



Independent Progress Report of PNG Australia Sexual Health Improvement Program (PASHIP)

AidWorks Initiative Number ING918

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Acronyms

AAP	Annual Activity Plan/s
ACFID	Australian Council for International Development
ADB	Asian Development Bank
ADRA	Adventist Relief Agency
ANGO	Australian Non-Government Organisation
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
ASHM	Australasian Society for HIV Medicine
AUD	Australian Dollar
AusAID	Australian Agency for International Development
CHAI	Clinton Health Access Initiative
CHS	Catholic Health Services
COMPASS	Clinical Outreach, Men's Programs, Advocacy and Sexual Health Services Strengthening
CPP	Church Partnerships Program
CSO	Civil Society Organisation
EHP	Eastern Highlands Province
EHSCIP	Eastern Highlands STI Clinical Improvement Project
ENB	East New Britain
ENBSHIP	East New Britain Sexual Health Improvement Program
GoPNG	Government of Papua New Guinea
HIV	Human Immunodeficiency Virus
HSDS	Health Sector Delivery Strategy (AusAID)
IBBS	Integrated Bio-behavioural Surveillance
IMR	Institute of Medical Research
IP	Implementing Partner/s (PASHIP)
IPR	Independent Progress Review
IRG	Independent Review Group
ISMPP	Integrated Sexually Transmitted Infection Management and Prevention Program
LNP	Lusa Numini Project
M&E	Monitoring and Evaluation
MTDP	Medium Term Development Plan 2011-2015
NACS	National AIDS Council Secretariat
NCD	National Capital District
NDoH	National Department of Health

NGO	Non-Government Organisation
NHIS	National Health Information System
NHP	National Health Plan (2011-2020)
NHS	National HIV and AIDS Strategy 2011-2015
NSA	Non-State Actors
PAC	Provincial AIDS Committee
PACs	Provincial AIDS Committee Secretariat
PASHIP	PNG-Australia Sexual Health Improvement Program
PDD	Project Design Document
PGK	Papua New Guinea Kina
PICT	Provider Initiated Counselling and Testing
PMG	Program Management Guidelines
PNG	Papua New Guinea
PRG	Program Reference Group
ProMEST	Provincial Monitoring, Evaluation & Surveillance Team
QA	Quality Assurance
QAI	Quality at Implementation
SCA	Save the Children Australia
SCiPNG	Save the Children in Papua New Guinea
SHFPA	Sexual Health and Family Planning Australia
SHP	Southern Highlands Province
SNS	Sub National Strategy
SO	Strategic Objective/s
SPSN	Strongim Pipol Strongim Nesen
STI	Sexually Transmitted Infection/s
STIMP	STI Management Program
SWAp	Sector Wide Approach
TAG	Technical Advisory Group
UNSW	University of New South Wales
VCT	Voluntary Counselling and Testing
VFM	Value for Money
WHP	Western Highlands Province

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Finally we thank all those with whom we have consulted for their time and frankness, especially those working in the field with tireless commitment in spite of the daily challenges they face.

Aid Activity Summary

Aid Activity Name	PNG-Australia Sexual Health Improvement Program		
AidWorks Initiative #	<u>ING918</u>		
Commencement Date	October 2007	Completion date	31.12.2012
Total Australian \$	AUD25,000,000 (upper limit)		
Total other \$			
Programs and Consortia	<ul style="list-style-type: none"> • 4 As: <i>Anglican Board of Mission (with Albion St. Centre)</i>, <i>Anglicare PNG</i> and <i>Anglican Health Services PNG</i> • STI Management Program (STIMP): <i>Caritas Australia (with Australasian Society for HIV Medicine (ASHM) and St Vincent's Hospital)</i>, <i>PNG Catholic Health Service (CHS)</i> • Clinical Outreach, Men's Programs, Advocacy and Sexual Health Services Strengthening (COMPASS): <i>Sexual Health and Family Planning Australia</i> (with <i>Family Planning New South Wales</i>, <i>New Zealand Family Planning International</i>; Melbourne, Cairns and Canberra Sexual Health Centres with <i>Help Resources (PNG)</i> <i>PNG Family Health Association</i> • East New Britain Sexual Health Improvement Program (ENBSHIP): <i>Burnet Institute (with Cairns Sexual Health Centre and International Women's Development Agency)</i> • Lusa Numini Project: <i>Save the Children Australia</i>, <i>Save the Children in PNG</i> • <i>Institute for Medical Research PNG</i> 		
Country/Region	PNG (8 Provinces): National Capital District, Southern Highlands, Oro, Simbu, Eastern Highlands, Morobe, East New Britain & East Sepik		
Primary Sector	Health/HIV		

Executive Summary

The Papua New Guinea Australia Sexual Health Improvement Program (PASHIP) is a partnership between five consortia of Australian Non-Governmental Organisations (ANGOs) and Papua New Guinea (PNG) organisations, the PNG National Department of Health (NDoH) and the Australian Agency for International Development (AusAID). These bodies share the common goal of reducing the incidence of HIV in PNG, through the provision of improved sexual health and sexually transmitted infection (STI) services to target communities. The AusAID funding agreements are with the five lead Australian NGOs, all of which have undergone AusAID's NGO accreditation process and are fully accredited by AusAID. It is a five year program from 2007-2012 with funding of up to AUD25 million.

Sexually transmitted infections are a critical health issue in PNG with high rates of infection particularly in the highlands provinces. More than two thirds of reported STI cases are in females. PASHIP was mobilised to address these issues and to model innovative forms of gender sensitive STI service delivery working through Non-State Actors¹ (NSAs) and provincial health departments.

The program's specific objectives are:

- to increase access to, and use of, STI management and prevention services by the target communities, including appropriate groups of which vulnerable populations such as youth and women are a part; and
- to determine and disseminate the elements of effective and innovative PNG-specific STI services to showcase opportunities to improve STI services nationally.

The program was initially coordinated and managed by the AusAID health program at Port Moresby Post but has subsequently moved to the HIV program. A PASHIP Secretariat was set up in 2008 in close collaboration with NDoH and AusAID to ensure alignment and coherence between PASHIP and national and sub-national health systems. The PASHIP Secretariat was envisaged to be central to the coordination and management of the Program. It was to consist of a Program Liaison Officer and an Administrative Support Officer, both jointly selected by NDoH and AusAID.

This Independent Progress Report (IPR) was commissioned with the following objectives:

- to assess the extent to which the program goal and objectives have been achieved including the research component;
- to assess consistency between management and implementation of the program and the program design;
- to identify issues which need to be addressed to improve the implementation and management of PASHIP through to December 2012 and recommend a course of action to accomplish this; and
- to inform future support for STI and HIV prevention in PNG beyond 2012.

The review took place between 11 and 29 November 2010.

¹ Non-State Actors refers to non government agencies including faith based and private organisations.

Several constraints limited the work of the IPR team:

- limited time for document review due to slow release of key documents, lack of organisation of documents, and large volume of documents;
- limited time in country, especially for site visits, resulting in the team failing to visit any rural sites;
- lack of full consideration of the potential for emerging security issues to disrupt and constrain the IPR schedule, resulting in pre-arranged trips to the Simbu Province and Kainantu in the Eastern Highlands Province (EHP) being cancelled. As a result the team did not visit any of the Caritas sites or the Kainantu Lusa Numini Project (LNP) site; and
- dearth of reliable/comparable data for analysis due to poor monitoring and evaluation (M&E) system.

Key Findings

PASHIP is highly relevant and enjoys a high level of concurrence with broader strategic frameworks in PNG and internationally.

The program is making good overall progress towards Objective 1 in terms of improving services and accessibility. All projects have strengthened clinical service delivery in the provinces where they work.

Some promising and sustainable models of NSAs delivering services in close partnership with provincial health divisions are emerging. In EHP, the LNP has recruited and managed clinical staff to deliver STI services through government clinics, and the provincial government has committed to taking over responsibility for these positions after 2012. Clinic attendance and exit surveys show great acceptance of the service. The Clinical Outreach, Men's Programs, Advocacy and Sexual Health Services Strengthening project in Morobe (COMPASS) has supported a clinical skills upgrade through a volunteer placement, and subsequent supervision will be conducted by the provincial health division.

PASHIP implementing partners (IP) are addressing gender equality structurally in their programs through

- the application of NDoH minimum standards at clinic sites, ensuring separate consultation spaces for males and females;
- the appointment of male and female service providers to work with male and female clients accordingly; and
- the provision of male and female condoms.

Substantively, gender inequality is addressed through community conversations and peer education. The issue of gender based violence and its links with HIV have been successfully raised through targeted discreet male involvement programs.

Progress towards Objective 2 has been much slower. This is largely because the significant management requirements of PASHIP were underestimated from inception. The Secretariat has failed to establish itself due to lack of institutional home and poor staff retention. As a result, PASHIP has been operating as a series of projects rather than a program. Monitoring has not been applied systematically across the program and this, together with the absence of any knowledge management plan, has seriously constrained program wide analysis and lesson learning.

The concept of a PASHIP-wide research component which could measure impact has not been realised. Although PASHIP is approaching its fourth year of implementation there is, as yet, no baseline data against which the impact of PASHIP could be measured after 2012. This is due in part to weak capacity of the IP for research but also slow mobilisation of the program in general, poor initial planning of the research component and poor oversight.

As a program, PASHIP has therefore been inefficient. However, with sustained support and attention to the Secretariat over the next two years, this situation can be remedied.

In spite of weak program management, some important lessons have been learned at project level.

- NSAs can provide good quality sexual health services in collaboration with government which is complementary rather than parallel.
- Effective partnerships with provincial health divisions depend on mutual accountability.
- Locally managed and owned models are more likely to be sustainable than externally managed ones.
- Clinical skills training needs to be supported by regular supervision and continuing professional development in order for quality to be maintained.
- Targeting men can increase their health service usage as long as male health workers are continually available.
- The greater number of women accessing services and an increasing demand for reproductive health services justifies an expanded service through STI facilities including family planning as a minimum.

There are excellent opportunities now, with the new Secretariat housed in the HIV program, to begin to pull PASHIP together as a program and better realise its achievements and synergies. There are many lessons to be learned from the program, which need to be systematically collected, collated and disseminated. These will inform any future collaboration between NSAs and provincial government offices for health service delivery.

Key Recommendations

Recommendations for the remaining two years focus on strengthening the Secretariat which will ultimately strengthen program management.

AusAID HIV program, PASHIP secretariat and NDoH:

- develop a joint action plan based on the recommendations in this report (see *recommendation 18, page 17*);
- strengthen the M&E function of the PASHIP Secretariat and IP to ensure that M&E is conducted according to a jointly agreed framework and applied program wide (see *recommendation 5, page 11 & recommendation 26, page 25*);
- organise field visits to all sites for joint induction and agree at least six monthly visits to help cement PASHIP as a program (see *recommendation 16, page 17*);
- begin documenting lessons learned to date and capture qualitative data (see *recommendation 11, page 14*);
- establish a Technical Advisory Group to support the Secretariat (see *recommendation 28, page 30*);

AusAID HIV Program and IMR.

- agree that data collected by the PNG Institute of Medical Research (IMR) to date be analysed and written up by the end of 2011 (*see recommendation 12, page 15*);

AusAID HIV program, the PASHIP Secretariat and IP:

- with National AIDS Council Secretariat (NACS), AusAID HIV program and NDoH, ensure that Annual Activity Plans (AAP) are aligned to the National HIV and AIDS Strategy 2011-2015 (NHS) and the National Health Plan 2011-2020 (NHP); (*see recommendation 1, page 6*);
- reorient the Program Reference Group (PRG) process to ensure that maximum benefit is obtained; (*see recommendation 10, page 14*); and

PASHIP Secretariat, NDoH and IP

- facilitate key refresher training courses for IP e.g. in Provider Initiated Counselling and Testing (PICT) and National Health Information System (NHIS). (*see recommendation 7 page 12 and recommendation 21 page 23*).

Post 2012, further attention to STI service delivery will be essential. This should be supported under the auspices of health sector support. The preferred way forward is for AusAID to engage an experienced facilitator to support the development of a participatory design. This would take place between now and 2012 and would require all partners to identify:

- what has worked and can be replicated or built on;
- where services are needed and where the gaps are; and
- which additional IP are needed.

Based on these consultations, a jointly developed health outcome oriented program for priority provinces would be facilitated.

The new program management would be supported by a flexible facility until such time that donor funds can be more accountably channelled through the Health Sector Wide Approach (SWAp).

Table: Evaluation Criteria (Summary)

These ratings are presented as an aggregate for the whole program. Some projects, therefore, would score higher if ranked individually.

Evaluation Criteria	Rating (1-6)	Explanation
Relevance	6	Highly relevant to current and future strategic frameworks e.g. NHS, Health Sector Delivery Strategy (HSDS), MTDP (Medium Term Delivery Plan) & NHP.
Effectiveness	4	All projects have increased access to and use of STI services (Objective 1). Innovative models emerging but limited focus on knowledge management is not capturing lessons learned well (Objective 2). Research component ineffective.
Efficiency	3	Program level efficiency very poor. Significantly more attention needed to program management under the Secretariat. Considerable variation between project efficiencies. LNP emerging as most efficient model. ANGO model of management is less cost efficient than locally managed.
Sustainability	4	PNG based IP with stronger institutional governance have greater prospects for longer term sustainability (LNP, Anglicare and CHS). Provincial health division commitment is vital for sustainability and not uniformly present in PASHIP provinces. Reliance on volunteers challenges sustainability.
Gender Equality	4	Gender equality addressed structurally through application of NDoH minimum standards which allows for separate consulting space for males and females; appointment of male and female service providers to work with male and female clients accordingly; provision of male and female condoms. Gender based violence and its links with HIV addressed in community conversations and through peer educators; special focus on male involvement.
Monitoring & Evaluation	2	Very poor across the program with no consistency. IP conducting their own M&E. Uneven reporting to Secretariat. Poor adherence to M&E framework.
Analysis & Learning	2	Limited analysis and learning across the program due to absence of knowledge management system. Some IP conducting their own analyses.

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

1. Introduction

The Papua New Guinea Australia Sexual Health Improvement Program (PASHIP) is a partnership between the Australian Agency for International Development (AusAID), Australian Non-Governmental Organisations (ANGOs), Papua New Guinea (PNG) organisations and the National Department of Health (NDoH) with a common goal to reduce the rate of increase of HIV transmission in PNG through the provision of improved sexual health and sexually transmitted infection (STI) services to target communities. It is a five year program, for the period 2007-2012, with funding of up to AUD25 million.

PASHIP is implemented by five consortia of ANGOs and PNG Non-Government Organisations (NGOs) to provide improved sexual health and STI services in several PNG provinces: the National Capital District (NCD), Southern Highlands Province (SHP), Oro, Simbu, Eastern Highlands Province (EHP), Morobe, East Sepik and East New Britain (ENB). The program also includes a significant bio-behavioural research component which is implemented by the PNG Institute of Medical Research (IMR).

