



**Sexual and  
Reproductive Health  
Integration Project  
Evaluation Report**

**Human Development Monitoring  
and Evaluation Services**

**July 2023**

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# Contents

- Executive summary ..... 1**
- 1. Context ..... 10**
  - 1.1. Burden of HIV, STIs and SRH ..... 10
- 2. About the program ..... 11**
  - 2.1. Program management and implementation..... 13
- 3. About this evaluation ..... 14**
  - 3.1. Key Evaluation Questions..... 14
  - 3.2. Methods ..... 15
  - 3.3. Limitations..... 15
- 4. Findings ..... 16**
  - 4.1. Impact ..... 16
  - 4.2. Effectiveness ..... 18
  - 4.3. Relevance and coherence ..... 33
  - 4.4. Gender..... 36
  - 4.5. Sustainability ..... 37
  - 4.6. Efficiency ..... 40
- 5. Conclusion and recommendations..... 45**
  - 5.1. Conclusion ..... 45
  - 5.2. Recommendations ..... 46
- 6. References..... 49**
- 7. Annexes..... 51**
  - 7.1. SRHIP Theory of Change – Phase 1 and 2..... 51
  - 7.2. Key Evaluation Questions and sub-questions ..... 60
  - 7.3. List of stakeholders interviewed ..... 62
  - 7.4. List of documents consulted ..... 67
  - 7.5. SRHIP integration services summary..... 70
  - 7.6. Indicator data ..... 75

## List of tables

Table 1.1.1 Phase 1 and Phase 2 intended SRHIP program outcomes .....	2
Table 2.1.1 Program design across Phase 1 and Phase 2 of SRHIP .....	12
Table 3.1.1 Key Evaluation Questions .....	14
Table 4.1.1 Assessment of contribution of the program to health systems strengthening .....	16
Table 4.2.1 Capacity building for system strengthening indicators .....	21
Table 4.2.2 Harmonising strategies and policies indicators .....	21
Table 4.2.3 Integration status of SRHIP-supported CCHS clinics as at December 2021 .....	23
Table 4.2.4 Service integration indicators.....	24
Table 4.2.5 Referral pathways indicators.....	25
Table 4.2.6 Health service delivery capacity building indicators .....	25
Table 4.2.7 Delivery of high-quality HIV and SH services indicators (up to December 2021) .....	26
Table 4.2.8 Partnership indicators up to December 2021 .....	28
Table 4.2.9 Engaging key populations indicators up to December 2021 .....	29
Table 4.2.10 Delivering services to key populations indicators .....	30
Table 4.2.11 Capacity building in delivering services to communities indicators.....	33
Table 4.6.1 COVID-19 indicators .....	44
Table 7.1.1 Theory of Change Phase 1 .....	51
Table 7.1.2 Theory of Change Phase 2 .....	58
Table 7.2.1 Key Evaluation Questions and sub-questions.....	60
Table 7.3.1 List of stakeholders interviewed.....	62
Table 7.3.2 Participation in interviews by cohort .....	66
Table 7.5.1 SRHIP integration Phase 1 .....	70
Table 7.5.2 SRHIP integration Phase 2 .....	72
Table 7.6.1 SRHIP Phase 1 results against targets (Jul 2017 to May 2020).....	75
Table 7.6.2 SRHIP Phase 2 results against targets (Jul 2020 to Dec 2021).....	77
Table 7.6.3 Common indicators for SRHIP for Phase 1 and 2 (Jul 2017 to Dec 2021) .....	80

## Abbreviations and acronyms

Term	Definition
<b>AHC</b>	Australian High Commission
<b>ANC</b>	Antenatal Care
<b>ANGAU</b>	Australian New Guinea Administrative Unit
<b>APNG</b>	Anglicare PNG
<b>AROB</b>	Autonomous Region of Bougainville
<b>ART</b>	Anti-Retroviral Therapy
<b>ASHM</b>	Australian Society for HIV, Viral Hepatitis and Sexual Health Medicine
<b>AUD</b>	Australian Dollars
<b>BI</b>	Burnet Institute
<b>CCHS</b>	Catholic Church Health Services
<b>CLM</b>	Community-led Monitoring
<b>CP&amp;S</b>	Child Protection and Safeguarding
<b>CSEP</b>	Comprehensive Strategic and Economic Partnership
<b>CSO</b>	Civil Society Organisation
<b>DAC</b>	Development Assistance Committee [OECD]
<b>DFAT</b>	Department of Foreign Affairs and Trade [Australia]
<b>EHP</b>	Eastern Highlands Province
<b>EOI</b>	End of Investment
<b>EOIO</b>	End of Investment Outcome
<b>EPC</b>	Expert Peer Counsellor
<b>FP</b>	Family Planning
<b>FSV</b>	Family Sexual Violence
<b>FSW</b>	Female Sex Worker
<b>GBV</b>	Gender-Based Violence
<b>GEDSI</b>	Gender Equality, Disability and Social Inclusion
<b>GoPNG</b>	Government of Papua New Guinea
<b>GTA</b>	Gender Transformative Approach
<b>HDMES</b>	Human Development Monitoring and Evaluation Services
<b>HIV</b>	Human Immunodeficiency Virus
<b>HPDB</b>	HIV Patient Data Base
<b>HPP</b>	Health Portfolio Plan
<b>KEQ</b>	Key Evaluation Question
<b>KPAC</b>	Key Population Advocacy Consortium
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MEL</b>	Monitoring, Evaluation and Learning
<b>MEP</b>	Monitoring and Evaluation Plan
<b>MMR</b>	Maternal Mortality Rate



<b>Term</b>	<b>Definition</b>
<b>MSM</b>	Men who have Sex with Men
<b>NAC</b>	National AIDS Council
<b>NCD</b>	National Capital District
<b>NDOH</b>	National Department of Health
<b>NHIS</b>	National Health Information System
<b>NHP</b>	National Health Plan
<b>OIC</b>	Officer-in-Charge
<b>PATH</b>	Papua New Guinea–Australia Transition to Health
<b>PHA</b>	Provincial Health Authority
<b>PICT</b>	Provider-Initiated Counselling and Testing
<b>PLHIV</b>	People Living with HIV
<b>PMG</b>	Project Management Group
<b>PNC</b>	Postnatal Care
<b>PNG</b>	Papua New Guinea
<b>PPE</b>	Personal Protective Equipment
<b>PPF</b>	PNG Partnership Fund
<b>PPTCT</b>	Prevention of Parent-to-Child Transmission
<b>PSF</b>	Partnering for Strong Families
<b>PWD</b>	Persons with Disabilities
<b>SH</b>	Sexual Health
<b>SLA</b>	Service Level Agreement
<b>SRH</b>	Sexual and Reproductive Health
<b>SRHIP</b>	Sexual and Reproductive Health Integration Project
<b>STI</b>	Sexually Transmitted Infection
<b>TAG</b>	Technical Advisory Group
<b>TB</b>	Tuberculosis
<b>TB BMU</b>	Tuberculosis Basic Medical Unit
<b>TG</b>	Transgender Group
<b>TOC</b>	Theory of Change
<b>TOR</b>	Terms of Reference
<b>TWG</b>	Technical Working Group
<b>VCCT</b>	Voluntary Confidential Counselling and Testing
<b>VFM</b>	Value for Money
<b>WHO</b>	World Health Organization

# Executive summary

## Background and context

Papua New Guinea (PNG) experiences some of the highest rates of sexually transmitted infections (STIs) in the world, and among the highest rates of Human Immunodeficiency Virus (HIV) in the Western Pacific region. Access to quality HIV/STI and reproductive health services, family planning (FP) and contraceptive choices is low. In PNG, women, girls, and marginalised groups are disproportionately affected by poor sexual and reproductive health (SRH) outcomes, because of constraints in the health sector and the challenging geographic environment. The maternal mortality rate (MMR) in PNG is high. A World Health Organization (WHO) report using service trends indicated that MMR was around 215 per 100,000 live births in 2016.<sup>1</sup>

## About the program

The Sexual and Reproductive Health Integration Project (SRHIP) is an AUD19,274,549 investment (July 2017 to February 2022) by the Australian Government Department of Foreign Affairs and Trade (DFAT). The Phase 1 project goal was to contribute to ‘SRH services for women, girls, and vulnerable groups’, and the End of Investment Outcome (EOIO) was to strengthen systems for the delivery of high quality, scaled SRH services, in primary health services at Catholic Church Health Services (CCHS) and Anglicare PNG (APNG) facilities. The SRHIP design was developed in response to a DFAT tender, which targeted SRH services for women and girls in PNG, with a focus on primary health services, integration, inclusiveness, and partnerships. Additional DFAT funding of AUD490,734 was provided to SRHIP to support the COVID-19 vaccine roll-out between February 2022 and December 2022 (as outlined in section 4.6).

## Implementation

SRHIP operated over 2 phases. Phase 1 (2017 to 2020) was managed under the PNG Partnership Fund (PPF) and Phase 2 (2020 to 2022) under the PNG–Australia Transition to Health (PATH) program. PPF and PATH were (and PATH continues to be) managed by Abt Associates. PATH is a key investment under the DFAT *Health Portfolio Plan 2018–2023* (HPP) and represents an evolving shift from a donor–recipient relationship to a more strategic partnership, under the Comprehensive Strategic and Economic Partnership (CSEP).<sup>2</sup>

SRHIP is implemented by a consortium of Australian and Papua New Guinean faith-based and civil society organisations (CSOs), combining the efforts of Catholic Church Health Services, Burnet Institute (BI), Australian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), and *Igat Hope*.

- **CCHS:** was the project lead and managed the contract, compliance, governance, implementation, and reporting. CCHS is administered by the Catholic Church and is fully integrated into the PNG government health system.
- **ASHM:** provided technical assistance, specifically for clinical and medical training and support for operations, clinical services, referral pathways, gender transformative processes, and responding to COVID-19, and was a key contributor to the monitoring and evaluation planning and activities of SRHIP.

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<sup>1</sup> Robbers et al., 2019, *Maternal and newborn health indicators in Papua New Guinea 2008–2018*.

<sup>2</sup> DFAT, Papua New Guinea–Australia Comprehensive Strategic and Economic Partnership, <https://www.dfat.gov.au/geo/papua-new-guinea/australia-papua-new-guinea-historic-documents/papua-new-guinea-australia-comprehensive-strategic-and-economic-partnership>

- **Burnet Institute:** contributed technical advice and guidance, was responsible for strategic planning of clinical integration, and provided technical advice on client-centred peer counselling and inclusiveness.
- **Igat Hope:** led the SRHIP work on peer counselling and provided lived experience regarding quality services for key populations and people living with HIV (PLHIV).
- **Anglicare:** is a health service delivery agency for HIV/STIs in PNG. It exited SRHIP in December 2019.

### Intended program outcomes

The aim of SRHIP was to improve sexual and reproductive health for women, girls, and vulnerable groups through better organisational alignment, workforce development, health service improvements, and community engagement. The project outline for both phases is provided in Table 1.1.1. The core of SRHIP, however, was a change management strategy to integrate 22 siloed HIV and sexual health (SH) voluntary confidential counselling and testing (VCCT) sites into primary health facilities. While reproductive health is referred to in the title and in the outcomes of Phase 1, the disease focus is HIV and SH. Reproductive health was not central to SRHIP, although reproductive outcomes were cited as indirect achievements. The revised Program Logic in Phase 2, which removed references to reproductive health, more accurately represents the intention of SRHIP. More details about the Program Logic for SRHIP are covered in section 2 of the report.

**Table 1.1.1 Phase 1 and Phase 2 intended SRHIP program outcomes**

Details	Phase 1	Phase 2
<b>Goal</b>	Improved SRH and wellbeing for women, girls and vulnerable groups.	Delivery of quality, scaled SRH services through strengthened systems, strengthened services, strengthened partnerships, and strengthened engagement at identified CCHS health facilities.
<b>End of Project Outcomes</b>	Strengthened systems for delivery of quality, scaled, SRH services through integration with primary health at CCHS facilities.	–
<b>Outcomes</b>	<p><b>Strong systems</b></p> <ul style="list-style-type: none"> <li>• Ensuring the CCHS Health and HIV Strategy is consistent across national and diocese operations.</li> <li>• Ensuring CCHS services are recognised within the national health system, including reporting of quality data through the National Health Information System.</li> </ul> <p><b>Strong services</b></p> <ul style="list-style-type: none"> <li>• Effective, sustainable systems enhance integration and scale up HIV, STI, and SRH services in selected provinces.</li> <li>• Improve quality and reach of HIV, STI and broader SRH services.</li> <li>• Ensuring that HIV, STI, SRH and primary health facilities and workforce are trained and supported throughout the integration process.</li> </ul>	<p><b>Strong systems</b></p> <ul style="list-style-type: none"> <li>• Strengthened integrated systems for management, monitoring and evaluation of high performing (effective and efficient) programs and services.</li> </ul> <p><b>Strong services</b></p> <ul style="list-style-type: none"> <li>• Strengthened integrated services providing high-quality HIV and SH care.</li> </ul> <p><b>Strong engagement</b></p> <ul style="list-style-type: none"> <li>• Strengthened engagement with community and key populations promoting universal access to quality HIV and SH services.</li> </ul> <p><b>Strong partnerships</b></p> <ul style="list-style-type: none"> <li>• Strengthened partnerships supporting a harmonised national and provincial HIV and SH response.</li> </ul>



Details	Phase 1	Phase 2
	<p><b>Strong engagement</b></p> <ul style="list-style-type: none"> <li>Communities demonstrate increased health-seeking behaviours related to SRH and wellbeing.</li> </ul>	

## About this evaluation

The Australian High Commission (AHC) in Port Moresby requested an end-of-program evaluation for SRHIP, covering Phases 1 and 2, to assess the project's progress towards its stated goals and outcomes. The evaluation was required to identify achievements, challenges, and lessons learned. This evaluation will help inform future DFAT investments in HIV/STI and SRH, and support future planning with the PNG National Department of Health (NDOH) and Provincial Health Authorities (PHAs). This independent evaluation was conducted by the Human Development Monitoring and Evaluation Services (HDMES) in the period November 2021 to May 2022. It follows the DFAT commissioned PPF review in 2019, which included an evaluation of SRHIP Phase 1, and was also undertaken by HDMES.<sup>3</sup>

## Key Evaluation Questions

The Key Evaluation Questions were developed in consultation with DFAT (refer to section 4 of the report).

## Methods

This review was implemented in accordance with DFAT Monitoring and Evaluation (M&E) Standards. A multi-methods approach was adopted, incorporating qualitative and quantitative data. Interviews were undertaken with 92 informants from program, government, DFAT, community, and health service users. A desk review of over 90 documents and field visits to 6 provinces were completed.

## Limitations

Due to COVID-19 constraints in Australia and PNG, many interviews were conducted via Zoom or telephone. It is likely that this introduced some constraints due to limited opportunity for rapport with online interviewees. While initially conceived as an end-of-program evaluation, the funding period for the project was extended by DFAT up to December 2023. As the evaluation captures data only to December 2021, this evaluation does not capture the full program period and the total performance of SRHIP.

## Findings

### Impact

SRHIP contributed to managing HIV and STIs in PNG, providing a significant number of services. In 2019, SRHIP identified 25% of all new HIV cases nationally (840/3,300)<sup>4</sup>, and achieved an anti-retroviral therapy (ART) uptake of 83% (700/840)<sup>5</sup>, higher than the national average of 52%<sup>6</sup>. From inception to December 2021, it supported over 92,660 HIV tests, 13,500 people to access treatment for STIs, 3,200 people initiated on HIV treatment, and 3,591 people to receive ART.<sup>7</sup> With the total

<sup>3</sup> Siegmann et al., 2020, *PPF Health grants review*.

<sup>4</sup> Numerator 840 = SRHIP 2019 Annual No. of HIV positive. Denominator = 3,300 Estimated annual HIV incidence per year. UNAIDS, 2017, *Country progress report – Papua New Guinea. Global AIDS monitoring 2017*.

<sup>5</sup> Numerator 700 = No. of people initiated on ART. Denominator = 840 No. of HIV positive. *SRHIP Annual Report 2019*.

<sup>6</sup> UNAIDS, 2017, *Country progress report – Papua New Guinea. Global AIDS monitoring 2017*.

<sup>7</sup> *SRHIP Annual Report 2021*.

number of people across PNG on ART estimated to be 32,018<sup>8</sup> in 2019, SRHIP – through its 22 facilities – was supporting over 10% of all ART clients in PNG (3,591/32,018)<sup>9</sup>.

## Effectiveness

### *Strong systems*

**Capacity building for health system management:** SRHIP delivered capacity building and improved health service management through training and follow-up support to CCHS and PHA staff on a wide range of project and management topics, from finance to monitoring and evaluation.

**Collaboration with national and provincial governments:** SRHIP engaged with the Government of Papua New Guinea (GoPNG), specifically NDOH and Provincial Health Authorities (PHAs). Technical engagement with NDOH was primarily through the HIV Technical Working Group (TWG) and the National Health Information System (NHIS).

### *Strong services*

**Integration of HIV and SH services:** SRHIP has been successful in trialling the integration of standalone siloed HIV/STI services into primary health facilities, using a structured approach based on the WHO Integration Toolkit. By the end of Phase 1, 18 of the 22 sites were functionally integrated, with operational changes inclusive of patient files, staffing roles and placements, and clinical pathways all completed. In Phase 2, there were 13 sites integrated that continued to receive management support to strengthen the integration changes.

**Referral pathways:** A SRH Referral Protocol was developed early in Phase 1 (March 2018) to guide staff when referring patients to specialist family planning clinics. The protocol was never operationalised, as the SRH Referral Policy was not approved until July 2022.

**HIV/STI clinical practice training:** Feedback on training was unanimously positive. Interviews indicated SRHIP had enabled non-HIV clinicians to identify and refer potential clients for counselling and testing.

**HIV/STI testing and treatment:** SRHIP delivered a high volume of HIV/STI testing and treatment, exceeding project targets. During Phase 2, the SRHIP Prescriber training resulted in 37 new ART prescribers and the roll-out of Complex HIV Case Management, which reduced total complex HIV care cases.

**Counselling services:** Stakeholders reported that CCHS provides high-quality counselling services and that SRHIP has made a positive contribution to clinical capacity.

### *Strong partnerships*

**Partnerships with PHAs:** Collaboration between PHAs and diocese offices varied from province to province. In some provinces there were strong informal partnerships for clinical referrals, especially laboratory and pathology services, but only 2 out of 11 Service Level Agreements (SLAs) were signed.

**Collaboration with NDOH:** SRHIP was a participant in the national HIV TWG and contributed to technical matters, such as new treatment protocols. Program updates, however, were not presented, resulting in NDOH having little understanding or awareness of SRHIP.

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<sup>8</sup> UNAIDS, 2020, *Country progress report – Papua New Guinea. Global AIDS monitoring 2020.*

<sup>9</sup> Numerator 3,591 = Total people receiving ART under SRHIP (*SRHIP Annual Report 2019*). Denominator = 32,018 Total people receiving ART in PNG (UNAIDS, 2020, *Country progress report – Papua New Guinea*).

**Collaboration among DFAT-funded HIV/STI initiatives:** Partnerships between DFAT SRH investments were weak. Under PPF, there was some cross-project communication about SRH investments, but no program alignment. This remains an area of need for PATH and DFAT.

### ***Strong engagement***

**Community engagement:** Community engagement was delivered through outreach services providing STI screening, and HIV counselling and testing, as part of integrated primary health outreach services. Data on the number of outreach sessions or clients was unavailable, so progress could not be measured.

**Engagement with diverse and key populations:** SRHIP engagement with key populations progressed slowly and results are limited. The development of the Behaviour Change Communication Toolkit was a key success, but formal partnerships with national advocacy groups, such as Key Population Advocacy Consortium (KPAC) and Callan Services, had not been completed at the time of the evaluation. SRHIP clinics reported they were receiving and treating persons with disabilities (PWD), but data on numbers was not captured.

**Engagement with children and adolescents:** Progress on youth activities has been slow. A Youth and Adolescent Advisory Committee was established in Phase 1 and a needs assessment undertaken in Phase 2, but there was limited evidence of practical steps to engage with young people.

## **Relevance and coherence**

### ***Relevance***

**Relevance to PNG context and key populations:** SRHIP is relevant to the PNG context, as it responds to PNG's HIV epidemic and high rates of STIs. Even though progress was limited, the project design is relevant in terms of its focus on key populations, as these groups carry higher disease rates than the general population, and have significant unmet HIV/STI and reproductive health needs.

### ***Coherence***

**Alignment with the Government of PNG, DFAT, and sector stakeholders:** *SRHIP aligns with the PNG National Health Plan 2011–2020 and the Papua New Guinea National STI and HIV Strategy 2018–2022. CCHS has updated its strategic plan in line with the new National Health Plan 2021–2030 (NHP). SRHIP aligns well with DFAT priorities in PNG. When first designed, it reflected the DFAT Health and Development Strategy 2015–2020 and Aid Investment Plan: PNG, 2015–16 to 2017–18 (extended to 2018–19) (2018) (Objective 3). It is aligned with the DFAT Health Portfolio Plan 2018–2023, specifically Outcome 3. SRHIP engagement with other sector actors has been limited, due to limited oversight from DFAT through PATH.*

## **Gender**

SRHIP provided a high volume of services for women, with 58,000 of the 94,000 people tested for HIV being women and girls, and 60% of the 3,200 people identified as HIV-positive being women. Capacity building in the gender transformative approach for health services was incomplete at the time of the evaluation, but scheduled for 2022. There were crucial oversights and missed opportunities that compromised the capacity of SRHIP to deliver on gender and women's health (see section 4.4 of the report).

## **Sustainability**

**Resourcing sustainability:** The SRHIP consortium model offers a positive approach for PNG. Incorporating a blend of local and international capability offers technical value and contributes to

sustainability through the transfer of skills. The combination of organisations, expertise, and management fees, however, are critical if partnerships are to be effective and financially feasible.

**National ownership over program outcomes:** National ownership over SRHIP outcomes and collaboration is minimal. Members of the consortium did not engage effectively with the NDOH about the program. Greater communication from DFAT, through PATH, could have improved awareness of SRHIP and other DFAT investments.

**Engagement with PHAs:** Engagement with PHAs has been stronger for clinical and medical matters, but weak for leadership and governance, largely due to a lack of PHA readiness.

**Financial sustainability of health services:** By absorbing siloed HIV/STI services into primary health care facilities, SRHIP has provided a model that could increase financial efficiency. Of the 22 clinics, 9 are now fully supported by CCHS and 13 are still supported with DFAT funds.

## Efficiency

**Cost-effectiveness and efficiency:** From an operational perspective, the SRHIP approach to integration offers other service providers an opportunity to learn from the project's experiences. However, the degree to which the integration has led to efficiency gains is unclear. While SRHIP provided efficiencies for clients and patients, by minimising travel to both HIV clinics and primary health facilities, the cost versus impact of this investment could not be determined. A financial data analysis was not part of the evaluation scope and the evaluators did not undertake a comparative analysis with other clinics.

**Consortium structure:** SRHIP comprised an innovative mix of partners with local and international expertise that covered most of the broader program needs. This provided a strong foundational base for the team. As the lead, CCHS delivered grant and project management, but either lacked focus, or technical direction from within the partnership, to adequately address inclusive and referral activities, and communication and external relations. The international partners provided technical assistance throughout the project and skilfully adapted to online working arrangements during the COVID-19 pandemic. ASHM provided competent leadership for medical and clinical training, but had limited skills in gender and monitoring, evaluation and learning (MEL). Burnet Institute provided niche products for SRHIP, such as the Integration Model and Behaviour Change Communication Toolkit, but had high staff turnover, which compromised momentum. *Igat Hope* brought learned experience of key populations through its Expert Peer Counsellor network, but its limited footprint within the project to only 2 provinces, and its constrained organisational capability, meant its value could not be scaled.

