for:

Directing, coordinating and managing the assignment, including the submission of reports outlined under clause 4.

Taking primary responsibility for assessing Component 1 Health System Development and Component 2 Primary Health Care and the Monitoring & Evaluation Framework of the Program.

Guiding the other MTR team member on the consistency and synergy of the cross cutting issues, ensuring these issues are properly assessed and addressed during the MTR mission and in the mission report. Assessing the current approaches of the Program management.

(b) HIV/AIDS Specialist (Zhao Pengfei)

The HIV/AIDS Specialist will:

Provide expert advice on national HIV/AIDS policy and good practice else where in China and how the policies/interventions can be adapted and implemented in TAR, including bringing knowledge and experience particularly on condom promotion and social marketing to inform the direction of the THSSP in this area.

Review the status and issues regarding the Non-health sector HIV response under the Program. Assess the appropriate level of focus of HIV interventions in TAR including consideration of how inclusion of work on infection control and safe blood transfusion to be fit with the current component and output.

Under the direction of the Team Leader, contribute to achieving the objectives of the mission and required outputs with a particular focus on Component 3-HIV and AIDS support including report writing for the review of this component.

(c) AusAID participation in the MTR

Mr John Godwin, HIV/AIDS Adviser will provide specific advice on AusAID HIV/AIDS policy and bring the experience of AusAID supported HIV/AIDS projects in the region to inform of the THSSP.

Ms Kirsty Dudgeon, First Secretary, Ms Linna Cai, Activity Manager, Mr Wang Jun, the Activity Manager will provide specific advice on AusAID China-Australia Health and HIV/AIDS Program; specific advice related to the management of the THSSP and AusAID policies, and other tasks as negotiated within the team and at the direction of the Team Leader.

(d) Translator (Frank Ding)

The translator will be engaged to accompany the mission travelling to Tibet and assist in translation work assigned by the MTR mission leader including translating the MTR TOR from English into Chinese.

6. REPORTING

6.1 All reports must:

(a) be prepared in accordance with AusGUIDE;

(b) be accurate and not misleading in any respect;

(c) allow AusAID to properly assess progress under the Contract;

(d) not incorporate either the AusAID or the Contractor's logo;

(e) be provided at the time specified in this Schedule; and

(f) incorporate sufficient information which allows AusAID to monitor and assess the success of the Services in achieving the objectives of AusAID's Gender and Development Policy.

6.2 The MTR Team will be required to provide the following reports:

(a) An Aide Memoire, to be cleared by AusAID, prior to leaving China.

(b) A draft Mission Report submitted to AusAID Beijing within 7 working days of the completion of the field study. Following receipt by the Team of written comments by AusAID, the Report will be finalised and submitted to AusAID within 5 working days.

(c) The draft and final reports should be provided electronically. Company's logo should not appear on the covers of any reports. Acceptance of the report by AusAID will be subject to agreement that the documentation meets the requirements of these TORs.

7. DURATION & TIMING

MTR members arrive in Beijing on 15 July 2007

Briefing in Beijing with Post and team discussion – 16 July 2007

Travel to Lhasa – 17 July 2007

Field mission -18-29 July 2007 (separate itinerary prepared)

Debriefing in Lhasa with Tibet counterparts-30 July 2007

Draft Report submitted 10 August 2007

AusAID comments by 17 August 2007

Revision of Draft Report submitted 24 August 2007

Final report submitted by 31 August 2007

Note: Background documents provided to the MTR members will include

1. China Country Program Strategy 2006-2010
2. A summary of AusAID Health Program Strategy for 2006-2010
3. The PDD for China Australia Integrated Health and HIV/AIDS Program
4. THSSP Annual Plan 07/08
5. THSSP TAG 1 Report
6. THSSP Briefing Paper for MTR prepared by the AMC
7. Relevant GoPRC policies including for primary health care, health system reform and HIV/AIDS
8. Other documents as appropriate

Annex 3

MTR Recommendations

Output 1.6

3. *Counterparts, the AMC and AusAID discuss options for, and agree on, support to the Shandong University public health management program after THSSP finishes (21 March 2009)*

4. *The AMC and counterparts consider implications of expanding other training to township level, including the feasibility and risks of expanding epidemiological training to township level and advise AusAID*

Output 2.3

3. *The AMC and counterparts include assessment of sustainability (e.g. operating costs such as petrol and maintenance, and availability of latter) when assessing ambulance use later in 2007*

Output 2.4

4. *The AMC and counterparts ensure that the proposed arrangements for managing, monitoring and evaluating the new cross-cutting Health Promotion Strategy do not detract from Component 2 needs continuing to be met*

Component 3 overall

5. *The AMC strengthen management of Component 3 by ensuring during recruitment that the new Component 3 Team Leader is a 'best fit' for progressing Component 3*

6. *The AMC and counterparts jointly develop a stronger strategic and operational workplan for Component 3 for the next 20 months, which incorporates strengthened engagement of the Regional CDC to support the planning and implementation of component 3 (for example through mobilizing RCDC expertise in training activities)*

7. *TRHB and THSSP in partnership, ensure that the focus of implementation efforts is on strengthening the surveillance system and intensifying targeted interventions among most at-risk populations to prevent the sexual transmission of HIV*

Output 3.1

8. *Counterparts, with THSSP support,*

(v) *consider appropriate NHSHR grant applications from regional level agencies and, where appropriate, other centres where interest is self initiated to strengthen response to demand and increase impact*
(vi) *ensure efficient and timely NHSHR approval processes*