The AusAID funding agreements are with the five lead ANGOs all of which have undergone AusAID's NGO accreditation process and are fully accredited by AusAID. The accreditation process aims to provide AusAID, and the Australian public, with confidence that the Australian Government is funding professional, well managed, community based organisations that are capable of delivering quality development outcomes. The criteria for full accreditation require that the NGO:

- can monitor, report and rate effectiveness of activities;
- has systems for continuous improvement of its management and operations;
- has documented partnerships with organisations in the countries where it works; and
- has assessed its own capacity and the capacity of its partner organisations to deliver and develop projects appropriate for that capacity.

The overarching document for the program is the PASHIP Concept Note of March 2006, which was designed as a flexible document to encourage innovative and different approaches from applicants.

PASHIP's goal, as defined in the Concept Note, is 'to reduce the rate of increase of HIV prevalence.' Its purpose is 'to reduce the prevalence of STIs through the provision and use of integrated sexual health services.'

The program's specific objectives are:

- increasing access to, and use of, STI management and prevention services by the target communities, including appropriate groups of which vulnerable populations such as youth and women are a part; and
- determining and disseminate the elements of effective and innovative PNG specific STI services to showcase opportunities to improve STI services nationally.

The program was originally coordinated and managed by the AusAID health program at Port Moresby Post in coordination with the HIV program. A PASHIP Secretariat was established at NDoH in 2008 in close collaboration with NDoH and AusAID to ensure alignment and coherence across systems. Program management responsibilities for PASHIP and the Secretariat were transferred to the PNG-Australia HIV Program in May 2009. Three of the programs (4 As, ENBSHIP, Lusa Numini) began implementation in late 2007 while the remaining programs began in 2008 (Caritas, COMPASS, IMR).

1.1. Country context

PNG has a high prevalence of STIs in both rural and urban areas. It is now well documented that the presence of some STIs is clinically linked to an individual's increased chance of contracting HIV.² STI management is therefore considered to be an essential component of any HIV prevention program.

Since PASHIP was designed there has been significant improvement in data collection, analysis and reporting of HIV and STIs in PNG. At a consensus workshop in June 2010, the national HIV prevalence among adults aged 15-49 was revised, and changed from 1.28 per cent (2006)³ to 0.9 per cent.⁴ This national rate disguises relatively high levels of HIV in some provinces, particularly the Highlands. According to the most recent sentinel surveillance report, seven provinces accounted for 90 per cent of all reported HIV cases in 2009.⁵ These included all provinces from the Highlands region: Western Highlands Province (WHP) (26.3 per cent), EHP (11.2 per cent), Enga (11.0 per cent), SHP (6.1 per cent), Simbu (5.7 per cent); and NCD (20.7 per cent) and Morobe (9.0 per cent).

The number of reported STI cases was also greater in the Highlands region (EHP 39.3 per cent, WHP 18.4 per cent, Simbu 9.7 per cent, SHP 4.7 per cent, and Enga 2.3 per cent); along with NCD (7.6 per cent), Morobe (3.6 per cent) and Madang (3.6 per cent). This data indicates that the Highlands provinces, NCD, Morobe and Madang are key priorities for STI prevention and treatment services.

More than two thirds of the total reported STI cases in 2009 were females. This ratio is the result of multiple factors. Women are more vulnerable to STIs and HIV than men, both physically and socially due to higher rates of sexual violence towards women. Polygamous marital practices also contribute to the gender imbalance. Finally, more women seek sexual health services than men, and STI screening for syphilis is included in antenatal clinic services.

It is important to acknowledge here the particular challenges of the program. The program's management complexity (with ANGOs working in consortia partnerships at various levels of capacity) and its technical ambition, together with the specific challenges of working in sexual health in PNG should be noted.

1.2. PASHIP Implementing Partners (IP) and locations

PASHIP is implemented by five consortia of Australian and PNG NGOs and the IMR. Their focus of work and various locations are described in the box below. For a full summary of each IP project objectives see Annex 1.

Table 1: Implementing Partners

Project name and implementing partners (IP)	Focus of work	Location
The 4 As: Anglican Board of Mission, Albion Street Centre (Australia), Anglicare StopAIDS (PNG) and Anglican	STI facility construction; STI service delivery; and Health Worker Training	Port Moresby, NCD and Oro Bay, Oro

² Grosskurth H, Gray R, Hayes R, Mabey D Wawer M (2001), Control of sexually transmitted diseases for HIV-1 prevention: understanding the implications of the Mwanza and Rakai trials, *The Lancet*, Vol 355, Issue 9219, pp 1981-1987

³ HIV and AIDS Estimation Report, NDoH, 2007

⁴ NACS and NDoH, Consensus Workshop on HIV Estimation in PNG, 8-10 June 2010

⁵ The 2009 STI, HIV and AIDS Annual Surveillance Report, NDoH, October 2010

Project name and implementing partners (IP)	Focus of work	Location
Health Services (PNG).		
STI Management Program (STIMP): Caritas Australia, National Catholic Family Life Apostolate of PNG & Solomon Islands, National Catholic Health Service of PNG, National Catholic AIDS Office of PNG & Solomon Islands, ASHM, Catholic Health Australia	STI service strengthening; clinic refurbishment; behavioural research	SHP and Simbu
Clinical Outreach, Men's Programs, Advocacy and Sexual Health Services Strengthening (COMPASS): Sexual Health and Family Planning Australia, Family Planning New Zealand, Canberra Sexual Health Centre in consortium with Help Resources (PNG) and PNG Family Health Association.	Men & Boys Program; Service Support & Outreach Services; STI services; training for health workers	Lae (Morobe), Wewak (East Sepik) & Rabaul (ENB)
East New Britain Sexual Health Improvement Program (ENBSHIP): Burnet Institute (Australia), Cairns Sexual Health Centre & International Women's Development Agency	STI clinical service improvement; community outreach through <i>stret toker</i> volunteers	ENB
Lusa Numini Project (LNP): Save the Children Australia, Save the Children in PNG	STI clinic construction/refurbishment; capacity building of health workers; outreach	West Goroka, Kainantu and Sigeri (EHP)
PNG Institute of Medical Research (IMR)	Integrated Bio-behavioural Surveillance (IBBS) for HIV and STIs	All PASHIP sites

1.3. The review objectives and questions

This Independent Progress Report (IPR) was commissioned with the following objectives:

- to assess the extent to which the goal and objectives of the program have been achieved including the research component;
- to assess consistency between management and implementation of the program and the program design;

- to identify issues which need to be addressed to improve the implementation and management of PASHIP through to December 2012 and recommend a course of action to accomplish this;
- to inform future support for STI and HIV prevention in PNG beyond 2012; and
- to consider how areas of the program can be strengthened. There are concerns about the implementation and effectiveness of the program and the review will make recommendations to improve effectiveness and efficiency.

In addressing these objectives the team was specifically asked to assess the following:

- whether the key objectives/outcomes of the PASHIP were realistic and have been or are on track to be met;
- the strengths, weaknesses, assumptions and appropriateness of the funding/implementation model (including its achievements, value for money, management processes and evaluation, research and monitoring systems);
- the achievement of sustainable benefits from the project that may be beneficial and useful to the Government of Papua New Guinea (GoPNG) for future projects, including the type of capacity development and research undertaken;
- the integration of AusAID's cross cutting policies, particularly gender, into PASHIP activities and lessons learned for future projects;
- coherence and linkages with other HIV & Health initiatives, other AusAID supported initiatives, such as the Sub-National Strategy (SNS), CARE, and other relevant Government of PNG (GoPNG) activities;
- the extent to which the environmental impacts (if any) of the project were managed;
- the relevance of PASHIP against the broader objectives of the Australian aid program in PNG;
- the relevance of the current Program Management Guidelines (PMG) (and make recommendations for changes); and
- the overall efficiency and effectiveness of PASHIP (and recommend a course of action to address identified constraints and identify areas for scale up).

For the complete Terms of Reference see Annex 2.

1.4. Review methodology

The methodology applied a mixture of approaches. These included document review, semi-structured interviews with individuals and groups representing the various stakeholders (see Annex 3 for Question Guide), and site observations. Consultations with service users were held where possible. Finally, partners were invited to make suggestions for improvements to PASHIP during the PRG meeting and cards were distributed to each participant and a suggestions box provided. Seven comments were received (see Annex 6).

There were several major constraints to this review:

- limited time for document review due to a) slow release of key documents (at time of writing some documents were still unavailable (particularly Annual Progress Reports for 2009 from some IP), b) lack of organisation of documents and c) the large volume of documents;
- limited time in country especially for site visits resulting in the team failing to visit any rural site;
- lack of full consideration of the potential for emerging security issues to disrupt and constrain the IPR schedule, which resulted in pre-arranged trips to Simbu

Province and Kainantu in EHP being cancelled (as a result the team did not visit any Caritas sites); and

- dearth of reliable/comparable data for analysis due to a poor monitoring and evaluation (M&E) system across the program.

These constraints must be borne in mind when considering the findings.

1.5. Review team

The review team consisted of the team leader Kate Butcher, technical specialist Shane Martin, GoPNG representative Mr Martin Korokan from the National Department of Planning & Monitoring and an AusAID representative from Canberra, Ms Bonita Maywald. The team was well balanced, with two women and two men, bringing a good mix of skills and experience, both local and international. There was no conflict of interest.

2. Review Findings

2.1. Relevance

The program goal and objectives remain relevant to the context of PNG. As outlined above, the STI epidemic in PNG continues to be of significant concern with high rates of infection. However, there is limited focus on the issue. As the Independent Review Group (IRG) noted,

STI services continue to be the poor cousin of HIV with only eight per cent of pregnant women (8,339) tested for syphilis – a slight increase from the six per cent tested in 2008.⁶

PASHIP is the only program outside NDoH's own STI program which specifically focuses on strengthening effective STI prevention and management services in PNG.

While most PASHIP sites are located in the priority provinces detailed in the Concept Note, the IPR team notes some inconsistencies. For example, there is no site in WHP, while there is a site in Oro. This is of concern given that in 2009 WHP reported 47 times more STI cases than did Oro.

Coherence and linkages

In some respects PASHIP has greater relevance today than when the concept was first approved. This is reflected in a range of new national development frameworks and policies due to commence in 2011. These include the PNG Medium Term Development Plan 2011-2015 (MTDP), the National HIV and AIDS Strategy 2011-2015 (NHS), and the National Health Plan 2011-2020 (NHP).

The MTDP prioritises improved service delivery, with a greater focus on partnerships with NSAs. The NHP provides a specific roadmap for improving health service delivery, including scaling up prevention, treatment care and support for STI and HIV to meet universal targets (NHP: Key Result Area 6.3).

The NHS provides an important strategic framework for PASHIP as it places a greater emphasis on STI prevention and management as a core HIV prevention strategy, improved STI/HIV surveillance, and improved service integration, especially for Provider Initiated Counselling and Testing (PICT) in STI services. PASHIP currently addresses five of the top ten interventions outlined in the NHS, and directly or indirectly addresses 40 out of the 105 Strategic Objectives (SOs) within the NHS (12 SOs under Priority Area 1 - Prevention; 7 SOs under Priority Area 2 – Counselling, Testing, Treatment, Care & Support; and 21 SOs under Priority Area 3 – Systems Strengthening).

PASHIP's focus on building partnerships between NSAs and government is also aligned with AusAID's emerging Health Sector Delivery Strategy (HSDS). HSDS aims to strengthen health service delivery at all levels in partnership with a range of state and non state agencies.

To cement PASHIP commitment to policy alignment, the secretariat should now support IP to reflect the new NHS and NHP in their Annual Activity Plans (AAP).

Recommendation 1: Enhance alignment of IP Annual Activity Plans with relevant national policies i.e. NHS and NHP.

PASHIP's focus on aligning services with government processes is in line with the Paris Declaration on Aid Effectiveness and its localised interpretation, Kavieng Declaration on Aid Effectiveness, the Accra Agenda for Action and the GoPNG

⁶ Independent Review Group on HIV and AIDS, Assessment Report, April-May 2010

Australia Partnership for Development. PASHIP also contributes to the Partnership for Development priority outcome of improved health as well as the Development Cooperation Treaty Review's recommended focus on health.

Globally, PASHIP's focus on reducing HIV through improved sexual health relates particularly to Millennium Development Goal 6: 'Combat HIV/AIDS, Malaria and Other Diseases.'

The Cairns Compact calls for more effective coordination of development resources. Opportunities for PASHIP to share lessons learned around partnerships between NSAs and government in delivering services exist with the new Asian Development Bank (ADB) Basic Health Services program (currently in design). This is likely to focus on West New Britain, Morobe, East Sepik, WHP and Enga and will look at improving primary health care services through partnerships between state and NSAs.⁷ Pooled funding for support to STI services may also be a consideration in the future.

There is room for improved coherence across AusAID's own programs. Three of the five IP are currently receiving funds from other AusAID sources, the Church Partnerships Program (CPP), the NGO grants program, Tingim Laip⁸ and Strongim Pipol Strongim Nesen (SPSN).⁹ The possible synergies and economies of scale that this might represent are currently not being realised. One way of addressing this would be to schedule PRG meetings to coincide with the NGO forum (this was proposed by a PASHIP partner).

Recommendation 2: Improve coherence across AusAID's own programs, for example by scheduling PRG meetings to coincide with the NGO forum and exploring synergies with SNS and SPSN.

At the provincial level, some implementing partners are coordinating efforts with SNS officers in the provinces where they are located (e.g. ENB and EHP). SNS officers attend steering committee meetings for IP and are kept informed of progress. However, there appears to be a limited understanding among IP of the SNS role in general. Given that both programs are ultimately pursuing improved service delivery, there is scope for the two programs to explore ways in which they can mutually benefit and strengthen each other.

2.2. Effectiveness

It is difficult to state conclusively to what degree PASHIP has contributed to the overall outcome of a reduced rate of increase of HIV by reducing the incidence and prevalence of STIs, through the provision and use of integrated sexual health services. However, it is clear that PASHIP has resulted in an increase of STI service availability in the provinces in which it operates. It has also supported the establishment or refurbishment of five STI service facilities (Mingende in Simbu, Lopi and Kainantu in EHP, Begabari in NCD and St Margaret's in Oro).

Currently, data collection and reporting is not consistent across projects. This makes it impossible to compare projects or to provide a *programmatic* picture of progress towards objectives. This is further confounded by the fact that the team did not visit all sites, or *any* Caritas sites, and the fact that several progress reports could not be provided.

⁷ From personal communication with Prof. Don Matheson of the ADB Proposed Project Preparatory Technical Assistance design team

⁸ AusAID program focusing on HIV service delivery through Civil Society Organisations (CSOs)

⁹ New AusAID program focusing on building capacity of CSOs for democratic governance

In the absence of comparative data, illustrative examples and indicative data are provided wherever they are available to demonstrate progress towards the two objectives.