**Governance mechanisms:** SRHIP established an internal Project Management Group (PMG) and Technical Advisory Group (TAG) early, which provided the partnership with cohesion early in the grant. Through the course of Phase 1 and 2, this strengthened CCHS management capability, as it drove leadership and management training sessions, reports, and governance and compliance activities. Engagement between the national CCHS head office and diocese offices was consistent, except for the period of COVID-19 travel restrictions. Provincial visits have strengthened the communication and engagement between diocese teams and SRHIP management.

**Adaptive management:** Adaptive management was evident in the relationship between SRHIP and PPF, but not PATH. By discontinuing the quarterly field trips, biannual reflection workshops, and post-report reviews carried out under PPF, there has been no cross-program collaboration and learning between SRHIP and wider PATH structures. Within SRHIP, internal reflection workshops

occurred at key junctures, such as between Phase 1 and 2, but there was limited evidence of regular, ongoing, evidence-based reflection that could have informed ongoing learning and decision-making.

#### **Operational research and monitoring and evaluation:**

*Operational research:* One of the two operational research activities was completed, but was not available to the evaluation team. Its impact for management and adaptive learning was not known.

*Theory of Change:* Theory of Change (TOC) designs were developed by ASHM in consultation with consortium members, but these lacked technical rigour and did not clearly articulate the causal pathways of SRHIP. A review of the TOC occurred between Phase 1 and 2, but was not reviewed periodically.

*Monitoring and Evaluation Plan (MEP):* The SRHIP MEP focused mostly on aggregated data capturing inputs and outputs, and prioritised GoPNG NHIS indicators to align with national health service indicators. The MEP did not support meaningful data collection, reporting, learning and adaptation, in line with DFAT standards. Important elements of the MEP are discussed in greater detail later in the report.

*Learning and adaptive management:* Critical interrogation of project implementation was a core agenda item of SRHIP PMG and TAG meetings. Beyond this, however, it appeared key managers did not engage in regular, formal reflections of M&E data.

*Reporting:* Reporting compared 6-monthly and annual targets only, making interpretation of cumulative program results difficult. The reports reflected the focus of working to activities and targets in the MEP, rather than drawing on data to consider and interrogate performance against outcomes.

#### **Impact of COVID-19 pandemic**

SRHIP was impacted by COVID-19, resulting in critical delays to project progress, such as inclusive activities for key populations, youth, and gender; and inability to access NDOH data for SRHIP reports. Frontline health workers also struggled with newly introduced COVID-19 protocols, illness, sick leave, burnout, and community resistance due to COVID-19 vaccine hesitancy. Additionally, travel restrictions prevented international technical advisers from making scheduled country trips. All of these challenges compromised project momentum in 2021 and 2022.

### **Conclusion and recommendations**

#### **Conclusion**

On balance, this evaluation finds that SRHIP has made progress on the Phase 2 stated goal and has scaled up integrated quality HIV and sexual health services at identified CCHS facilities. While not all outcomes were achieved in full, from inception to December 2021, the consortium made more progress on Outcomes 1 and 2, mixed progress on Outcome 3, and minimal progress on Outcome 4.

Given CCHS experience with DFAT grants, it performed strongly in upholding donor requirements and pivoted well to embed GoPNG strategies, policies, and COVID-19 requirements in executive and program operations. With complementary support from ASHM, and given that the core business of CCHS is as a service provider, SRHIP upscaled quality services, delivering more complete HIV and SH care. SRHIP made headway on technical and clinical activities, but struggled with activities beyond these, such as gender, external relations, and communications. These were areas of weakness not within the consortium mix. Inclusiveness was the slowest performing area for SRHIP, even though the Behaviour Change Communication Toolkit was groundbreaking. SRHIP failed to address barriers for youth, sex workers, men who have sex with men, transgender individuals, and people with



disabilities, as it underestimated the time and effort needed to cascade the toolkit, upskill health staff, and build key population networks. Had SRHIP commenced this outcome earlier, more progress would have been made.

A key lesson from this evaluation was the lost opportunity to include reproductive health in the design, which would have provided greater value for money, compounded health impacts, and improved SRHIP's gender credentials and maternal outcomes.

The ambitiousness of SRHIP, and the complexity of implementing integrated primary health services in PNG, to donor timelines, means that there is still more to be done. This review recommends that HIV and STI interventions continue to be funded. Projects with a quality and evidence-based focus should be resourced, especially those that apply structured approaches to working with and through PNG organisations and GoPNG systems. Where necessary, international expertise or organisational capacity to partner with local organisations should be embraced, to strengthen rather than substitute gaps in local capacity. Continuing inclusive activities and mainstreaming access for marginal and key populations is strongly recommended. Engaging local organisations with expertise in this area, such as *Igat Hope*, would be advantageous, but these organisations often need significant administrative and management strengthening if they are to operate at scale. Incorporating targeted approaches for men and women, as well as youth, transgender individuals, and other key population subgroups, is necessary if better sexual health outcomes are to be achieved. More effective communication with NDOH is critical and relationship management should be led by DFAT, as part of its donor and GoPNG advocacy activities. Finally, third parties should be engaged for rigorous analysis of project proposals, theory of change, gender approaches, and monitoring and evaluation plans. This should be done at the outset and throughout the implementation period to ensure stronger adherence to donor requirements and program aspirations.

The following recommendations are offered to strengthen the current and potential investments in HIV/STI and SRH and to optimise DFAT investments to date.

## Recommendations

The following recommendations have been developed to strengthen the SRHIP investment.

***Recommendations 1 to 3 are proposed for action during the remainder of Phase 2, and to be actioned by SRHIP.***

**Recommendation 1:** The SRHIP consortium continues to finalise integration activities and deliver on committed targets.

**Recommendation 2:** Progress formalising engagement partnerships with key population and vulnerable groups, to guide inclusive counselling and operational tools and practices.

**Recommendation 3:** Continue to strengthen engagement with community groups to increase SRH awareness, reduce stigma, and increase access to services.

***Recommendations 4 and 5 are proposed for SRHIP Phase 3 design and implementation, and are to be actioned by PATH or DFAT.***

**Recommendation 4:** DFAT and PATH frame the scope of a Phase 3 to incorporate learning from SRHIP Phase 1 and 2, in conjunction with developments in national and subnational responses to HIV/STI.

**Recommendation 5:** PATH to actively support and collaborate with grantees and SRHIP under the Frontline Health Outcomes workstream to improve mutual implementation and governance activities.

***Recommendation 6 is proposed for future DFAT programming in HIV/STI/SRH and family planning in PNG, and is to be actioned by DFAT.***

**Recommendation 6:** In national and subnational forums, and in collaboration with other donors and program implementers, DFAT continues to communicate about existing and new project investments in HIV/STI and SRH to enhance coordination and coherence across donors, and with NDOH and PHAs.

# 1. Context

## 1.1. Burden of HIV, STIs and SRH

**PNG's HIV epidemic is a mixed epidemic with variations in prevalence and incidence across population groups.** In 2017, the prevalence for the general population was estimated to be 0.9%, with at least 48,000 PLHIV. Annual incidence was considered at 3,300 new cases per year. These estimates could be higher, as approximately 20% of PLHIV do not know their status.<sup>10</sup> Sub-populations, such as female sex workers (FSWs), men who have sex with men (MSM), and transgender groups (TG), have higher HIV rates than the wider community. In 2017, the HIV prevalence was 14.9% for FSWs and 8.5% for MSM. Furthermore, the HIV prevalence varies according to geography, with higher rates recorded in urban areas. Port Moresby, the national capital, is considered to have the highest burden of HIV. This is followed by regional clusters in Lae, Mount Hagen, Goroka, Jiwaka, Simbu, and Southern Highlands. Nationally, access to and uptake of ART is estimated to be 52% of PLHIV.<sup>11</sup> HIV prevention activities include condom distribution, pre- and post-exposure prophylaxis, voluntary male circumcision, and education and awareness campaigns. Data on condom use is general. Recent reports indicate access and use of condoms in the general population is low. Recent interventions to reach and test key populations indicate nearly half of the estimated FSWs, MSM, and TG were reached in 2019.<sup>12</sup>

**STIs increase the risk of HIV transmission and are a health burden on their own.** Research indicates that the STI burden in PNG has been high since 2012<sup>13</sup> and the national prevalence is the highest in the Western Pacific region<sup>14</sup>. A 2016 study reported 43% of women attending antenatal clinics were diagnosed with an STI<sup>15</sup> and over half of FSWs and 34% of MSM have more than one STI<sup>16</sup>.

**PNG's maternal mortality rate is high, but the rate varies depending on the data source.** A WHO report using service data trends indicated the MMR was around 215 per 100,000 live births in 2016.<sup>17</sup> National reports indicate significant weakness in antenatal care (ANC) attendance, family planning uptake, and supervised deliveries. The *2019 Sector Performance Annual Review (SPAR)* in 2020 reported that only 48% of pregnant women attend an ANC clinic and only 36% have a supervised delivery in a health facility.<sup>18</sup> UNAIDS reports that only 1 in 5 women are tested for HIV in ANC clinics.<sup>19</sup> Only 136 couples out of every 1,000 women of reproductive age are using modern contraceptive methods (e.g. oral contraceptives, implants, or condoms). Alternative data indicates the contraceptive rate is around 25%, and unmet family planning need is about 30%.<sup>20</sup> Women who are educated, over 20 years of age, and living in urban areas, have better access to contraception than those under 20 years of age, in remote locations, or with lower education attainment.<sup>21</sup>

<sup>10</sup> UNAIDS, 2017, *Country progress report – Papua New Guinea. Global AIDS monitoring 2017.*

<sup>11</sup> UNAIDS, 2018, *Country progress report – Papua New Guinea. Global AIDS monitoring 2018.*

<sup>12</sup> UNAIDS, 2020, *Country Progress report – Papua New Guinea. Global AIDS monitoring 2020.*

<sup>13</sup> Newman, L, et al., 2015, *Global estimates of the prevalence and incidence of four curable sexually transmitted infections in 2012 based on systemic review and global reporting.*

<sup>14</sup> Government of PNG & NAC, 2018, *Papua New Guinea National STI and HIV Strategy 2018–2022.*

<sup>15</sup> Chlamydia 22.9%, trichomonas 22.4%, gonorrhoea 14.2%, active syphilis 3%, HSV2 28%, and HIV 0.8%.

<sup>16</sup> Government of PNG, 2021, *National Health Plan 2021–2030, Vol. 2A.*

<sup>17</sup> Robbers et al., 2019, *Maternal and newborn health indicators in PNG 2008–2018.*

<sup>18</sup> NDOH, 2020, *2019 Sector Performance Annual Review: Assessment of sector performance 2015–2019, National report.*

<sup>19</sup> UNAIDS, 2020, *Country Progress report – Papua New Guinea. Global AIDS monitoring 2020.*

<sup>20</sup> UNFPA Papua New Guinea, n.d., *What we do: Sexual and reproductive health.* <https://png.unfpa.org/en/topics/sexual-reproductive-health-11>

<sup>21</sup> National Statistical Office & ICF, 2019, *Papua New Guinea Demographic and Health Survey 2016–18.*

## 2. About the program

The Sexual and Reproductive Health Integration Project is an Australian Government AUD19,274,549 investment to assist the Government of PNG in health service delivery. It spanned the period July 2017 to February 2022 and was implemented in 2 phases: Phase 1 from 1 July 2017 to 31 May 2020 and Phase 2 from 1 July 2020 to 28 February 2022.<sup>22</sup> An additional AUD490,734 was provided to SRHIP to support service delivery for the COVID-19 vaccine roll-out, between February 2022 and December 2022.

SRHIP was developed in response to a DFAT-funded tender, which sought to improve SRH primary health services for women and girls. The project design was also to encompass integration, inclusion, and partnerships. The project goal<sup>23</sup> was to deliver quality and scaled SRH services at identified CCHS health facilities through 4 outcomes – strengthened systems, services, partnerships, and engagement.

Prior to SRHIP, Catholic Church Health Services and Anglicare PNG supported a network of VCCT sites (22 for CCHS and 2 for APNG) that had been receiving DFAT funding. The sites provided HIV counselling, testing, prescribing of ART, STI syndromic management, home-based care, and support for PLHIV. With the retreat of DFAT from funding standalone siloed HIV services, the SRHIP design set out to incorporate the VCCT sites into primary health facilities (aid posts, health centres, and urban clinics)<sup>24</sup>, to preserve the VCCT services and strengthen the quality and reach of HIV and SH service delivery.

The scope of the tender was aimed at strengthening sexual and reproductive health. Even though this was retained in the name of SRHIP, there was no clear explanation about how SRHIP would define or manage women's health, and reproductive services such as antenatal and postnatal care were not visible in the design. The benefits and positive impacts on reproductive outcomes resulting from managing and treating HIV and STIs, however, were well cited to justify a focus on HIV and SH. SRHIP focused on sexual health, integration, primary health care, inclusion, and partnerships. Given that the proposal, and its Monitoring and Evaluation Plan, were accepted and approved by DFAT, it is assumed that SRHIP was recognised as offering an important and valuable development for HIV and primary health services in PNG.<sup>25</sup> It is noteworthy that at the same time and under the same umbrella of the PNG Partnership Fund another DFAT investment called Partnering for Strong Families (PSF) directly focused on reproductive health through a consortium with Marie Stopes PNG and Susu Mamas. Interviewees commented that PSF directly focused on reproductive health, while SRHIP focused on sexual health, and both focused on quality services, partnerships, inclusion, and integration.

SRHIP Phase 1 had a three-pronged approach reflected in the 3 intermediate outcomes. The first was to build the capacity of the management systems and processes of the PNG implementing partners, CCHS, *Igat Hope*, and APNG, and establish institutional and administrative foundations required to drive the integration agenda. The second was to strengthen and enhance the capacity of frontline health workers and clinical mechanisms to deliver high-quality integrated services. The third was to

<sup>22</sup> Phase 2 was granted an extension to December 2023, due to extended delays and interruptions resulting from the COVID-19 pandemic.

<sup>23</sup> The Program Logic of Phase 2, which replaced Phase 1, will be used in this evaluation.

<sup>24</sup> Depending on the facility, different levels of care and competence are provided for first aid, clinical diagnosis, treatment and management of common ailments, TB screening and referral, antenatal and postnatal care clinics, health promotion and education, couples counselling, family planning, and outreach programs. Conditions that cannot be managed are referred to the next level up.

<sup>25</sup> Consortium interviews.

strengthen engagement with communities through behaviour change communication to improve health-seeking behaviour.

In late 2019, as Phase 1 was ending, DFAT commissioned an independent review of the PPF grant, which managed SRHIP. The evaluation recommended SRHIP strengthen key areas. These included: stronger focus on how HIV and SH services would be integrated with primary health clinics; building structured referral pathways to other allied services; developing clearer definitions regarding what service integration looked like; improving access for key populations; and improving monitoring and evaluation.<sup>26</sup>

In view of the findings from the PPF review, the second phase of SRHIP consolidated the transition agenda and revised critical elements. This included more purposely reviewing the project outcomes and revising the Program Logic; developing a structured approach, framework and definitions for integration; having a clearer focus on staff capability to support quality integrated services; and more considered approaches to community engagement with vulnerable groups to improve inclusiveness and universal access.

In summary, the strategic areas across both phases were consistent and SRHIP focused on 4 core areas: institutional and organisational capacity; health service capacity; partnership harmonisation capacity; and diversity and inclusion capacity. Phase 1 was an inception and learning period, and Phase 2 was a consolidation period. The Program Logic for Phase 1 and the Theory of Change for Phase 2 are provided in Annex 7.1, but these are synthesised in Table 2.1.1 below.

**Table 2.1.1 Program design across Phase 1 and Phase 2 of SRHIP**

Strategy	Outcome <sup>27</sup>	Key activities
<b>Strengthening services</b>	Strengthened integrated services providing high-quality sexual health care.	<ul style="list-style-type: none"> <li>Support integration of standalone HIV and SH services delivered by CCHS into CCHS-managed GoPNG primary health care facilities.</li> <li>Support implementation of referral pathways, both within the CCHS network, between CCHS and external partners, and between other stakeholders in the primary health care network.</li> <li>Train health workers in CCHS and primary health services to deliver high quality HIV and SH services, counselling services, and outreach to key populations.</li> <li>Support the scaled delivery of HIV and SH services.</li> </ul>
<b>Strengthening engagement</b>	Strengthened engagement with community and key populations promoting universal access to quality HIV and sexual health services.	<ul style="list-style-type: none"> <li>Build strong relationships with community and key populations.</li> <li>CCHS and primary health services provide high-quality health services to key populations.</li> <li>Build capacity of health services to implement gender transformative models of health care.</li> </ul>
<b>Strengthening partnerships</b>	Strengthened partnerships supporting a harmonised national and provincial HIV and SH response.	<ul style="list-style-type: none"> <li>Build partnerships between CCHS services, PHAs and NDOH.</li> <li>NDOH and PHAs participate in governance of SRHIP.</li> </ul>

<sup>26</sup> Siegmann et al., 2020, *PPF Health grants review*.

<sup>27</sup> Using Phase 2 outcome statements.



Strategy	Outcome <sup>27</sup>	Key activities
Strengthening systems	Strengthened harmonised systems for management, monitoring and evaluation of high-performing (effective and efficient) projects and services.	<ul style="list-style-type: none"> <li>Capacity building for health service management for CCHS and primary health service providers.</li> <li>Harmonise strategic direction and policy and procedures of CCHS services with provincial and national health policies and procedures.</li> <li>Harmonise data collection and information sharing between the CCHS network and provincial and national data collection methods.</li> </ul>

## 2.1. Program management and implementation

### Management

SRHIP Phase 1 was managed under the PNG Partnership Fund, while Phase 2 was managed under the PATH program, which is the subsequent investment to PPF. PPF and PATH were mutually-agreed initiatives between the Government of Australia and the Government of PNG, and both have provided grants to NGOs to deliver services on behalf of GoPNG. PPF and PATH were both managed by Abt Associates in the period covered by this review.

### Implementation

SRHIP is overseen by a consortium of Australian and Papua New Guinean faith-based and civil society organisations, including CCHS, APNG, Burnet Institute, ASHM, and *Igat Hope*. The consortium partners have combined knowledge and experience in the delivery of health services in PNG, and technical expertise in HIV and STI treatment and management, capacity building, and health management practices.

- CCHS** was the project lead for SRHIP, and managed the contract, oversaw compliance and governance, led implementation, and submitted the financial and progress reports. CCHS is administered by the Catholic Church and is fully integrated into the PNG government health system. It delivers health services on behalf of NDOH, in line with national policies and strategies, through its network of 247 primary health clinics and 22 VCCT sites (now integrated into primary health facilities). Apart from a few roles, all CCHS staff are on the government payroll and GoPNG funds operations for basic health services, drugs, and medical supplies. CCHS supplements its financial base with donor grants to optimise its services and implement key projects. It has a specific focus on primary health and includes nutrition, tuberculosis (TB), and maternal and child health services, as well as HIV and STI counselling, testing and treatment. Static clinics are supplemented with mobile health patrols and health promotion programs. Traditional contraceptive methods acceptable to the Catholic Church (e.g. periodic abstinence) are endorsed, but requests for modern methods (e.g. contraceptive pill or implant) are referred to other facilities.
- ASHM** provided technical assistance, specifically for clinical and medical training and support for operations, clinical services, referral pathways, gender transformative processes, and responding to COVID-19. It provided system strengthening support for CCHS and monitoring and evaluation of SRHIP. ASHM is an Australian not-for-profit organisation that provides support for the HIV, viral hepatitis, and sexual health workforce. It has been working in PNG for over 20 years.
- Burnet Institute** contributed technical advice and guidance to the SRHIP consortium. It is responsible for strategic planning, clinical integration, and technical advice on client-centred

counselling and inclusiveness. BI is an Australian not-for-profit organisation that focuses on medical research and has led or collaborated on health programs in PNG for over 13 years.

- **Igat Hope** led the SRHIP work on peer counselling and provided technical advice regarding quality services for people living with HIV. *Igat Hope* began operations in 2003 and is the national advocacy network for people living with HIV/AIDS. It oversees member networks in 17 provinces in PNG, trains and supports peer counsellors and peer educators, and collaborates on the delivery of HIV services.
- **Anglicare** is a health service delivery agency for HIV/STIs in PNG. It was a member of the SRHIP consortium during Phase 1, but its engagement concluded in December 2019.

SRHIP commenced Phase 1 with the full quota of 24 VCCT sites: 22 managed by CCHS and 2 managed by APNG. APNG concluded its involvement in SRHIP during Phase 1, withdrawing its 2 VCCT sites. SRHIP subsequently focused on the 22 CCHS sites. In Phase 1, SRHIP worked on 22 sites, and in Phase 2 it worked on 13 of the original 22 sites from Phase 1.

### 3. About this evaluation

The Australian High Commission in Port Moresby requested an end-of-program evaluation to review Phases 1 and 2. The evaluation seeks to assess SRHIP progress towards its stated goals and outcomes, and to identify achievements, challenges, and lessons learned. This review is to inform future DFAT investments in SRH and contribute to collaborative health planning with NDOH and PHAs.

This independent evaluation was conducted by HDMES, with data collection in the period November 2021 to May 2022. It follows the earlier evaluation undertaken in 2019, which reviewed the PPF and covered SRHIP Phase 1.

#### 3.1. Key Evaluation Questions

The Key Evaluation Questions were developed in consultation with DFAT and are outlined in Table 3.1.1. The sub-questions under each key evaluation question are shown in Annex 7.2.

**Table 3.1.1 Key Evaluation Questions**

Principle	Key Evaluation Question
<b>Impact</b>	What difference does the intervention make in: strengthening systems for delivery of quality, scaled SRH services, and expanding its reach and coverage of STI, HIV, SRH and primary health services within CCHS facilities?
<b>Effectiveness</b>	Is the project delivering on outcomes as planned?
<b>Relevance and coherence</b>	How well does the intervention meet the needs of PNG, including those most vulnerable?
<b>Gender</b>	To what extent have gender and social inclusion principles been incorporated into the program?
<b>Sustainability</b>	To what extent are the positive changes and effects of the investment sustainable after the grant ends?
<b>Efficiency</b>	To what extent is the organisational model (e.g. funding, resource allocation, team structure, governance mechanisms) effective and efficient?
<b>Recommendations</b>	What are the lessons learned and recommendations for future DFAT investments in SRH?

## 3.2. Methods

The evaluation was designed and implemented in accordance with DFAT Monitoring and Evaluation Standards. A multi-methods approach was adopted, incorporating qualitative and quantitative data. The evaluation methods included key informant interviews, a document review, and provincial site visits.

- Interviews were conducted with 92 stakeholders from NDOH, DFAT, PATH, PHAs, health facilities, SRHIP consortium members, community leaders, and SRHIP service users. Annex 7.3 provides the full list of stakeholders consulted.
- Over 90 documents including SRHIP progress reports, consortium agreements, and national planning and policy documents were reviewed. Annex 7.4 provides the full list of reviewed documents.
- Six provinces were visited – New Ireland, Morobe, Madang, National Capital District (NCD), West Sepik, and Eastern Highlands. The provinces were selected with a view to ensuring diversity of provinces.

Data was synthesised against the Key Evaluation Questions and triangulated to develop findings. Findings were tested and developed through a stakeholder workshop in June 2022, and ongoing consultations with the SRHIP team, NDOH, and DFAT, during the course of the evaluation. Quantitative data presented in this report is drawn from SRHIP progress reports, which included data from inception to December 2021. Stakeholder interviews were conducted up to May 2022.

## 3.3. Limitations

Due to COVID-19 constraints in Australia and PNG, many interviews were conducted via Zoom or telephone. This may have introduced some constraints to sharing information, due to limited opportunity for rapport with online interviewees. Potential biases were mitigated through the interview sample of 92 stakeholders, supplemented by additional qualitative data from the document review.

While initially conceived as an end-of-program evaluation, the program was extended by DFAT up to December 2023, and the evaluation therefore does not capture the full program period.

## 4. Findings

Findings are presented against the key principles guiding the evaluation questions: impact, effectiveness, relevance and coherence, gender, sustainability, and efficiency.