9. *Counterparts, and THSSP support, a review of progress of non-health sector engagement and NHSHR-funded activities by the end of 2007, to determine future direction of the NHSHR grants scheme and its budget allocation and advise AusAID of its recommendations*

Output 3.2

10. *Counterparts consider THSSP supporting*
(iv) *further improvement of current surveillance practices through adaptation of serological and behavioural surveillance to the TAR context*
(v) *strengthened data collection methods and data use and*
(vi) *THSSP maintain a focus on building capacity for HIV testing, while exploring opportunities with counterparts to strengthen the regional HIV surveillance system*

11. *RCDC request THSSP support to establish reasonable referrals between the model STI clinic and on-going outreach interventions among entertainment workers (this should be a win-win arrangement to meet health care needs among entertainment workers and to increase the use of the existing clinic services)*

Output 3.3

12. *Counterparts and THSSP collaborate to document and promulgate the Shannan experience, including the planning processes, implementation approaches, and progress to date to assist expansion of similar interventions to other places*

13. *TRHB, with technical support from THSSP, lead relevant interventions among vulnerable populations including emerging high risk populations such as IDUs and MSM groups*

Output 3.4

14. *TRHB lead awareness raising campaigns with a focus on mobile populations and at county level (e.g. Linzhou) when mobile populations return home from Lhasa and request THSSP technical assistance*

15. *As previously requested by TRHB and LMBH, THSSP support expansion of the number of HIV/AIDS billboards to include billboards on buses and*

in bus stations, on trains and in train stations, along highways and at and in the airport

Output 3.5

16. *For condom use, in line with China's AIDS Regulations effective 1 March 2006,*

vi. *counterparts, with THSSP support, consider a rapid assessment to have better understanding about condom availability and accessibility by MARPs*

vii. *TRHB lead condom use strategies at prefecture level engaging PSB, Tourism, Culture and FP departments, as well as entertainment establishment managers*

viii. *THSSP advocate and plan (with TRCDC and Lhasa Health Bureau) for targeted interventions among most-at-risk populations in Lhasa, such as condom use by entertainment workers and their clients, and peer education*

ix. *THSSP support TRHB for key non-health sector agencies' study tours on successful condom use at relevant sites within China for lessons learned for adaptation to Tibet*

x. *counterparts and THSSP reassess possibilities to speed up delayed proposals on condom promotion to be funded under the NHSHR grants*

Program Management

17. *Counterparts and THSSP strengthen mechanisms for management and coordination and in doing so consider, and build on, the following and report on progress in the next Six Monthly Report*

(i) Strategy development and monitoring

- *quarterly meetings of THSSP and the CPD (Xi Le)*
- *PWG*

(ii) Management and coordination

- *monthly meetings of THSSP and the Chinese Coordinator (Li Jiang)*
- *early consultation by THSSP of the Chinese Coordinator (Li Jiang) on all high-level coordination matters*
- *regular ad hoc communication between ATL and Chinese Coordinator*
- *AMC re-assessment of whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 as above*

(iii) Component 3 leadership and management

- *possibly similar arrangements to Component 2 (weekly counterpart and THSSP meetings)*

- *and consider also replication of the decision-making arrangement of Component 1 (e.g. CPD, ATL, and Chinese and Australian Component 3 Team Leader)*

(iv) More frequent communication

- *continuation of THSSP/counterpart ad hoc meetings (daily, weekly) and communications as required*

(v) Implementation

- *Counterparts focus on implementation and THSSP on support*

18. *The AMC re-assess whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 through the current Component 1 training coordinator, to strengthen communication and progress, and counterpart satisfaction with THSSP's responsiveness to requests*

19. *The AMC ensure that leadership accountability for Component 3 is clear, consider the PTD spending additional time in-country to add additional strength to Component 3, and, if agreed, AusAID consider agreeing to funding this additional PTD time through unallocated STA budget*

20. *The AMC request and GOTAR provide all relevant current policies, strategies and guidelines and THSSP*

iii. document specific linkages between these and THSSP-supported activities (e.g. in the log frame and M&E Table) and

iv. ensure all planning, advisor support and M&E is linked to them

21. *The AMC re-assess whether they can respond to the Counterpart request for overall coordination of training in Components 1 and 3 through the current Component 1 training coordinator, to strengthen communication and progress, and counterpart satisfaction with THSSP's responsiveness to requests*

22. *The AMC arranges for translation of the full MTR and provides copies to counterparts and all THSSP staff*

23. *For advisor recruitment,*

(i) the AMC and counterparts consider the merits of C/STA inputs where C/LTA recruitment is problematic

(ii) the AMC consider further strategies for overall LTA and STA recruitment, such as recruiting from untapped institutions in Inland China and reviewing its executive search processes for opportunities for strengthening, including assessing strategies used by professional executive search firms for ideas to achieve strengthened outcomes

24. *The AMC request and GOTAR provide all relevant current policies, strategies and guidelines and THSSP*

(i) document specific linkages between these and THSSP-supported activities (e.g. in the log frame and M&E Table) and
(ii) ensure all planning, advisor support and M&E is linked to them

25. *AusAID consider that the final THSSP annual plan should be the 12 months from March 2008 to (i) enable a clear sense of strategies and sustainability (ii) the degree of underspend by end-THSSP and (iii) that an exit strategy be included*

26. *AusAID, counterparts and the AMC agree timelines for (i) the Activity Completion report and (ii) the Independent Completion Report and any other Program completion processes, as part of the recommended 2008-2009 planning process*