PASHIP key achievements include:

- increased access to and uptake of STI services in PASHIP sites;
- increased numbers of STI facilities compliant with NDoH minimum standards;
- increased access to male and female condoms;
- gender based violence and its links with HIV being discussed openly at community level;
- increased availability of quality clinical staff in PASHIP provinces;
- agreed uptake of these staff positions by the provincial health departments (in EHP);
- joint supervisions with provincial health department (in EHP); and
- initiation of male involvement programs.

Progress towards Objective 1: Increase access to and use of STI management and prevention services

All models are seeking to improve both the supply of quality services and demand for them, and all partners are working in collaboration with provincial health divisions.

Lusa Numini Project (LNP), Save the Children Australia (SCA) and Save the Children in PNG (SCiPNG): The LNP in EHP is supporting the operations of Lopi clinic in Goroka and the Whitehouse Clinic at Kainantu. Original plans to work in Sigere have had to be suspended due to tribal fighting (this has also affected Caritas work in Det). Since the project began operating in 2008, the number of clients presenting for STI services has steadily increased from 2,773 (2,099 females and 674 males) to 7,475 clients in September 2010 (4,546 females and 2,929 males). This represents a growth over the two year period of 170 per cent. A cumulative 16,038 clients (10,302 female and 5,736 male) have received STI services at two PASHIP supported clinics in EHP. Over the same period, the proportion of males accessing STI services increased from 24 per cent in 2008 to 40 per cent in September 2010.

This is a positive trend and suggests that LNP is on track to ensuring males and females are equitably accessing STI services. LNP was the only partner able to provide the team with trend data.

LNP does not have a specific outreach component and notes that clients hear about the clinics by 'word of mouth'. It is important to note that Save the Children is running three other programs in the same location and these also provide information about STIs, HIV and relevant services. Nevertheless, the importance of word of mouth cannot be underestimated as it is a good gauge of community acceptance of a service and thus its quality. Word of mouth was also cited by the 4As project as a reason for client attendance.

East New Britain Sexual Health Improvement Program (ENBSHIP) Burnet Institute: The ENBSHIP project is focusing more intensively on creating demand and has developed an approach using volunteer 'stret tokers'. These individuals are trained during five workshops in sexual health and communication skills. They then work in communities on a one to one basis or in group sessions to discuss the issue of sexual health and promote access to services. HIV is currently not a direct part of the

training. One *stret toker* noted that 'people really want to know about HIV but we are not trained in that.'

Recommendation 3: It is strongly recommended that ENBSHIP liaise with the Provincial AIDS Committee and its secretariat (PAC/s) to ensure that *stret tokers* are equipped with correct factual information on HIV so that they can respond to community demand.

Since the *stret toker* program began, 3130 one-to-one sessions on STI awareness have been delivered. In the same period, 1748 community sessions have been conducted, and 319 individuals referred to health facilities. *Stret tokers* have distributed 7632 condoms to date. Most Significant Change Story methodology is used in the *stret toker* program, and stories of cultural shifts are being reported. These have included a growing appreciation among communities of the importance of addressing gender based violence and gender inequalities, as well as an increasing openness to condom use.

In addition, conversations with health workers and government health officials revealed a perception that some traditional cultural taboos have shifted. This is considered a result of PASHIP clinical staff being far more comfortable talking about sex and sexuality with clients, and conducting more thorough sexual histories. In some areas, it was reported that clients are far less concerned with being seen in queues at STI clinics. This shows promise for 'normalising' sexual health seeking behaviours.

ENBSHIP supports STI service delivery by working through the existing government system. This unfortunately means that the supply of services cannot always be guaranteed. In one of the clinics which ENBSHIP supports (Butuwin) there is one male STI clinician in attendance only two days a week.

This is problematic, as the program cannot always guarantee service availability, having raised community expectations. Available data shows that between January and September 2010, Vunapope hospital (Catholic Health Services (CHS)) saw 667 cases of STIs while the government operated Butuwin clinic saw only 31 in the same period. Vunapope has both male and female clinicians and Butuwin has only male. ENBSHIP is now considering refocusing attention to clinics with an already higher caseload rather than attempting to cover all facilities.

LNP has overcome this problem by recruiting a full complement of STI staff for Lopi clinic and three out of eight staff at Kainantu to ensure a constant and predictable service can be provided.

In EHP, supervision of STI services delivered by LNP is conducted by the Provincial Disease Control Officer and in collaboration with LNP. In ENB this is not happening and the onus of supervision falls on ENBSHIP. This demonstrates the importance of provincial commitment to the issue of sexual health.

Recommendation 4: It is recommended that ENBSHIP seek support from NDoH and SNS to secure operational commitment from the Provincial Health Division of ENB.

Clinical Outreach, Men's Programs, Advocacy and Sexual Health Services Strengthening (COMPASS), Sexual Health and Family Planning Australia: COMPASS is developing a distance health worker curriculum which focuses on improving both skills and attitudes of health workers. The latter issue emerges as critical in increasing access. The Lopi clinic staff cites several instances of clients coming from as far away as ENB because of the reputation of Lopi staff as being very friendly and non-judgmental. A community health worker from ENB herself said, 'Before I had the [STI] training I used to shout at people who had STIs because I didn't know what to do. Now I can treat them I don't shout any more.'

COMPASS is also working through existing government systems and providing technical support and backstopping for staff to improve clinical performance. This includes a range of training sessions, some clinical rotations and training in conducting clinical Quality Assurance (QA). The development of the clinical QA tool has become a sustainable monitoring activity as it is now administered by the Provincial STI/HIV Coordinator.

COMPASS also included the appointment of a medical officer through the Australian Volunteer International program in its design. Feedback from NDoH indicated that this approach has been more effective in building clinical skills than short term technical assistance and was also cost effective.

Discussions with the provincial and district health officials revealed a very strong ownership of the project and high satisfaction with the work that COMPASS has been doing to support STI service delivery in Morobe province.

Although ENBSHIP and COMPASS are taking similar approaches to health system strengthening it is clear that provincial ownership and commitment to PASHIP differs in the two provinces.

STI Management Program (STIMP), Caritas: As mentioned above, none of the Caritas sites were visited during this mission. Data is derived from reports or discussions. This Caritas managed program works with a wide range of existing CHS organisations in PNG. Their programs are based in quite challenging environments. These include the Southern Highlands, where tribal disputes have influenced uptake and delivery of services. Involvement in PASHIP has resulted in the building of a health service facility and construction of two staff houses in Det ensuring staff attendance at the clinic, and the establishment of a men's clinic in Simbu. Because the PASHIP component of Caritas complements existing services, it is difficult to make attributions to PASHIP alone. However, Caritas noted that work under PASHIP has resulted in 'better record keeping and monitoring of STI statistics.'

The 4As, Anglican Board of Mission, Albion centre, Anglicare and Anglican Health Services: The 4As project operates in NCD and in Oro. A large part of the 4As project was the building of a new clinic (Begabari). This has suffered significant delays and the first week of its opening coincided with the IPR mission.

Anglicare is relatively new in clinical service delivery, having built its reputation on Voluntary Counselling and Testing (VCT). While waiting for the clinic to be finalised, STI service accreditation was achieved and services delivered from the existing VCT premises. Estimates were made by the 4A's clinical team of up to 10 people attending on busy days for STI treatment and 15 for VCT, but on average about two people attended per day for STI treatment and about 8 for VCT. Given Begabari's location in NCD, higher rates of attendance should be expected in the near future.

Anglicare reported that between January and December 2010, 262 cases of STI were detected in men and 242 in women. The majority of male STI cases were reported among men aged 25-34 years followed by men aged 15-24 years, while the majority of female STI cases were reported among women in the 15-34 age group (that is, the 15-24 and 25-34 age groups were equally represented). One client was under 15 years old. Careful attention should be paid to the collection of this data to ensure that the construction has offered value for money. Outreach was also proposed to nearby settlements and the university to notify people of the new clinic's services. Given the high case load of other clinics in the Moresby area, there is ample opportunity for the 4As to begin marketing their services and formalising greater collaboration with government services (e.g. Heduru) and the NCD Health Department.

Estimates provided by St Margaret's in Oro suggest that approximately four to five people attend the clinic in a week for STI services. In addition one respondent noted that for a government clinic, the staffing is inadequate: 'Currently I have only one member of staff though three to four were mentioned in the design.'

Recommendation 5: The IPR team recommends greater attention to and application of program wide M&E systems to capture key information in a systematic way (see M&E section – 2.8, Recommendation 26).

Has capacity building of local NGOs been effective?

PASHIP encouraged consortia between ANGOs and local PNG NGOs in order to build capacity in country. The IP all have different approaches to this and some have succeeded better than others. LNP is part of SCiPNG which is already a well established organisation with strong institutional capacity and governance. Caritas runs STIMP as an integral part of Caritas work in PNG through the CHS. As such its capacity building of partners is an ongoing process regardless of PASHIP.

The 4As consortium included Anglican Board of Mission, Albion Street Centre in Australia and Anglicare and Anglican Health Services in PNG. Both local NGOs reported a lack of attention to institutional capacity. This is evidenced by the fact that the PASHIP coordinator position at Anglicare PNG has been vacant for 1.5 years and at St Margaret's for a year. 4As reported that they were focused on employing a PNG national to fill this position, which has resulted in lengthy delays in the current PNG employment climate. Anglicare reported that effective capacity building had occurred locally through clinical rotations at other services (e.g. Poro Sapot Project) and attendance at other PASHIP partner trainings (e.g. COMPASS) but was less convinced by the utility of overseas study tours.

Recommendation 6: The IPR recommends that PASHIP should focus on local solutions e.g. clinical rotations and attachments with other STI services within PNG, rather than promoting overseas clinical placements.

Both COMPASS and ENBSHIP planned to work with local NGOs and both reported difficulties in these relationships, either because of high staff turnover or low ownership of the project. Nevertheless, COMPASS has demonstrated that clinical capacity can be built sustainably without reliance on a local NGO as long as there is provincial and district commitment.

Application of Provider Initiated Counselling and Testing (PICT)

The most recent IRG report noted that

in 2008 there were 56,412 cases of STI reported nationally, but only 6 per cent of these were offered or accepted an HIV test. This is a missed opportunity and a huge threat as large numbers of individuals leave health services not knowing they are HIV positive.⁹

The review team was asked to investigate this specifically. This was challenging in light of the lack of data reported by IP. Using LNP as an example (where data from PASHIP sites is consistently collected and reported), it is apparent that greater efforts are needed to facilitate the uptake of PICT at STI services. For the month of October 2010, 6 per cent of clients at Lopi Clinic had a HIV test through PICT (which is consistent with the national average), while 24 per cent of clients at Whitehouse Clinic in Kainantu accepted PICT.

⁹ Independent Review Group on HIV and AIDS, Assessment Report, April-May 2010

The NHS target for PICT is that 100 per cent of clients accessing STI services will be given PICT. There is clearly a long way to go in achieving this. When asked how clients responded to the PICT approach one PASHIP service provider replied,

We tell them the test is available if they want it and leave it to them to make the choice. It's a free country... Most people refuse having an HIV test. Women who are positive for syphilis often say they don't want a test but they will think about it.

This provides a fair reflection of most people's responses. It suggests that a greater understanding of how PICT differs from VCT may be needed. This was reiterated by the representative from the Clinton Health Access Initiative (CHAI) in Goroka.

Certainly the implications of a positive test for women are likely to be experienced differently from men, and this may influence their choice. In addition, STI service providers may be reluctant to promote testing if they are not able to provide Anti-Retroviral Therapy (ART) or in areas where ART is not available. However, there may be a range of other reasons, so further investigation and understanding is required before any assumptions are made about how best to address the issue. While the focus of PASHIP is STI service delivery rather than direct HIV services there is an equal need to ensure that VCT sites are also offering STI tests wherever possible (for example where the VCT site is part of a health facility) or at least referrals to STI services. LNP links its services in this way and 4As is planning to manage referrals on site so that those seeking VCT can also readily access STI services although the services will be kept separate 'in case people don't want STI services.'

The IPR team noted a need for greater emphasis to be placed on PICT, ensuring that it is well understood by clinical staff and offered at every STI consultation. There also needs to be a greater focus on collaboration between VCT and STI services across all PASHIP clinical partners and AusAID's broader HIV&AIDS Program.

Recommendation 7: Provide a program of refresher training for clinical staff supported by PASHIP on key issues including PICT; ensure all STI consultations offer PICT and better collaboration between VCT and STI services (see also recommendation 21).

Prevention

Significant effort has gone into upgrading and expanding clinical skills for STI screening and management. However, IP have not lost sight of the importance of prevention and several strategies are emerging.

All sites visited are providing male and female condoms, and basic primary and secondary prevention information. As mentioned earlier, no Caritas sites were visited but the team was assured that at Caritas sites, a comprehensive prevention and counselling program consistent with the approach of the Catholic Church is reported as being conducted. Whilst the program approach ensured cooperation with NDoH, Caritas did not fund the promotion nor distribution of condoms. It was the Government of PNG through its own agency that supplied the stock of condoms.

Anecdotal evidence from some PASHIP sites indicated that men have a preference for female condoms while women have a preference for male condoms. The common reason cited for women's low uptake of female condoms is lack of understanding in how to use them correctly. This suggests that female condom demonstrations with female clients are not universally conducted across all sites. Where the scant condom distribution data has been provided to the IPR team, it is evident that the rate of female condom distribution is extremely low. Considering that females outnumber males at a rate of 2 to 1 in accessing STI services, there are

significant missed opportunities for education with female clients on the benefits of female condoms.

Recommendation 8: The IPR team recommends that all PASHIP partners include specific outputs for actively promoting male and female condoms in their Annual Activity Plans (AAPs), with specific attention to standardising the practice of demonstrating female condom use with female clients to increase the uptake of female condom use.

As mentioned elsewhere no Caritas site was visited. From information provided in the public report *Sik nogut o nomol sik* it emerged that at the Caritas Gogolme Health Centre 'one of the strategies used to minimise multiple infections and re-infections is not to offer treatment until both sexual partners show up.'¹⁰ Couple counselling and testing has reportedly improved since this strategy was introduced. There are obvious ethical and legal dilemmas implicit in this approach.

Recommendation 9: The IPR recommends that the Secretariat and NDoH should address the strategy of refusing of treatment to individuals as a matter of priority.

Couple counselling is also encouraged at the clinics the team visited. However, respondents noted that there are problems with couple counselling particularly with regard to gender inequality. If a woman tests positive for syphilis through an antenatal check she is understandably fearful that disclosure to her partner may result in violence. Nevertheless, having to deal with anger during couple counselling was reported by several practitioners as a common occurrence, and presents an occupational risk to health workers.

Measuring the success of prevention efforts is complex, but one indicator the IPR team investigated was the number of repeat infections. In discussion with IP and subsequently with NDoH it is clear that there is confusion about whether the NHIS forms can capture repeat visits for STIs; 'We do have people coming again and again for STIs but this is not recorded.'

Overall, the IPR team noted that PASHIP is making good progress towards Objective 1. Better reporting and capture of information through knowledge management and improved M&E (see below) will provide a more solid evidence base for the future.