### 4.1. Impact

**This section responds to the following Key Evaluation Questions:**

What difference did the intervention make in:

- Strengthening systems for delivery of quality, scaled SRH services?
- Expanding reach and coverage of STI, HIV, SRH and primary health services within CCHS facilities?

### Contribution to strengthening systems

In this section, the WHO ‘Six Building Blocks of a Health System’ has been adopted as a framework for assessing the contribution of SRHIP to strengthening the health system.<sup>28</sup> Table 4.1.1 summarises findings with a brief description of the project’s contribution.

**Table 4.1.1 Assessment of contribution of the program to health systems strengthening**

Building block	Assessment of program contribution
<b>Health services</b> Effective, quality, when needed, to those who need them	<ul style="list-style-type: none"> <li>• SRHIP delivered a high volume of HIV/STI testing and treatment and exceeded most of the clinical targets for HIV/STI testing and treatment (see Table 4.2.7).</li> <li>• Integrating VCCT sites with primary health clinics was considered a key enabler of expanding access to HIV and STI services.</li> <li>• CCHS leveraged the community catchments connected to their primary health clinics to increase its access into the general population.</li> <li>• SRHIP implemented activities to increase reach to key, or sub-populations, but the actual client reach cannot be quantified as no data was collected on the number of people receiving services who identify as a key population.</li> <li>• Interviews indicated SRHIP engagement with key or sub-populations such as FSWs and MSM was limited, largely due to COVID-19 related delays on inclusive activities.</li> </ul>
<b>Health workforce</b> Responsive, fair, efficient, competent, productive.	<ul style="list-style-type: none"> <li>• SRHIP delivered a range of activities for capacity building through training and mentoring diocese staff, PHAs, and consortium partners on STI/HIV testing and treatment, data management, sensitisation to principles of inclusive service delivery, and health service management.</li> </ul>
<b>Health information</b> Production, analysis, dissemination, and use of timely information.	<ul style="list-style-type: none"> <li>• SRHIP contributed to operational improvements and harmonisation of data systems at service and provincial levels, ensuring its facilities were reporting HIV service data into the NDOH NHIS and HIV SURV 1 and 2 systems.</li> <li>• Information sharing across government and non-government partners is beyond the capability of SRHIP to influence.</li> </ul>
<b>Medical products, vaccines, and technologies</b> Equitable access, safe, scientifically sound, and cost-effective.	<ul style="list-style-type: none"> <li>• SRHIP rolled out and adopted the new PNG HIV Treatment Guidelines to all SRHIP facilities, ahead of other service providers. Training was provided for 100 trainees, including SRHIP staff and PHA HIV Coordinators.</li> <li>• SRHIP actively engaged with Area Medical Stores and NDOH to ensure ART and STI medical supplies and drugs were consistently available in both phases.</li> </ul>

<sup>28</sup> WHO, 2007, *Everybody’s business – strengthening health systems to improve health outcomes: WHO’s framework for action*, <https://apps.who.int/iris/handle/10665/43918>

Building block	Assessment of program contribution
	<ul style="list-style-type: none"> <li>• Viral load testing was embedded as part of the clinical HIV/ART protocol in two facilities (Mount Hagen and NCD). All other SRHIP clinics collected and sent specimens to provincial hospitals for analysis.</li> </ul>
<b>Health financing</b> System raises adequate funds for health. Promotes efficiencies.	<ul style="list-style-type: none"> <li>• The cost-effectiveness of the integration of VCCT sites into primary health services was anecdotally highlighted by several stakeholders as positive, reducing operational and overhead costs, but financial analysis was unavailable to support this.</li> <li>• Beyond SRHIP, the capacity of GoPNG to finance HIV health projects remains a challenge, with ongoing heavy reliance on donor funding.</li> </ul>
<b>Leadership and governance</b> Effective oversight, coalition-building, regulation, and accountability.	<ul style="list-style-type: none"> <li>• National and provincial ownership over SRHIP outcomes and collaboration was weak and could be strengthened. SRHIP cannot do this without support from PATH and DFAT. SRHIP is limited in its capacity to engage with and influence NDOH executive and central agency mechanisms.</li> </ul>

## Expanding reach of services

SRHIP services have reached a significant proportion of PLHIV in PNG and have contributed to managing HIV in PNG. For example, based on the estimated annual HIV incidence of 3,300 per year (see section 2.1 above), SRHIP identified around 25% of new HIV-positive cases in 2019 (840/3,300). SRHIP also achieved an 83% ART uptake rate (700/840), substantially higher than the national average of 52%. From inception to December 2021, SRHIP has supported:

- Over 92,660 HIV tests through VCCT and provider-initiated counselling and testing (PICT).
- Over 13,500 people accessed treatment for STIs.
- Over 3,200 people were initiated on HIV treatment.
- Over 3,591 people receiving ART.<sup>29</sup>

With total people on ART in PNG in 2019 estimated at 32,018<sup>30</sup>, SRHIP was supporting more than 10% of all clients on ART in PNG (3,591/32,018).<sup>31</sup>

It is not possible to quantify the extent to which SRHIP expanded reach of STI, HIV, SRH, and primary health services within CCHS facilities, because data was not reported by facility or province at the time of this evaluation. However, many interviewees reported that SRHIP did contribute to increased reach of HIV/STI services within CCHS facilities. The following factors were perceived to have contributed to this:

- Integration of HIV/STI services into primary health facilities has allowed clients to access counselling and treatment without the stigma of accessing a standalone HIV/STI service.
- Primary health staff have improved HIV/STI counselling and treatment skills.
- The large population catchment linked to CCHS primary health users enabled more people from remote, rural, and urban settlements to receive HIV/STI counselling and testing during outreach.

<sup>29</sup> SRHIP Annual Report 2021.

<sup>30</sup> UNAIDS, 2020, *Country progress report – Papua New Guinea. Global AIDS monitoring 2020*.

<sup>31</sup> Numerator 3591 = Total people receiving ART under SRHIP (SRHIP Annual Report 2019). Denominator = 32,018 Total people receiving ART in PNG (UNAIDS, 2020, *Country progress report – Papua New Guinea. Global AIDS monitoring 2020*).



- The introduction of counselling services in a primary care setting, buttressing HIV VCCT with holistic care, has encouraged clients to continue treatment.
- Stakeholders were unanimous in their regard for the quality of STI/HIV testing and treatment provided by CCHS.

## 4.2. Effectiveness

**This section responds to the following Key Evaluation Question:** is the project delivering on outcomes as planned?

An overview is provided of what has been achieved against the following program outcomes:

- **Strong systems:** Strengthened and harmonised systems for management, monitoring, and evaluation of high performing projects and services.
- **Strong services:** Strengthened integrated services providing high-quality sexual health care in a primary health setting.
- **Strong partnerships:** Strengthened partnerships supporting a harmonised national and provincial HIV and STI response.
- **Strong engagement:** Strengthened engagement with community and key populations, promoting universal access to quality HIV and SH services.

### Key findings

#### Strong systems

##### Capacity building for health system management

- SRHIP delivered capacity building to dioceses, and provincial and consortium partners to improve health service management. Training and follow-up support was provided on topics such as finance, monitoring and evaluation, data management, project management, leadership, communications, and compliance.

##### Collaboration with national and provincial governments

- SRHIP engaged with GoPNG at 2 levels – through the NDOH and PHAs. Engagement with NDOH was primarily technical and with the PHAs primarily operational.
- SRHIP worked closely with the NHIS Unit to ensure service data was aligned with NDOH health information systems, and data was entered into the HIV Patient Data Base and the SURV 1 and 2. When NDOH forms were revised, CCHS adapted accordingly. Health service training for CCHS staff was extended to NDOH and PHA partners, consolidating the collaboration. During the COVID-19 pandemic, engagement was delayed, which compromised data collection for reports.

#### Strong services

##### Integration of HIV and SH services

- SRHIP has been successful in trialling how to integrate standalone HIV/STI services into primary health care facilities. At the end of Phase 1, a structured framework with 4 models was developed using the WHO Integration Toolkit. At the end of Phase 1, 18 of the 22 sites were successfully integrated, and in Phase 2, 13 had been transitioned but required continued donor-funded management support. The integration process is continuing.

## Referral pathways

- A SRH Referral Protocol was developed in March 2018, in Phase 1, to guide CCHS staff when referring patients from CCHS clinics to specialist family planning clinics. The protocol was not operationalised, however, as the SRH Referral Policy was not approved until July 2022. CCHS staff affirmed they were providing verbal referrals from SRHIP clinics to family planning clinics, but there was no data to confirm this.

## HIV/STI clinical practice training

- Feedback on training was unanimously positive, with interviewees reporting it enabled non-HIV clinicians to identify and refer potential clients for counselling and testing.

## HIV/STI testing and treatment

- SRHIP delivered a high volume of HIV/STI testing and treatment, exceeding targets. During Phase 2, SRHIP Prescriber training resulted in 37 additional ART prescribers located across 13 primary health facilities, and the roll-out of the new PNG HIV Treatment Regimen was considered by clinicians to have reduced the frequency of complex care cases.

## Counselling services

- Stakeholders reported that CCHS provides high-quality counselling services and that SRHIP has made a positive contribution to clinical capacity.

## Strong partnerships

### Partnerships with PHAs

- Collaboration between PHAs and diocese offices varied between provinces. In some provinces there were strong informal partnerships in place, and in NCD St Therese Clinic is fully embedded within the PHA system. Progress on SLAs was slow with only 2 reported as signed.

### Collaboration with NDOH

- At the national level, SRHIP was a member on the HIV TWG and provided technical input to topics such as HIV Complex Case Management, medical supplies, and viral load testing sites, but NDOH had little oversight and minimal knowledge of SRHIP. CCHS did not effectively communicate about the program, and SRHIP felt that this engagement could have been better supported by PATH or DFAT.

### Collaboration among DFAT-funded HIV/STI initiatives

- There was no collaboration or alignment between the various HIV, STI, and SRH investments of DFAT.

## Strong engagement

### Community engagement

- Community engagement was predominantly undertaken during outreach services. STI screening and HIV counselling and testing were provided as part of integrated primary health outreach services. Patients who tested positive were referred to static clinics for follow-up care.

### Engagement with diverse and key populations

- SRHIP engagement with key populations was delayed and progressed slowly, due to internal capacity within the consortium, and then due to COVID. Burnet Institute developed a

groundbreaking Behaviour Change Communication Toolkit in Phase 1, which targeted key populations and newly diagnosed PLHIV. Eight *Igat Hope* Expert Peer Counsellors (EPCs) used the toolkit in 5 facilities in 2 provinces. Key population training for frontline health workers was conducted in 4 provinces, but follow-up action to engage local key population networks remains outstanding. Formal partnerships have not been entered into with national advocacy groups, such as KPAC and Callan Services, at the time of the evaluation.

- Implementation of an action plan to strengthen CCHS engagement with key populations was scheduled for 2022.
- SRHIP clinics reported receiving and treating persons with disabilities, but data on numbers of clients is not captured. A PWD Integration Assessment was undertaken in 2021 to inform the development of a PWD Strategy. The strategy is not yet completed, but is intended to identify what can be provided in terms of complex requirements and clinic-friendly special needs services.

### Engagement with children and adolescents

- Progress on youth activities has been slow. SRHIP established the Youth and Adolescent Advisory Committee in Phase 1 and a youth needs assessment was undertaken in Phase 2 to inform planning. There is limited evidence of SRHIP taking practical steps to engage with young people.

### Gender transformative approach

- Capacity building in the gender transformative approach for health services was incomplete at the time of the evaluation.

## Outcome: Strong systems

**This section provides a description of SRHIPs contribution to the following project outcome:**

*Strengthened and harmonised systems for management, monitoring, and evaluation of high - performing (effective and efficient) projects and services.*

An overview of what has been achieved against the following program activities is provided, and the contribution to the program outcomes:

- Capacity building on health service management.
- Harmonising strategic direction and policies and procedures of CCHS with provincial and national health policies and procedures.

### Capacity building on health service management

SRHIP delivered a large amount of health management training on a wide range of topics for CCHS managers, diocese staff, and consortium and provincial partners. Topics covered monitoring and evaluation, finance, project management, health leadership, communications, and compliance. Apart from Anglicare PNG and *Igat Hope*, this training was well attended (see Table 4.2.1).<sup>32</sup> While participants indicated the training contributed to operational improvements, organising tasks and better data management, post-training assessments of the impact of training on participants' skills, knowledge, or behaviour were not undertaken.

<sup>32</sup> APNG had low involvement in SRHIP before leaving in 2019, and *Igat Hope* did not prioritise this training over other activities.

**Table 4.2.1 Capacity building for system strengthening indicators**

Indicator	Phase	Result/target	Achievement
Number of CCHS staff received training in project management.	Phase 1	10/10	100%
Number of CCHS, Anglicare and <i>Igat Hope</i> staff received technical support and training on M&E.	Phase 1	51/50 staff 8/6 workshops	102% 133%
Number of Anglicare and <i>Igat Hope</i> staff trained in project operations to ensure capacity to meet subcontract requirements in finance and data reporting.	Phase 1	3/10	30%
Number of CCHS Diocese M&E Officers who have attended Data Quality Master Training.	Phase 2	19/11	173%
Number of SRHIP facilities with staff trained in data quality by CCHS Diocese M&E Officers.	Phase 2	6/13	46%
Number of CCHS staff trained and supported to deliver robust project and finance management.	Phase 2	20/26	77%
Number of CCHS Health Managers trained in diocese health management.	Phase 2	30/11	273%

The co-facilitated NDOH NHIS Unit and SRHIP data management workshops were a stand-out success and were uniformly recognised by interviewees as invaluable. These improved the capability of SRHIP to report service outputs through the NHIS. It was a core concern of SRHIP that a parallel data system be avoided, and CCHS staff endeavoured to enter data into the NDOH HIV platforms – Surveillance 1, 2, and the HIV Patient Data Base (HPDB). During implementation, however, the HIV data systems were transitioning from a paper-based system to electronic online platforms. SURV 1 and 2 forms were also being revised, with a new layout and additional indicators to capture Triple Elimination data (HIV, Hep B, and Syphilis). ASHM facilitated the training with NDOH to improve data entry and reporting. After the training, SRHIP managers noted that monthly reports were submitted with fewer data gaps and delays. Training recipients reported that the training had contributed to their better understanding of how to use and extract information from the different platforms for service management purposes. These combined efforts have resulted in SRHIP being better aligned with the NDOH NHIS, and GoPNG is capturing all service data from SRHIP.

### **Harmonising strategic direction, policies, and procedures of CCHS with provincial and national health policies and procedures**

SRHIP endeavoured to harmonise with NDOH strategic directions through regular attendance at HIV Technical Working Group meetings. Table 4.2.2 outlines meetings with NDOH.

**Table 4.2.2 Harmonising strategies and policies indicators**

Indicator	Phase	Result/target	Achievement
Number of quarterly meetings with NDOH to brief on project strategy, workplan and TAG.	Phase 1	22/12	183%
Number of integrated CCHS and Anglicare clinics where current National HIV Guidelines (including test and treat) and National TB Guidelines are available and implemented.	Phase 1 Phase 2	24/24	100%
Number of integrated CCHS and Anglicare clinics procuring equipment, medication and resources through primary health mechanisms.	Phase 1	24/24	100%

Indicator	Phase	Result/target	Achievement
Number of nationally approved new innovative technological approaches to HIV and STI testing implemented throughout project period.	Phase 2	No target	2
Number of CCHS Strategic Planning 2021–2025 documents aligned with NHP 2021–2030.	Phase 2	2/3	66%

A key result from these meetings was that the strategic direction of CCHS is now fully aligned with the new *National Health Plan 2021–2030*. The 10-year strategic plan, monitoring and evaluation plan, and implementation framework, for CCHS all reflect the same timeline, vision, goals, mission, principles, values, objectives, and key result areas as the NHP.

ASHM represented SRHIP on the TWG and contributed to NDOH technical discussions and developments on strategies and policies. These included contributing to the new Three Test Algorithm (Syphilis, Hep B, and HIV), and worked with members on strengthening access to viral load testing sites, medical supplies, and ART medication for SRHIP clinics.

## Outcome: Strong services

**This section provides a description of the project’s contribution to the following project outcome:** *Strengthened integrated services providing high quality sexual health care.*

An overview of what the program has achieved against the following activities is provided, and their contribution to the program outcomes:

- Support integration of standalone HIV and SH services delivered by CCHS-managed primary health care facilities.
- Support implementation of referral pathways both within the CCHS network, between the CCHS network and external partners, and between stakeholders in the primary health care network.
- Training health workers in CCHS and primary health services to deliver high-quality HIV and SH services, counselling services, and outreach to key populations.
- Support the scaled delivery of high-quality HIV and SH services.

As reproductive services were not a focus of the SRHIP, scaling up and the effectiveness of services only applies to HIV and sexual health services. This is more fully outlined under ‘Scaled delivery of high-quality HIV and SH services’ further on in this section.

### Service integration

Positive progress has been made in integrating the services of 22 VCCT sites with CCHS primary health facilities.

The 2020 independent review of the PPF, which included a review of SRHIP Phase 1, recommended that SRHIP would benefit from clearer definitions on service integration and needed to develop a more formal and robust approach to integration.<sup>33</sup> In response, SRHIP developed 4 integration models using the WHO Integration Toolkit. These were upgrade, integrate, remain, or close. The 7 WHO criteria from this framework enabled SRHIP to assess and categorise the transition results in Phase 1 and identify sites requiring continued and sustained support going forward into Phase 2. The number of facilities receiving support in Phase 1 and 2 respectively is outlined in Table 4.2.3.

<sup>33</sup> Siegmann et al., 2020, *PPF Health grants review*.

*Everything is integrated now which means HIV/STI patients no longer feel afraid to visit the clinic. This is better than the standalone. It is more accessible now.* NCD clinician

This integration approach was a core achievement of SRHIP, as it provided a structured framework for integrating clinical services, assets, staff, administrative processes, patients, and confidential data.<sup>34</sup> By testing the model, SRHIP has lessons about absorptive capacity and how to sequence organisational change management. At the end of Phase 1, 18 VCCT sites had transitioned on an operational level, and 5 of those no longer needed donor funding. Phase 2 has continued to provide management, operational, and funding support to 13 sites, to support staff strengthening processes.

**Table 4.2.3 Integration status of SRHIP-supported CCHS clinics as at December 2021**

Integration model	Phase 1	Phase 2
<b>Model 1: UPGRADE</b> Standalone HIV clinic upgraded to a Level 2 or 3 health centre.	7	6
<b>Model 2: INTEGRATE</b> Standalone HIV clinic integrated with an existing Level 2, 3 or 4 Health Centre.	4	3
<b>Model 3: REMAIN</b> Standalone HIV clinic with funding from the diocese and/or GoPNG sources.	7	4
<b>Model 4: CLOSURE AND CLIENT TRANSFER</b> Close standalone HIV clinics, and transfer patients	4	0
<b>TOTAL CLINICS</b>	22	13

Health managers commented that dismantling standalone VCCT sites was a positive development in PNG, and SRHIP improved services for people who frequently avoid specialist VCCT sites for fear of being seen. Moreover, some patients confirmed that they avoid admitting to signs and symptoms of an STI or HIV in a regular (non-SRHIP) primary health clinic, because these often lack the requisite clinical skills or confidentiality.

More broadly, it appears the SRHIP approach to integration was not well understood by stakeholders. Interviews with other organisations reported they were unclear about the definitions of the different integration models. For example, Model 3 'remain' was understood as the VCCT site being physically separate ('standalone'). Within the SRHIP criteria, however, they are considered to be integrated because they are providing HIV/STI referrals. In the example of Rebiambul, in Mount Hagen, Western Highlands Province, 3 facilities are within walking distance – a primary health clinic, urban clinic, and ART facility. Prior to SRHIP they were not considered integrated, because their services, systems, and staff were not aligned. Now, after SRHIP, all 3 facilities rotate staff interchangeably, and patients are provided with a continuum of care that was not previously evident. Under SRHIP this is considered as 'integrated'.

Some of the activities and results supporting the integration agenda are outlined in Table 4.2.4.

<sup>34</sup> SRHIP Annual Report 2021.



**Table 4.2.4 Service integration indicators**

Indicator	Phase	Result/target	Achievement
SRH Integration Toolkit, approved by CCHS and Anglicare, is completed.	Phase 1	1/1	100%
HIV standalone facilities are functionally integrated and providing health services (staff competent in VCCT, PICT, prevention of parent to child transmission (PPTCT), HIV case management, reporting and HIV Patient Database).	Phase 1 Phase 2	18/22 13/13	40% In progress
Percentage of clinic sites providing HIV counselling and testing are maintained once services integrated.	Phase 1	100%/100%	100%
Percentage of clinic sites providing STI (syndromic) management are maintained or increased once services integrated.	Phase 1	100%/100%	100%
Percentage of integrated project facilities completing and submitting NHIS/SURV forms on time.	Phase 1	80%/75%	106%
Number of HIV standalone facilities assessed and provided with integration reports.	Phase 1	22/22	100%
Number of staff trained on differentiated models of integrated care.	Phase 1	18/10	180%

## Referral pathways

Referral pathways were a critical element of SRHIP, and performance was mixed.

Given that CCHS operates under Catholic doctrine, family planning and long-acting reversible methods (i.e. implants and IUDs) and short-term methods (i.e. Depo-Provera or combined oral contraceptive pill) are not offered or endorsed in CCHS clinics. For this reason, an SRH Referral Policy and procedures were included in the SRHIP design, and this was a target in the MEP, for Phase 1 and 2. In March 2018, CCHS developed a 'Referral Procedure for Reproductive Health', which included a guidance note, referral form and register to track and monitor referrals out of CCHS clinics for family planning. The protocol was never operationalised, however, as the SRH Referral Policy was not approved until July 2022. Interviewees indicated that verbal referrals were being provided to patients, but evidence of this was not available to the evaluation team.

Referrals for other services are embedded as standard clinical practice in CCHS and SRHIP clinics. Pathology services form the bulk of referrals including viral load and TB sputum tests. Specimens are collected in the clinics, or patients are referred directly to provincial hospital laboratories. In Madang, the Bethany Clinic refers HIV clients experiencing gender-based violence (GBV) to the CCHS safehouse at Alexishafen Health Centre. In NCD, SRHIP clinics (St Therese and St Paul) engage with World Vision (TB Community Provider program) to refer patients for ART or TB DOTS treatment, and follow-up, as required.

Table 4.2.5 presents SRHIPs performance on referrals for non-Catholic services. Referrals related to parish-based education sessions on marriage counselling and guidance, and to services such as family sexual violence units at provincial hospitals. Evidence of these occurring was not available at the time of the review.

**Table 4.2.5 Referral pathways indicators**

Indicator	Phase	Result/target	Achievement
Number of SRHIP facilities with established referral pathways to SRH services.	Phase 2	0/13	0%
Number of project facilities operating parish-based education sessions supporting referral pathways.	Phase 1	5/5	100%

### Health service delivery training

There was wide and positive feedback from interviews regarding the impact of training on HIV/STI clinical practice. Table 4.2.6 presents performance on training and professional development indicators. Clinician respondents identified that PICT training had enabled non-HIV staff in outpatient and primary health clinics to easily identify and refer suspected HIV cases for counselling and testing. Clinicians commented that the rate of testing had increased due to PICT training, but there was no quantitative evidence of the impact on frequency of services, or quality of care, as training indicators focused on outputs alone, such as number of people trained. Surveys and post-training assessments could have captured changes in knowledge, attitudes, or practices, which would have strengthened evidence to assess the effectiveness of these activities.