27. *The AMC, in consultation with counterparts,*
(i) revise certain aspects of the M&E Table as discussed during the MTR, including outcome indicators at Purpose and Component 1 level for the next Six Monthly Report
(ii) include available and relevant GOTAR indicators in the M&E Table, to which THSSP support is contributing

28. *AusAID consider a TAG in March 2008 to review Component 3 progress only and the Component 3 aspects of the 2008-2009 annual plan (as recommended above) and the TAG report be an input to the AMC's Activity Completion Report and the Independent Completion Report; AusAID consider by January 2008 whether a TAG for Components 2 and 3 and Program Management would add value or not*

Annex 4

People Consulted/Met

Name	Title	Organisation
Kirsty Dudgeon	First Secretary	AusAID Post Beijing
Cai Linna	Senior Program Officer	AusAID Post Beijing
Chris Morgan	Outgoing Program Director	THSSP Lhasa
Lisa Rankin	Incoming Program Director	THSSP Lhasa
Cath Barker	Australian Team Leader	THSSP Lhasa
Jean Allen	Australian PHC LTA	THSSP Lhasa
Ken Swann	Australian HIV & AIDS LTA	THSSP Lhasa
Professor Jung	CSTA/Safe Blood Supply	THSSP Lhasa
Yaxi	Seconded CLTA/Component 3	Lhasa Municipal Health Bureau
Anna	AYAD	THSSP Lhasa
Dawar	Division Chief	DOFCOM TAR
Tsering Yudren	Deputy Division Chief	DOFCOM TAR
Mr. Lieu		DOFCOM TAR
Xi Le	Deputy Director General/ Chinese Program Director	Tibet Regional Health Bureau
Le Jiang	Deputy Divisional Director, Regional CDC & THSSP Chinese Coordinator	Tibet Regional Health Bureau
Dr Jiang Zu Gang	Policy Advisor	Tibet Regional Health Bureau – HIV Office
Mme Yeah	HIV Unit	Tibet Regional Health Bureau
Ye Xiaohui	THSSP	Laboratory Adviser
Wang De-yao	Party Secretary & Vice Dean	TUMC
Han Zhiying	Associate Professor	TUMC
Xian Yingying	Lecturer	TUMC
Pingcuo	Party Secretary	Lhasa Regional Blood Centre
Ciren Dunzhu	Vice Director	Lhasa Regional Blood Centre
Zhang Fusheng		RPHB
Dr Gelek	Director/CTL Component 2	Lhasa Municipal Health Bureau
Dr Wang Xiao Li	Division Director	Lhasa Municipal Health Bureau – PHC
Lu Mi	Vice Director	Lhasa Municipal Health Bureau – MCH
Qang Jon Li	Director, Rural Health Department	Lhasa Municipal Health Bureau – MCH
Dun Ju	Vice Director, Infectious Diseases Section	Regional CDC
Zhang Yong		Regional CDC
Qiangba	Deputy President, Medical Treatment	Lhasa Hospital No. 2
Wang Qinhua	Head of Nursing (former Head of Infection Control Department)	Lhasa Hospital No. 2
Li Bing	Public Security Bureau,	Lhasa PSB

Name	Title	Organisation
	Narcotics Team	
Ms. Hua	Public Security Bureau, Narcotics Team	Lhasa PSB
Mr. Doengy	HIV AIDS Prevention Officer	Lhasa BOH
Awang	Deputy Director General, General Narcotics Team	Lhasa Narcotics Bureau
Mr. Puzhen	General Narcotics Team	Lhasa Narcotics Bureau
Wangqing		Lhasa Tourism Bureau
Zong Jun	Head, Health Clinic	TUMC
Qinglin	Head	Import and Export Quarantine Bureau
Mr. Hu		Lhasa Cultural Bureau
Ms. Pung	Vice President	Lhasa City Women's Federation
Ms. Li	Legal Rights Section	TAR Women's Federation
Wu Yaxin		Lhasa Education and Sports Bureau
Ms. Yang		Lhasa Education and Sports Bureau
Wang Ping		Army Police Hospital, TAR
Lu Ming	Vice Director	Lhasa Municipal Health Bureau
Quda	Vice Director	Lhasa Municipal Health Bureau
Laba Duoji		Lhasa Municipal Health Bureau
Wang Xiaoli	Division Director	Lhasa Municipal Health Bureau – PHC
Mr Lai You Wen	CLTA	THSSP Lhasa
Nima	Director	Linzhou County Health Bureau
Gou	Deputy Director	Linzhou Health Bureau
Suolang	Director	Linzhou Hospital
Jiuwang	Doctor	Linzhou Hospital
Cicheng	Director	Linzhou CDC
Jiayong	Vice Director	Linzhou CDC
Yu Fei	Director	Shannan Hospital
Hu Jingquan	Party Secretary	Shannan Hospital
Sangbing	Vice Director	Shannan Hospital
Ciren	Doctor	Shannan Hospital
Jiana	Doctor	Shannan Hospital
Zhaxi Wangdui	Doctor	Shannan Hospital
Zhou Xinjun	Doctor	Shannan Hospital
Panduo	Finance Dept.	Shannan Hospital
Yin	Medical Affaris Dept.	Shannan Hospital
He	Director, General Office	Shannan Hospital
Pingcuo	Information Centre	Shannan Hospital
Jiang Yufeng	Pharmacy Management	Shannan Hospital
Duoji		HIVAIDS Office, Lhasa MHB
Awang	Vice Director General	Regional Narcotic Control
Puzhen		
Wangqing		Lhasa Tourism Bureau
Zong Jun		TUMC
Yaxi		RCDC
Qinglin		Regional Administration of Quarantine and Inspection
Wu Yaxin		Lhasa Education Bureau
Wang Ping		Tibet Armed Police Hospital
Jiang Zugang		RCDC

Annex 5

Reference Documents

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Australian Government. AusAID. CON 12484. Variation Summary Schedule (Variation Orders 1.0; 2.0; 3.0; 4.0)

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Bates G., and Okie S., China and HIV — A Window of Opportunity. The New England Journal of Medicine. Vol. 356:1801-1805. Number 18. May 3, 2007.

Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (2005). Recommendations.

Godwin, P., O'Farrell, K F., Misra, S. Five Myths About the HIV Epidemic in Asia. DOI: 10.1371/journal.pmed.0030426. October 3, 2006

GOPRC. Action Plan for the Containment and Control of HIV/AIDS in China (2006-2010)

GOPRC. AIDS Regulations (effective 1 March 2006)

GOTAR. 11th Five Year Development Plan (2006-2010)THSSP. Annual Plan. July 2007 – June 2008. 22 May 2007

GOTAR. 11th Five Year Plan of Human Resource Development

GOTAR. 11th 5 year Plan of TAR to Prevent and Control HV/AIDS

GOTAR. Guidelines for Women and Children Development 2001-2010

GOTAR. Members and Responsibilities of the TAR HIV/AIDS Prevention Working Committee

GOTAR. Strategic Framework for Preventing and Controlling HIV/AIDS (2004-2010) (? not yet officially endorsed)

Recommendations of the *Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (2005)*.

THSSP. Detailed Budget Review for SGF Activities Undertaken for Progress in Stage One (Baseline Survey) June-September 2006. Undated

THSSP. MCH Work/EMNC Timeline. Component 2. 2007

THSSP. Middle Management Timeline. Component 2. 2007

THSSP. M&E Framework: Indicator Changes and Rationale. Undated

THSSP. Proposed curriculum for county and township doctor training in basic EMNC (undated)

THSSP. Summary for middle management training workplace assignment (undated)

THSSP. Newsletter. July 2007

UNAIDS. Country Harmonization and Alignment Tool (CHAT). Draft Version (for review and pilot testing only). Version 3.1 (Prepared by Anne Gillies, UNAIDS Consultant). August 2006

United Nations. HIV/AIDS Declarations (2001 and 2006)

Wu Z. et al. Evolution of China's Response to HIV/AIDS. *The Lancet* 2007; **369**:679-690

Annex 6

Aide Memoire

Aide Memoire
Mid Term Review
Tibet Health Sector Support Program
27 July 2007

The views expressed in this Exit Brief are those of the Mid Term Review Team[21] and may not necessarily be those of the Governments of the Tibet Autonomous Region or Australia.

1. THSSP aims to
   - Focus on TAR's priority health needs and health system reforms
   - Respond to current and emerging priority needs in TAR
   - Link to and support GOPRC and GOTAR policies and reform initiatives
   - Be led by GOTAR

   Goal
   To improve the health of the people of the Tibet Autonomous Region (TAR) particularly those who have the greatest need, through strengthening health services.
   Purpose
   To strengthen the health system in TAR.
   Components
   1. Health Systems Development
   2. Primary Health Care Support
   3. HIV/AIDS Support

   THSSP Finishing Date
   21 March 2009 (20 months).

2. Mid Term Review Key Objectives
   - Review achievements to date
   - Review progress in applying the 2006 TAG recommendations
   - Identify current implementation issues
   - Make recommendations to improve THSSP performance including activity implementation

3. Key findings: THSSP Principles

THSSP Principle 1: THSSP links to and supports GOPRC and GOTAR policies and reform initiatives
THSSP activities do link to and support GOPRC and GOTAR but this need to be explicitly documented, for example:

(i) Outputs 1.1 and 2.1 linked to the new personnel development requirements
(ii) Component Two Outputs to relevant aspects in the TAR Guidelines for Women and Children Development 2001-2010
(iii) Component 3 Outputs to GOTAR's various HIV/AIDS plans, strategies and guidelines

Recommendation: THSSP document specific linkages to relevant GOTAR policies and reforms which THSSP activities are supporting (e.g. in logframe, M&E Table)

THSSP Principle 2: THSSP responds to current and emerging priority needs in the TAR
GOTAR counterparts confirm that THSSP activities continue to support GOTAR health and HIV priorities.

[21] The Mid Term Review Team was Gillian Biscoe (Team Leader), Professor Zhao Peng Fei (Component 3), John Godwin (Component 3, in-country 9-22 July). The Team was accompanied by GOA AusAID (Beijing Post) officials First Secretary Kirsty Dudgeon (21 July-28 July), Ms. Cai Linna (Senior Program Officer and THSSP Activity Manager - to 26 July) and Mr. Wang Jun (Senior Program Officer and incoming THSSP Activity Manager).

THSSP Principle 3: There is ownership and leadership of THSSP activities by GOTAR partners
The CPD continues to exercise strong leadership (Mr. Xi Le). High level Chinese coordination arrangements (Mr. Li Jiang) have been clarified. Chinese leadership and ownership of Components 1 and 2 (Mr. Gerlic) are strong and there are many successes. The strong contribution of Dr. Jiang Zu Gang in Component 3 is noted. The following recommendations are suggestions for discussion to build on existing mechanisms for overall THHSP coordination, THSSP strategic direction and its monitoring, and for further progress in Component 3 in particular.