Progress towards Objective 2: 'Identify and share effective and innovative PNG specific STI service approaches'

To date there has been no attention to developing a knowledge management system to support PASHIP and this has seriously constrained achievement towards Objective 2. Although PASHIP is modelling innovative approaches to STI service delivery and is learning valuable lessons from the process, the lack of attention to systematic knowledge management fails to do the program justice.

The PRG meetings occur twice a year and all partners attend including representatives of provincial health, NDoH, ANGOs and local IP. As such, the meetings offer an excellent opportunity for exchange of experience and innovation but this opportunity is not yet being realised. All respondents agreed that the previous PRG in Goroka was extremely useful since it provided an opportunity for partners to see a project in action. This generated much discussion and interest but the notes taken from the meeting have been lost and never circulated.

¹⁰ Gibbs, P. and Mondu, M., 'Sik nogut o nomol sik', Caritas, 2010

The PRG represents an opportunity for PASHIP to build a community of practice among NSAs involved in sexual health service delivery. This can serve as a knowledge hub for the program and should be expanded to include other practitioners in STI services who currently do not receive PASHIP funds, for example Oil Search, Esso Highlands, CHAI and the ADB rural enclaves program (ending in June 2011). IP representatives themselves suggested that they could facilitate the meetings instead of hiring an external facilitator. Indeed, one respondent noted of the PRG 'we need to move from 'knowing' to 'doing' jointly.

The Secretariat should manage the logistics while the IP rotates facilitation, thus dispensing with an external facilitator. The focus of the PRG should be more on reflection and analysis than on administrative issues which could be better managed virtually in part. In addition, a rescheduling of PRG meetings to coincide with NGO forums would maximise synergies between STI and HIV service providers and save costs. It is felt that this reorientation will serve two purposes: firstly it will enhance the effectiveness of the PRG mechanism and secondly it will make a more useful contribution to Objective 2.

Recommendation 10: The IPR Team recommends that a reorientation of the PRG is needed to enhance joint learning and action. This should include more virtual administration, increased focus at meetings on reflection and analysis; increased involvement of IP in the PRG process; scheduling of meetings to coincide with NGO forums; expansion of attendance to non PASHIP STI service providers as observers; regular minuting and development of action plans to be monitored by the secretariat liaison officer.

Some interesting examples of skills exchange have occurred across PASHIP partners. COMPASS and ENBSHIP partners have been trained by LNP, and clinical attachments have occurred where new staff shadow more experienced practitioners. Caritas has organised attachments for newly trained staff to Mendi hospital. Caritas produced a research report in 2010 entitled *Sik nogut o nomul sik*¹¹ which seeks to assess local knowledge, attitudes and practices around STI and HIV in SHP and develop strategies based on the findings.

Over the remaining two years of PASHIP considerable effort is needed to develop a knowledge management system which can capture these emerging examples of good practice. This is different from M&E (see below) and should focus specifically on documentation and lessons learned.

Recommendation 11: A consultant with experience in managing Most Significant Change Methodology or other participatory approaches be recruited for six months to document each IP model, its perceived success and challenges in order to arrive at a set of principles for successful NSA and government partnerships.

2.3. Research

The initial confusion between roles and responsibilities of the IMR in relation to M&E and research has hampered progress in this area for the duration of the program. As a result there is still no baseline data available against which to measure PASHIP progress.

IMR was engaged to implement the bio-behavioural research component, which included conducting bio-behavioural surveys at three time points in the PASHIP life cycle (baseline, mid-point and end of program). The decision-making process did not include a capacity assessment to ensure that IMR had the technical and human

¹¹ Ibid.

resource capacity to undertake this enormous task. This is despite an AusAID study in 2008 concluding that 'IMR's capacity was already thinly stretched.'¹²

Issues with the baseline study include:

- **Timing:** Most IP had commenced implementation before IMR could conduct biological and behavioural baseline data collection. Notwithstanding the capacity issues at IMR, programmatically the baseline should have started at least 12 months prior to any implementation activity.
- **Specimen management:** Due to the nature and timing of data collection in the field, specimens were often stored in conditions that may have affected their integrity, thereby raising concerns on the quality of analysis.
- **Communication:** Much confusion between IMR and other IP as to who is responsible for arranging to provide HIV positive results to research participants. This should have been clearly articulated in the research protocol and PASHIP partner agreements (if this was to be an IP responsibility).
- **Delays in providing HIV results to participants:** In some instances there were delays of up to six months in providing confirmed HIV reactive results to research participants.
- **Delays in providing baseline data:** PASHIP is now entering its fourth year and baseline results are still not available. However, they are expected to be completed in the coming weeks. This however, raises concerns about the utility and applicability of the baseline results to PASHIP; with serious reservations about the rationale for continuing with the next two data collection exercises, as indicated in the program design.
- **Reporting:** Reporting on progress with the research component has not been compliant with PASHIP management guidelines. Only one progress report was submitted and no financial acquittals provided to date.

Due to the difficulties encountered in this component, and in light of the upcoming national Integrated Bio-behavioural Surveillance (IBBS), the IPR team strongly recommends the following:

Recommendation 12: IMR together with UNSW focus on analysing their existing PASHIP data and writing it up by end-2011 and that this will conclude their direct involvement in the program.

By way of a post script, the AusAID HIV program office advised IMR of this recommendation after the Aide Memoire presentation and it was accepted as UNSW was already assisting IMR with data analysis.

2.4. Efficiency

Consistency of design with management and implementation

Program design is detailed in the PASHIP Concept Note. Although the Concept Note conceived PASHIP as a program, the reality is that it has been implemented as a series of projects loosely connected through the Secretariat. This appears to be due to a lack of clarity around management and coordination arrangements.

PASHIP is a health service delivery improvement program. As such, it was intended to come under AusAID's Health Sector Program. The PASHIP PMG stipulate that a Secretariat 'central to the coordination and management of the Program' be established. According to the PMG, 'the Secretariat will consist of a team of two

¹² IMR, Human Resource Workforce Plan Design, 2008

people: a Program Liaison Officer and an Administrative Support Officer, jointly selected by NDoH and AusAID’.

The PASHIP Secretariat was established in 2008 to enable greater coordination between implementing partners, AusAID and NDoH. The Secretariat was resourced with two positions and was located within the Disease Control Branch at NDoH. Unfortunately lack of appropriate space within NDoH meant that the Secretariat had no permanent home, often having to ‘hot desk’ as desks became free. In addition, since the Sexual Health & STI advisor to the NDoH had no direct counterpart in the Department, technical support for PASHIP was reliant on only one individual already overstretched. The Secretariat appointees left within a year of being appointed.

Recommendation 13: Recruit and appoint the NDoH STI/Sexual Health Program Manager Position.

The design also underestimated the complexity of the program and subsequent management demands. It became clear that AusAID’s health program could not provide the necessary time or attention to PASHIP. In May 2009, programmatic oversight of the program moved to the PNG Australia HIV Program. This coincided with the physical relocation of the secretariat from the NDoH to the AusAID HIV Program office. However, staff-related issues continued to undermine effective management resulting in a lack of necessary attention.

In recognition of these shortcomings and the complexity of the Program, the HIV Program upgraded the AusAID activity management position from Assistant Program Manager to Program Manager. A new Secretariat liaison officer was also appointed in November 2010 and began work the same week that the review team arrived in country.

The design included research as an important aspect of all IP work. However, there was significant confusion at inception around differences between research and M&E, and who was responsible for each function. IMR was identified to take the lead in guiding and conducting bio-behavioural surveys as part of a programmatic evaluation framework. This decision was made without sufficient consideration of IMR capacity both technically and in terms of human resources. An earlier assessment of IMR’s overall human resources capacity already suggested that IMR was ‘stretched extremely thinly.’¹³ For more detailed discussion on the research component see above (at 2.3).

Finally, a general point of note is that the original concept of providing ‘comprehensive sexual health services’ has been limited by the program objectives which focus on STI services alone. There are opportunities over the next two years to look at how the program might expand its focus to include a broader understanding of sexual health in PNG. To this end, the IPR team suggests an improved dialogue between the PASHIP secretariat and IP with the PNG Sexual Health Society.

Recommendation 14: Establish dialogue with the PNG Sexual Health Society with a view to holding an annual conference for NSAs involved in sexual health service delivery as a way of raising the profile of sexual and reproductive health beyond STIs.

Program Management: the Secretariat

Since its inception, PASHIP has suffered from a lack of ownership and leadership at the national level. As described earlier, the Secretariat’s positioning under the AusAID health program and NDoH did not function effectively (for the Secretariat

¹³ IMR, Human Resource Workforce Plan Design, 2008

TOR see Annex 5). Subsequently, the following issues have challenged PASHIP efficiency:

- Poor oversight and lack of rigor applied to reviewing annual plans and reports submitted by IP.
- Lack of responsiveness to IP queries.
- Delays in grant disbursements after mobilisation.
- Lack of standardisation in reporting formats making comparisons between partner performance difficult, particularly with the view to demonstrating Value For Money (VFM).
- Lack of consistency in reporting on core indicators. Only LNP consistently reported key indicators enabling some trend analysis and an understanding of how outcomes are contributing to project and programmatic objectives and goals.
- Errors in financial reporting going unchecked, with some IP not declaring interest earnings or rolling interest earnings into subsequent budgets without seeking AusAID approval. The fully accredited ANGOs, who provide the PASHIP financial and progress reporting to AusAID, have been assessed as having effective financial systems for accounting for funding.
- Many IP confusing logical framework terminologies, confusing outputs with outcomes and targets with indicators. In fact some IP are still reporting on inputs delivered, where they should be reporting on outputs at a minimum and preferably outcomes. Fully accredited ANGOs have been assessed as being able to monitor, report and rate the outcomes and impact of development activities.
- No analysis of financial data/acquittals: Several IP reported one reason for variations between budgets and actual expenditures in 2009 was the lower Australian Dollar (AUD) value against the Papua New Guinea Kina (PGK), while another IP reported the stronger AUD was the reason for under-spending. Further, some explanations provided by IP for financial variances were cut and pasted from previous reports.

Stakeholders were largely unaware of the PMG for PASHIP. AusAID management noted that the PMG need to be updated as they do not include adequate explanation for Project Managers on how to manage program variations. This has resulted in some IP managers focusing too rigidly on their individual Project Designs. Other issues which need to be reflected in the PMG include guidance on the Quality at Implementation (QAI) reporting, and PASHIP's position on clinic launching and overseas study tours. Once these revisions are made the amended guidelines need to be circulated to all IP.

Recommendation 15: Revise Program Management Guidelines

With the appointment of a new Liaison Coordinator and upgrading of the AusAID Activity Manager's position there are now significant opportunities to improve program management efficiency and effectiveness. The team identified the need for a joint induction program for the Liaison Coordinator and Activity Manager together with the NDoH STI sexual health advisor where possible, with subsequent field visits to IP sites at least twice yearly. The induction program should include adequate orientation to the GoPNG/AusAID health delivery strategy and the new SPSN and SNS programs to ensure alignment.

Recommendation 16: Organise a joint induction program for the Liaison Coordinator and Activity Manager with subsequent field visits to IP sites at least twice yearly.

Recommendation 17: Align the PASHIP secretariat’s orientation to GoPNG/AusAID health delivery strategy and the new SPSN and SNS programs

While PASHIP is clearly a health service delivery program the IPR team recognises that the shift to the HIV program was a matter of expedience. Over the next two years, focus must be on ensuring alignment of PASHIP activities with the NDoH sexual health program and forging strong relationships.

The IPR team commends the recent AusAID attention given to strengthening the Secretariat, and recommends a consolidated plan of action to improve its performance. The plan of action should be based on recommendations arising from this report and should form a road map for the remainder of the program and into the future.

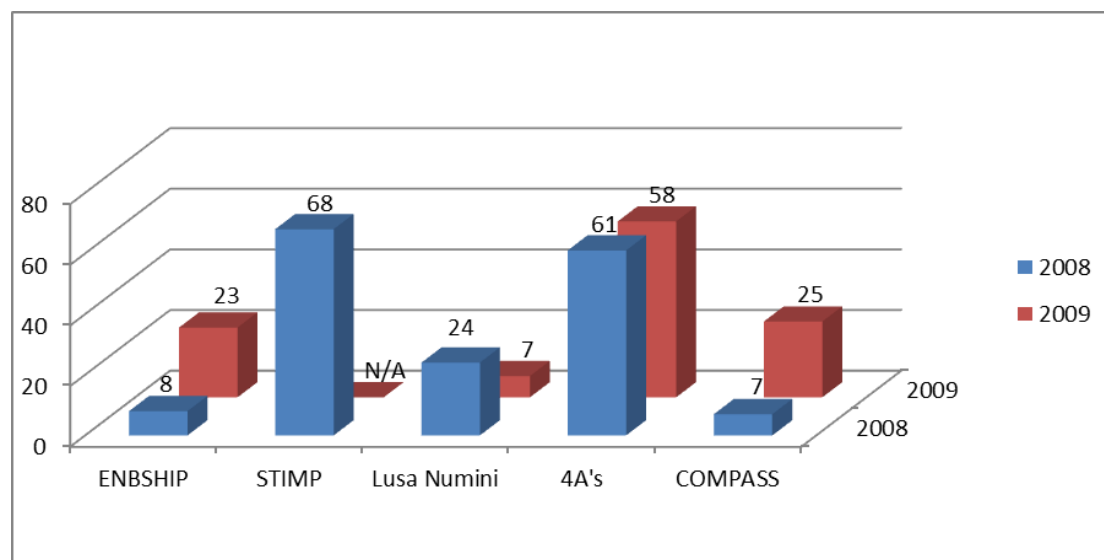
Recommendation 18: Develop a joint action plan based on recommendations in this report to chart the way forward over the remainder of the program.

Financial Efficiency

The team analysed the financial acquittals and documentation provided in order to assess PASHIP financial efficiency. Figure 1 below provides a basic analysis for expenditures of PASHIP partners against approved annual budgets. This should help the Secretariat to track how each project is faring and trigger alerts as to when issues may need to be explored in more detail. For example, as seen in Figure 1, the 4As under spent against the budget for 2008 and 2009. This is primarily due to delays in the construction of the Begabari clinic. The addition of the 2010 data when it is available will demonstrate whether the IP has been able to close this gap. Conversely, LNP has successfully closed the gap in its variations to budget, while also having experienced delays in construction and refurbishment of two clinics.

Tracking expenditures in this way will enable the Secretariat to predict whether or not there will be a significant underspend at the program level and take measures accordingly to reallocate unspent funds where they can be used.

Figure 1: Percentage of Budget Unspent (2008 & 2009)



Recommendation 19: Track IP under spending and identify areas for redistributing financial resources that are aligned with PASHIP objectives.

Project management: The Implementing Partners (IP)

The Review Team noted a lack of connection between some PNG based IP and their Australian based management. This was acknowledged by both Australian and PNG partners, who stated that ‘Managing a project from a distance can result in a lack of responsiveness and attention to needs on the ground’.

In addition, overseas based management can lack a cultural appreciation of what is important in PNG. Respondents from one IP noted that during a recent Australian study tour ‘not everything we saw was applicable here in PNG because of the differences in resources.’