**Table 4.2.6 Health service delivery capacity building indicators**

Indicator	Phase	Result/target	Achievement
Number of HIV practitioners received Master Mentor training, and providing effective clinical mentoring to targeted facility health workers.	Phase 1	73/30	243%
Number of integrated facility staff received training and mentoring in HIV, STI and SRH clinical practice.	Phase 1	124/50	248%
	Phase 2	23/100	23%
Number of experienced health workers trained to provide clinical mentoring within workplace.	Phase 2	102/60	170%
Number of health workers trained as HIV prescribers.	Phase 2	56/30	186%
Number of HIV prescribers receive mobile based education on revised HIV guidelines.	Phase 2	10/10	100%

The output achievements in clinical mentoring and prescriber training exceeded targets and filled critical gaps in HIV health service provision by CCHS. By the end 2021, the SRHIP HIV Prescriber training resulted in 37 additional ART prescribers located across 13 primary health facilities. The SRHIP MEP did not provide quantitative data by facilities, which could have tracked number of people on ART within each facility, but this would need to be measured against other factors influencing ART uptake, such as quality of counselling, and personal or family support and resources to continue clinical appointments. However, it is possible that the additional HIV prescribers contributed to the high rate of ART uptake in SRHIP. Overall, SRHIP had an uptake rate of 83% of HIV-positive cases accepting ART (700/840)<sup>35</sup>, while the national average was 52%.<sup>36</sup>

### Scaled delivery of high-quality HIV and SH services

#### Scaled delivery

SRHIP has delivered a high volume of HIV/STI testing and treatment and has exceeded or is close to meeting its clinical targets. Output indicators across Phases 1 and 2 include:

<sup>35</sup> Numerator 700 = No. of people initiated on ART. Denominator = 840 No. of HIV positive. *SRHIP Annual Report 2019*.

<sup>36</sup> UNAIDS, 2017, *Country progress report – Papua New Guinea. Global AIDS monitoring 2017*.

- 13,563 people accessed treatment for STIs.
- 3,200 people were initiated on HIV treatment.
- 94,000 HIV tests through VCCT and PICT.

Other performance indicators are summarised in Table 4.2.7.

**Table 4.2.7 Delivery of high-quality HIV and SH services indicators (up to December 2021)**

Indicator	Phase	Result/target	Achievement
Number of people tested for HIV (VCCT).	Phase 1	53,219/52,486	105%
Number of people tested for HIV (PICT).	Phase 1	20,578/16,880	122%
Number of people tested positive to HIV.	Phase 1	2,607/2,342	111%
	Phase 2	2,576/2,342	73%
Number of VCCT and PICT tests conducted.	Phase 2	1,8865/25,970	73%
Number of people treated for STIs (syndromic STI management).	Phase 1	9,527/9,178	104%
	Phase 2	3,629/1,715	212%
Number of people newly initiated on ART.	Phase 1	2,546/2,226	114%
	Phase 2	743/810	92%
Number of people receiving ART at the end of the reporting period.	Phase 1	4,489/9,281	48%
	Phase 2	3591/4461	80%
Number of people retained on ART at 12 months post-initiation of treatment.	Phase 1	Reported 2019 only	65%
Number of SRHIP facilities with established Quality Improvement mechanisms.	Phase 2	10/13	77%

SRHIP service outputs indicate CCHS is providing effective HIV/STI clinical services and delivering on its contracted targets. ART adherence results in Phase 1 (48%) were low, but interviewees suggested this is due to under-reporting rather than poor performance, as SRHIP was unable to access data without NDOH consent and the NHIS transfer to the online platform prevented full access to data. To address and improve reporting on ART adherence, SRHIP collaborated with the NDOH and installed the HPDB in 3 sites at the end of Phase 1, and another 8 in Phase 2. This roll-out is continuing and has contributed to more accurate reporting of ART adherence in Phase 2 (80%). Assessments of overall performance of SRHIP clinics, compared to non-SRHIP clinics, were not undertaken by the evaluation team.

Establishing quality assurance mechanisms in facilities during Phase 2 was delayed, due to COVID-19 related disruptions and diminished staff capacity. Staff illness, absences, burnout, and commitment to COVID-19 protocols, consumed staff attention and reduced available time for planned SRHIP activities.

*This program has been a gamechanger for the type of service that they are able to provide at their facility. Previously, the facility was only providing VCCT services and after they got the clearance to do prescribing and others, they have improved their services. They have equipped the whole facility to be sensitive to the needs of the clients, to identify and test possible cases and provide the necessary counselling, etc. This program enabled them to be able to provide this level of service and that is appreciated. PHA Staff Member*

Scaled SRH services was a goal of SRHIP and is covered under section 4.1 Impact against national indicators. When considering the scaling of services using the SRHIP MEP, scale cannot be easily quantified for 3 key reasons. The number of facilities reporting data was not consistent across both

phases. Instead of collecting data from all 22 integration sites across both Phases 1 and 2, service data in Phase 2 was collected from 13 facilities only, which prevented the evaluation team from drawing conclusions about scale. Additionally, measuring scale could have been determined if referrals from HIV counselling and testing to reproductive services, such as ANC, FP, and PPTCT, had been included in the MEP. Increasing reproductive health services through PICT could have provided an alternative approach to measuring scale, but this could not be ascertained. Furthermore, there is a lack of disaggregated data in the MEP. Without annual data broken down into services by facility and age group, observations about service scale cannot be determined. Combined, these all masked the true scale and reach of services under SRHIP. Better MEP design and planning could have facilitated more analysis of progress and impact.

Importantly, there were scaling successes for some services within SRHIP, particularly HIV testing through PICT. From July to December 2019, 5,241 people received an HIV test through PICT, which represents a 78% increase on the baseline PICT tests for the same period in 2017 (2,938).<sup>37</sup>

### High-quality services

Established quality improvement mechanisms were not formalised in all clinics (refer to Table 4.2.7). SRHIP reports indicate that the interruptions due to COVID-19 over 2020 and 2021 hindered progress in this area. Stakeholders unanimously reported that CCHS provided high-quality services. Patients and clinicians alike commented that SRHIP had positively contributed to clinical practices, with improvements in service quality, counselling, diagnosis, and reach. Patient comments across multiple provinces noted the high work ethic, quality of care, and privacy they experienced at CCHS clinics. It was noted that some clients were attending SRHIP clinics from outside the clinic catchment to access the high-quality services and preferred to attend SRHIP clinics than non-SRHIP clinics closer to home. One client commented staff had 'gone an extra mile' to deliver her ART in person when she had missed a clinical appointment.

Several clients interviewed identified that they were encouraged to stay on treatment because their quality of life had improved. SRHIP counselling services, including couples counselling, have been seen as a positive differentiator of the CCHS clinics. The inclusion of counselling as well as testing and medication at primary health clinics has offered a holistic approach to managing HIV and SH.

*Her case where her husband is negative and she is positive would not have gone the same way had they gone to another facility. Through the counselling that they received, her husband was able to support her and they continue to live together and he is her treatment supporter. Client interview*

### Medical resources

Regular supply of ART and STI medical treatment and drugs, and access to viral load testing, were challenges across both phases. SRHIP endeavoured to improve these processes to ensure patients received consistent medical care, which is critical for PLHIV on ART, through the TWG. Diocese staff advocated at Area Medical Stores, at the subnational level. One success was Morobe PHA who had signed a Service Level Agreement with CCHS and have good relations with the CCHS Health Manager and diocese office. This enabled SRHIP to access medical and drug supplies and pathology testing. CCHS embedded viral load testing at two SRHIP sites (NCD and Mt Hagen) and all other clinics collected and sent specimens to Provincial Hospital Labs for analysis. Information on turn-around time for pathology results to adapt medication regimens was unavailable at the time of the evaluation.

<sup>37</sup> SRHIP Progress Report July to December 2019.

## Outcome: Strong partnerships

This section provides a description of the project's contribution to the following outcome: *Strengthened partnerships supporting a harmonised national and provincial HIV and sexual health response.*

An overview of what the program has achieved against the following activities is provided, and their contribution to the program outcomes:

- Build partnerships between CCHS services, PHAs and NDOH.
- NDOH and PHAs participate in governance of CCHS services.

SRHIP partnerships with GoPNG national and provincial partners was mostly strong, but there were some inconsistencies in critical areas, such as program advocacy with the NDOH, and SLAs with PHAs.

### Partnerships with Provincial Health Authorities

Only 2 PHAs had entered into formal agreements with CCHS – Morobe and Southern Highlands Provinces (see Table 4.2.8). Interviewees confirmed that establishing formal agreements with PHAs had been difficult, given differences in PHA readiness and motivation. Six provinces have informal agreements in place, but this approach was replaced in Phase 2, with SRHIP focusing on SLAs. Engaging PATH for more active assistance might enable greater progress with this indicator, but, notably, SRHIP interviewees reported that formal agreements are not necessarily a barrier to collaboration.

**Table 4.2.8 Partnership indicators up to December 2021**

Indicator	Phase	Result/target	Achievement
Number of SRHIP CCHS dioceses in defined agreements with PHAs.	Phase 1	2/5	40%

### Partnership with National Department of Health

At the national level, SRHIP engaged with GoPNG to strengthen discrete activities, including data systems, data entry, and reporting. This occurred through joint NHIS and HIV Prescriber training, Technical Working Group membership, and use of the NHIS and HIV reporting systems. CCHS is on the National AIDS Council (NAC) Steering Committee, but the NAC has yet to operationalise its work.

Engagement between SRHIP and NDOH on strategic programmatic issues has been non-existent. Interviews with NDOH indicated little knowledge of SRHIP, and NDOH was not included in SRHIP governance forums. While the HIV TWG has partner updates as a running item on the agenda, interviews indicated that these did not occur. This may be in part due to the TWG being more of a clinical and medical forum to resolve technical matters, competing priorities at NDOH, and CCHS prioritising frontline health work over external public relations. SRHIP stakeholders identified difficulty accessing senior members of NDOH, and multiple stakeholders asserted that government cooperation with SRHIP could benefit from further DFAT involvement, or strategic input from PATH. These entities have greater leverage than the SRHIP team to garner senior NDOH engagement.

### Partnerships with external health programs and services

While DFAT has several investments in HIV/STI and reproductive health – for example, the Partnering for Strong Families project (contraception and SRH), the UNICEF Saving Lives, Spreading Smiles project (maternal and newborn care), the World Vision TB/HIV program in NCD and Western Province, and the KPAC Community-Led Monitoring (CLM) program for HIV – multiple interviews confirmed that communication between these investments is missing. For example, CCHS staff had

not heard of the Community-Led Monitoring program, even though it is directly related to CCHS HIV outreach work. Multiple stakeholders commented that more communication and collaboration across programs would improve synergies, reduce duplication, and compound impact. Interviews indicated that PATH, as the overarching facility managing several DFAT investments for HIV/STI/SRH, could lead in this area, but has not to date.

## Outcome: Strong engagement

**This section provides a description of the project's contribution to the following outcome:**

*Strengthened engagement with community and key populations promoting universal access to quality HIV and sexual health services.*

An overview of what the program has achieved against the following activities is provided, and their contribution to the program outcomes:

- Build strong relationships with community and key populations.
- CCHS and primary health services provide high-quality health services to key populations.
- Build capacity of health services to implement gender transformative models of health care.

### Build strong relationships with community and key populations

At the time of the evaluation, SRHIP effectiveness in building strong relations with communities and key populations was still in the preparatory stage and had not demonstrated any measurable community traction.

#### Community engagement

In Phase 1 SRHIP commenced community engagement focusing on behaviour change messages, using word-of-mouth communication through clients, outreach, and the *Igat Hope* network. While this engagement has cultural and social merit, in that it is confidential and discreet, singular person-to-person communication will not facilitate a significant increase in service demand. Engagement could be strengthened by partnering with other community-based providers in the relevant provinces.

CCHS successfully delivered HIV/STI education sessions for women, girls and vulnerable groups, reaching 692% of its target. The scope and content of these activities, composition of the audiences, engagement mechanisms to reach audiences, and the extent to which gender and targeted messaging reached key people, was not known at the time of writing.

Table 4.2.9 below provides data on SRHIP performance against indicators for engaging with key populations.

**Table 4.2.9 Engaging key populations indicators up to December 2021**

Indicator	Phase	Result/target	Achievement
Number of women and girls including vulnerable groups attending SRH Education Sessions.	Phase 1	3,114/450	692%
Number of facility catchment communities of integrated CCHS and Anglicare clinics where SRH Behaviour Change Communication Toolkits are implemented.	Phase 1	5/5	100%
Number of peer counselling sessions conducted by EPCs using SRHIP SRH and HIV Counselling and Education Toolkit.	Phase 2	9,364/4,000	234%



Indicator	Phase	Result/target	Achievement
Number of SRHIP dioceses engaged with provincial key population networks.	Phase 2	0/11	0%
Number of SRHIP facilities with established key population friendly approaches (demand generation).	Phase 2	0/13	0%

### Engagement with diverse and key populations

Progress on disability inclusion has been slow. Clinic managers interviewed for this evaluation affirmed their clinics were providing HIV/STI services to people with special needs, but this was not witnessed. Disability service data was not included in the SRHIP MEP and is not captured through the NHIS. Moreover, SRHIP was not collecting it at the facility level either. To date, a needs assessment had been undertaken, but there was no evidence of SRHIP taking practical action to promote inclusion. The target to improve acceptability and accessibility of HIV and sexual health services for PWD at 5 facilities has not been met (0/5). SRHIP management was considering how to better meet the needs of PWD; for example exploring accessibility ramps, railings, and toilets, and clinical approaches for more client-centred services to balance patient confidentiality with guardian consent.

Nationally, partnerships with groups like KPAC, which represents the voices of key populations, and Callan Services, which provides services for PWD, are not established. Interviews indicated these groups are being approached by multiple DFAT grantees, and demand has overburdened their capacity to respond. While partnerships with national entities provide the opportunity for shared learning and strategic guidance, their capacity to respond is limited.

### Engagement with adolescents and young people

SRHIP has under-delivered on youth activities, with no facilities providing youth-tailored services at the time of this evaluation (0/10). SRHIP established the Youth and Adolescent Advisory Committee in Phase 1 and completed an adolescent youth assessment in Phase 2 to inform a strategic response. The assessment was undertaken in 3 areas: a rural area (Bereina, Central Province), an urban area (Gerehu, Port Moresby), and a peri-urban area (Mendi, Southern Highlands). The youth strategy, youth sensitisation training for staff, and practical steps to engage with youth, had not yet been delivered at the time of the evaluation.

SRHIP clinical data shows that testing and treatment of children represents a very small proportion of services. Children under 15 years accounted for 3% of people receiving HIV testing and 1% of people receiving HIV treatment. Both these had a relatively even split between boys and girls. Apart from static clinics, CCHS mobile clinics visit schools to access more young people, but not all schools welcomed these, and the total number of services during outreach was not recorded in the MEP. Tables 4.2.10 and 4.2.11 provide performance data on key inclusive activities.

**Table 4.2.10 Delivering services to key populations indicators**

Indicator	Phase	Result/target	Achievement
Operational Research Framework to evaluate integration process developed and approved by Ethics Committee.	Phase 1	1/1	100%
Operational Research completed.	Phase 1	½	50%
Brief Situational Analysis of CCHS and Anglicare HIV, STI, SRH and primary health services completed.	Phase 1	1/1	100%
Project Communications Strategy, detailing internal and external communication mechanisms, including	Phase 1	1/1	100%

Indicator	Phase	Result/target	Achievement
communication pathways with NDOH, Provincial Health, PPF and DFAT, is completed.			
Number of SRHIP facilities providing HIV and sexual health outreach services.	Phase 2	No data/13	Not known
Number of health workers trained to improve SRHIP service access for key populations (supply).	Phase 2	60/40	150%
Number of SRHIP facilities with adolescent and young adult (AYA) tailored service approaches.	Phase 2	0/10	0%
Number of SRHIP facilities with improved acceptability and accessibility of HIV and sexual health services for PWD.	Phase 2	0/5	0%

One of two operational research pieces was completed, but not sighted. This is covered in section 4.6 Operational Research and Monitoring.

### Addressing gaps in delivery to key populations

Apart from key populations covered above, another key group not covered in SRHIP is pregnant mothers. Interviewees highlighted the need for strengthening prevention of PPTCT. Clinicians and clients noted that integration with primary health care had improved access for HIV-positive mothers, but this was not captured in the MEP. This represents a significant area of need that could be addressed by CCHS. This is discussed in more detail below under Gender, in section 4.4

### Future directions

Implementation of an action plan to strengthen CCHS engagement with key populations is scheduled for 2022, but had not yet been developed at the time of this evaluation. It is recommended that future phases of the program deliver a more comprehensive approach to community engagement, with a particular focus on diverse groups.

### Deliver high-quality services for key populations

#### Feedback on quality of services

Interviewees provided mostly positive feedback about the welcoming tone of SRHIP clinics. Reports revealed that SRHIP delivers high-quality STI/HIV services to diverse populations and that SRHIP supports PWD, PLHIV, sex workers, MSM, and transgender people, although visibility of this was absent given there is no data collection of clients from these demographic groups. Staff interviews indicated that key populations are increasingly welcomed, and clients commented they felt treated with respect and in a professional manner. Other interviews observed that there was more acceptance of diverse populations in CCHS clinics over time, and sensitisation and awareness building with staff and the dioceses was progressing.

One interviewee noted that key populations sometimes felt uncomfortable or intimidated about presenting at a Catholic Church Health Service. They expressed that other key population clients preferred non-CCHS clinics (such as Anglicare), citing convenience of location, staff attitudes, and composition of staff. Non-CCHS clients were not interviewed to understand these issues in more depth, but this feedback indicates that continuity of inclusive approaches under SRHIP remains relevant.

### Women and girls

Monitoring data indicates that CCHS is reaching women. Women represent over 62% of the 94,000 people tested for HIV and 60% of the 3,200 HIV-positive clients. The SRHIP MEP, however, does not

capture gender by age, and so total number of women above and below 15 years is not evident. While women are accessing reproductive services in the CCHS primary health facilities, through antenatal and postnatal care clinics, fertility counselling, referrals for modern methods, and PPTCT, occasions of service for these are not captured in the MEP. The inclusion of, access to, and treatment for girls and adolescents has room for improvement in SRHIP. Further discussion about the SRHIP approach to gender is covered in section 4.4.

### **Accessibility for marginalised groups**

SRHIP does not capture quantitative data on marginalised groups, as this has been mostly a donor driven agenda, rather than a GoPNG requirement.<sup>38</sup> Moreover, in the case of MSM and FSW clients, they often do not wish to identify themselves as part of a marginalised group, due to stigma and shame.

The GoPNG NHIS database, which SRHIP uses, does not have functionality to collect data on marginalised groups, nor is it within the control of SRHIP to change this. SRHIP could collect data about indicators of marginalisation from clients, but this would require establishing a separate database, and would add complexity the service consultation time (to seek and report on personal, private information about sexual and gender orientation) and to M&E Officers' workloads. Data from other partners working in the SRHIP catchment could be captured, to provide some insights into the size/needs of key populations in the catchment.

### **Community outreach**

While community outreach services are a core element of SRHIP, the SRHIP reports did not provide data on outreach services. Reasons for this were unclear to the evaluators, especially as clinicians delivering outreach services indicated patrols had enabled access to more people. COVID-19 did impact on these services and as a result of this there were less outreach visits in Phase 2, due to travel restrictions and vaccination resistance. These challenges were in part overcome by including HIV/STI support in co-facilitated joint outreach clinics with partners such as FHI 360 (NCD).

### **Capacity building**

Capacity building to support engagement and service delivery for key populations made good progress, but lacked continuity and traction in follow-up activities.

A Behaviour Change Communication Toolkit was developed and introduced in Phase 1, specifically for key populations and newly diagnosed PLHIV. The toolkit was innovative and evidenced-based, and well-received by stakeholders. It takes a client-centred approach, rather than following the usual practice of peer counsellors sharing their story, and addresses gaps in counselling services and common misconceptions. Ten key topics were identified that could guide sessions and build health literacy, life skills, and positive health behaviours.<sup>39</sup> The topics are provided as prompt cards that the client can select, therein guiding the content of the counselling session. In 2019, 8 *Igat Hope* Expert Peer Counsellors were trained in its use. They commenced using it in 5 SRHIP facilities, in 2 provinces, and in catchment communities during group awareness sessions. The number of people attending sessions was not captured, so impact could be determined.

Another approach to capacity building for key populations was sensitisation training in 4 locations – Goroka, Mount Hagen, Port Moresby, and Morobe – for 20 key staff to deepen their understanding of inclusiveness. Following this training, staff were to develop action plans and engage local key

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<sup>38</sup> At the time of this evaluation, the NDOH was making changes to its data collection system to include PWD.

<sup>39</sup> Topics range from Introduction to HIV, Living with HIV, Treatment and Compliance, through to HIV and Pregnancy, and Human Rights.

population networks to improve reach into subgroups. At the time of this evaluation, engagement with local key population networks was lagging. Further progress on these activities was scheduled for 2022.

Interviewees noted that scaling up capacity building to improve service delivery approaches for key populations should be a focus for subsequent program investments.

**Table 4.2.11 Capacity building in delivering services to communities indicators**

Indicator	Phase	Result/target	Achievement
Learning and Development Plans completed for organisational capacity building with CCHS, APNG, and <i>Igat Hope</i> .	Phase 1	1/1	100%
Number of <i>Igat Hope</i> staff trained, supported and demonstrating improved organisational governance for project operations.	Phase 1	3/3	100%
Number of sustainability reports and funding submissions to NDOH, PHAs and other domestic funders completed and submitted by <i>Igat Hope</i> .	Phase 1	1/1	100%
Number of SRHIP staff received technical support and training on child protection, gender and inclusion, sub-grant management and other relevant policies.	Phase 1	No target	All CCHS staff (100%) trained in Child Protection
Number of <i>Igat Hope</i> expert counsellors recruited and trained in expert patient services that improve clinical pathways and care for PLHIV.	Phase 2	7/10	70%
Number of health workers trained in HIV Complex Case Management.	Phase 2	10/20	50%
Number of HIV Specialist Services established for HIV Complex Case Management.	Phase 2	1/1	100%

Training in Child Protection and Safeguarding (CP&S) was successfully delivered to all CCHS staff. No targets were set, as CP&S was a compulsory element of all training and staff onboarding.

### 4.3. Relevance and coherence

**This section responds to the following Key Evaluation Questions:**

**Relevance**

- How well does the intervention meet the needs of PNG, including those most vulnerable?

**Coherence**

- How well does the program align with NDOH, provincial, and other strategies and plans?
- How does this program align with and complement work elsewhere in the sector?

## Key findings

### Relevance

#### Relevance to PNG context

- SRHIP is relevant to the PNG context, as it responds to PNG's high rates of HIV and STIs and sought to progress integrated care for HIV and STI service delivery.

#### Relevance for key populations

- The program is relevant in terms of its focus on key populations, as they have significant unmet HIV/STI and reproductive health needs.
- The delivery of activities to improve engagement and services for PWD has had limited impact under SRHIP. Accessing and providing services for PWD is time-consuming, expensive, and complex. Service providers for PWD and service providers for HIV/STI services have differing approaches to patient confidentiality, sometimes diametrically opposed. Moreover, identification as a PWD is complex, with no single definition of what constitutes disability. These differences result in significant time and resources spent, with slow progress on outcomes.
- Donors might consider the provision of more resources to fund specific expertise and technical capability if the needs of PWD are to be comprehensively addressed.

### Coherence

#### Alignment with the Government of Papua New Guinea

- SRHIP aligns with the PNG *National Health Plan 2011–2020*, the *National STI and HIV Strategy 2018–2022*, and CCHS has updated its strategic plan in line with new *National Health Plan 2021–2030*.

#### Alignment with DFAT

- SRHIP aligns well with DFAT priorities in PNG. When first designed, it reflected the DFAT *Health and Development Strategy 2015–2020* and *Aid Investment Plan, PNG (2018)* (Objective 3). It is positioned with the DFAT *Health Portfolio Plan 2018–2023*, specifically Outcome 3. In terms of ongoing coherence, the program outcomes of SRHIP continue to align with those of DFAT, as one of multiple SRH/HIV/STI interventions included in the Health Security pillar of the *Australia–PNG Development Plan (2021)*.

#### Alignment with other stakeholders in the sector

- SRHIP engagement with other sector actors has been limited.

## Relevance

The design and approach of SRHIP is relevant to the PNG context, as it responds to PNG's high rates of STIs, mixed HIV epidemic, and service integration gaps for HIV and primary health (refer to section 2 and 3).