Recommendation: Counterparts and THSSP discuss the following suggestions for building on existing mechanisms:

1.Strategy
- *quarterly meetings of THSSP and the CPD (Xi Le)*

2. Management and coordination
- *monthly meetings of THSSP and the Chinese Coordinator (Li Jiang)*
- *early consultation by THSSP of the Chinese Coordinator (Li Jiang) on all high-level coordination matters*

3. Component 3 leadership and management
- *possibly similar arrangements to Component 2*
- *and consider replication of the decision-making arrangement of Component 1 (e.g. CPD, ATL, and Chinese and Australian Component 3 Team Leader)*

4. Day-to-day issues
- *continuation of THSSP/counterpart ad hoc meetings and communications as required*

5. Implementation
- *Counterparts focus on implementation and THSSP on support*

THSPP Principle 4: THSSP takes an integrated approach to gender awareness and cultural sensitivity.
Satisfactory.

THSSP Principle 5: THSSP outputs are designed to be sustainable in the TAR.
Satisfactory.

THSSP Principle 6: THSSP works within existing GOTAR information systems and plans wherever possible.
Much of GOTAR information is available to THSSP while some data is sensitive and not available. THSSP is utilising GOTAR information systems wherever possible. See Principle 1 above re THSSP working within GOTAR plans. See Principle 3 above re THSSP working within GOTAR systems.

Recommendation: THSSP, in consultation with counterparts,
(i) revise certain aspects of the M&E Table as discussed during the MTR, including outcome indicators at Purpose and Component 1 level, and
(ii) include available and relevant GOTAR indicators in the M&E Table, to which THSSP support is contributing.

THSSP Principle 7: Technical advisor inputs are used across components wherever possible to create synergy and linkages between outputs.
This is continually increasing e.g. Health Promotion Strategy, training (Outputs 1.1 and 2.1), infection control. Some re-documentation would highlight this further.

Recommendation 5: THSSP document THSSP training initiatives as a cross-cutting plan and continue to monitor for synergy and to avoid duplication

THSSP Principle 8: THSSP collaborates with other development projects, particularly those working in or near TAR.
Regular meetings are held where appropriate, and there is exchange (e.g. study tours) between relevant development projects and experiences in Inland China and overseas.

4. Key Findings: Components

Component 1 Health System Development (cross-cutting through all Components)

Note: Component 1 is cross-cutting through all Components

Objective: Improved health system effectiveness in TAR at the strategic and operational levels.

Overall progress: Highly satisfactory

Output 1.1: Management development
Outcome Indicator: Senior health managers report a change in management skills and practice.
Highly satisfactory progress which includes change management initiatives e.g. Shannan Prefecture Hospital: Cost Management and Culture Building; Linzhi Prefecture Hospital: Five Year Planning, Cost Management and Culture Building; Linzhi CDC: Learning Organisation and Culture Building; Lhasa CDC: TB survey, MIS building. Output 1.1 and 2.1 activities are being merged.
No recommendation(s) required.

Output 1.2: Improved Training Practices
Outcome indicator: TUMC deliver Department of Education curriculum using participatory method.

Highly satisfactory progress which includes reports from TUMC of improved student learning as participatory teaching methods are implemented, and cross cutting improvements e.g. in Component 2.

No recommendation(s) required.

Output 1.3: Sustainable safe blood supply
Outcome indicators: (i) Voluntary non-remunerated blood donor recruitment system established; (ii) Number of voluntary blood donations.

Highly satisfactory progress which includes voluntary blood supply achieved in Lhasa and National Accreditation of Regional Blood Centre. Further technical support planned to RBC.

No recommendation(s) required.

Output 1.4: Infection Control

Outcome indicator: Infection control and universal precautions standards operating procedures are drafted and adopted.
Significant recent progress including a two year work program developed for (i) infection control and (ii) clinical management of HIV. National training, infection audit and knowledge surveys completed, and seminar program delivered, at Lhasa No. 2 Hospital. Advisor support continuing.
No recommendation(s) required.

Output 1.6: Disease Control and Emergency Preparedness

Outcome indicator: Improved application of CDC guidelines for epidemic response
This is a new Output. Strategic framework of activities developed and is satisfactory. Negotiations are nearing completion for a two-year Public Health Management program at Shandong University. On current time lines, graduation will be after THSSP finishes on 21 March 2009.
Recommendation: Counterparts, THSSP and AusAID negotiate options for support to the Public Health Management program after THSSP finishes (21 March 2007).

Component 2 Primary Health Care Support

Objective: Improved effectiveness and quality of and access to integrated rural health services in the four PHC program counties

Overall progress: Highly satisfactory
Evidence (high level example to which THSSP has contributed)

Impact Indicators	2004	2006
Infant mortality (GOTAR and THSSP Indicator)	49.31	32.2
Neonatal Mortality (GOTAR Indicator)	30.5	26.1

LMHB data provided to MTR

Output 2.1: Improved practices by county health managers to manage integrated services

Outcome Indicator: County managers report a change in management skills and practices.
Highly satisfactory progress including improved planning and operational management. Activities being merged with Output 1.2.
No recommendation(s) required.

Output 2.2: Mother, child and family health

Outcome Indicators:

- Increased proportion of births with skilled attendant and increased use of health facilities for maternal and neonatal care, especially for pregnancy and childcare complications.
- Increased number of health facilities with staff trained in maternal and neonatal care, especially for pregnancy and childbirth complications.
- Implementation of standard treatment protocols.
- Increased diagnosis and treatment of childhood illnesses.

Highly satisfactory progress, including through EMNC training, application of new practices and publishing of a practically-oriented text book.
No recommendation(s) required.

Output 2.3: Improved access to services at all levels of the system

Outcome Indicator: Reduced case fatality rates for conditions which depend on timely referral.