An analysis of each IP expenditure on personnel costs (management coordination and Technical Assistance) for 2008 and 2009 in terms of whether these are Australian or PNG-based shows some interesting trends (refer to Figure 2 & 3 below). This has ranged from 100 per cent of personnel costs being based in PNG (LNP) to 99 per cent being Australian-based (for the 4As in 2009).

Based on progress reports made available to date, there appears to be somewhat of an inverse relationship emerging between the degree to which projects are managed off-shore and the achievement of development health outcomes¹⁴.

Figure 2: 2008 Personnel Costs: Australian & PNG Based (Actual)

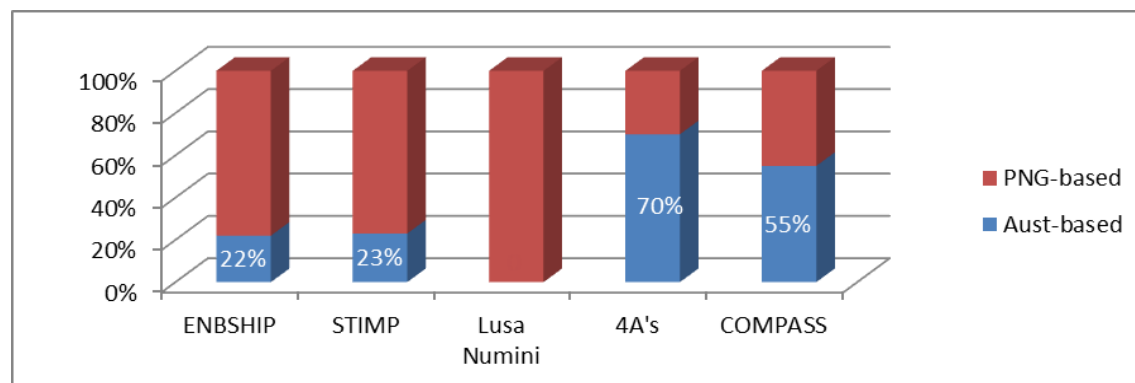
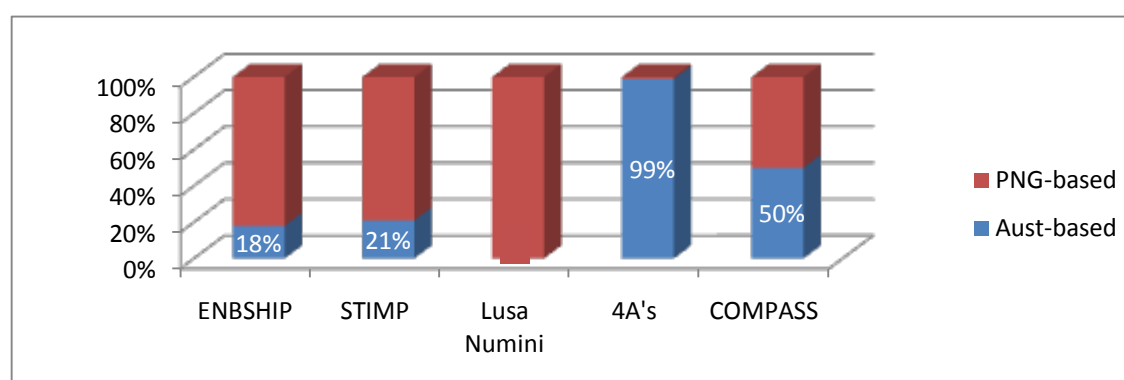


Figure 3: 2009 Personnel Costs: Australian & PNG Based (Actual)



¹⁴ 4As has provided new advice that in 2009 Anglicare and Anglican Health Services employed a number of in-country staff who worked on the PASHIP program but their salaries were paid by other funding sources within Anglicare and did not draw on PASHIP funds. However this has not been made clear in reporting to date. 4As will provide further information to AusAID about sources of funding for these in-country positions.

Broader cost effectiveness of PASHIP is difficult to establish because of a lack of baseline data or impact data. However, anecdotally some clinics appear to have very low case loads and this may bring into question their relative value for money. St Margaret's in Oro mentioned a weekly case load of about 4-5 people for STI services and 1-2 for VCT. This is compared to Anglicare, who estimated that about 10 people have been coming daily for STI treatment and 15 for HIV. It will be important to see an increase in caseload with the opening of Begabari to justify its investment and this may require outreach into the community or community consultations to reveal what the barriers to access are.

A cost benefit analysis would be helpful over the next two years to ascertain expected and actual caseloads per clinical site. However, this is beyond the purview of PASHIP alone given its current time frame.

LNP is already investigating its own efficiency having developed a plan which tracks service use and staffing levels. To avoid an anticipated saturation of existing clinics, LNP is planning to roll out the approach to all districts. This issue of saturation where popular clinics become victims of their own success was also described by Caritas: 'at Mingende people in the local community complain that the rural hospital is too accessible and that people are coming from "outside".' PASHIP is well placed to be describing and disseminating innovative strategies which IP are developing to avoid this.

Although all projects were required to complete a risk assessment matrix in their submissions for PASHIP funding, it is clear that these have not been well deployed. While the Global Financial Crisis (and its impact on costs of materials) may not have been foreseeable, difficulties in recruitment and retention are a perennial issue and could have been better predicted and managed. In addition, where infrastructure is concerned all projects experienced delays and increase costs. SCA noted that an important lesson had been learned here and that, 'usually you go for the cheapest option but that quickly becomes more expensive'. Guidelines were suggested which could illustrate what a quality tender and costing equation should look like, and these lessons learned should be captured by the knowledge management system recommended on page 14 (see recommendation 11).

2.5. Impact

It is not possible to determine the impact of PASHIP activities for a variety of reasons.

- PASHIP is still a program in process and has not yet completed its designated term and so assessing impact is currently inappropriate.
- There is no true baseline for PASHIP sites collected before interventions began.
- Many other concurrent activities for HIV and STI prevention and treatment in some project sites render attribution impossible.
- Most projects are not collecting data to report on outcomes.

Nevertheless, as described above, progress is being made and the IPR team recommends that there should be a consolidated effort over the next two years to refocus project activities to describe outcomes and to begin a more systematic application of M&E across the program as well as to establish a knowledge management system which can capture qualitative data in particular (see recommendations 4 and 10).

2.6. Sustainability

Sustainability of PASHIP activities and outcomes depends both on the model being applied and the nature of the IP. The church-based IP have both made clear that they have integrated improved STI services into their existing health services and that these will continue beyond PASHIP.

Anglicare management also commented on the fact that improved STI services would continue with or without PASHIP funding. From this perspective, PASHIP support to the faith-based organisations to improve both skills and infrastructure improvement (including housing for health staff in the Southern Highlands) is indeed sustainable. The institutional capacity to provide supervision for skills and maintenance for buildings will remain.

For the remaining IP, chances of sustainability lie in both the effectiveness of their partnership with government, particularly at provincial level, and the commitment of partnering government institutions to the issue.

Partnership with government is expressed in a variety of ways by different IP types. Caritas notes that PASHIP 'partners work closely with government. Government and other health service providers are invited to workshops and other program activities. However it is not always easy to convince them to attend.'

COMPASS's work towards a nationally accredited health worker curriculum for better management and treatment of STIs is likely to be sustainable, in that it will be incorporated into the national curriculum and rolled out through a government training system. Its support to clinical capacity building is now being managed by provincial health, ensuring greater sustainability. However, there is concern over sustainability of the Men and Boys Outreach Program. While the program has made some notable achievements (addressing the needs of men and boys, including their role in addressing violence against women and girls) it requires a local institutional home to continue. The same situation is evident with the *stret toker* program in ENB.

The LNP is already planning a move into the remaining districts in EHP to enhance coverage but also sustainability. More services will mean that Lopi and Kainantu are not overwhelmed by demand and can continue to offer high quality services. The move will also provide an opportunity for a phased approach to government taking over the funding and management of clinical positions. This planning is conducted collaboratively with provincial health. Evidence of this cooperation was provided by EHP supervisory reports of LNP sites and LNP site data being instantly accessible by the provincial health office. EHP has formally committed to take over all running costs of LNP clinics, including salaries, by 2012. Experience from LNP also shows that focusing on sufficient quality personnel is a worthwhile investment for positive clinical health outcomes. The location of personnel in line positions with a view to provincial government assuming responsibility over time is a critical aspect of sustainability.

The ENBSHIP approach to health system strengthening and the mobilisation of *stret toker* volunteers is more challenging in terms of sustainability. The provincial health department lacks capacity for adequate supervision and mentoring of staff, which help to cement new skills and ensure quality. As such, the project relies heavily on its own staff for this. In addition, the mobilisation of the *stret toker* program throws into question the sustainability of volunteerism. Some *stret toker* volunteers noted that working on a voluntary basis is difficult at times, especially where travel costs are involved. The NGO forum¹⁵ is already discussing this issue and PASHIP should link up with it.

¹⁵ PNG Australia HIV and AIDS program civil society engagement.

PASHIP still has two years to run. This presents an excellent opportunity to reflect on and document the different approaches taken, and to measure government counterpart appetite to continue the activities after the program is completed (see recommendation 11). There is no doubt that the LNP provides the most hopeful model of all IP visited during the IPR in terms of direct service delivery.

The IPR team's initial observations on elements of sustainable approaches include:

- receptive provincial health departments and personnel;
- consistent collaboration and cooperation with provincial health and other partners;
- continuing professional development for staff;
- local management in tune with local culture; and
- strong institutional governance of the IP.

Discussions on an exit strategy have begun through the PRG, but have tended to be somewhat fragmented. Certainly the next two years offer an opportunity for IP to identify what is working, what is not and what can realistically be sustained with what resources. LNP again is making steps towards this and the approach it is taking might be useful for other IP. While some discussion has taken place, it has not been systematic. The IPR team notes a need for PASHIP to focus on developing a transition strategy over the next to years. This is described under the matrix of options (see Option 1, page 34).

Recommendation 20: PRG should include a focus on developing a participatory transition strategy for post 2012.

2.7. Gender equality and other cross cutting issues

Gender equality

All PASHIP partners are focusing on gender equality in service delivery. COMPASS, Caritas and ENBSHIP have specific programs aimed at increasing men's access to services and awareness of STIs. With the exception of Caritas Det clinic, IP involved in physical refurbishment or building of facilities appear to have adhered to NDoH minimum standards and ensured that there is safe and private space for men and women separately, as well as having male and female staff to see them. All sites visited offered male and female condoms to clients.

Anecdotal evidence from the COMPASS Men and Boys Program suggests that their work is having a positive impact on men's attitudes and behaviours. One Most Significant Change story from the wife of a participant in the program stated:

Before John joined the program he was a very aggressive man. In the community he himself was a leader but he usually tolerated drunkards, wife abusers... swearing, doesn't care about family etc. After the [...] training he advocates to the community on positive lifestyle, talks in a positive and calm manner to his family, [does] referrals to police and assists victims for counselling, [mediates] law and order problems. He is a respected leader who won a lot of admiration from the community. He also brings the program into the church and other organisations within his sphere of influence.

Interestingly, women in the local communities have started to complain that there is no program for them. They see the positive changes occurring in the males and they feel that they would benefit from a program that works with women. This issue has been taken up by COMPASS, which is currently exploring developing a program for women with a Lae-based NGO.

The *stret toker* volunteers in ENB noted that young men and older women were most likely to seek STI services. The volunteers suggested that this may be due to local cultural reasons: younger women cannot afford to be seen as sexually active until they are married, while older men have too much to lose in terms of status. However, in Mingende Men's clinic, which is a dedicated male service, almost half the men accessing services were over 35 years of age.

When asked about the role that violence plays in HIV and STI transmission several respondents noted that it often comes down to sex. This is confirmed in Caritas research which 'found that at least half the domestic violence is caused by arguments over sex. This domestic violence is often sexual violence.' This issue requires further research and could be supported through PASHIP.

National data on STIs shows a trend of about two thirds more female patients coming forward for STI services than men (this is also reflected by LNP data provided earlier). PASHIP efforts to increase men's health seeking behaviour for STI is laudable. However, there is room for PASHIP to broaden its scope and include a greater focus on reproductive health, especially family planning, given the high proportion of female clients. This is in line with recommendations made at the recent Project Coordination Board meeting of UNAIDS calling for better Linking of Sexual and Reproductive Health (SRH) services with HIV/AIDS interventions in practice".

Environment and Child Protection Issues

There were some concerns about the environmental impacts of clinical waste management. In urban areas the systems are largely in place, but after discussion, it appears that greater focus on infection control and the construction of approved disposal pits is needed for rural sites. Although these are general primary health concerns they also relate to STI service delivery.

The 4As and LNP noted that a few children have been brought in for STI services and there is a growing concern around issues of child protection. Systems to address child abuse in PNG are nascent and PASHIP could make a useful contribution through data capture and collaboration with the appropriate government departments (Department for Community Development, NDoH).

Child sexual abuse is a growing concern in PNG and is reflected in the NHS framework. From the IPR team's discussions and observations, only LNP has reported on children presenting with STIs, noting an average of at least one child per week being brought to the STI clinic. LNP reporting systems capture this information by presenting data in age disaggregated categories. Systems in PNG for dealing with child sexual abuse are not fully developed. However, LNP has developed experience in this area and created referral networks with local paediatricians and community organisations such as Family Voice in EHP.

Recommendation 21: The IPR team recommends a capacity building program for partners in child protection; expansion of services to include sexual and reproductive health services particularly family planning; improved clinical waste management (See also Recommendation 7).

2.8. Monitoring and Evaluation

Monitoring and evaluation of the program has been extremely weak despite external technical support. An M&E framework for the program was developed between 2007 and 2008, but has not been consistently applied by IP as a result of the weak Secretariat and subsequent weak overall program management. Thus, it is not possible to say whether activities have made a significant difference at an epidemiological level. The confusion around the role of IMR in this has exacerbated the situation. However the ANGOs could also have been expected to perform better

on M&E given they are fully accredited by AusAID. As part of the accreditation process, they have been assessed as able to monitor, report and rate the effectiveness of activities. Indicators for the M&E accreditation criteria include an understanding of AusAID's Quality Rating System and evidence of qualitative judgments in monitoring reports.

To further complicate matters, IP are following different logic models. Most are outputs rather than outcomes focused, and some are input and activity focused. As a consequence, reporting is uneven and there has been little or no guidance on how to harmonise approaches. The team found that interesting data does exist within different projects, but is not being captured in the progress reporting formats. The introduction of QAI may assist with this. However, it should be noted that stakeholders did not feel properly consulted regarding the introduction of QAI, and perceive QAIs as an additional reporting burden. It is recommended that a program-wide QAI be collated, as this would reduce the reporting burden on IP and help cement a PASHIP program identity. There is a precedent for this approach in the region in the Solomon Islands NGO Partnership Agreement (Strongim Yumi Tugeta).

Recommendation 22: It is recommended that a program wide QAI be considered.