As a principal provider of primary health and HIV/STI services on behalf of GoPNG, SRHIP has successfully trialled 4 service integration models that embed or co-locate HIV/STI services in or around a single primary health clinic. This is particularly relevant given that the PNG health setting is experiencing deepening limitations around health resourcing and finances.

The SRHIP design is also relevant in its attempt to target the most vulnerable, especially women, adolescents, children, and sub-populations with HIV, although progress against some targets was slow. The key limitation of the current model under CCHS as a Catholic provider was the inability or unwillingness to offer or refer women to the full suite of SRH services, and specifically modern contraception.

The delivery of program activities intended to improve engagement with, and service delivery for, PWD is needed, but there are cost implications. Health activities intended to improve engagement and services for PWD are time-consuming, resource-intensive, and complex. Service providers for PWD and service providers for HIV/STI services have differing, and sometimes opposing, approaches to patient confidentiality. Clinical governance requirements for HIV/STIs require *confidential* client-centred approaches, while service providers for PWD require *non-confidential* approaches often requiring the involvement of third parties such as guardians, organisational approval, or sign language translators. Moreover, identification as a person with a disability is complex. Some people assert they have a disability when they need glasses, while others do not acknowledge their incapacity as a disability because they have learned to live with it, such as those with a physical impediment or partial blindness. These differences result in significant time and resources spent to align principles and approaches, and challenge the efficiency and effectiveness of universal health service grants. Combining services for universal health access with key populations, in a single grant, presents dilemmas that grantees struggle to manage. Specialised, and targeted grants should be explored by donors when seeking to improve health equity outcomes for PWD.

## Coherence

### Alignment with Government of PNG priorities

SRHIP is well aligned with key PNG NDOH policies and effectively contributing to national strategies. Across both phases, the SRHIP design followed the guiding principles of the *Papua New Guinea National STI and HIV Strategy 2018–2022*. These included progressing a public health approach, universal health coverage, respectful partnerships and aligning services with PNG systems. SRHIP also follows the broader NHP and is aligned with 5 of the 8 Key Result Areas. More recently, the new NHP directly informed the new *CCHS Strategic Plan 2021–2030* released in 2022 (refer to the section above, ‘Harmonising strategic direction, policies, and procedures of CCHS with provincial and national health policies and procedures’).

It also aligns with PNG *Health Sector Partnership Policy 2014*, specifically 3 of the 4 overarching objectives – strengthen health sector coordination and implement innovative and cost-effective health service options; expand partnerships with churches and NGOs; and expand the reach of quality health services through improved collaboration with relevant stakeholders. CCHS has updated its *Strategic Plan 2021–2030* in line with the new *National Health Plan 2021–2030*.

### Alignment with DFAT priorities

SRHIP aligns well with DFAT priorities in PNG. It is in-step with the DFAT *Health and Development Strategy 2015–2020* and *Aid Investment Plan, PNG (2018)* (Objective 3), and the *Health Portfolio Plan 2018–2023*, specifically Outcome 3. The HPP notes that,

‘Outcome [3] will support improving the quality and coverage of these services, in particular through ensuring they are better integrated (currently many HIV services are standalone) and



also firmly part of national primary health care... there is an urgent need to provide more integrated health care so that services... are readily and easily available.’<sup>40</sup>.

### Work elsewhere in the sector

SRHIP engagement with other sector actors has been limited. There is scope to strengthen collaboration and communication across various DFAT investments in HIV/STI and reproductive health. DFAT funds an array of projects for these services, however, communication between these investments is limited. The previous section ‘Outcome: Strong Partnerships’ (‘Partnerships with external health programs and services’) expands on this point.

## 4.4. Gender

### This section responds to the following Key Evaluation Questions:

- To what extent have gender and social inclusion principles been incorporated into the program?
- Are there any success stories in gender equality that can be highlighted?

### Key findings

- A key success of SRHIP was its high volume of women receiving services. From inception to December 2021, 94,000 people were tested for HIV, and of those 62% were women. Of the 3,200 people identified as HIV-positive, 60% were women. This is consistent with comparative population data in PNG, where 59% of PLHIV are women (15 years and older).<sup>41</sup>
- SRHIP recruited a Gender Equality, Disability and Social Inclusion (GEDSI) Focal Point and developed GEDSI guidelines and an activity plan, but progress on GEDSI-related activities was limited at the time of the evaluation.
- The formal SRH Referral Policy for women and girls to access reproductive services, such as modern family planning methods, was developed in Phase 1, but never operationalised as the policy was not approved until July 2022.<sup>42</sup>
- When viewing SRHIP in relation to the DFAT HPP 2018–2023, SRHIP presented a missed opportunity that could have enhanced the maternal health performance of DFAT, and the gender credentials of SRHIP. Interview participants confirmed that when DFAT approved the SRHIP proposal in 2017, it endorsed the Program Logic and MEP. These had a singular focus on HIV and sexual health service integration, workforce development, and systems strengthening. Had DFAT applied a wider maternal health lens, SRHIP could have been extended to include CCHS reproductive services, ANC clinics and ANC staff, especially as these were already available in CCHS clinics.

A key success of SRHIP was its high volume of women receiving services. From inception to December 2021, 94,000 people were tested for HIV, and of those 58,000 services (62%) were for women and girls. Of the 3,200 people identified as HIV-positive, the sex disaggregation was 60% female to 40% male, consistent with comparative population data in PNG, where 59% of PLHIV are women (15 years and older)<sup>43</sup>.

<sup>40</sup> DFAT PNG Health Sector Program July 2018–June 2023 (p. 48).

<sup>41</sup> Government of Papua New Guinea, 2021a, . *National Health Plan 2021–2030. Volume 1. Policies and strategies* (pp. 1–29).

<sup>42</sup> PNG Partnership Fund, 2020, *PPF Health Phase II. Design document*.

<sup>43</sup> Government of Papua New Guinea, 2021a, *National Health Plan 2021–2030. Volume 1. Policies and strategies*. (pp. 1–9).

Under SRHIP, CCHS recruited a GEDSI Focal Point and developed GEDSI guidelines and an activity plan. The evaluators are unable to comment on progress against GEDSI-related activities, as this information was not available at the time. The formal SRH Referral Policy for women and girls to access reproductive services, such as family planning, was developed in Phase 1. It was never operationalised, however, as the SRH Referral Policy was not approved until July 2022.<sup>44</sup> Systems to enable inclusive clinical approaches, such as the gender transformative approach, were delayed in part due to COVID-19 travel restrictions preventing participation of international consortium partners, and also limited capacity of local staff to progress SRHIP activities. These were scheduled for implementation in 2022. Success stories relating to gender equality in the program, while possibly experienced, were not identified by the evaluators.

When viewing SRHIP in relation to the DFAT HPP 2018–2023, it presented a missed opportunity that could have enhanced the maternal health performance of DFAT, and the gender credentials of SRHIP. Interview participants confirmed that when DFAT approved the SRHIP proposal in 2017 it endorsed the Program Logic and MEP that had a singular focus on HIV and sexual health services. Had DFAT applied a wider maternal health lens, SRHIP could have been extended to include CCHS reproductive services, ANC clinics and ANC staff, especially as these were already available in CCHS clinics. This would have facilitated a focus on PPTCT, ANC clinics, and HIV screening rates within these, and referrals for family planning, and could been included in the current SRHIP design. This is all the more important given that PPTCT is an area of immediate need, with only 1 in 4 ANC attendees receiving HIV screening.<sup>45</sup>

Moreover, the interface between HIV/STIs and SRH has been a long-awaited development in PNG. Within SRHIP, HIV patients can access basic reproductive health checks, and couples counselling with the possibility of a referral for modern contraceptives. In some clinics, full antenatal and postnatal care, supervised deliveries, TB assessments and referral, and PPTCT, are being provided, including in Rebiambil in Western Highlands Province, Veifa in Central Province, and Alexisshafen in Madang Province. It is unfortunate that this was not considered for inclusion at the stage of SRHIP design or during implementation. Annex 7.5 summarises the integration progress of SRHIP for all facilities across these services, in both phases.

The evaluation team recognises that these lessons learned are made in hindsight and presents this as an opportunity for subsequent investments. While current SRHIP reports do not have these occasions of service in the MEP, a retrospective analysis of these services, using the NHIS, could assess whether SRHIP increased reproductive services in CCHS clinics. This would also test whether SRHIP did contribute to maternal health outcomes.

## 4.5. Sustainability

**This section responds to the following Key Evaluation Questions:**

To what extent are the positive changes and effects of the investment sustainable after the grant ends, including:

- Is GoPNG through NDOH or the PHAs able to deliver, support, plan, budget or coordinate integrated HIV services?
- Was there any sign of community ownership and leadership?

<sup>44</sup> PNG Partnership Fund, 2020, *PPF Health Phase II. Design document*.

<sup>45</sup> UNAID. (2020). *Country Progress Report, PNG*.

## Key findings

### Resourcing sustainability

- The SRHIP consortium model offers an effective approach for PNG. A blend of local and international capability offers value and contributes to sustainability, but the combination of organisations and selection of expertise is critical if the partnerships are to be effective.

### National ownership over program outcomes

- National ownership over SRHIP outcomes and collaboration has been weak. Members of the consortium did not engage effectively with NDOH about the program. The TWG could be a vehicle for updates on SRHIP, but it operates mostly as a technical rather than a programmatic forum. Greater communication from DFAT could improve awareness of SRHIP, and other DFAT investments.

### Engagement with PHAs

- Engagement to lead and consolidate processes at the subnational level has remained limited due to lack of PHA readiness.

### Financial sustainability of health services

- By absorbing standalone HIV/STI services into primary health care facilities, SRHIP has provided a model that could increase financial efficiency. Of the 22 integrated clinics, 13 are still being supported, but 5 no longer require ongoing donor funding.

The prospect of sustainability for SRHIP is minimal. The GoPNG capacity to lead, guide and support SRHIP is limited at the national and provincial level, due to constraints in absorptive capacity and readiness. Furthermore, GoPNG has limited funds to resource essential health services, such as routine immunisation, let alone specific projects with strategic value, such as SRHIP.

## Resourcing sustainability

GoPNG health services remain heavily reliant on donor funding, and 76% of HIV programming is donor-funded.<sup>46</sup> This is unlikely to change. Continuing donor support to build on the developments of SRHIP is advisable.

The SRHIP consortium model was effective in that the large investment into training, both financial and time, resulted in technical assistance being transferred from ASHM to PNG personnel. As the project progressed, the PNG medical doctor for SRHIP increasingly assumed ownership and led clinical and medical training, mentoring, and technical advice. By December 2021, the PNG doctor was replacing the role provided by ASHM. This is significant in that it demonstrated SRHIP had transferred skills to the PNG leadership and had reduced reliance on an international partner.

The 2020 PPF review<sup>47</sup> identified that DFAT expectations of sustainability were different to those in the SRHIP design. Clarity in the expectations around government ownership and funding is

<sup>46</sup> PNG *National STI and HIV Strategy 2018–2022*.

<sup>47</sup> Siegmann, L., Larkin, M., Kulumbu, E., & Sweeney, D. (2020). *PPF health grants review*. HDMES for AHC.

encouraged, as this would embed future program design with a shared understanding about roles and responsibilities of implementation partners and GoPNG.

## **National ownership over program outcomes**

National ownership of SRHIP was weak. Apart from SRHIP-related technical issues, such as medical supplies and ART medication, NDOH interviews indicated it had limited knowledge of the project. Indeed, the HIV Unit Manager did not have oversight of project achievements or developments. Strategic support from DFAT, as a funder of key investments such as PATH, as well as from WHO and others, could improve this communication. CCHS could also engage with the NDOH Public Health Manager and the HIV Unit to share program updates and data from progress reports.

## **Engagement with PHAs**

While there was positive and solid collaboration with PHAs in some provinces, this was mostly around clinical and medical alignment rather than programmatic ownership. For example: the NCD CCHS clinics are fully integrated into the PHA system, with aligned data, drug supply, referrals, and reporting; in Sandaun, outreach clinics have been delivered in partnership with the PHA; in Eastern Highlands there has been collaborative planning and shared resources, and referral pathways; and in Morobe, CCHS has access to government viral testing services at ANGAU Hospital.

Only 2 PHAs had signed SLAs with SRHIP in the period from July 2017 to December 2022. Collaboration and coordination at the PHA governance level was largely absent, except in a few provinces. PHAs cited a lack of engagement by diocese offices, and vice versa. Competing and fluctuating priorities on the part of PHAs meant that the SRHIP team was not always in a position to influence engagement outcomes. Access to key executives and managers requires extensive time and commitment to progress system strengthening activities. Quarterly PHA Partnership Committees, as statutory requirement of PHAs, are a vehicle to improve program traction, and should include both diocese and CCHS attendees.

## **Financial sustainability of health services**

A financial assessment was not part of the evaluation scope, and without detailed financial information this evaluation has been unable to make assessments about the financial sustainability of SRHIP health services. In the absence of financial data, the combination of integrating VCCT sites into the established primary health facilities, as well as strengthening the capability of local organisations and improving technical capacity of staff, it would appear that financial gains would flow from SRHIP. These would be in the areas of combined HIV/STI and primary health workload, more effective use of assets, and combined outreach and mobile patrols. Transferring technical competence to PNG experts, engaged in the project, would also reduce the reliance on, and costs for, international assistance.

## 4.6. Efficiency

### This section responds to the following Key Evaluation Questions:

To what extent is the organisation model (e.g. funding, resource allocation, team structure, governance mechanisms) effective and efficient?

- How has adaptive management or continuous improvement occurred and contributed to cost-effective delivery?
- To what extent has the program used operational research and monitoring of progress and achievements for programming, learning, and accountability?
- How has the emergence of COVID-19 impacted implementation?

### Key Findings

#### Cost-effectiveness and efficiency

- SRHIP has trialled an innovative approach to integration, enabling other service providers to learn from the project's experiences. SRHIP has provided efficiency gains for clients and patients, through integrated services, but the cost versus impact of this investment cannot be determined, as financial data was unavailable to the evaluators.

#### Consortium structure

- SRHIP comprised a good mix of partners, with local and international expertise that covered most, but not all, of the broader project needs. As the lead, CCHS delivered solid grant and project management, but lacked focus to adequately address GEDSI activities. The international partners provided technical assistance throughout the project and adapted to online working arrangements resulting from the COVID 19 pandemic. *Igat Hope* brought learned experience around key populations, through its Expert Peer Counsellor network, but greater organisational capability is required if their value is to be harnessed.

#### Governance mechanisms

- The establishment in 2017 of the internal Project Management Group and Technical Advisory Group provided the partnership with administrative and technical cohesion early in the grant. This strengthened the management position of CCHS to drive leadership and project management training, financial and progress reports, and governance and compliance activities.
- Engagement between the national CCHS head office and diocese offices was inconsistent, due to COVID-19 related lockdowns, but was otherwise strong.

#### Adaptive management

- Adaptive management was evident in the relationship between SRHIP and PPF, but not PATH.
- SRHIP engaged in internal reflection workshops, at key programmatic junctures, such as between Phase 1 and 2, but there was limited evidence of regular, evidence-based reflection, learning, and decision-making.

#### Operational research and monitoring

- **Operational Research:** One of the two operational research activities was completed.

- **Theory of Change:** Both Phase 1 and 2 Theory of Change designs were developed by ASHM in consultation with consortium members, but these lacked technical rigour and did not clearly articulate the causal pathways of SRHIP.
- **Monitoring and Evaluation Plan:** The SRHIP MEP focused mostly on aggregated data around inputs and outputs, and prioritised GoPNG NHIS indicators to align with national health service indicators. This, however, did not support meaningful data collection, reporting, learning and adaptation, in line with DFAT standards.
- **Learning and Adaptive Management:** Evidence-based decision-making was a core agenda item of SRHIP PMG and TAG meetings. Beyond this it was unclear whether key managers were engaged in regular, formal reflection of M&E data.
- **Reporting:** Reporting compares 6-monthly and annual targets, making interpretation of cumulative program results difficult. The emphasis in reports reflected the focus on working to activities and targets in the MEP, rather than drawing on data to consider and interrogate the project's performance against the outcomes.

### Impact of COVID-19 pandemic

- SRHIP was impacted by COVID-19, resulting in loss of momentum and delays in critical areas such as training and inclusiveness activities for key populations, youth, and gender. COVID-19 impacted SRHIP reporting, as staff were unable to access necessary data for reports. Health service targets were compromised, as frontline health workers juggled newly-introduced COVID-19 protocols and the fallout of frontline health work during a pandemic. Travel restrictions prevented the international technical advisers from making scheduled country trips.

## Cost-effectiveness and efficiency

SRHIP trialed a new and innovative approach to integration, which has provided lessons from which other service providers and implementation partners could learn. The development of the 4 integration models (refer to Table 4.2.3) in Phase 2 has provided SRHIP with experiences that should be shared with NDOH, PHAs, implementation partners and donors, many of whom are seeking to move away from siloed health services to integrated models of care. Integration is likely to result in efficiency gains; for example: closing VCCT sites with low numbers of ART clients and transferring patients to aligned but better-performing facilities (NCD, Milne Bay, Madang, and Western Province); or integrating VCCT services with primary health services and preparing staff to deliver more services with better technical, M&E, and administrative training, mentoring and support. In the absence of financial information, the evaluation team are unable to conclusively quantify the financial benefits of integration.

## Consortium structure

SRHIP comprised a relevant mix of partners, garnering local and international expertise well-suited to most of the needs of the program. Consortium members covered most areas of the program, including clinical and medical technical assistance, grant and project management, and knowledge on system strengthening and inclusiveness. Three key areas missing from the consortium were monitoring and evaluation (resulting in SRHIP unable to report on its complete impact, as outlined later in this section), communication and external engagement (resulting in poor engagement by SRHIP with NDOH on project development), and gender (resulting in critical oversights outlined in section 4.4 above).



CCHS has been a strong performer within the SRHIP grant, but needs to expand its focus and capacity to strengthen approaches to inclusiveness for young people, MSM, FSWs, and PWD. The delay around the SRH Referral Policy and protocol provides pertinent learning for future investments that include activities not aligned to Catholic principles. Ensuring the inclusion of a non-Catholic service provider to supplement services provides a possible solution.

ASHM led on medical and clinical assistance and took a consistent frontline role in providing technical assistance. ASHM also enabled much of the clinical training modules, including Complex HIV Case Management, Master and Clinical Mentor, HIV Prescriber and Quality Improvement, and Gender Transformative Approach pilot training. ASHM provided technical leadership on M&E, developing the Program Logic, Theory of Change, and MEPS. In addition, they provided ongoing guidance and support on monitoring, data quality and reporting, for reporting purposes. Limitations in the MEP could have been addressed with a peer review from an M&E provider, external to SRHIP.

Burnet Institute provided niche products for SRHIP and led technical direction for integration and inclusiveness. BI developed the Integration Framework and Models in collaboration with consortium partners (refer to Table 4.2.3), as well as the Behaviour Change Communication Toolkit. The strength of the toolkit was mentioned by stakeholders and *Igat Hope* Expert Peer Counsellors as having improved ART adherence. BI completed the first operational research output and drafted the CCHS National Strategy aligning CCHS with the NHP. They also provided training on inclusiveness, specifically Expert Patient Counselling, Adolescent and Youth Services, Key Populations workshops, and Train the Trainer for the HIV Peer Counselling Toolkit.

*Igat Hope* brought strong learned experience around key populations, through its Expert Peer Counsellor network, but had limited input as they only operated in and around 5 facilities. Greater organisational capability is required if their value is to be harnessed.

More broadly, the consortium model adopted by SRHIP offers an effective approach for PNG. Blending local entities with international expertise provides technical value and contributes to sustainability outcomes. However, the combination of organisations and selection of expertise is critical. Local entities need to have strong governance and administrative systems, deep technical content, and skill in delivering programs for donor-funded grants. Using GoPNG-funded organisations, such as CCHS, has merit, in that it contributes to local organisations' development and in-country capability. When local expertise is unavailable, the international component is paramount, but requires a combination of strong technical and development credentials, understanding of PNG health systems, cross-cultural proficiency, and personnel who are flexible and adaptable to the needs of PNG.

## **Governance mechanisms**

The establishment by SRHIP of an internal PMG and TAG in 2017 provided strong partnership and technical cohesion early in the grant. Throughout Phase 1 and 2, this strengthened the leadership position and management capability of CCHS as it drove financial and progress reporting on governance and compliance measures.

Engagement between the national CCHS head office and diocese offices was sometimes challenging, with COVID-19 related competing priorities causing delays. With full travel arrangements now in place, and post-COVID-19, provincial visits have resumed strengthening communication and engagement.

## Adaptive management

As the grant manager of SRHIP, PATH's management has opportunities to improve. Under PPF, the grant manager with SRHIP carried out quarterly field trips and biannual reflection workshops that were considered extremely useful. These ceased at the start of PATH and, up to the time of the evaluation, there has been no cross-program collaboration between SRHIP and wider PATH structures. This could have improved performance in areas of mutual interest, such as GEDSI, PHA engagement, and MEP design and reporting. Focusing PATH staff and resources to support SRHIP would improve project understanding and strategic collaboration.

Apart from one reflection workshop at the end of Phase 1, and regular PMG and TAG meetings, internal reflection workshops for all CCHS head office staff did not occur as consistently as some deemed necessary. Interviews indicated that, while there were regular operational meetings, multiple training, and frequent informal discussions, reflection activities were infrequent. At the field level, regular visits to provinces occurred in Phase 1, which enabled joint supervisory visits specifically aimed at adaptive management. During the COVID-19 lockdowns, however, these ceased, which interrupted management support to diocese offices. These were resuming at the time of the evaluation.

## Operational research and monitoring

**Operational research:** One of the two operational research activities was completed, but was not available to the evaluation team. Comments indicated it covered the integration process and provided case studies for 4 sites, but it was unclear if it had been used for wider reflection. Information and learning from this work should be shared to inform wider discussions about integrated models of care.

**Theory of Change:** The Phase 1 Theory of Change underwent adaptations based on informal learning during implementation. The Phase 2 Theory of Change was further refined following the independent PPF program review. Both were developed by ASHM in consultation with consortium members and approved by PATH, but lacked technical rigour. The designs had an unbalanced approach to outcome indicators; for example, the strengthening partnerships outcome only had one indicator while other outcomes had substantially more. Outcomes and outputs often crossed over, and some activities were described as outcomes, and vice versa. Collectively, these did not clearly articulate the causal pathways of SRHIP.

**Monitoring and Evaluation Plan:** The SRHIP MEP focused mostly on aggregated data around inputs and outputs, and prioritised GoPNG NHIS indicators to align with national health service indicators. This, however, did not support meaningful data collection, reporting, learning and adaptation, in line with DFAT standards. Instead, it limited the ability of SRHIP to fully assess the effectiveness of the investment. For example, without including age categories for women, SRHIP could not efficiently consider the impact of its services on youth; without disaggregating services by facility and year, SRHIP could not measure the efficacy and impact of training; by only following 13 sites in Phase 2, rather than all 22 sites across both phases, the MEP diminished the ability of SRHIP to measure the full impact of integration and measure overall progress on outcomes.

**Learning and adaptive management:** Evidence-based decision-making was a core agenda item of SRHIP PMG and TAG meetings. Beyond this, however, it was unclear whether key managers were engaged in reflection of M&E data. Some interviews indicated this was an area of need and would have contributed to more learning and development.

**Reporting:** Reporting compared 6-monthly and annual targets, making interpretation of cumulative program results difficult. Moreover, the emphasis in reports reflects the focus on working to activities and targets in the MEP, rather than drawing on data to consider and interrogate the project's performance against the outcomes. The data framework could be more clearly structured to identify targets and achievements for a reporting period, as well as cumulative program results.

These monitoring and evaluation issues could be addressed by workshopping the program with PATH and SRHIP, if a subsequent phase is envisaged. Furthermore, strengthening the logic of the Theory of Change, and including rigorous peer review, would improve its utility as a management tool, to inform decision-making, strategy, and contribute to a shared vision across multiple partners.