Satisfactory progress including supply of 14 ambulances to township level in February: some commissioned very recently because of legal tax and registration issues. Their use is to be evaluated and possible further procurement planned. Community workshops in Linzhou promoting hospital deliveries.
No recommendation(s) required.

Output 2.4: Effective health promotion (cross cutting)

Outcome Indicator: Health staff and community agencies (such as Women's Federation) are active in health promotion, including counselling during clinical work.
This Output is cross-cutting through all Components. Many challenges but some good, more recent progress. New cross-cutting Health Promotion Strategy should further assist. Activities in 2.2, 2.3, and 3.4 will also assist progress, as will 3.1. MTR recommendations in Component 3 may also assist. The engagement of Women's Federation is addressed in Component 3.
No recommendation(s) required.

Component 3 HIV/AIDS Support

Objective: Improved effectiveness of the TAR response to HIV & AIDS

Outcome Indicators: (i) changes in community awareness and decrease in risk behaviours and (ii) health sector with increased capacity to lead, plan and implement HIV responses in line with national policy and international good practice.

Overall progress

With support of THSSP, many activities have been undertaken. There is better progress in health promotion and in Output 3.2 (HIV laboratory testing and model STI clinic), but relatively slow progress in other Outputs. Given that TAR in general has a low HIV epidemic (overall prevalence below 0.1%), the MTR acknowledges that many necessary activities (particularly in Lhasa) have been conducted - except targeting men who have sex with men (MSM). The WHO/UNAIDS recommended prioritizing interventions by epidemic stage and target population may be helpful in jointly planning a more detailed operational plan (see recommendation below, and summary WHO/UNAIDS matrix attached).

In recent years, GOTAR has paid greater attention to fostering multi-sectoral forces to combat HIV transmission in the Region in order to keep its epidemic below 0.1% by 2010. The key to success is closely associated to targeting the right groups, identifying and applying appropriate approaches, and ensuring the effectiveness, coverage, intensity and continuation of relevant preventive and medical interventions.

The next step response (20 months from August 2007) should focus on re-clarifying priority areas of work (such as surveillance, targeted interventions among most-at-risk groups, e.g. entertainment workers and their clients, injecting drugs users and MSM, awareness and HIV prevention among vulnerable groups and preparedness for HIV prevention in the general population).

In a nutshell, there are challenges and opportunities ahead. The THSSP therefore has great potential to contribute to the more coordinated and effective HIV/AIDS and STI response in TAR in the coming 20 months, as long as all necessary intervention services are timely and correctly delivered by the right providers and to the persons of greatest need.

Strategic Level Recommendations

- *Recommendation 1: Strengthen component management by identifying an Australian Component 3 Team Leader with HIV practical and operational experiences, strategic thinking and team building skills, and delegate he or she to take responsibility fore Component 3*
- *Recommendation 2: Jointly develop a more detailed operational workplan for Component 3 for the next 20 months, with coordinated support of Chinese Component Coordinator Dr Li Jiang under the leadership of Mr Xi Le, which incorporates the operational recommendations below under each Output*
- *Recommendation 3: Strengthen engagement of Regional CDC to support the planning and implementation of Component 3, e.g. mobilizing RCDC expertise as "trainers" in training activities*
- *Recommendation 4: Implementation efforts should be focused on improving surveillance system and increased relevant targeted intervention for prevention of HIV sexual transmission (highlighted by Xi Le) among Most At Risk Populations (MARPs)*

Output 3.1: Effective stakeholder response to HIV/AIDS

Outcome indicator: HIV responses implemented in health and other relevant sectors.

Progress includes NHSHR guidelines simplified, and review of 2nd phase proposals has commenced. MTR has confidence that the non-health sector response is strengthening, but progress will need to be monitored and evaluated.

Recommendations

1. *The NHSHRS Grant should focus on non-health sectors under Lhasa municipality, while still welcoming agencies from TAR level, given the previous experience and the limited time duration to come (20 months up to 21 Mar 2009)*
2. *Ensure efficient and timely approval of proposals*
3. *Assess the progress of NHSHR by end of 2007*

Output 3.2: HIV & AIDS & STI surveillance and response

Outcome indicator: Comprehensive surveillance data on HVI and STIs, including passive surveillance and sentinel surveys, are used in HIV policy, planning and evaluation.

Good progress including laboratories, model STI clinic, beginning progress on clinical care protocols.

Recommendations

1. *Strengthen cooperation between THSSP and RCDC to improve regional surveillance protocol, through involving RCDC in supporting component implementation, seconding 1-2 Chinese speaking experts to work respectively on surveillance and targeted intervention for 1-2 months within RCDC HIV unit*
2. *Link on-going HIV and STI screening activities to improve surveillance programme, and increase health education for people tested under both Regional and National initiatives*
3. *Further improve model STI clinic: precisely follow STI management standard to avoid over diagnosis and over treatment; strengthen counselling in terms of time, more active condom promotion, skills and a customer-friendly approach; be open at times to suit the customer (e.g. lunchtime, after work)*
4. *Identify reasonable referral between Model STI Clinic and on-going outreach intervention among sex workers*

Output 3.3: Reduced risk behaviours among vulnerable groups

Outcome indicator: Changes in risk behaviour targeted by RHB and RCDC.

Progress incudes the across-components Health Promotion Strategic Plan and an outreach pilot targeting female entertainment workers commenced in Shannan recently commenced.