Some models of good practice which focus on outcomes are emerging. These could be applied across all IP. In the LNP, a patient satisfaction tool has been developed and is used on a quarterly basis for measuring client satisfaction at the STI clinics. This is a positive innovation and one that could be replicated across all PASHIP sites. The international literature indicates that measuring health outcomes is particularly difficult. Patient/client satisfaction has been generally accepted as a close proxy for measuring health outcomes, as more satisfied patients are more likely to be adherent to recommended treatments and to remain in contact with the health service. The tool will need to be adapted further and the IPR team has suggested to LNP that they collaborate with social researchers at IMR or NRI to refine the tool. Once refined and standardised, the patient satisfaction tool it could be used in all PASHIP sites on a quarterly basis.

Recommendation 23: After the LNP patient satisfaction survey is refined and standardised, employ it as a monitoring tool across PASHIP sites.

The COMPASS project has also developed an internal QA clinical audit tool. This is administered by provincial/district health officials in a participatory manner with health staff at facilities. The tool enables facilities to identify weaknesses (for example, sharps management or record keeping), establish a time-bound action plan for areas identified for improvement, and then track changes over time. A recent internal analysis revealed that 8 of the 11 clinics that completed repeat QA assessments have shown improvement in their scores, some with fairly significant improvements.

Recommendation 24: The IPR team recommends that after discussion with NDoH this clinical QA tool should become standard monitoring practice across all PASHIP sites.

There also appears to be some confusion around the NHIS forms and how they should be filled in. In Lopi clinic the IPR team was told that the form needs to see 'a tally between number of clients and number of infections, which means that you cannot record multiple infections.' This perception was repeated in ENBSHIP although the forms have actually been designed to collect information on multiple infections. It was also felt that the NHIS form does not allow for the recording of repeat infections. These issues need to be addressed as a matter of urgency to ensure that data capture flowing through NHIS is relevant and useful.

Recommendation 25: The IPR team recommends further support for all IP to improve reporting of clinical and prevention data.

The Secretariat now needs to work intensively with partners to ensure that the jointly agreed indicators in the 2008 M&E framework are aligned to the new NHS and NHP and are measured systematically across the program.

In addition to NHIS data sets, the following data (disaggregated by sex and age) should be easily accessible by the Secretariat from all IP as a minimum.

Box 1: Recommended data for inclusion in IP progress reports

- number of clients accessing services
- number of clients diagnosed with an STI
- number of clients treated for an STI
- number of clients provided with PICT for HIV
- number of clients taking up testing for HIV
- number of clients provided with STI and HIV prevention information
- number of clients provided with condoms (disaggregated by type of condom)
- number of clients presenting as a result of partner management referrals
- number of clients presenting with repeat infections.
- number of clients with multiple infections

Overall the lack of attention to program-wide M&E has challenged the IPR team in assessing its achievements. Nevertheless, some IP have attempted to monitor their own activities and this should be commended. There is a strong need now for a stronger focus on M&E and a revised M&E framework to ensure alignment with the new NHS and NHP. For this to happen a dedicated position attached to PASHIP is required as short term engagements in the past have failed to gain traction.

Recommendation 26: The IPR team strongly recommends the appointment of an M&E specialist to the Secretariat to ensure that data is collected and collated over the remainder of the program cycle and that the M&E framework is revised to align with new NHS and NHP. In addition M&E specialist/skills should be supported in each project.

2.9. Analysis and learning

All Project Design Documents were required to demonstrate a situation analysis and problem matrix as a basis for their activities. Subsequent analysis and learning across the program is more difficult to ascertain.

PASHIP has provided opportunities for IP collaborations such as work attachments and joint trainings. Those involved have noted that these have been extremely useful as a learning experience and should be built upon.

Recommendation 27: The IPR team recommends that the secretariat organises joint peer reviews and site visits to facilitate more in-depth analysis and joint learning.

Individual IP are at different stages of analysis within their own projects. As mentioned, LNP is already analysing its service usage and arriving at strategies to avoid clinic saturation and staff burnout. Caritas has completed its research and

published peer reviewed strategies to address emerging issues in its report *Sik nogut o nomol sik*.

With reconfiguration, the PRG could offer an excellent platform for these experiences to be shared and discussed and for more in-depth analysis overall. Currently the focus is on administrative issues and individual presentations. Much of this business could be managed virtually in advance of the meeting which would allow time for greater reflection and sharing amongst IP. In addition, the team felt that there is value in expanding attendance at PRGs to include other STI service providers as observers, for example Oil Search, CARE, LNG, ADB rural enclave operators (see Recommendation 10 page 13).

2.10. Review criteria ratings

The IPR team was tasked to report on the progress of PASHIP as a program. As noted, PASHIP is yet to be realised as a program. It currently operates as a collection of projects loosely connected through the PASHIP Secretariat. The IPR ratings in the table below were agreed by the whole team and reflect PASHIP as a 'program.' As such, several categories are rated 3 or below. The explanation for these lower ratings has been discussed throughout the report and includes the absence of any knowledge management, very weak coordination, and a poor M&E system.

The IPR team would like to make it clear that had the task been to appraise each individual project against each of the criteria, the outcome would be markedly different. The IPR has noted throughout the report that some projects have achieved excellent results, demonstrating innovation, strong management, sustainable practice, and an evidence base from which to scale up their initiatives. It is these projects that could form the basis of an effective national program for sexual health and STI management in the future.

Generally, progress towards Objective 1 has been reasonably good. Progress towards Objective 2, as detailed in this report, has been exceptionally challenging. It is for this reason that ratings for the program against each criterion are skewed downwards at 3 or below. This should not be interpreted as a significant failure. The IPR team is confident that if each of the major weaknesses identified in this report is addressed, a future assessment would yield a more positive outcome. This is possible within the remaining two years.

Table 2: Review Criteria Ratings

Evaluation Criteria	Rating (1-6)	Explanation
Relevance	6	<ul style="list-style-type: none"> • Highly relevant to the development context at the time the Concept note (“design document”) was approved. • PASHIP has even greater relevance under the post-2010 key development frameworks and PNG national strategies. These include the MTDP, the NHP and the NHS. PASHIP will contribute to five of the “Top Ten Interventions” outlined in the new NHS. • PASHIP also presents some important synergies with AusAID’s emerging new framework of support to the PNG Health Sector: The Health Sector Delivery Strategy which is to include HIV&AIDS (HSDS: in draft)
Effectiveness	4	<ul style="list-style-type: none"> • Difficult to state the degree to which PASHIP has contributed to the overall outcome to “<i>reduce the rate of increase of HIV by reducing the incidence and prevalence of STIs through the provision of integrated sexual health services</i>” given poor M&E • Some good progress under Objective 1 <ul style="list-style-type: none"> - All models focused on strengthening supply of quality STI services and community/target group demand for services; with varying degrees of emphasis (vis-à-vis the emphasis on supply or demand side of the equation). - Concerns over effectiveness of models with little or less emphasis on strengthening supply of quality services. - Some innovative models emerging, with some showing significant achievements in STI service delivery. • No attention to developing an effective knowledge management system for PASHIP. This has seriously constrained achievement towards Objective 2. <ul style="list-style-type: none"> - Format for PRG is a lost opportunity for innovation and creativity - needs to be less didactic and “administration focused” and seek greater opportunities for highlighting and promoting innovation and achievement. • Research component generally ineffective. Baseline data still not completed as program moves into its 4th year. Lost opportunity for conducting any impact analysis when PASHIP’s current 5-year term is completed.
Efficiency	3	<ul style="list-style-type: none"> • Program level efficiency very poor due to poorly managed and resourced Secretariat. This has resulted in: <ul style="list-style-type: none"> - Poor oversight and lack of rigor applied to reviewing AAPs and annual progress reports. - Delays in grant disbursements after mobilisation. - Lack of standardisation in reporting making comparisons and VFM assessments between implementing partners very challenging. - Lack of consistency in reporting on key indicators and no trend analysis being undertaken as a result. - Errors in financial reporting going unchecked. - No analysis of financial acquittals provided by IP. - ANGO model of management is less cost efficient than

Evaluation Criteria	Rating (1-6)	Explanation
		<p>locally managed models .</p> <ul style="list-style-type: none"> - Considerable variation between individual project efficiencies; with LNP emerging as the most efficient model. • Significantly more attention needed to program management and coordination under a revitalised and better resourced Secretariat.
Sustainability	4	<ul style="list-style-type: none"> • PNG based IP with stronger institutional governance have greater prospects for longer term sustainability (LNP, Anglicare and CHS). • Provincial health division commitment is vital for sustainability and not uniformly present across all PASHIP provinces <ul style="list-style-type: none"> - In EHP, a model of good practice is emerging with important lessons learned to be shared across other provinces. • Clear evidence of emerging sustainability within some projects (e.g. EHP dept. of health including costs of LNP-funded clinical staff into 2012 recurrent budget; COMPASS-initiated health worker curriculum is soon to be presented to the NDoH curriculum accreditation committee. If approved, this will be rolled out nationally). • Reliance on volunteers within some projects will present challenges for sustainability. • Discussions on exit strategies have started within PRG but are yet to evolve into anything tangible. Discussions still somewhat fragmented on this issue.
Gender Equality	4	<ul style="list-style-type: none"> • Gender equality addressed structurally through application of NDoH minimum standards which allows for separate consulting space for males and females. • Appointment of male and female service providers to work with male and female clients accordingly. • Provision of male and female condoms. • Gender based violence and its links with HIV addressed in community conversations, through peer educators and at clinical level in some cases. • Special focus on male involvement in 3 programs.
Monitoring & Evaluation	2	<ul style="list-style-type: none"> • M&E of the program has been extremely weak despite external Technical Assistance provided in the earlier stages and that ANGOs fully accredited by AusAID have been assessed as being able to monitor, report and rate effectiveness of activities. • M&E framework for the program not consistently applied by all IP due to weak overall program management & absence of a dedicated M&E specialist attached to the program (i.e. within the Secretariat). • Confusion around role of IMR for M&E at beginning of program – took 12 months to resolve and clarify M&E responsibilities. • IP are following different logic models; with most focused on outputs. Some IP still reporting on inputs and activities. Very few reporting on outcomes. • Some models of good practice emerging in regards to

Evaluation Criteria	Rating (1-6)	Explanation
		monitoring tools (e.g. the LNP client satisfaction tool and the COMPASS clinical QA audit tool). <ul style="list-style-type: none"> • Some IP do not have a dedicated M&E officer on their team. • PASHIP has missed an important opportunity to strengthen and improve NHIS reporting. • Overall the lack of attention to program wide M&E has challenged the IPR team in terms of assessing achievements.
Analysis & Learning	2	<ul style="list-style-type: none"> • Limited analysis and learning across the program due to absence of knowledge management system. • Some IP conducting their own analyses. • Current PRG format does not naturally facilitate a robust analysis and learning environment. • PRG must be reoriented to have a greater focus in this regard.

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

Key lessons learned at project level

- NSAs can provide good quality sexual health services in collaboration with government which is complementary rather than parallel.
- The provision of high quality and predictable services may be enough to stimulate increased usage as clients that access services through word of mouth.
- Effective partnerships with provincial health divisions depend on mutual accountability.
- Locally managed and owned models are more likely to be sustainable than externally managed ones.
- Success depends on IP having relatively high institutional capacity and governance (SCiPNG, CHS) and a high level of commitment from provincial health divisions.
- Clinical skills training needs to be supported by regular supervision and continuing professional development in order for quality to be maintained.
- Targeting men can increase their health service usage as long as male health workers are continually available.
- The greater number of women accessing services and an increasing demand for reproductive health services justifies an expanded service through STI facilities including family planning as a minimum.
- The application of minimum standards for clinics is ensuring that services respond to both men and women's needs.
- Further capacity building is needed for IP to ensure accurate and timely NHIS reporting and PICT is properly understood and applied; to enable IP to manage incidences of child sexual abuse and explore ways of expanding STI services to meet broader reproductive health needs particularly family planning.

3. Conclusion

PASHIP's strengths lie in its innovation and relative flexibility in testing different approaches to improve STI services, together with its focus on local level service delivery. IP have managed to increase access to STI services in the provinces where they operate through quality service supply and building community demand. Gender equality has been well incorporated across the program and there are indications that this work is helping to change cultural norms with regard to attitudes towards sexual health and health seeking behaviours.

Different IP display different strengths, depending in part on their locus of management. Those which are closely connected to local operations appear to be more successful and are likely to be more sustainable than those with principal management overseas.

The PASHIP program's weaknesses stem from an underestimation of the complexity of the program from the beginning. This, together with its history of poor management and lack of institutional home, has meant that over the last 3 years PASHIP has been operating as a series of projects rather than as a program.

This has reduced efficiency of the program, as there has been no consistent attention to financial or operational oversight or to the development of a knowledge management system that can capture lessons learned. The PRG has been a missed opportunity, but over the next two years could support better experience exchange and the development of concrete lessons learned. This will mean abandoning external facilitation and working more collaboratively with IP to rotate facilitation. There is no shortage of ideas among IP about how to manage this, as was clear during the November 2010 PRG meeting.

One approach to strengthening the performance base of PASHIP is to establish a Technical Advisory (TAG) group, made up of representatives from NDoH, PNG Sexual Health Society, AusAID's HIV, health and SNS programs and the private sector. The function of the TAG would be to oversee approvals of QAI reports and AAPs. Such a group will enhance cross-sectoral working and add rigour to the program.

Recommendation 28: Establish and formalise a Technical Advisory Group (TAG) to oversee approvals of Quality at Implementation Reports and AAPs submitted by IP. The TAG membership should include key expertise from NDoH, PNG Sexual Health Society, private sector, AusAID's SNS Program, the HIV Program and the Health Sector Team. At least one member of the TAG must have demonstrated gender expertise in the PNG context.

The original idea of research was not well thought through and has resulted in delays and confusion. Baseline measurements have not come to pass and PASHIP must now agree an exit for IMR from the program. This notwithstanding, opportunities for further research should emerge through enhanced knowledge capture and documentation of lessons learned so far, for example reasons for slow uptake of PICT, impact of gender based violence on sexual health.

A concerted effort is now needed to build PASHIP management capacity through the Secretariat and its identity as a program over the next two years.

The decision to move PASHIP Secretariat and management to the HIV program was one of practicality. However, PASHIP is a health service delivery program and as such the Secretariat should develop and maintain close links with NDoH and the AusAID health program so that lessons learned through the program can benefit other health service delivery programs.

The NHP provides an excellent opportunity for PASHIP:

The already strong links with the churches, which are so vital to health service delivery in this country, can be strengthened further. The health sector will use evidence in its relationships with central agencies at the national level to advocate for further resources for health. The special skills of civil society can also be better harnessed. Involvement of the private sector in the delivery of health services needs to become commonplace.

PASHIP can certainly add value here.

Current indications are that PASHIP will yield important lessons learned about the role of NSAs working in partnership with government to provide sexual (and reproductive) health services. However, to arrive at these lessons a significant effort is required. It will be necessary to ensure that effective program wide monitoring is applied across projects. Equally, that a knowledge management system is established which can capture qualitative data then collate and disseminate it in an accessible way.