## Impact of COVID-19 pandemic

SRHIP was impacted by COVID-19, resulting in critical delays around project performance, especially on inclusiveness activities for key populations, youth, and gender. COVID-19 also impacted on SRHIP reporting, as staff were unable to engage with the NDOH officials due to absences and conflicting priorities, limiting access to necessary data for SRHIP reports. Health service targets were compromised as frontline health workers juggled newly-introduced COVID-19 protocols, illness, sick leave, burnout, and community resistance against health workers due to COVID-19 vaccine hesitancy. The impact of travel restrictions prevented international technical advisers from making scheduled country trips. All of these factors resulted in interrupted project momentum and team cohesion.

In response to these pressures, the consortium pivoted to respond to programmatic and clinical adaptations, to address COVID-19 related requirements. Online platforms were used as much as possible, and ASHM led a WhatsApp group forum. This enabled immediate, two-way communication between staff and the consortium leadership, to address frontline service needs (for example, personal protective equipment (PPE) and COVID-19 triaging protocols), or receive guidance on how to respond to widespread community misinformation (such as on the COVID-19 vaccine). The focus on pivoting unfortunately resulted in diverting management attention, time, and resources away from SRHIP, and affected project momentum.

Data on the responsiveness of SRHIP to the COVID-19 crisis is outlined in Table 4.6.1

**Table 4.6.1 COVID-19 indicators**

Indicator	Phase	Result/target	Achievement
Number of health workers reached directly with information and support on COVID-19, universal precautions, continuation of HIV and sexual health services and stigma and discrimination.	Phase 1	47/50	94%
Number of SRHIP health workers reached indirectly with support on HIV, sexual health and COVID-19.	Phase 1	138+/200	70%
Number of SRHIP health workers reached with information and support during COVID-19 <sup>48</sup> (2021).	Phase 2	107/100	107%
Number of CCHS facilities with established COVID-19 Safety Facility Plans <sup>49</sup> (2021).	Phase 2	8/13	62%
Number of COVID-19 IEC materials developed <sup>50</sup> (2021).	Phase 2	8/8	100%

<sup>48</sup> New indicator in January 2021.

<sup>49</sup> New indicator in January 2021.

<sup>50</sup> New indicator in January 2021.

SRHIP received an additional AUD490,734 in DFAT funding to support the COVID-19 vaccine roll-out for the period February to December 2022. COVID-19 vaccine support activities generally included technical assistance on planning, staff vaccinations, vaccine delivery, transport and logistics, cold chain, data management, vaccine safety, communications, and demand generation.

## 5. Conclusion and recommendations

### 5.1. Conclusion

On balance, this evaluation finds that SRHIP has made progress on the Phase 2 stated goal and has scaled up integrated quality HIV and sexual health services at identified CCHS facilities. While not all outcomes were achieved in full, from inception to December 2021, the consortium made more progress on Outcomes 1 and 2, mixed progress on Outcome 3, and minimal progress on Outcome 4.

Given CCHS experience with DFAT grants, it performed strongly in upholding donor requirements and pivoted well to embed GoPNG strategies, policies, and COVID-19 requirements in executive and program operations. With complementary support from ASHM, and given the core business of CCHS as a service provider, SRHIP upscaled quality services delivering more complete HIV and SH care. SRHIP made headway on technical and clinical activities, but struggled with activities beyond these, such as external relations and communications. These were areas of weakness not within the consortium mix. Inclusiveness was the slowest performing area for SRHIP, even though the Behaviour Change Communication Toolkit was groundbreaking. SRHIP failed to address barriers for youth, sex workers, men who have sex with men, transgender individuals and people with disabilities, as it underestimated the time and effort needed to cascade the toolkit, upskill health staff, and build key population networks. Had SRHIP commenced this outcome earlier, more progress would have been made.

A key lesson from this evaluation was the lost opportunity to include reproductive health in the design, which would have provided greater value for money, compounded health impacts, and improved the gender credentials and maternal outcomes of SRHIP.

The ambitiousness of SRHIP and the complexity of implementing integrated primary health services in PNG, to donor timelines, means there is still more to be done. This review recommends that HIV and STI interventions are continued to be funded. Projects with a quality and evidence-based focus should be resourced, especially those that apply structured approaches to working with and through PNG organisations and GoPNG systems. Where necessary, international expertise or organisational capacity to partner with local organisations should be embraced, to strengthen rather than substitute gaps in local capacity. Continuing inclusive activities and mainstreaming access for marginal and key populations is strongly recommended. Engaging local organisations with expertise in this area, such as *Igat Hope*, would be advantageous, but smaller organisations often need significant administrative and management strengthening if they are to operate at scale. Incorporating targeted approaches for men, women, as well as youth, transgender individuals, and other key population subgroups, is necessary if better sexual health outcomes are to be achieved. More effective communication with NDOH is critical and relationship management should be led by DFAT, as part of its donor and GoPNG advocacy activities. Finally, third parties should be engaged for rigorous analysis of project proposals, Theory of Change, and Monitoring and Evaluation Plans. This should be done at the outset and throughout the implementation period to ensure stronger adherence to donor requirements and program aspirations.

## 5.2. Recommendations

The following recommendations have been developed to strengthen the SRHIP investment.

**Recommendations 1 to 3 are proposed for action during the remainder of Phase 2, and to be actioned by SRHIP.**

### Recommendation 1

The SRHIP consortium continue to finalise integration activities and deliver on committed targets. Specific activities could include:

- Progress the final 5 CCHS facilities (located in Eastern Highlands, Madang, West Sepik, and Morobe<sup>51</sup>) as planned, and complete integration and referral systems, to fully realise HIV/STI and primary health integration.
- Collaborate with NDOH on health information data systems to transfer the remaining facilities using the old health information system to the new NDOH health information system.
- Consider options to preserve the high standard of HIV/STI staff clinical skills established under Phase 1 and 2, such as refresher training.
- Through qualitative assessments, such as surveys, measure the impact of training and capacity building on operations and clinical work practices.
- Where possible, and within the timeframe, revise the use and focus of PHA SLAs to include shared learning and best practice, subnational coordination, data management, training, and referral pathways, to improve the sustainability of integration efforts.
- Undertake a systematic learning and reflection review to ensure lessons learned are captured, and adaptations made where possible in the time remaining, and to inform Phase 3.

### Recommendation 2

Progress formalising engagement partnerships with key population and vulnerable groups, to guide inclusive counselling and operational tools and practices. Specific activities could include:

- Formalise agreements with KPAC and Callan Services, and collaboratively coordinate on:
  - Local key population networks.
  - Identification and incorporation of diverse approaches in clinical and counselling practices.
  - Development of a Disability Action Plan based on the PWD integration needs assessment.
- Approve and roll out the SRH Referral Policy and gender transformative approach.
- In conjunction with the Youth Advisory Committee, roll out the Adolescent and Young Adult Action Plan.
- Investigate options to reduce ‘loss to follow up’ for patients on treatment plans.

### Recommendation 3

Continue to strengthen engagement with community groups to increase SRH awareness, reduce stigma, and increase access to services. Specific activities could include:

- Include HIV/STI expertise in all outreach units to strengthen access to specialist care, while providing services in remote, peri-urban, or rural locations.

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<sup>51</sup> As described in the *SRHIP Annual Report 2021*.

- In collaboration with PATH and DFAT, identify stakeholders working with communities and seek out opportunities where outreach impacts can be increased; for example, with the multilaterally-funded USAID CLM project.
- Leverage *Igat Hope's* existing peer-to-peer national network to increase the uptake of HIV/STI testing and treatment. This is a synergistic opportunity that would extend the impact of SRHIP and the PLHIV informal and extensive national network of *Igat Hope*.

**Recommendations 4 and 5 are proposed for a SRHIP Phase 3 design and implementation, and are to be actioned by PATH or DFAT.**

#### **Recommendation 4**

DFAT and PATH frame the scope of a Phase 3 to incorporate learning from SRHIP Phase 1 and 2, in conjunction with developments in national and subnational responses since 2020 to HIV/STI and reproductive health. Specific activities suggested are:

- DFAT, through PATH or HDMES, to uses the 2022 Global Fund disease burden survey and USAID CLM mapping to identify where future SRH needs exist, against current government and non-government responses and investments.
- DFAT, with PATH and implementing partners, agree on the definition, scope, and terms of 'integration' required with NDOH, PHAs, stakeholders and communities, to establish clear expectations in subsequent grant designs.
- DFAT, through PATH or HDMES, rigorously assesses the quality of proposal documentation for Phase 3, and critically review the Theory of Change and approach to MEL and reporting. Following SRHIP Phase 3 contracting, the Theory of Change, MEL system and reporting be updated as required, and DFAT to provide oversight to ensure ongoing quality and relevance.
- DFAT and PATH develop streamlined mechanisms for engagement of KPAC and Callan Services to ensure multiple program designs and implementation do not burden smaller PNG NGOs.
- Within the SRHIP Phase 3 scope, DFAT and PATH retain but calibrate expectations of service delivery organisations' capability to progress inclusion activities with diverse populations such as PWD, sex workers, and other marginalised groups.

#### **Recommendation 5**

PATH to actively support and collaborate with grantees under the Frontline Health Outcomes workstream, and SRHIP, on mutual implementation and governance activities. Specific activities include:

- PATH includes DFAT, NDOH, and PHAs in quarterly governance reflection workshops.
- PATH coordinates and cooperates with all sub-grantee partners, including SRHIP implementers, ensuring complementary facilitation on mutual program activities and shared compliance requirements (e.g. safeguarding, GEDSI, and preventing sexual exploitation, abuse and harassment).
- PATH reintroduces joint field trips to SRHIP sites, inclusive of DFAT and NDOH attendance, to improve understanding of grantee projects, facilitate strategic and adaptive learning, and support validation of results.
- PATH, with DFAT and NDOH, facilitates best practice workshops or reflection forums across providers to share and roll out SRHIP CCHS successes, such as the Behaviour Change Communication Toolkit.



- PATH supports increased coherence and cooperation between DFAT-funded PATH sub-grantees inclusive of SRHIP, to optimise synergy and effectiveness when working with PHAs and other subnational partners (e.g. accessing local key population networks).

**Recommendation 6 is proposed for future DFAT programming in HIV/STI/SRH and family planning in PNG, and is to be actioned by DFAT**

**Recommendation 6**

In national and subnational forums, and in collaboration with other donors and program implementers, DFAT continues to communicate about existing and new project investments in HIV/STI and SRH to enhance coordination and coherence across donors and with NDOH and PHAs. Specific activities include:

- DFAT considers options for how to best support NDOH to strengthen donor coordination.
- DFAT to continue to strengthen relations with NDOH lead managers, to improve engagement on and ownership of DFAT investments in HIV/STI and SRH.
- DFAT shares with NDOH, and other donors, evaluation learning to assist evidence-based decision-making for current and future investments, enhancing alignment and reducing duplication.

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## 7. Annexes

### 7.1. SRHIP Theory of Change – Phase 1 and 2

Table 7.1.1 Theory of Change Phase 1

End of Project Outcomes	Immediate or Intermediate Outcomes	Key Outputs	Theory of Change	Assumptions	Risks (Risk Register Code)
<p><b>EOPO1:</b> Strengthened systems for delivery of quality, scaled SRH services through integration with primary health at CCHS &amp; Anglicare facilities</p>	<p><b>IO1:</b> <b>Effective, sustainable systems enhance integration and scale up of HIV, STI and SRH services</b></p>	<p><b>O1.1:</b> <i>CCHS &amp; Anglicare institutional systems and governance support integration and scale up</i></p> <ul style="list-style-type: none"> <li>• Functional National Integration Team</li> <li>• Approved CCHS &amp; Anglicare SRH Integration Strategies</li> <li>• Operational Research Framework &amp; Reports</li> <li>• CCHS staff trained in project management, including sub-grant management, resulting in submission of quality finance, data and project reports on time</li> <li>• Anglicare &amp; Igat Hope staff trained in project operations resulting in submission of quality</li> </ul>	<p>The SRHIP is guided by international evidence supporting mainstreaming of HIV services into SRH and primary health, to promote universal access to prevention, testing, treatment and management<sup>52</sup>. The project is focussed on integration of HIV &amp; SRH services to better meet the complex and diverse sexual health needs of women, girls and vulnerable groups<sup>53</sup>. Integrating HIV and SRH services been proven to:</p> <ul style="list-style-type: none"> <li>• Increase the uptake of health services</li> <li>• Increase the range of services available</li> <li>• Improve the quality of services and efficient use of resources</li> <li>• Enable health systems to respond to client needs and improve overall client satisfaction<sup>54</sup>.</li> </ul> <p>Changes to the funding environment, along with advances in treatment and</p>	<ul style="list-style-type: none"> <li>• That a structured approach to integration of HIV &amp; SRH services into primary health mechanisms achieves efficiencies in workloads and systems within PNG context</li> <li>• That CCHS, Anglicare and consortia partners collaborate effectively and efficiently to support establishment and function of the National Integration Team and the integration process</li> <li>• That integrated HIV, STI &amp; SRH services under SRHIP demonstrate efficiencies in economy</li> </ul>	<ul style="list-style-type: none"> <li>• National Election during June-July 2017 creates disruptions to project operations and travel with potential impact on delaying project progress (P1)</li> <li>• Recruitment and retention of appropriate project personnel delays implementation and project progress (HR1)</li> <li>• Challenges in alignment of CCHS &amp; Anglicare national and dioceses strategies delays approval and rollout of the SRH Integration Strategy</li> </ul>

<sup>52</sup> Leach-Lemens. (2013). Integration of HIV care into primary care reduces deaths in South African trial. Available at <http://www.aidsmap.com/Integration-of-HIV-care-into-primary-care-reduces-deaths-in-South-African-trial/page/2749811>.

<sup>53</sup> IPPF. (2014). Improving SRH and HIV Integration is key for delivering new multipurpose prevention technologies. Available at <http://www.ippf.org/blogs/improving-srh-and-hiv-integration-key-delivering-new-multipurpose-prevention-technologies>.

<sup>54</sup> IPPF, LSH&TM, Population Council & Gates Foundation. (2014). Integration Initiatives: Strengthening the evidence base & good practice for linking HIV and SRHR. Available at <http://www.integrainitiative.org/projects/integrainitiative/overview-and-objectives>.

End of Project Outcomes	Immediate or Intermediate Outcomes	Key Outputs	Theory of Change	Assumptions	Risks (Risk Register Code)
		<p>finance, data and project reports on time</p> <ul style="list-style-type: none"> <li>SRHIP demonstrates full contract compliance</li> <li>CCHS &amp; Anglicare staff trained in health system and service strengthening resulting in organisational facilities demonstrating strengthened systems for integration</li> <li>CCHS &amp; Anglicare SRH Sustainability Model Reports</li> </ul> <p><u>Q1.2:</u> <i>Processes and mechanisms designed for integration and scale up</i></p> <ul style="list-style-type: none"> <li>Situational (Baseline) Analysis Reports</li> <li>SRH Integration Model &amp; Toolkit</li> </ul> <p><u>Q1.3:</u> <i>CCHS &amp; Anglicare align with national health systems including data reporting (NHIS &amp; eNHIS)</i></p> <ul style="list-style-type: none"> <li>Functional CCHS &amp; Anglicare data systems support national data reporting</li> <li>Project Communications Strategy</li> </ul>	<p>technology, demand innovative approaches to continued delivery of essential SRH services. The SRHIP will ensure continued and responsive provision of HIV and STI services to CCHS and Anglicare patients without duplicating national health mechanisms, whilst strategically addressing integration, sustainability and scale-up of quality SRH services within primary health care. The project aims to deliver a stronger continuum for SRH that is responsive to patient needs.</p> <p>SRHIP will address:</p> <ul style="list-style-type: none"> <li><b>Institutional Integration</b> – ensuring CCHS and Anglicare Health &amp; HIV strategies are consistent across national and diocese operations</li> <li><b>Service Integration</b> – ensuring that HIV, STI, SRH and primary health facilities and workforce are trained and supported throughout the integration process</li> <li><b>Project Integration</b> – ensuring all projects are integrated within services</li> <li><b>Sector Integration</b> – ensuring CCHS and Anglicare services are aligned with NDoH, recognised within the national health system and reporting data through national data pathways (NHIS, eNHIS).</li> </ul> <p>The systematic approach of the project aims to maximise efficiencies across integrated services, an area that</p>	<p>and scale that enable development of a sustainable model for exploration of domestic and broader funding options, as required.</p>	<p>within organisational facilities (T1)</p> <ul style="list-style-type: none"> <li>Organisational capacity at consortia partners to fulfil project requirements results in delays of performance based funding (O1)</li> <li>SRHIP operations or project integration outcomes affected by changes in national funding, including funding reductions or capping of primary health budget envelopes (P2)</li> <li>Security and natural disaster risks relevant to project and context, impacts on SRHIP operations and travel with potential delay in project progress (P4).</li> </ul>

End of Project Outcomes	Immediate or Intermediate Outcomes	Key Outputs	Theory of Change	Assumptions	Risks (Risk Register Code)
		<ul style="list-style-type: none"> <li>NDoH &amp; key stakeholders engaged with project and integration process</li> </ul>	demonstrates conflicting results in international research thus far <sup>5556</sup> . The established National Integration Team, with development and formalisation of an Integration (Scale Up) Strategy and Toolkit, will have full capacity to continue integration of SRH into primary health care across organisational facilities by end of project. The operational research report will serve to guide any future integration planning for STI and HIV services within PNG.		
	<b>IO2: Improved quality and reach of HIV, STI and broader SRH services</b>	<p><b>O2.1:</b> <i>CCHS &amp; Anglicare clinical workforce trained in, and providing, quality STI, HIV &amp; SRH services in integrated clinics and primary health facilities</i></p> <ul style="list-style-type: none"> <li>CCHS &amp; Anglicare HIV Practitioners trained in, and providing, effective clinical mentoring to targeted facility health workers</li> <li>CCHS &amp; Anglicare health staff trained and mentored in HIV, STIs and SRH, and</li> </ul>	To achieve integration and delivery of quality HIV, STI and broader SRH services within CCHS and Anglicare primary health care, the clinical workforce must be competent and confident in attending to patients presenting with SRH needs <sup>57</sup> . The sexual health workforce in PNG has limited access to continuing professional development <sup>58</sup> that promotes reflective practice, supports the introduction of updated clinical guidelines and builds advanced practice. And there is ongoing need for development of an evidence base, through grounded operational and clinical research, to enable scale-up of	<ul style="list-style-type: none"> <li>Strategic integration of HIV, STI and SRH services into Primary Health Services will increase accessibility of these services</li> <li>Clinical workforce training, mentoring and capacity building will result in increased competence and confidence of clinicians to attend to patients with HIV, STI and SRH needs</li> </ul>	<ul style="list-style-type: none"> <li>Existing quality and workload at HIV standalone facilities does not enable integration within project timelines, and hence delays performance based funding (HR2)</li> <li>Resistance of health and facility staff to integration process, including staff of non-HIV specific services</li> </ul>

55 Obure, C., Jacobs, R., Guinness, L., Mayhew, S. & Vassal, A. (2016). Does integration of HIV and sexual and reproductive health services improve technical efficiency in Kenya and Swaziland? An application of a two-stage semi parametric approach incorporating quality measures. Available at <http://www.sciencedirect.com/science/article/pii/S0277953616300132>.

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58 Worth, H., Rule, J., Buchanan, H., Kelly, A., Amos, A., Kaitani, M., Browne, K., Roberts, G. & Taylor, R. (2012). HIV and Human Resources Challenges in Papua New Guinea: An Overview. Available at [https://sphcm.med.unsw.edu.au/sites/default/files/sphcm/Centres\\_and\\_Units/LM\\_HIV-PNG\\_Report.pdf](https://sphcm.med.unsw.edu.au/sites/default/files/sphcm/Centres_and_Units/LM_HIV-PNG_Report.pdf).



End of Project Outcomes	Immediate or Intermediate Outcomes	Key Outputs	Theory of Change	Assumptions	Risks (Risk Register Code)
		<p>demonstrating increased confidence and competence in HIV, STI &amp; SRH clinical practice</p> <ul style="list-style-type: none"> <li>CCHS &amp; Anglicare SRH Referral Policy &amp; Procedures (including access to family planning)</li> </ul> <p><u>Q2.2:</u> <i>Existing HIV standalone services assessed and integrated</i></p> <ul style="list-style-type: none"> <li>CCHS &amp; Anglicare health staff trained in differentiated models of care and demonstrate understanding of integration processes</li> <li>HIV standalone services assessed and integrated with SRH &amp; Primary Health</li> <li>HIV specialist services established for complex case management</li> </ul> <p><u>Q2.3:</u> <i>Targeted HIV, STI and SRH services are integrated with primary health care</i></p>	<p>effective and efficient SRH and integrated services<sup>59</sup>. The SRHIP will provide the CCHS, Anglicare &amp; Igat Hope workforce with the clinical and systems strengthening training, mentoring and capacity building required to achieve effective integration of HIV, STI and SRH services. CCHS and Anglicare have a cadre of highly experienced HIV Practitioners. These specialists will be used to boost capacity and lead change across the organisation<sup>60</sup>. Dependant on facility assessment outcomes, further training will be provided for health staff to promote quality SRH, STI, HIV, comorbidity and gender-based violence services. Realising the restrictions of access to a full suite of SRH services under CCHS and Anglicare, the SRHIP will work establish SRH Referral Policy &amp; Procedure guidelines at both organisations that promotes connection of women, girls and vulnerable groups to all the services required (including family planning) for full realisation of sexual health and wellbeing.</p>	<ul style="list-style-type: none"> <li>Health system strengthening training, mentoring and capacity building will result in improved clinical management systems at targeted facilities</li> <li>HIV Practitioners will engage in mentoring role for other health staff</li> <li>That innovative and technological approaches to HIV &amp; STI testing and treatment (such as community based rapid testing) will be approved by NDoH during project duration</li> <li>Women, girls and vulnerable groups with increased access to integrated HIV, STI and SRH services will be empowered to improve their sexual and reproductive health</li> </ul>	<p>being discriminatory to patients seeking HIV testing or treatment (HR3)</p> <ul style="list-style-type: none"> <li>Training, mentoring and capacity building does not result in enhanced workforce performance, improved quality of services or increased HIV, STI &amp; SRH testing and treatment (through PICT) (HR4)</li> <li>National, provincial or local procurement issues or supply chain management beyond project control resulting in delayed equipment, medication or resources for facility operations and patient care (P3)</li> <li>Resistance at diocese or community level to engagement with SRH Toolkits and for</li> </ul>

<sup>59</sup> Haregu, T., Steswe, G., Elliott, J. & Oldenburg, B. (2014). Developing an Action Model for Integration of Health System Response to HIV/AIDS and Noncommunicable Diseases in Developing Countries. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4825372>.

<sup>60</sup> WHO. (2005). WHO recommendations for clinical mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained settings. Available at <http://www.who.int/hiv/pub/guidelines/clinicalmentoring.pdf>.