Recommendations

- *Document experience of Shannon when evaluated at four-month point including planning process, implementation approach, and progress to date and expand similar intervention to other places*
- *Advocate and develop operational plan with relevant targeted intervention (e.g. 100% condom use programme) among most-at-risk groups in Lhasa including entertainment workers and their clients*
- *Support to implement 100% condom use programme at prefecture level led by GOTAR engaging PSB/ Tourist/Culture/FP departments, entertainment establishment managers and through peer education targeting both EE based and freelance sex workers*
- *Monitor male outcomes in STI clinics (given 80% of males with STIs have symptoms and 80% of females do not) to verify non-use of condoms and where the STI infection/risk might come from*
- *Organise study tour(s) of key non-health sector agencies (PSB, Cultural Bureau, Tourism Bureau) to understand how 100% CUP is implemented (e.g. to Hubei for provincial wide 10% CUP condom promotion strategy and to Beijing) and Beijing Dongcheng District Health Bureau*
- *Explore or implement relevant intervention among emerging high risk groups like IDUs and MSM*
- *Conduct a rapid assessment to have better understanding about condom availability and accessibility by MARPs.*

Output 3.4: Improved awareness and knowledge of HIV & AIDS and STI prevention and control among the general population

Outcome indicator: Community knowledge of HIV and AIDS and how to prevent them is increased.

Progress includes WAD activities to engage senior leadership involvement, billboards and other general IEC distribution activities conducted.

Recommendations:

1. *Focus on mobile population @ county level (e.g. when they return from Lhasa) and mobile population in Lhasa*
2. *Support to training for journalists and editors on how to report HIV/AID, as part of enhanced non-health sector response*
3. *Expand "bill board" education approach to include buses and bus stations, trans and trains stations*
4. *Continue to make use the WAD opportunity to engage senior political commitment on HIV/AIDS*

Output 3.5: Improved access to quality condoms

Outcome indicator: (i) Increased availability of quality condoms at selected sites; (ii) Increased demand for condoms at selected sites.

A key issue is that the condom social marketing proposal is pending approval; there are concerns about its inappropriateness.

Recommendations

1. *Conduct a rapid assessment to better understand the condom availability and accessibility by MARPs in selected sites; mapping of condom outlets (such as pharmacies, etc.) about condom availability and who are buying them; interviewing entertainment workers about where and how they obtain condoms when necessary*
2. *Issues related to condom promotion should be timely addressed, by using existing channels to increase condom accessibility among MARPs: specifically, engaging Family Planning, tourism, culture, Commerce departments in condom promotion and condom use for high risk populations. Social marketing expert(s) can be hired to train relevant staff with a focus on concept and skills for promotion of safer sex and condom use;*
3. *Clarify with CPD on the reason that Tibet University condom promotion proposal is not approved, and the approval status of the Lhasa Health Bureau social condom promotion proposal*

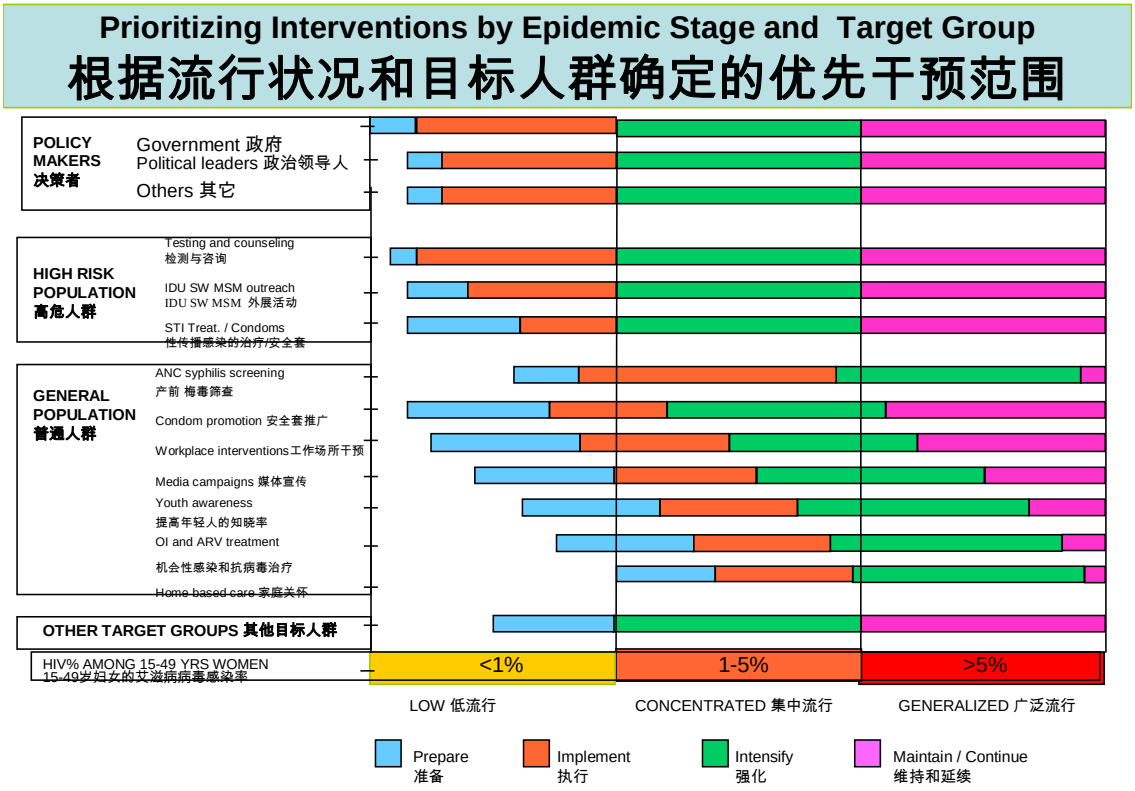
5. Program Management

Recommendations

1. *Previous recommendation made under Principles (above)*
2. *THSSP re-allocate budget to support Component 3*
3. *AusAID determine arrangements for possible THSSP under spend*
4. *Provide draft Exit Strategy to AusAID – timing to be negotiated*
5. *More vigorously promote TAR successes e.g. through conference presentations (Inland China and internationally), publications and stories.*
6. *Recruitment*
    a. *Chinese LTA and STA continue to be recruited wherever possible*
    b. *THSSP discuss with the THSSP Chinese Coordinator his preferred involvement during the selection process of THSSP advisors*