4. Recommendations

4.1. The next two years

The recommendations for 2011–2012 are provided sequentially as they appear in the report. They are allocated suggested timelines and responsibilities, with key recommendations and lead responsibility being shown in bold type. The recommendations made for post 2012 are presented as a matrix of options for consideration.

Recommendation	Timeframe	Responsibility
1. Enhance alignment of IP annual plans with relevant national policies; specifically the NHS and NHP. This could be outsourced initially and undertaken as a desk exercise and shared at the next PRG.	Qtr 1 2011	<ul style="list-style-type: none"> • AusAID HIV Program Office • PASHIP Secretariat • PASHIP IP
2. Ensure greater coherence across HIV programs particularly PASHIP, CPP, Tingim Laip and HIV grants program and explore possible synergies with SNS and SPSN.	Qtr 2 2011	<ul style="list-style-type: none"> • AusAID HIV Program • PASHIP Secretariat
3. Ensure 'stret toker' volunteers have basic HIV information and understanding through ENB PAC.	Qtr 1 2011	<ul style="list-style-type: none"> • ENBSHIP • PASHIP Secretariat • ENB HRCs
4. Address issue of lack of operational commitment for ENBSHIP from Provincial Health Division.	Qtr 1 2011	<ul style="list-style-type: none"> • NDoH STI/HIV program • PASHIP secretariat
5. Strengthen the M&E function of the PASHIP Secretariat and IP by establishing a system for program wide data collection (see also recommendation 26.).	Qtr 1-2 2011	<ul style="list-style-type: none"> • AusAID HIV Program Office • PASHIP Secretariat • NDoH
6. Focus on local solutions and cease the practice of overseas clinical placements.	Qtr1 2011	<ul style="list-style-type: none"> • PASHIP Secretariat • AusAID HIV Program
7. Provide a program of refresher training for all clinical staff supported by PASHIP IP on key issues i) PICT, ensuring all STI consultations offer PICT ii) child protection iii) sexual and reproductive health and family planning and linkages between VCT and STI iv) clinical waste management etc.	Qtr 2-4 2011	<ul style="list-style-type: none"> • NDoH STI/HIV Program • PASHIP secretariat • IP

<p>8. All IP include specific outputs for promotion of female and male condoms in their annual activity plans.</p>	<p>Qtr 1 2011</p>	<ul style="list-style-type: none"> • PASHIP IP
<p>9. Address the current strategy of refusing treatment to individuals without partners as a matter of priority</p>	<p>Qtr 1 2011</p>	<ul style="list-style-type: none"> • NDoH STI/HIV Program • Caritas
<p>10. Revise the format and process of PRGs to enhance joint learning and action: Manage administrative issues virtually where possible to allow time in the PRG for reflection and analysis. Consider rotating the facilitation between partners and dispense with an external facilitator. Allow an agenda to be jointly determined. Develop action plans during each meeting which are then followed up virtually or actually by the Liaison Officer. Schedule meetings to coincide with NGO forums. Expand attendance to other non PASHIP SRH practitioners as observers.</p>	<p>Qtr 1-2 2011</p>	<ul style="list-style-type: none"> • AusAID HIV Program Office • PASHIP Secretariat • PASHIP IP
<p>11. Engage a participatory specialist for six months to begin collecting and collating key lessons learned from PASHIP implementation so far.</p>	<p>Qtr 2 2011</p>	<ul style="list-style-type: none"> • NDoH STI/HIV Program • AusAID HIV Program • PASHIP Secretariat
<p>12. Support IMR to write up their data analysis (quantitative and qualitative) and determine where and how best it can be used; abandon next surveys.</p>	<p>Qtr 1 2011</p>	<ul style="list-style-type: none"> • AusAID HIV Program Office • PASHIP Secretariat • PNG IMR • PNG Surveillance Technical Working Group • UNSW
<p>13. Recruit and appoint the NDoH STI/Sexual Health Program Managers Position.</p>	<p>Qtr 2 2011</p>	<ul style="list-style-type: none"> • NDoH STI/HIV Program
<p>14. Establish dialogue with the PNG Sexual Health Society with a view to holding an annual conference for NSAs involved in sexual health service delivery as a way of raising the profile of sexual and reproductive health beyond STIs.</p>	<p>Qtr 2 2011</p>	<ul style="list-style-type: none"> • PASHIP Secretariat • NDoH STI/HIV Program • PNG Sexual Health Society • PASHIP IP
<p>15. Revise Program Management Guidelines</p>	<p>Qtr 2 2011</p>	<ul style="list-style-type: none"> • AusAID HIV

<p>to ensure relevance, by providing advice on QAI reporting, clinic launching, overseas study tours, and procedures for variations to contract. Circulate to partners.</p>		<p>Program Office</p> <ul style="list-style-type: none"> • NDOH • PASHIP Secretariat
<p>16. Conduct a joint induction for the Liaison Officer and Activity Manager with visits to all field sites. These visits should be conducted at <u>least</u> twice a year, with initial visits to include the NDoH STI/Sexual Health Adviser (where possible).</p>	<p>Commencing Qtr 1 2011</p>	<ul style="list-style-type: none"> • AusAID HIV Program Office • PASHIP Secretariat • NDoH STI/HIV Program
<p>17. Align the PASHIP Secretariat's orientation to GoPNG/AusAID health delivery strategy, the new SPSN and the SNS program.</p>	<p>Qtr 1-2 2011</p>	<ul style="list-style-type: none"> • AusAID HIV Program Office • AusAID Health Sector Team
<p>18. Develop a joint action plan based on this report.</p>	<p>Qtr1 2011</p>	<ul style="list-style-type: none"> • PASHIP secretariat • NDoH • AusAID HIV program office
<p>19. Track IP under-spending and identify areas for redistributing financial resources that are aligned with PASHIP objectives.</p>	<p>Qtr 2 2011</p>	<ul style="list-style-type: none"> • PASHIP IP • PASHIP Secretariat
<p>20. Focus on transition strategy for post 2012. LNP has already made plans for transition and their experience should be disseminated among other IP and space should be provided at the PRG to discuss this.</p>	<p>Qtr 2-4 2011</p>	<ul style="list-style-type: none"> • PASHIP IP • PASHIP Secretariat • NDoH STI/HIV Program • Provincial Health authorities • AusAID Health and HIV/AIDS Programs
<p>21. Develop a capacity building program for partners in child protection; sexual and reproductive health services particularly family planning; improved clinical waste management (See also Recommendation 7).</p>	<p>Qtr 2-4 2011</p>	<ul style="list-style-type: none"> • NDoH STI/HIV Program • PASHIP secretariat • IP
<p>22. Consider a program wide QAI (c.f. Solomon Islands NGO partnership agreement).</p>	<p>Qtr 2 2011</p>	<ul style="list-style-type: none"> • AusAID HIV Program
<p>23. Support LNP to revise client satisfaction tool and incorporate as a standard monitoring activity in all PASHIP projects.</p>	<p>Qtr 2-4 2011</p>	<ul style="list-style-type: none"> • PASHIP IP • PASHIP Secretariat • PNG IMR/NRI?

24. Adopt the COMPASS clinical QA tool as standard monitoring practice across all PASHIP clinical sites.	Qtr 2-4 2011	<ul style="list-style-type: none"> • PASHIP IP • PASHIP Secretariat • NDoH STI/HIV Program • Provincial Health authorities
25. Improve reporting of clinical and prevention data and strengthen NHIS reporting by providing training at PRG forums.	Qtr 1-2 2011	<ul style="list-style-type: none"> • PASHIP secretariat • NDoH STI/HIV Program • ProMEST Teams
26. Appoint an M&E specialist to the PASHIP secretariat to establish a simple system which is accessible to all partners and which captures both quantitative and qualitative data. Revise the M&E framework to align with NHP and NHS.	Qtr 1-2 2011	<ul style="list-style-type: none"> • AusAID HIV Program office • PASHIP Secretariat • NDoH STI/HIV Program
27. Organise peer reviews and joint site visits as a means of sharing and joint learning between IP.	Qtr 2-4 2011	<ul style="list-style-type: none"> • PASHIP IP • PASHIP Secretariat
28. Establish and formalise a Technical Advisory Group (TAG) to oversee approvals of Quality at Implementation Reports and AAPs submitted by IP. The TAG membership should include key expertise from NDoH, PNG Sexual Health Society, private sector, AusAID's SNS Program, the HIV Program and the Health Sector Team. At least one member of the TAG must have demonstrated gender expertise in the PNG context.	Qtr 1-2 2011	<ul style="list-style-type: none"> • NDoH STI/HIV Program • AusAID HIV Program • PASHIP Secretariat

4.2 Recommendations post 2012

Given the importance of sexual health in PNG and the limited attention currently given to this, it is strongly recommended that some form of support is continued. This support should build on the principle of local ownership. The following matrix of options is provided to inform the future of PASHIP post 2012. Option 1 is the preferred option.

Table 3: Matrix of Options for post 2012

Option	Pros	Cons
1. Over 2011-12 facilitate a participatory design process involving all partners to identify a) what has worked and can be replicated or built on b) where services are needed and where the gaps are c) which additional	Mutual accountability. Relevance. Greater coverage where it matters. Jointly owned.	Innovative approach and may be risky. Awaiting review of HIV program and finalisation of HSDS. Will require a highly skilled

Option	Pros	Cons
<p>IP are needed.</p> <p>Based on these consultations facilitate a jointly developed health outcome oriented program for priority provinces.</p> <p>The new program would be managed by a flexible facility until such time that the NDoH could assume the role.</p> <p>This would be augmented by a draw down contract for a team of international specialists in sexual and reproductive health service delivery.</p>	<p>Greater synergy.</p> <p>Program rather than vertical projects.</p> <p>May not require large funds where govt. is prepared to take on costs (EHP).</p> <p>This process would serve as both transition strategy and future design.</p> <p>Including NDoH in design enhances chances of ownership.</p>	<p>participatory facilitator.</p> <p>Difficulty in identifying local partners with sufficient capacity in all priority provinces.</p>
<p>2. Direct funding from AusAID to individual NSAs through grants mechanism.</p>	<p>Existing mechanism.</p> <p>May enable greater coherence of approaches.</p>	<p>High administrative burden.</p> <p>PASHIP becomes HIV program rather than health program.</p>
<p>3. Develop an NSA basket funding mechanism for health service delivery whose management is outsourced earmarking % for sexual and reproductive health.</p>	<p>Conforms to Cairns compact and shared resources (not only AusAID money).</p> <p>Conforms to current thinking on outsourcing grants mechanism.</p> <p>Lessons learned from STI service delivery can be applied to primary health care programs.</p>	<p>Missed opportunities for building on existing success.</p> <p>Lose the program principle.</p>
<p>4. Traditional design by external consultant.</p>	<p>Tried and tested model.</p>	<p>Can take a long time, reducing momentum.</p> <p>Does not foster national or local level ownership.</p>
<p>5. Extend current program with addition of WHP and abandonment of Oro.</p>	<p>Builds on lessons learned so far.</p>	<p>Will not necessarily maximise lessons learned.</p> <p>Difficulty in identifying local partners with sufficient capacity in all priority provinces.</p>

Annex 1: Implementing Partner Project Objectives and Outputs

Implementing Partner and Locations	Focus	Outputs
IMR: EHP (covering all PASHIP provinces)	Research	<ul style="list-style-type: none"> To collect data from the target populations in the project sites that will guide the implementing NGOs with their STI intervention programs. Focus on the higher outcome and impact assessment indicators that will be measured at baseline, midterm and end line of the PASHIP program. Compare baseline research data with mid-term and end line data to show if there is any behaviour change, increase in knowledge about STIs, decrease in the prevalence of STIs, decrease in level of stigma and discrimination and increase in community support for people living with HIV/AIDS. Lessons learnt will be used by the implementing NGOs and other stakeholders to improve project performance and for policy planning at the national level.
Anglican Board of Mission (4As): NCD, Oro	Clinical service delivery	<p><i>Objective 1: to increase access to, and utilisation of, STI services in the designated sites.</i></p> <p>Output 1.1: Clinics that deliver STI services established in Waigani, NCD and Oro Bay, Oro.</p> <p>Output 1.2: Clinic designs that address issues of gender, mobility and confidentiality in accessing services and adhere to GoPNG standards completed</p> <p>Output 1.3: Appropriate STI services promoted with target communities</p> <p><i>Objective 2: to provide a comprehensive STI service in the designated sites delivered by well trained and qualified staff.</i></p> <p>Output 2.1: Institutional capacity to deliver and monitor STI services assessed and improved</p> <p>Output 2.2: STI clinic staff competent and knowledgeable in the diagnosis and treatment of STIs</p> <p>Output 2.3: STI services provided in accordance with NDoH policies, procedures and protocols</p>

Implementing Partner and Locations	Focus	Outputs
		<p><i>Objective 3: to effectively manage the program through a partnership approach.</i></p> <p>Output 3.1: Program management team established and operated effectively</p> <p>Output 3.2: Program monitoring, evaluation and reporting systems established and operated effectively</p> <p>Output 3.3: Relevant activities coordinated with other stakeholders, including other PASHIP partners</p>
<p>Caritas (STIMP): Chimbu, SHP</p>	<p>Community research and development</p> <p>Clinical service improvement</p> <p>Lab improvement</p>	<p><i>Component 1: Research and development</i></p> <p>Output 1.1: To better understand people's knowledge and attitudes towards sexual health and STI's</p> <p>Output 1.2: To identify strategies that have been, and are being, effective in changing community attitudes and behaviours in relation to their sexual health</p> <p>Output 1.3: To identify key underlying cultural factors which contribute to high prevalence of STI and HIV</p> <p><i>Component 2: Clinical service improvement</i></p> <p>Output 2.1: Upgrading and development of health facilities</p> <p>Output 2.2: Staff capacity development</p> <p>Output 2.3: Laboratory capacity improved</p>
<p>Sexual Health and FP Australia (COMPASS): ENB, Morobe, East Sepik</p>	<p>HW training, community education and outreach. focus on men & boys</p> <p>Clinical service strengthening</p>	<p><i>Component 1: Mens and boys program</i> (Yr 1 ENB and Morobe Provinces; Year 2 East Sepik Province)</p> <p>Output 1: Awareness raised and positive change supported among men and boys on sexual health and related behaviours</p> <p><i>Component 2: Health worker training Morobe Province (Year 1) and East Sepik (Year 2)</i></p> <p>Output 2: Training provided for staff of provincial and district health services on STI treatment in Morobe and East Sepik Provinces</p>