End of Project Outcomes	Immediate or Intermediate Outcomes	Key Outputs	Theory of Change	Assumptions	Risks (Risk Register Code)
		<ul style="list-style-type: none"> <li>Increased PICT events for HIV and STI management of women, girls and other vulnerable groups</li> <li>CCHS &amp; Anglicare integrated clinics demonstrate practice that aligns with National HIV Guidelines (including test and treat, PMTCT, PEP) and National HIV.TB Guidelines (including IPT)</li> <li>CCHS &amp; Anglicare integrated clinics procure HIV, STI &amp; SRH equipment, medication and resources through primary health systems</li> <li>Innovative and technological approaches that seek to increase HIV &amp; STI testing and treatment are implemented at CCHS &amp; Anglicare integrated clinics when nationally approved (including community based rapid testing)</li> </ul>	<p>The SRHIP integration of services aims to achieve universal access to HIV and STI prevention, testing, treatment and management. Improved health systems and clinical management (including adherence to National Clinical Guidelines) at targeted facilities will enable increased numbers and quality of service events<sup>61</sup>. Provider Initiated Counselling &amp; Testing will enable opportunistic testing and management for women, girls and vulnerable groups within the primary health care model. The project will be responsive to, and support implementation of, any nationally approved innovative and technological approaches to HIV &amp; STI testing and treatment. This will enable continued alignment with NDoH systems and seek to further scale access to these essential services. HIV specialist services will be established to provide complex case management at identified sites, to ensure quality care by experienced practitioners. Procurement of HIV, STI and SRH resources (including medications) through centralised primary health mechanisms will assist to streamline supply chain mechanisms, promote cost-effectiveness and enable a cost-analysis to inform</p>	<p>and wellbeing (including adoption of safer sex practices and family planning)</p> <ul style="list-style-type: none"> <li>That there are high quality SRH services, including family planning, accessible to CCHS &amp; Anglicare facilities and patients.</li> </ul>	<p>feedback on integrated services (T2)</p> <ul style="list-style-type: none"> <li>Inadequate application of gender and diversity inclusion principles does not enable full engagement and reach among the target populations of women, girls and vulnerable groups (T3)</li> <li>Child Protection issues identified during project implementation (T4)</li> <li>Changes in HIV service delivery through applied differentiated models of integrated care, and the integration process, provides challenges for PLHIV in accessibility and acceptability of treatment and support (T5)</li> <li>CCHS &amp; Anglicare ethics and principles of practice restrict access for women, girls and vulnerable groups to a</li> </ul>
		<p><u>Q2.4:</u> <i>Women, girls and vulnerable groups are involved in service delivery and quality assurance</i></p>			

61 SADC. (2015). Minimum Standards for the Integration of HIV and SRH in the SADC Region. Available at <http://www.integrainitiative.org/wp/wp-content/uploads/2015/12/tmp-11285-SADC-Min-Stds-Eng-final-1158402048.pdf>.

End of Project Outcomes	Immediate or Intermediate Outcomes	Key Outputs	Theory of Change	Assumptions	Risks (Risk Register Code)
		<ul style="list-style-type: none"> <li>Community feedback mechanisms established at CCHS &amp; Anglicare integrated clinics and feedback used to guide reorientation of services and drive quality improvement</li> <li>Igat Hope staff are trained in, and demonstrate, improved organisational governance mechanisms</li> <li>Igat Hope staff and members are trained in, and provide, expert patient services that improve clinical pathways and care for PLHIV</li> <li>Igat Hope Expert Patient Sustainability Model Report</li> </ul>	development of sustainable funding models at CCHS and Anglicare. Use of community feedback on integrated facilities, and the meaningful involvement of PLHIV (including expert patients), will ensure that the services meet, and continue to be orientated to, the needs of the women, girls and vulnerable groups they are designed to reach <sup>62</sup> .		<ul style="list-style-type: none"> <li>full suite of SRH services (including family planning) (T6)</li> <li>Increased testing through integrated clinics (and improved PICT practice) increases the demand, and burden on organisation based supply chains, for delivery of equipment, medications (including ART) and resources (T7)</li> <li>Organisational capacity at consortia partners to fulfil project requirements results in delays of performance based funding (O1)</li> <li>Security and natural disaster risks relevant to project and context, impacts on SRHIP operations and travel with potential delay in project progress (P4).</li> </ul>
	<b>IO3: Communities demonstrate</b>	<b>O3.1: Women, girls and vulnerable groups from targeted</b>	Global literature continues to place behaviour change communication at the centre of HIV and SRH models of care, on	<ul style="list-style-type: none"> <li>That existing church networks at CCHS and Anglicare are receptive</li> </ul>	<ul style="list-style-type: none"> <li>Resistance at diocese or community level to engagement with SRH</li> </ul>

<sup>62</sup> Stop AIDS Alliance. (2012). Intensify linkages between HIV and sexual and reproductive health and rights for maximum impact: Stop AIDS Alliance policy position. Available at [http://www.stopaidsnow.org/sites/stopaidsnow.org/files/SRHR\\_IntensifyLinkages\\_SAA.pdf](http://www.stopaidsnow.org/sites/stopaidsnow.org/files/SRHR_IntensifyLinkages_SAA.pdf).

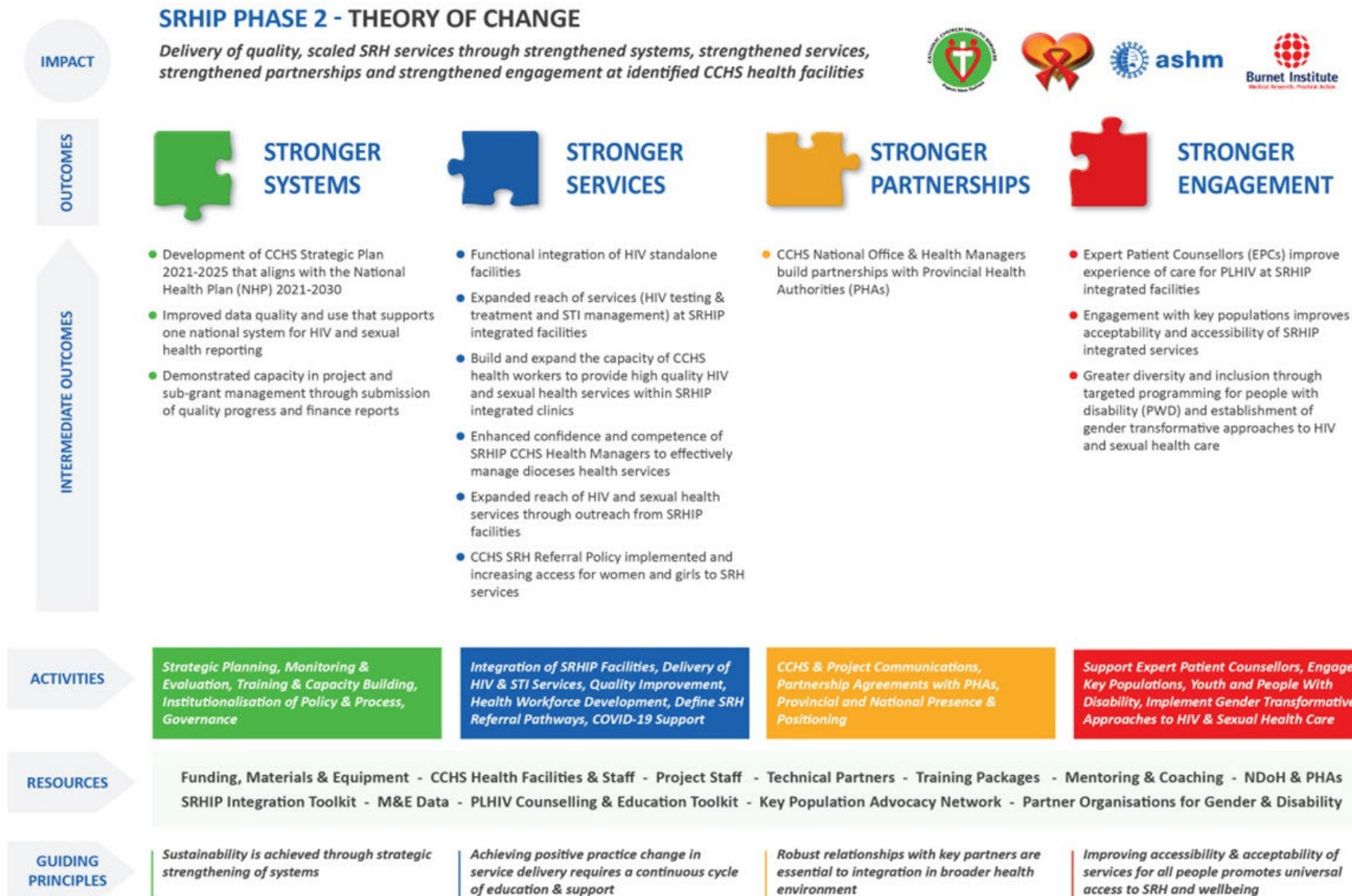
End of Project Outcomes	Immediate or Intermediate Outcomes	Key Outputs	Theory of Change	Assumptions	Risks (Risk Register Code)
	<b>increased health seeking behaviours related to SRH and wellbeing</b>	<p><i>communities drive demand for STI, HIV and SRH services, demonstrated by increased health seeking and clinic presentations</i></p> <ul style="list-style-type: none"> <li>Community SRH BCC Toolkit developed and implemented in facility catchment communities of targeted integrated CCHS &amp; Anglicare clinics</li> <li>Increased presentations of women, girls and vulnerable groups to integrated clinics for SRH services</li> <li>Established patient access pathways from targeted communities to CCHS &amp; Anglicare integrated clinics that provide SRH services</li> </ul>	<p>the basis that identifying and working with personal motivational factors can determine of the likelihood of individuals engaging in protective and proactive health seeking behaviours<sup>63</sup>. SRHIP will engage with existing church networks, including youth groups, to develop and disseminate SRH behaviour change communication (BCC) messages. A standardised, innovative toolkit will be developed for BCC delivery across the broader CCHS and Anglicare networks, leveraging off existing national peer education materials. To ensure connection of individuals to services, community to primary health patient access pathways will be identified within targeted facility catchment communities of the SRHIP<sup>64</sup>.</p>	<p>to engagement with SRHIP and use of the SRH BCC Toolkit</p> <ul style="list-style-type: none"> <li>That women, girls and individuals from vulnerable groups with improved understanding of SRH will seek HIV, STI and broader health services.</li> </ul>	<p>Toolkits and for feedback on integrated services (T2)</p> <ul style="list-style-type: none"> <li>Inadequate application of gender and diversity inclusion principles does not enable full engagement and reach among the target populations of women, girls and vulnerable groups (T3)</li> <li>Child Protection issues identified during project implementation (T4)</li> <li>Changes in HIV service delivery through applied differentiated models of integrated care, and the integration process, provides challenges for PLHIV in accessibility and acceptability of treatment and support (T5)</li> <li>Organisational capacity at consortia partners to</li> </ul>

<sup>63</sup> Glanz, K., Barbara, K., Rimer, K. & Viswanath, K. (2015). Health Behaviour: Theory, Research & Practice: 5<sup>th</sup> Edition. Wiley & Sons.

<sup>64</sup> UNAIDS & Stop AIDS Alliance. (2015). Communities Deliver: The Critical Role of Communities in Reaching Global Targets to End the AIDS Epidemic. Available at [http://www.unaids.org/sites/default/files/media\\_asset/UNAIDS\\_JC2725\\_CommunitiesDeliver\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/UNAIDS_JC2725_CommunitiesDeliver_en.pdf).

End of Project Outcomes	Immediate or Intermediate Outcomes	Key Outputs	Theory of Change	Assumptions	Risks (Risk Register Code)
					fulfil project requirements results in delays of performance based funding (O1) <ul style="list-style-type: none"> <li>• Security and natural disaster risks relevant to project and context, impacts on SRHIP operations and travel with potential delay in project progress (P4).</li> </ul>

**Table 7.1.2 Theory of Change Phase 2**





## 7.2. Key Evaluation Questions and sub-questions

Table 7.2.1 Key Evaluation Questions and sub-questions

Principle	Key Evaluation Questions	Sub-questions
<b>Impact</b>	<p>What difference does the intervention make in:</p> <ul style="list-style-type: none"> <li>• Strengthening systems for delivery of quality, scaled SRH services?</li> <li>• Expanding its reach and coverage of STI, HIV, SRH and primary health services within CCHS facilities?</li> </ul>	<ul style="list-style-type: none"> <li>• What are the positive and negative impacts of the program as a result from this intervention, including unexpected impacts?</li> <li>• Have some cohorts (age, gender, location, level of (dis)ability) been more or less impacted and why?</li> <li>• Has the program reach been more or less than expected?</li> </ul>
<b>Effectiveness</b>	<ul style="list-style-type: none"> <li>• Is the project delivering on outcomes as planned?</li> </ul>	<p><b>Program outcomes</b></p> <ul style="list-style-type: none"> <li>• Strengthened integrated systems for management, monitoring and evaluation of high performing (effective and efficient) projects and services</li> <li>• Strengthened integrated services providing high-quality HIV and sexual health care</li> <li>• Strengthened partnerships supporting a harmonised national and provincial HIV and sexual health response</li> <li>• Strengthened engagement with community and key populations promoting universal access to quality HIV and sexual health services</li> </ul>
<b>Relevance and coherence</b>	<ul style="list-style-type: none"> <li>• How well does the intervention meet the needs of PNG, including those most vulnerable? (This will incorporate dimensions of alignment with PNG, NDOH, provincial and other strategies and plans, equity of program reach across gender, ages, locations, disability)</li> </ul>	<ul style="list-style-type: none"> <li>• How does this program align with and complement work elsewhere in the sector?</li> </ul>
<b>Gender</b>	<ul style="list-style-type: none"> <li>• To what extent have gender and social inclusion principles been incorporated into the program?</li> </ul>	<ul style="list-style-type: none"> <li>• Are there any success stories in gender equality that can be highlighted?</li> </ul>
<b>Sustainability</b>	<p>To what extent are the positive changes and effects of the investment sustainable after the grant ends, including:</p> <ul style="list-style-type: none"> <li>• NDOH (GoPNG) and PHAs' ability to deliver, support, plan, budget and coordinate integrated HIV services?</li> <li>• Community ownership and leadership?</li> </ul>	–

Principle	Key Evaluation Questions	Sub-questions
<b>Efficiency</b>	To what extent is the organisational model (e.g. funding, resource allocation, team structure, governance mechanisms) effective and efficient?	<ul style="list-style-type: none"> <li>• How has adaptive management or continuous improvement occurred and contributed to cost-effective delivery?</li> <li>• How has the emergence of COVID-19 impacted implementation?</li> <li>• To what extent has the program used operational research and monitoring of progress and achievements for programming, learning and accountability?</li> </ul>
<b>Recommendations</b>	What are the lessons learned and recommendations for future DFAT investments in SRH?	How could any positive unexpected impacts be optimised and negative minimised?

### 7.3. List of stakeholders interviewed

There were approximately 100 stakeholders consulted, most by interview. Others were able to contribute through meetings, via email or through the June 2022 workshop. Stakeholders based in the provinces have their province identified in the right-hand column.

**Table 7.3.1 List of stakeholders interviewed**

#### AHC/DFAT

Name	Designation/role	Consultation	Province
Catherine Herron	First Secretary	Interview	–
Lara Andrews	Counsellor	June Workshop	–
Anna Gilchrist	First Secretary	June Workshop	–
Emeline Cammock	First Secretary Health Security (COVID-19/TB/HIV/Malaria)	Interview	–
Dianne Dagam	Senior Program Manager – Rural Health Team (PATH contract)	Interview	–
Will Robinson	Former Counsellor	Interview	–
Cathy Stoesel	Assistant Program Manager, HIV program	June Workshop Meetings	–
Celina Smith	First Secretary, Health Security	June Workshop Meetings	–

#### ASHM – SRHIP consortium

Name	Designation/role	Consultation	Province
Nikki Teggelove	International Programs Advisor, ASHM	Interview	–
Brooke Dickson	SRHIP Project Manager, ASHM	Interview	–
Dr Arun Meron	Technical Advisor, ASHM	Interview	–

#### Burnet Institute – SRHIP consortium

Name	Designation/role	Consultation	Province
Sherel Nama	Finance and M&E Manager	Interview	–
Meredith Tutumang	In-country Representative, BI	Interview	–
Lisa Davidson	International Health Technical Adviser, Co-head of global head policy practice and Community Action Group – support to SRHIP	Interview	–
Dean Cassano	SRHIP Project Manager	Interview	–
Chad Hughes	Deputy Director for Disease Elimination	Interview	–

#### Callan Services

Name	Designation/role	Consultation	Province
Priscilla Kare	Administrator	Interview	NCD

**PNG Callan Services – Mt Sion Inclusive Education Resource Centre**

Name	Designation/role	Consultation	Province
Don Waipe	Deputy Principal, Mt Sion Inclusive Education Resource Centre	Interview	EHP
Justin Wagame	Principal, Mt Sion Inclusive Education Resource Centre	Interview	EHP

**CCHS – SRHIP consortium**

Name	Designation/role	Consultation	Province
Baeau Tai	Executive Assistant	Interview	–
Dr John Millan	Chairperson, PNG SRH Association/ SRH Consultant	Interview	–
Graham Apian	Project Director, CCHS	Interview	–
Maureen Lesley	Project Officer, CCHS	Interview	–

**Global Fund**

Name	Designation/role	Consultation	Province
Elin Bos	Fund Portfolio Manager PNG	Interview Donor meeting	–

**Health facility administration staff**

Name	Designation/role	Consultation	Province
Cecilia Tsikula	Prescriber (Stella Maris VCCT)	Interview	New Ireland
Augustine Tirupia	Community Health Worker (Stella Maris VCCT)	Interview	New Ireland
Sr Geraldine Arua	Health Manager, Port Moresby Diocese	Interview	NCD
William Vagi	Diocese Health Integration Officer, Port Moresby Diocese	Interview	NCD
Dr Pauline Mpongo	Health Manager, Lae Diocese	Interview	Morobe
Samantha Tiran	Diocese Health Integration Officer, Lae Centre of Mercy – CCHS Lae Diocese	Interview	Morobe
Nola Marita	Health Manager, CCHS Madang Diocese	Interview	Madang
Amanda Sombu	Health Manager, Vanimo Diocese	Interview	Sandaun
Gabriel Molonges	Health Manager, Kavieng Diocese	Interview	New Ireland
Elizabeth Koia	Health Manager, Chimbu Diocese (oversees Goroka Diocese)	Interview	EHP
Alfred Koko	Diocese Health Integration Officer, Goroka Diocese	Interview	EHP
Sr Gracie Panakkakl	Officer-in-Charge (OIC) (Nursing Officer), St. Paul's Clinic, Gerehu, CCHS Port Moresby Diocese	Interview	NCD
Julie Bamban	Master Mentor/Prescriber (senior staff mentoring others), St Paul's Clinic, Gerehu, NCD	Interview	NCD
Sr Julie Yambuahan	OIC (Nursing Officer), St Therese Urban Clinic, Hohola, NCD	Interview	NCD

Name	Designation/role	Consultation	Province
Sr Helen Dadaratoa	Master Mentor/Prescriber/Nursing Officer, St Therese Urban Clinic, Hohola, NCD	Interview	NCD
Theresita Sandu	Prescriber, Bethany VCCT/ART (transferred to Alexishafen)	Interview	Madang
Rachael Markus	Diocese Health Integration Officer, Vanimo Diocese/Prescriber, West Sepik, St Anthony Aid Post, Vanimo	Interview	Sandaun
Roselyn Sapak	OIC, Stella Maris VCCT, Kavieng	Interview	New Ireland
Stanis Taufilik	Master Mentor/Prescriber, Stella Maris VCCT, Kavieng	Interview	New Ireland
Rose Mundua	OIC/ART Prescriber/Counsellor, St. Joseph VCCT, Goroka Diocese	Interview	EHP
Sr Mikayla	ART Prescriber – Pharmacy	Interview	Morobe
Daniel Pius	ART Prescriber, Counsellor, Coordinator	Interview	Morobe
Joycelyn Amilawan	Master Mentor/Prescriber, OIC for St Anthony's clinic	Interview	Sandaun

#### ***Igat Hope* – SRHIP consortium**

Name	Designation/role	Consultation	Province
Mark Kitan	Field Support Officer	Interview	–
Margie Yamdop	Project Manager, <i>Igat Hope</i>	Interview	–

#### **Key Population Advocacy Consortium**

Name	Designation/role	Consultation	Province
Lesley Bola	Executive Director	Interview	–
Cathy Ketepa	Chair, KPAC	Interview	–

#### **National AIDS Council**

Name	Designation/role	Consultation	Province
Tony Lupiwa	Acting Director	Interview	–

#### **NDOH**

Name	Designation/role	Consultation	Province
Dr Penial Boas	Manager, HIV Program/Chairperson, Technical Working Group	Interview	–
Namarola Lote	HIV Data Manager	Interview	–

#### **PATH**

Name	Designation/role	Consultation	Province
Angela Wasson	Data Management and Analytics Adviser	Via email	–
Pamela Kamaya	Team Lead Performance Adaptive Systems	Via email	–
Milena Dalton	Senior Manager, Frontline Health Outcomes	Interview	–

Name	Designation/role	Consultation	Province
Luke Elich	Previously Manager, Frontline Health Outcomes, Strategy	Interview	–
Geoff Miller	Previously PATH Team Leader	Interview	–
Brett Cowling	Previously PATH Team Leader	Via email	–
Kelwyn Browne	Manager, Health Facility at Mabaduan	Interview	Western
Ray Krai	Manager, Frontline Health Outcomes	Via email	Western

**PHA**

Name	Designation/role	Consultation	Province
Sr Maira	Team Leader, HIV Unit	Interview	New Ireland
Mathew Densil	Project Officer – HIV/AIDS and STI	Interview	NCD
Kelly Masere	Director, Public Health	Interview	Morobe
Sr Pauline Mitiel	Family Health Coordinator, Morobe PHA	Interview	Morobe
Lucy Dani		Interview	Morobe
Dr Geita Morea	A/Deputy Director, Curative Services	Interview	Sandaun
Sr Christine Trintenmok	Sister-in-Charge Family Health Services	Interview	Sandaun
Dr Penny Charles	Director, Curative Health Services	Interview	New Ireland
Dr Paula Zzferio	Director, Curative Health Services	Interview	New Ireland
Sr Jennifer Robert	Team Leader, ANC, Maternal and Child Health	Interview	New Ireland
Sr Gerarda Kula	Team Leader, WBC/FP	Interview	New Ireland
Opo Kairu	Deputy Director, Public Health	Interview	EHP

**SRH clients**

Name	Designation/role	Consultation	Province
–	–	Anonymous – 18 people – interview	–

**UNAIDS**

Name	Designation/role	Consultation	Province
Patricia Ongpin	Regional Fast Track Advisor, Regional Support Team – Asia and the Pacific	Interview Meeting	–
Mosende Zimmbodilion	Strategic Information Advisor	Interview	–

**USAID**

Name	Designation/role	Consultation	Province
Rebecca F. Price	Country Coordinator, Papua New Guinea and Vanuatu	Interview Meeting	–
Percy Pokeya	Program Management Specialist, HIV Team Lead	Interview	–



**WHO**

Name	Designation/role	Consultation	Province
Martin Taylor	Ex. PPF/AHC Health Adviser	Interview	–

**World Vision International**

Name	Designation/role	Consultation	Province
Agnes Tal	Portfolio Manager, Health and Gender	Interview	–
Clement Chipokolo	Director, Program Operations	Interview	–
George Raubi	Responsible for the designing, planning and implementation of TB activities funded by Global Fund throughout PNG.	Interview	–

**Table 7.3.2 Participation in interviews by cohort****Gender**

Cohort	Percentage
Male	43.8%
Female	56.2%

**Cohort**

Cohort	Number
DFAT	8
Other donors	5
Government – national, provincial, health, NAC	15
Patients	18
SRHIP	14
Health Facility staff (CCHS)/Diocese/Clinicians	19
NGOs/CSOs	5
PATH	8
<b>TOTAL</b>	<b>92</b>

Note: One stakeholder interviewed identified themselves as living with a disability.

## 7.4. List of documents consulted

The following is an alphabetical list of documents consulted in the preparation of this report.