Annex 7

Priority HIV/AIDS interventions by epidemic stage and target group



Annex 8

An 'at a glance' overview of HIV in TAR

The TAR Regional CDC state that there have been 41 reported HIV diagnoses (total cumulative cases).

There is systematic HIV screening of pregnant women, prisoners, army recruits, hospital patients (pre-operative, TB patients & patients presenting with fever of unknown origin), and blood donors. Occasionally high risk groups in Lhasa are screened in community settings by Lhasa CDC. All drug users in TAR are tested for HIV when arrested. The reported number of HIV diagnoses is likely to represent a fraction of the actual prevalence of HIV in the community i.e. the vast majority of people living with HIV will not have been tested or diagnosed.

The nature and extent of the HIV epidemic is unknown. Experts on the review team are of the view that the HIV epidemic is likely to still be at low levels compared to neighbouring provinces and highly concentrated among specific sub-populations, particularly injecting drug users, sex workers and their clients (including mobile workers), and men who have sex with men. There is no evidence of HIV spreading among the general adult population.

New national HIV estimates are to be released in coming weeks and it may be useful for THSSP to request access from the China CDC to the breakdown by region i.e. the Tibet figures for planning purposes.

The number of IDUs is uncertain but is thought to be increasing. Most drug users are thought to reside/work in Lhasa.

Of the 3,487 people screened for HIV by Lhasa CDC by the end of 2006, 10 were diagnosed with HIV. Six of the ten were drug users, most of whom are thought to be migrants from other provinces/regions. It is not known whether HIV is being acquired by drug users in Tibet but it is reasonable to assume that some transmission is occurring locally.

There is at least one commercial venue (gay bar) for men who have sex with men in Lhasa. UNAIDS conducted an educational intervention at that site in 2006. The MSM population is unknown but likely to be boosted by the seasonal influx of tourists and commercial travellers.

Lhasa is experiencing an economic boom associated with rising tourism numbers and the opening of the Beijing-Lhasa rail link. Economic development has accelerated since THSSP's inception. This brings with it increased HIV risks particularly as it creates an expanded market for the sex industry, which is observed to be booming particularly over the summer months. Tibet borders on 3 provinces that are within the top six within China in terms of highest national HIV prevalence (Yunnan, Xinjiang and Sichuan). Much of the migrant workforce is thought to originate in Sichuan and coastal provinces.

There has been little demand for HIV clinical services. There have been 5 people with HIV who have presented for HIV care. Three died. One was transferred to Xinjiang and one to Sichuan. TB is highly prevalent which means that any future HIV epidemic is likely to be characterised by TB-HIV co-infection and associated high mortality rates and demands on hospital services.

In summary since the THSS Program was designed there are new indications that Lhasa in particular is at risk of an HIV epidemic that is likely to be at a low level but expanding and highly concentrated among injecting drug users, sex workers and their clients, and possibly also men who have sex with men.

Anticipated pattern of the epidemic

As has been the case in bordering provinces and elsewhere in the proximate region (e.g. Nepal, Burma, Vietnam) it can be anticipated that local HIV epidemics in TAR will in effect be ignited/'kick-started' by injecting drug use (as it is a highly effective means of transmission) then maintained and spread further by sex work i.e. HIV will likely initially spread rapidly among an urban IDU population, may reach saturation among that injecting group within just a few years, and cross-over to sex workers and their clients. It can be assumed that some sex workers and some clients of sex workers will also be drug users. (See, for example, the work of Tim Brown et al on modelling Asian epidemics). Further more, given the large number of, and variety in, male clients (of two cities visited by the MTR HIV specialists, 3-13 clients per day per sex worker among Tibetan sex workers in Lhasa and 0-10 clients per day per worker among Han sex workers in Shannan), there is "time-bomb" potential that an HIV explosion could happen in sex workers in TAR, if low condom use rate and low uptake of STI treatment services among female entertainment workers continues. There is also likely to emerge a concentrated epidemic among MSM unless targeted health promotion is introduced.

Institutions

Lhasa Municipal HB and CDC are keen to explore an expanded response to HIV prevention. Shigatse CDC have not agreed to work with THSSP on HIV (or indeed other THSSP activities).

Lhasa Regional Hospital No 2 is the designated infectious disease and HIV treatment hospital, and is working well with THSSP on infection control and HIV clinical care. Regional CDC provides confirmatory testing.

There are no harm reduction services such as methadone maintenance or needle and syringe programs.

The non health sector agencies are yet to develop HIV plans although with THSSP support some baseline surveys have been conducted.

Sources of other HIV support for the regional response

US CDC GAP provides support to the Regional CDC. Since 2005 CDC Gap has equipped six prefectures with preliminary screening facilities and supported training.

Burnet Institute provides targeted health promotion and condoms for sex workers and their clients under the AusAID NGO Cooperation Program (ANCP).