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## 7.5. SRHIP integration services summary

**Table 7.5.1 SRHIP integration Phase 1**

Fac. no.	Org.	Province	Clinic name & location	Baseline services	Integration process	HIV/STI	End of Phase 1 – integrated services	GoPNG reporting
1	CCHS	NCD	St Joseph's Clinic Boroko	HIV and STI services	Transferred to St Therese and St Pauls	Yes	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	SURV 1 & 2 and NHIS
2	CCHS	Western	Home of Peace VCCT Clinic Daru	HIV and STI services	Transferred to Daru General Hospital	Yes	–	–
3	CCHS	Western	Good Samaritan Day Care Centre Kiunga	HIV and STI services	Integrated to Kiunga Urban Clinic	Yes	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	SURV 1 & 2 and NHIS
4	CCHS	Central	Louise Vangeke VCCT Clinic Bereina	HIV and STI services	Integrated to Veifa Health Centre	Yes	VCCT, HIV Care & Treatment, STI Screening, TB Screening, PICT, ANC, Supervised Delivery, Primary Health, and Outreach	SURV 1 & 2 and NHIS
5	CCHS	Milne Bay	Star of Hope VCCT Clinic Alotau	HIV and STI services	Transferred to Alotau General Hospital	Yes	–	–
6	CCHS	Gulf	Consolata VCCT Clinic Site Kikori	HIV and STI services	Remain	Yes	–	SURV 1
7	CCHS	Hela	St Francis Kupari VCCT Tari	HIV and STI services	Upgrade to St Francis Kupari Urban Clinic	Yes	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	SURV 1 & 2 and NHIS
8	CCHS	Southern Highlands	Epeandea VCCT Clinic Mendi	HIV and STI services	Upgrade to Epeandea Urban Clinic Mendi	Yes	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	SURV 1 & 2 and NHIS
9	CCHS	Western Highlands	Rebiamul VCCT, ART Hagen	HIV and STI services	Integrated to Rebiamul Health Centre	Yes	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	SURV 1 & 2 and NHIS

Fac. no.	Org.	Province	Clinic name & location	Baseline services	Integration process	HIV/STI	End of Phase 1 – integrated services	GoPNG reporting
10	CCHS	Jiwaka	Shalom VCCT site Banz	HIV and STI services	Integrated to Bans Urban Clinic	Yes	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	SURV 1 & 2 and NHIS
11	CCHS	Eastern Highlands	St Joseph VCCT site Goroka	HIV and STI services	Remain & Strengthen as St Joseph Integrated Clinic	Yes	VCCT, HIV Care & Treatment, STI Screening, Primary Health, and Outreach	SURV 1 & 2
12	CCHS	Morobe	Bishop Henry VCCT Clinic Lae	HIV and STI services	Upgrade to Community Health Post	Yes	ANC, FP, SRH and Health Education	SURV 1 & 2
13	CCHS	Madang	Bethany VCCT Clinic Madang Town	HIV and STI services	Integrated to Alexishafen Health Centre	Yes	VCCT, HIV Care & Treatment, STI Screening, TB Screening, PICT, ANC, Supervised Delivery, Primary Health, and Outreach	SURV 1 & 2 and NHIS
14	CCHS	Madang	Malala Health Clinic Bogia	HIV and STI services	Remain and strengthen	Yes	ANC, FP, SRH and Health Education, Supervised Delivery	SURV 1 & 2 and NHIS
15	CCHS	East Sepik	Sepik Centre of Hope, Wewak	HIV and STI services	Integrated into Wirui Health Centre	Yes	ANC, FP, SRH and Health Education	SURV 1 & 2 and NHIS
16	CCHS	AROB	Mary Mother Hope VCCT Buka	HIV and STI services	Remain and strengthen	Yes	HIV Care and Treatment	SURV 1
17	CCHS	AROB	Our Lady of Mercy VCCT Arawa	HIV and STI services	Remain and strengthen	Yes	HIV Care and Treatment	SURV 1
18	CCHS	AROB	St Vincent de Paul VCCT Buin	HIV and STI services	Integrate HIV into Turiboiru Health Centre	Yes	VCCT, HIV Care & Treatment, STI Screening, TB Screening, PICT, ANC, Supervised Delivery, Primary Health and Outreaches	SURV 1 & 2
19	CCHS	New Ireland	Stella Maris VCCT Kavieng	HIV and STI services	Integrated to Lemakot Health Centre	Yes	ANC, FP, PNC, SRH and Health Education	SURV 1&2 & NHIS
20	CCHS	East New Britain	Peter Torot VCCT St Mary's Vunapope	HIV and STI services	Integrate HIV into Vunapope Hospital	Yes	VCCT, HIV Care & Treatment, STI Screening, TB Screening, PICT, ANC, Supervised Delivery, Primary Health and Outreaches	SURV 1&2 & NHIS

Fac. no.	Org.	Province	Clinic name & location	Baseline services	Integration process	HIV/STI	End of Phase 1 – integrated services	GoPNG reporting
21	CCHS	West Sepik	St Anthony of Padua VCCT site Vanimo	HIV and STI services	Remain and strengthen	Yes	VCCT, HIV Care & Treatment, STI Screening, ANC, Primary Health, and Outreaches	SURV 1
22	CCHS	West New Britain	Sacred Heart VCCT Kimbe	HIV and STI services	–	–	–	–
23	APNG	NCD	Begabari VCCT Site Port Moresby	HIV and STI services	–	Yes	Reproductive Health Referral	SURV 1 & 2
24	APNG	Western Highlands	Newtown VCCT Clinic Mt Hagen	HIV and STI services	–	Yes	Reproductive Health Referral	SURV 1 & 2

**Table 7.5.2 SRHIP integration Phase 2**

Fac. no.	Org.	Province	Clinic name and location	Facility level	Phase 2 services	Phase 2 reproductive services	HIV prescriber	GoPNG reporting
1	CCHS	NCD	St Therese Urban Clinic Hohola	Level Two	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	ANC/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing / PPTCT	5	SURV 1, 2 and NHIS
2	CCHS	NCD	St Pauls Urban Clinic Gerehu	Level Two	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	ANC 1st to 4th visit/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing/ PPTCT	4	SURV 1, 2 and NHIS
3	CCHS	Western Province	Good Samaritan Kiunga	Level Two	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	ANC 1st to 4th visit/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing/ PPTCT	2	SURV 1, 2 and NHIS



Fac. no.	Org.	Province	Clinic name and location	Facility level	Phase 2 services	Phase 2 reproductive services	HIV prescriber	GoPNG reporting
4	CCHS	Central Province	Veifa Louie Vangeke VCCT Bereina	Level Three	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	ANC 1st to 4th visit/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing/PPTCT	2	SURV 1, 2 and NHIS
5	CCHS	Southern Highlands Province	Epeanda VCCT Clinic Mendi	Level Two	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	ANC 1st to 4th visit/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing/PPTCT	5	SURV 1, 2 and NHIS
6	CCHS	Western Highlands Province	Rebiamul VCCT and ART Mt Hagen	Level Three	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	ANC 1st to 4th visit/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing/PPTCT	7	SURV 1, 2 and NHIS
7	CCHS	Eastern Highlands	St Joseph VCCT Goroka	VCCT	VCCT, HIV Care & Treatment, STI Screening, PICT, Primary Health, and Outreach	ANC Education & Referrals	1	SURV 1, 2
8	CCHS	Morobe Province	Bishop Henry VCCT Lae	Level One	VCCT, HIV Care & Treatment, STI Screening, PICT, ANC, Primary Health, and Outreach	ANC 1st to 4th visit/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing/PPTCT	1	SURV 1, 2 and NHIS
9	CCHS	Madang Province	Alexishafen Health Centre Madang	Level Three	VCCT, HIV Care & Treatment, STI Screening, TB Screening, PICT, ANC, Supervised Delivery,	ANC 1st to 4th visit/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing/PPTCT	4	SURV 1, 2 and NHIS

Fac. no.	Org.	Province	Clinic name and location	Facility level	Phase 2 services	Phase 2 reproductive services	HIV prescriber	GoPNG reporting
					Primary Health and Outreaches			
10	CCHS	East Sepik Province	Sepik Centre of Hope Wewak	Level Two	VCCT, HIV Care & Treatment, STI Screening, TB Screening, PICT, ANC, Supervised Delivery, Primary Health and Outreaches	ANC 1st to 4th visit/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing/PPTCT	3	SURV 1, 2 and NHIS
11	CCHS	West Sepik Province	St Anthony VCCT Vanimo	VCCT	VCCT, HIV Care & Treatment, STI Screening, TB Screening, PICT, ANC, Primary Health, and Outreach	ANC 1st to 4th visit/TT 1 & 2/Delivery planning/Malaria prophylaxis/Iron supplements/Nutrition/FP counselling natural methods/Syphilis testing/PPTCT	1	SURV 1
12	CCHS	AROB	Mary Mother Hope VCCT Buka	VCCT	VCCT, HIV Care & Treatment, Referral	ANC Education & Referrals	1	SURV 1, 2
13	CCHS	AROB	Our Lady of Mercy VCCT Arawa	VCCT	VCCT, HIV Care & Treatment, Referral	ANC Education & Referrals	1	SURV 1, 2

## 7.6. Indicator data

The tables below provide assessments of SRHIP results, in 3 sections. Table 7.6.1 covers Phase 1 and quantifies results against targets, specific to Phase 1. Table 7.6.2 covers Phase 2 and captures results against targets, specific to Phase 2, up to December 2021. Table 7.6.3 covers Phase 1 and 2 and tracks the only indicators measured across both phases up to December 2021.

**Table 7.6.1 SRHIP Phase 1 results against targets (Jul 2017 to May 2020)**

Legend	Achievement
Green = [G]	Over 90% achieved
Amber = [A]	Over 50 % achieved
Red = [R]	Under 50% achieved

### Phase 1

Indicator no. and description	Result/target	Achievement %
1.1 HIV standalone facilities are functionally integrated and providing health services	18/24	75% [A]
1.1.1.1 Head contract finalised. Detailed service agreements between CCHS and consortium partners are executed	1/1	100% [G]
1.1.1.2 Project Management Group (PMG) and Technical Advisory Group (TAG) are established	24/20	120% [G]
1.1.1.3 Project office equipped to meet project management and operational requirements is established	1/1	100% [G]
1.1.1.4 Full complement of staff recruited	No data	95% [G]
1.1.2 Project strategy and workplan approved by National Office and dioceses	2/2	100% [G]
1.1.3.1 Operational Research Framework to evaluate integration process developed and approved by ethics committee	1/1	100% [G]
1.1.3.2 Operational Research completed	1/2	50% [A]
1.1.4.1 Learning & Development Plans completed for organisational capacity building with CCHS, APNG & <i>Igat Hope</i>	1/1	100% [G]
1.1.4.2 No. CCHS staff received training in project management	10/10	100% [G]
1.1.4.3 No. CCHS, Anglicare & <i>Igat Hope</i> staff received technical support and training on M&E	51/50 staff 8/6 workshops	102% [G] 133% [G]
1.1.4.4 No. SRHIP staff received technical support and training on child protection, gender & inclusion, sub-grant management and other relevant policies	No data provided, only % complete	100% [G] (Child Protection only)
1.1.4.5 No. Anglicare and <i>Igat Hope</i> staff trained in project operations to ensure capacity to meet subcontract requirements in finance and data reporting	3/10	30% [R]
1.1.5 SRH Sustainability Reports completed by CCHS & Anglicare	0/1	0% [R]
1.1.6 Brief Situational Analysis of CCHS & Anglicare HIV, STI, SRH and primary health services completed	1/1	100% [G]
1.1.7 SRH Integration Toolkit, approved by CCHS & Anglicare, is completed	1/1	100% [G]

Indicator no. and description	Result/target	Achievement %
1.1.8 Percentage of integrated project facilities completing and submitting NHIS/SURV forms on time	80/75	106% [G]
1.1.9.1 Project Communications Strategy, detailing internal and external communication mechanisms including communication pathways with NDOH, Provincial Health, PPF & DFAT is completed	1/1	100% [G]
1.1.9.2 No. quarterly meetings with NDOH to brief on project strategy, workplan and TAG	22/12	183% [G]
2.1.1.1 Percentage of clinic sites providing HIV counselling and testing are maintained once services integrated	18/18	100% [G]
2.1.1.2 Percentage of clinic sites providing STI (syndromic) management are maintained or increased once services integrated	18/18	100% [G]
2.1.1.3 No. HIV practitioners received Master Mentor training, and providing effective clinical mentoring to targeted facility health workers	73/30	243% [G]
2.1.2.1 No. integrated facility staff received training and mentoring in HIV, STI & SRH clinical practice	124/50	248% [G]
2.1.2.2 No. people tested for HIV (VCCT)	53,219/52,486	105% [G]
2.1.2.3 No. people tested for HIV (PICT)	20,578/16,880	122% [G]
2.1.2.4 No. people tested positive to HIV	2,607/2,342	111% [G]
2.1.2.5 No. people treated for STIs (syndromic STI management)	9,527/9,178	104% [G]
2.1.2.6 No. people newly initiated on ART	2,546/2,226	114% [G]
2.1.2.7 No. people receiving ART at the end of the reporting period <sup>65</sup>	4,489/9,281 NB	48% [R]
2.1.2.8 No. people retained on ART at 12 months post initiation of treatment	–	Reported 2019 only = 64% [A]
2.1.3 No. staff trained on differentiated models of integrated care	18/10	180% [G]
2.1.4.1 No. HIV standalone facilities assessed and provided with integration reports	24/24	100% [G]
2.1.4.2 No. HIV standalone facilities functionally integrated with SRH & primary health system	18/24 <sup>66</sup>	75% [A]
2.1.5 No. HIV specialist services providing complex case management	0/5	0% [R]
2.1.6 No. Integrated CCHS & Anglicare clinics where current National HIV Guidelines (including test and treat) and National HIV.TB Guidelines are available and implemented	24/24	100% [G]
2.1.7 No. Integrated CCHS & Anglicare clinics procuring equipment, medication and resources through primary health mechanisms	24/24	100% [G]
2.1.8 No. Nationally approved new innovative & technological approaches to HIV & STI testing and treatment that are implemented throughout the project period	0	0% [R]
2.1.9 No. <i>Igat Hope</i> staff trained, supported and demonstrating improved organisational governance for project operations	3/3	100% [G]
2.1.10.1 No. <i>Igat Hope</i> expert counsellors recruited and trained in expert patient services that improve clinical pathways and care for PLHIV	7/10	70% [A]

<sup>65</sup> Point in time indicator, not cumulative across periods or phases.

<sup>66</sup> 24 is inclusive of the 2 facilities managed by Anglicare and 22 managed by CCHS.

Indicator no. and description	Result/target	Achievement %
2.1.10.2 No. Integrated facilities where <i>Igat Hope</i> staff and members have taken active steps to improve clinical pathways and care for PLHIV	5/5	100% [G]
2.1.11 No. Sustainability reports and funding submissions to NDOH, PHAs and other domestic funders completed and submitted by <i>Igat Hope</i>	0/1	0% [R]
2.1.12.1 No. Health workers reached directly with information and support on COVID-19, universal precautions, continuation of HIV and sexual health services and stigma and discrimination	47/50	94% [G]
2.1.12.2 No. SRHIP health workers reached indirectly with support on HIV, other blood-borne viruses, sexual health and COVID-19	138+/200 (Data incomplete)	100% [G]
3.1 No. Women and girls including vulnerable groups attending SRH Education Sessions	3,114/450	692% [G]
3.1.1 No. Facility catchment communities of integrated CCHS & Anglicare clinics where SRH Behaviour Change Communication Toolkits are implemented	5/5	100% [G]
3.1.2 No. project facilities operating parish-based education sessions supporting referral pathways	0/5	0% [R]

**Table 7.6.2 SRHIP Phase 2 results against targets (Jul 2020 to Dec 2021)**

Legend	Achievement
Green = [G]	Over 90% achieved
Amber = [A]	Over 50 % achieved
Red = [R]	Under 50% achieved

**Phase 2 (to Dec 2021)**

Indicator no. and description	Result/target <sup>67</sup>	Achievement %
1.1.1 No. CCHS Strategic Planning 2021-2025 documents aligned with NHP 2021–2030	2/3	66% [A]
1.2.1 No. CCHS diocese M&E Officers who have attended Data Quality Master Training	19/11	173% [G]
1.2.2 No. SRHIP facilities with staff trained in data quality by CCHS diocese M&E Officers	6/13	46% [R]
1.3.1 No. formal governance meetings conducted for SRHIP with attendance by all consortium partners	38/38	100% [G]
1.3.2 No. CCHS staff trained and supported to deliver robust project and finance management	20/26	77% [A]
2.1.1 No. HIV standalone facilities functionally integrated with primary health services	13/13 <sup>68</sup>	100% [G]
2.1.2 No. SRHIP facilities with established Quality Improvement mechanisms	10/13	77% [A]

<sup>67</sup> Annual and six-monthly reporting compared to 2022 trend data for clinical indicators (identified as 'alternative source').

<sup>68</sup> Including Phase 1 and Anglicare (2), there are 27 clinics in total. SRHIP Phase 2 only had 13 clinics, but reporting is against the total program for this indicator.

Indicator no. and description	Result/ target <sup>67</sup>	Achievement %
2.2.1 No. VCCT & PICT tests conducted	18,865/25,970	73% [A]
2.2.2 No. People tested positive to HIV	689/945	73% [A]
2.2.3 No. PLHIV initiated on ART	743/810	92% [G]
2.2.4 No. PLHIV receiving ART at end of reporting period	3,591/4,461	80% [G]
2.2.5 Percentage PLHIV adhering to ART at 12 months	No data reported	–
2.2.6 No. People treated for STIs	3,629/1,715	212% [G]
2.3.1 No. Experienced health workers trained to provide clinical mentoring within workplace	102/60	170% [G]
2.3.2 No. Health workers trained as HIV prescribers	0/30	0% [R]
2.3.3 No. HIV prescribers receive mobile based education on revised HIV guidelines	10/10	100% [G]
2.3.4 No. Health workers provided with clinical education in HIV Counselling & Testing, HBV and sexual health	23/100	23% [R]
2.3.5 No. Health workers trained in HIV Complex Case Management	10/20	50% [A]
2.3.6 No. HIV Specialist Services established for HIV Complex Case Mgt	0/1	0% [R]
2.3.7 (2021) No. SRHIP health workers reached with information & support during COVID-19 <sup>69</sup>	1/2	50% [A]
2.3.7 (2020) No. SRHIP health workers reached with information & support during COVID-19 <sup>70</sup>	28/52	54% [A]
2.3.8 (2020) No. PNG HIV and sexual health specialists' capacity built to facilitate SRHIP trainings <sup>71</sup>	0/0	0% [R]
2.4.1 No. CCHS Health Managers trained in diocese health management <sup>72</sup>	30/11	273% [G]
2.5.1 No. SRHIP facilities providing HIV and sexual health outreach services	No data/13	Not known
2.6.1 No. SRHIP facilities with established referral pathways to SRH services	0/13	0% [R]
2.7.1 (2021) No. SRHIP health workers reached with information & support during COVID-19 <sup>73</sup>	107/100	107% [G]
2.7.2 (2021) No. CCHS facilities with established COVID-19 Safety Facility Plans <sup>74</sup>	8/13	62% [A]
2.7.3 (2021) No. COVID-19 IEC materials developed <sup>75</sup>	8/8	100% [G]
3.1.1 No. SRHIP-CCHS dioceses in defined agreements with PHAs	1/5	20% [G]
4.1.1 No. peer counselling sessions conducted by EPCs using SRHIP SRH & HIV Counselling and Education Toolkit	9,364/4,000	234% [G]
4.2.1 No. SRHIP diocese engaged with provincial key population networks	0/11	0% [R]

<sup>69</sup> New indicator in January 2021.

<sup>70</sup> Only a SRHIP Phase 2 indicator in 2020.

<sup>71</sup> Only a SRHIP Phase 2 indicator in 2020.

<sup>72</sup> Quality and Leadership training counted here and elsewhere; double-counted.

<sup>73</sup> New indicator in January 2021.

<sup>74</sup> New indicator in January 2021.

<sup>75</sup> New indicator in January 2021.

Indicator no. and description	Result/ target <sup>67</sup>	Achievement %
4.2.2 No. SRHIP facilities with established key population friendly approaches (demand)	0/13	0% [R]
4.2.3 No. Health workers trained to improve SRHIP service access for key populations (supply)	0/40	0% [R]
4.2.4 No. SRHIP facilities with adolescent and young adult tailored service approaches	0/10	0% [R]
4.3.1 No. SRHIP facilities with improved acceptability and accessibility of HIV and sexual health services for PWD	0/5	0% [R]
4.3.2 No. SRHIP facilities with gender transformative approaches that improve access to SRHIP HIV and sexual health services for women and girls	0/13	0% [R]

Note: Some indicators were measured in 2020 and not 2021, and vice versa (e.g. 2.3.7, 2.3.8; 2.7.1–2.7.3).



**Table 7.6.3 Common indicators for SRHIP for Phase 1 and 2 (Jul 2017 to Dec 2021)**

Legend	Achievement						
Green = [G]	Over 90% achieved						
Amber = [A]	Over 50 % achieved						
Red = [R]	Under 50% achieved						

Phase 1 indicator	Result/ target <sup>2</sup>	Achievement %	Phase 2 indicator (to Dec 2021)	Result/ target <sup>76</sup>	Achievement %	Inception to Dec 2021 <sup>77</sup> Result/ target <sup>78</sup>	Achievement %
1.1 HIV Standalone facilities are functionally integrated and providing health services	18/24 <sup>79</sup>	75%	2.1.1 No. HIV standalone facilities functionally integrated with primary health services	13/13	100%	22/25	88% [A]
1.1.4.2 No. CCHS staff received training in project management	10/10	100%	1.3.2 No. CCHS staff trained and supported to deliver robust project and finance management	20/26	77%	30/36	83% [A]
1.1.4.3 No. CCHS, Anglicare & <i>Igat Hope</i> staff received technical support and training on M&E	51/50 staff 8/6 workshops	102% 133%	1.2.1 No. CCHS diocese M&E Officers who have attended Data Quality Master Training	19/11	173%	70/61	115% [G]
2.1.1.3 No. HIV practitioners received Master Mentor training, and providing effective clinical mentoring to targeted facility health workers	73/30	243%	2.3.1 No. Experienced health workers trained to provide clinical mentoring within workplace	102/60	170%	175/90	194% [G]

<sup>76</sup> Using data from phase when indicator measured or consolidated across 2017–2021 for 13 common indicators.

<sup>77</sup> Annual and six-monthly reporting compared to 2022 trend data for clinical indicators (identified as ‘alternative source’).

<sup>78</sup> Target to December 2021, not EOI target.

<sup>79</sup> 24 is inclusive of the 2 facilities managed by Anglicare and 22 managed by CCHS.

Phase 1 indicator	Result/ target <sup>2</sup>	Achievement %	Phase 2 indicator (to Dec 2021)	Result/ target <sup>76</sup>	Achievement %	Inception to Dec 2021 <sup>77</sup> Result/ target <sup>78</sup>	Achievement %
2.1.2.1 No. Integrated facility staff received training and mentoring in HIV, STI & SRH clinical practice	124/50	248%	2.3.2 No. Health workers trained as HIV prescribers	0/30	0%	124/80	155% [G]
2.1.2.2 No. People tested for HIV (VCCT)	53,219/ 52,486	105%	2.2.1 No. VCCT & PICT tests conducted	18,865/ 25,970	73%	92,662/ 95,336	97% [G]
2.1.2.3 No. People tested for HIV (PICT)	20,578/ 16,880	122%	2.2.1 No. VCCT & PICT tests conducted	18,865/ 25,970	73%	92,662/ 95,336	97% [G]
2.1.2.4 No. People tested positive to HIV	2,607/2,342	111%	2.2.2 No. People tested positive to HIV	689/945	73%	3,296/3,287	100% [G]
2.1.2.5 No. People treated for STIs (syndromic STI management)	9,527/9,178	104%	2.2.6 No. People treated for STIs	3,629/ 1,715	212%	13,156/ 10,893	121% [G]
2.1.2.6 No. People newly initiated on ART	2,546/2,226	114%	2.2.3 No. PLHIV initiated on ART	743/810	92%	3,289/3,036	108% [G]
2.1.2.7 No. People receiving ART at the end of the reporting period	4,489/9,281	48%	2.2.4 No. PLHIV receiving ART at end of reporting period	3,591/ 4,461	80%	3,591/4,461	80% [A]
2.1.2.8 No. People retained on ART at 12 months post initiation of treatment	–	–	–	–	–	–	Reported 2019 only 64% [A]
2.1.5 No. HIV specialist services providing complex case management	0/5	0%	2.3.6 No. HIV Specialist Services established for HIV Complex Case Management	0/1	0%	0/6	0% [R]