Implementing Partner and Locations	Focus	Outputs
		<p><i>Component 3: Advanced service support Morobe Province (Year 1) and national in Year 2 (Distance Learning Certificate in Sexual Health offered)</i></p> <p>Output 3: Advanced qualification trialled using open learning mode</p> <p>Output 4: Strengthened clinical and management capacity in existing STI referral centres or alternative centres</p> <p><i>Component 4: Outreach service</i></p> <p>Output 5: Outreach sexual health clinical and related services strengthened</p>
SCA (Lusa Numini): EHP	STI clinical and outreach	<p><i>Component 1: Support to STI/VCT service provision in West Goroka urban clinic</i></p> <p>Output 1.1: West Goroka Urban Clinic operating with infrastructure and equipment to agreed standards to support STI/VCT service provision</p> <p>Output 1.2: Recruitment, training and staff management system in place, providing clinic and support staff with technical and communication skills appropriate to the needs of all clients</p> <p>Output 1.3: Clinic patient management system removes barriers to access for vulnerable groups through an appropriate referral mechanism</p> <p>Output 1.4: STI/VCT clinical management systems developed and operational within Urban clinic including reporting, planning and procurement of STI drugs, condoms and other medical supplies</p> <p>Output 1.5: District and clinic health managers progressively assuming responsibility for management and monitoring of STI/VCT services</p> <p><i>Component 2: Support to the White House Clinic Kainantu District Hospital</i></p> <p>Output 2.1: White House clinic operating with infrastructure and equipment to agreed standards to</p>

Implementing Partner and Locations	Focus	Outputs
		<p>support STI/VCT service provision</p> <p>Output 2.2: Recruitment, training and staff management system in place, providing clinic and support staff with technical and communication skills appropriate to the needs of all clients</p> <p>Output 2.3: Clinic patient management system removes barriers groups through an appropriate referral mechanism</p> <p>Output 2.4: STI/VCT clinical management systems revised and operational within Kainantu Clinic including reporting, planning and procurement of STI drugs, condoms and other medical supplies</p> <p>Output 2.5: District and clinic health managers progressively assuming increased responsibility for management and monitoring</p> <p><i>Component 3: Support for clinical outreach from provincial level to Ungai Bena district</i></p> <p>Output 3.1: Ungai-Bena health centre operating with infrastructure and equipment to acceptable standards to support STI service provision</p> <p>Output 3.2: Goroka Urban Clinic STI staff supporting syndromic STI treatment service and referral in Ungai Bena through regular outreach</p> <p>Output 3.3: Ungai Bena health facility staff skilled in the provision of STI syndromic treatment and STI referral service</p> <p>Output 3.4: Syndromic management systems and referral mechanisms developed and operational</p> <p><i>Component 4: Project planning and management</i></p> <p>Output 4.1: Partnership and management arrangements between SCiPNG, the Department of Health and other relevant stakeholders collaboratively developed, signed and operational</p> <p>Output 4.2: Effective financial, management and communication systems</p>

Implementing Partner and Locations	Focus	Outputs
		<p>Output 4.3: Effective monitoring and reporting systems which engages all relevant stakeholders</p> <p>Output 4.4: Effective evaluation and planning systems in collaboration with IMR which provide lessons learned to guide project delivery and provincial planning for STI and HIV prevention and treatment</p>
<p>Burnett ENBSHIP: ENB</p>	<p>Clinical service support to GoPNG ENB</p>	<p><i>Component 1: Gender Sensitive Community Engagement in the Prevention of STIs</i></p> <p>Objective 1.1: To increase the capacity of women and men to make positive and informed sexual and reproductive health decisions</p> <p>Objective 1.2: To increase the use of health services by women and men for sexual health information and treatment</p> <p><i>Component 2: Local Capacity Building for Improved STI Response</i></p> <p>Objective 2.1: To improve the capacity of the formal health sector including health administrations, hospitals and other health services in ENB to provide effective prevention and treatment services for STIs</p> <p><i>Component 3: Coordination and Project Management</i></p> <p>Objective 3.1: To improve coordination of STI service delivery in ENB</p> <p>Objective 3.2: To maintain effective project management</p>

Annex 2: Terms of Reference

The PNG-Australia Sexual Health Improvement Program Independent Progress Report

Purpose

Provide an independent assessment of the progress against objectives of the PNG-Australia Sexual Health Improvement Program (PASHIP) referencing AusAID assessment criteria¹⁶. In particular, the evaluation will examine the initiative's management model, strengths and comparative advantages and also provide lessons for future programs.

Background

The PNG-Australia Sexual Health Improvement Program (PASHIP) is a partnership between Australian NGOs, PNG organisations and the National Department of Health. All partners share a common goal to reduce the incidence of HIV in PNG, through the provision of improved sexual health and STI services to target communities.

PASHIP is implemented by five AusAID fully accredited NGOs (Burnet Institute, Save the Children, Sexual Health and Family Planning Australia, The Anglican Board of Mission and Caritas Australia) partnering with PNG organisations to provide improved sexual health and STI services across PNG, specifically in the National Capital District, Southern Highlands, Western Highlands, Oro, Simbu, Eastern Highlands, Morobe and East New Britain Provinces. The research component is implemented by the Institute of Medical Research.

This is a five year program with funding of up to \$25 million that commenced in September 2007 and will end in December 2012. It was established to complement existing government and church health services, and respond to the urgent need to rapidly scale up STI prevention and treatment services in higher-risk areas.

The goal of the program is to reduce the rate of increase of HIV by reducing the incidence and prevalence of STIs through increased community health seeking behaviour with regard to sexual health and the consequent increased use of improved existing sexual health services or the provision of new ones.

The role of the NDoH is to provide leadership and direction on PNG health sector plans, priority policies. Other roles include:

- provides technical input to program partners on diagnostic methods, treatment protocols and national standards for STI facilities
- guidance in establishing relationships with provincial and district health authorities, churches and other STI service providers
- provides technical input and final approval on training programs and IEC materials
- provide guidance on registration of all clinical staff and advisers with relevant government health authorities

The PASHIP Secretariat (comprising a liaison officer) is central to the coordination and management of the Program. The Secretariat works closely with the NDoH and

¹⁶ Guidelines: Manage the Independent Evaluation of an Aid Activity

AusAID to ensure alignment between PASHIP and the NDoH systems. An AusAID Program Manager manages the funding agreements with the participating NGOs.

The range of services to be implemented by the NGOs included capacity building in human resource management, clinical skills training, quality assurance control and training, STI community awareness and consequent increased health seeking behaviour, youth and peer education, community action research and health care provision via STI clinical facilities (including prevention, diagnosis, treatment, education and partner management). Some interventions were to be targeted to vulnerable groups such as sex workers, men who have sex with men and/or youth while other interventions were targeted to the general population. Each NGO planned to implement a unique combination of the various interventions.

The program was designed to achieve the following objectives:

- a) Increase access to, and use of, STI management and prevention services by the target communities, including appropriate groups of which vulnerable populations such as youth and women are a part.
- b) Determine and disseminate the elements of effective and innovative PNG-specific STI services to showcase opportunities to improve STI services nationally.

In achieving these objectives, the project was expected to contribute to the following broad national outcomes:

- a) Reduced prevalence and incidence of STIs in the area where the programs are operating.
- b) Evidence that the targeted population in the program areas is practicing safer sex.
- c) Innovative STI management programs tested and lessons learned disseminated to government and other agencies involved in STI, HIV and AIDS prevention and treatment programs.

Health staff in the program areas are able to deliver quality STI services and undertake appropriate surveillance activities.

While the scope of activities funded through this program was flexible to allow NGOs to work to their strengths and capitalise on opportunities in the locations where they are working, NGOs were required to design a program of activities that would:

- a) Have a primary focus on the prevention and management of STIs.
- b) Provide appropriate referrals for other services.
- c) Where necessary and appropriate, provide additional services (e.g. counselling and testing for HIV, rape crisis support and wider sexual health services). Linkages with ARV providers and support for people living with HIV are likely to be appropriate.
- d) Demonstrate innovative ways in dealing with the constraints inherent to the delivery of STI services in PNG.
- e) Identify risks and articulate appropriate ways to manage them.
- f) Articulate the process of expansion (if anticipated) in the types of services and geographic area.
- g) Research is a central component of all projects established under the Program. The Institute for Medical Research (IMR) was contracted as the key research partner to undertake baseline studies in NGO sites to support the

dissemination of the elements of effective and innovative PNG specific STI services and to showcase opportunities to improve STI services nationally.

The research component covers clinical, social and operational/action aspects of the Program. The program of research undertaken was appraised by AusAID and GoPNG prior to commencing.

In relation to the NGO's provision of additional services (see 11c above), challenges in relation to the diagnosis and treatment of HIV have been highlighted by the Independent Review Group (IRG)¹⁷. The IRG May 2010 assessment notes that in 2008 there were 56,412 cases of STI reported nationally, but only 6 per cent of these were offered or accepted an HIV test (implying 4,200 cases of HIV were not diagnosed). The IRG recommends higher targets for national HIV testing in all STI cases and, in particular, rolling out Provider Initiated Counselling and testing to 80% of the health facility testing sites within one year. This is a key area for the evaluation to consider for the future of the program.

Objective of the Independent Progress Report

The objectives of the evaluation are to:

- a) Assess the extent to which the goal and objectives of the program have been achieved including the research component.
- b) Assess consistency between management and implementation of the program and the program design.
- c) Identify issues that need to be addressed to improve the implementation and management of PASHIP through to December 2012 and recommend a course of action to accomplish this.
- d) Inform future support for STI and HIV prevention in PNG beyond 2012.
- e) Consider how areas of the program can be strengthened. There are concerns about the implementation and effectiveness of the program and the review will make recommendations to improve effectiveness and efficiency.

Scope of the evaluation

Independent evaluations of aid program activities provide information for AusAID's assessment of aid program effectiveness, lessons to AusAID and implementation partners on aid program management, inform design of new activities and inform management of existing activities.

The evaluation will assess and rate the project against the eight criteria defined in the AusAID guideline, 'Manage the Independent Evaluation of an Aid Activity', which includes the five OECD DAC criteria of relevance, effectiveness, efficiency, impact and sustainability; and the three additional AusAID criteria of monitoring and evaluation, gender equality, and analysis and learning (further detail is at Attachment A). The rating scale used is 1 – 6, with 6 indicating very high quality and 1 indicating very low quality. A rating below 4 indicates that an activity has been rated as less than satisfactory against a criterion.

The team will examine the following issues, which are of particular significance for gathering lessons learned:

¹⁷ The Independent Review Group is an independent and transparent mechanism for the review of the national response to HIV and AIDS, established in 2007. The IRG conducts a periodic higher level assessment of performance against the NSP, reporting to the National AIDS Council (NAC), after which its reports are made public.

- a) assess whether the key objectives/outcomes of the PASHIP were realistic and have been or are on track to be met;
- b) assess the strengths, weaknesses, assumptions and appropriateness of the funding/implementation model (including its achievements, value for money, management processes and evaluation, research and monitoring systems);
- c) assess the achievement of sustainable benefits from the project that may be beneficial and useful to the GoPNG for future projects, including the type of capacity development and research undertaken;
- d) assess the integration of AusAID's cross cutting policies, particularly gender, into PASHIP activities and lessons learned for future projects;
- e) assess the coherence and linkages with other HIV & Health initiatives; other AusAID supported initiatives (SNS, CARE, etc); and with other relevant GoPNG activities;
- f) assess the extent to which the environmental impacts (if any) of the project were managed;
- g) assess the relevance of PASHIP against the broader objectives of the Australian aid program in PNG;
- h) assess the relevance of the current Program Management Guidelines and make recommendations for changes;
- i) assess the overall efficiency and effectiveness of PASHIP and recommend a course of action to:
 - address identified constraints;
 - identify areas for scale up;
 - ensure that maximum advantage is obtained for the remainder of the project and future projects in line with the new National Health Plan – Key Result Area 6, the new National HIV Strategy and recommendations of the May 2010 Independent Review Group Assessment Report.

To examine these issues, the evaluation team will:

- j) Develop an Evaluation Plan for AusAID approval. The Plan will:
 - i. be in accordance with the ToRs;
 - ii. specify the evaluation and design approach;
 - iii. detail the proposed evaluation and design questions and audience;
 - iv. specify team member roles and responsibilities.
- k) Undertake a desk study of all (but not limited to) documents listed in the Reference Documents in paragraph 28 of these ToRs.
- l) Conduct consultations including with:
 - i. AusAID in Canberra including the NGO section and Port Moresby (Health and the HIV and AIDS programs) to provide and receive briefing on relevant issues;
 - ii. key stakeholders from Australia and PNG;
 - National Department of Health in particular the Disease Control Branch of the Division of Public Health;

- National AIDS Council Secretariat;
 - Provincial Health officials in NCD, Simbu, Eastern Highlands, Morobe and East New Britain;
 - Institute of Medical Research in Goroka, Eastern Highlands;
 - Program partners: (Australian partners will be interviewed in and around the margins of the Program Reference Group meeting for PASHIP on 18 and 19 November. These meetings are attended by partners both local and Australian based);
 - the 4 A's project implemented by the Anglican Board of Missions in partnership with Anglicare StopAIDS, Anglican Health Service and Albion Street Centre Australia)
 - Caritas Sexual Health Program in Simbu implemented by Caritas Australia in partnership with Australasian Society for HIV Medicine, Catholic Health Australia and PNG Catholic Health Services)
 - Lusa Numuni Project implemented by Save the Children Australia in partnership with Save the Children in PNG and Eastern Highlands Provincial Health
 - Clinical Outreach, Men's Programs, Advocacy and Sexual Health Services Strengthening in Lae implemented by the Sexual Health and Family Planning Australia in partnership with HELP Resources, PNG Family Health Association, Family Planning New Zealand and Canberra Sexual Health Centre
 - East New Britain Sexual Health Improvement Program implemented in partnership with East New Britain Provincial Government, PNG Family Health Association in partnership with International Women's Development Agency, the Burnet Institute and Cairns Sexual Health Centre
- iii. the five NGO consortia will provide a briefing on their experience in implementing the program and their perception of key issues, strengths and weaknesses; and
- iv. AusAID, GoPNG and other stakeholders at the completion of the evaluation to present the Aide Memoire.
- m) Review PASHIP project records, any reports to date and any other related information that is required to ensure quality of data presented;

- n) Facilitate workshops with counterparts and other key stakeholders, as appropriate, to explore any issues that may not have been captured in existing reports.

Composition of the Independent Progress Review Team

1. The Evaluation Team will consist of four to five members comprising:
 - a) Team Leader (with monitoring and evaluation expertise);
 - b) Sexual Health/STI and HIV specialist;
 - c) GoPNG representative from Department of National Planning and Monitoring (DNPM);
 - d) GoPNG representative from the Department of Health; and
 - e) AusAID (Canberra).
2. Skill set required by the team:
 - a) Experience in project/program planning, monitoring and evaluation;
 - b) Technical expertise in sexual health, STI and HIV;
 - c) Knowledge of the Australian aid program and experience in aid program development, planning, monitoring and evaluation;
 - d) Knowledge of governments and governance issues in PNG;
 - e) Excellent interpersonal and communication skills, including a proven ability to liaise and communicate effectively with Papua New Guineans (including GoPNG officials). Fluency in Tok Pisin desirable;
 - f) Ability to provide timely delivery of high-quality written reports;
 - g) Good understanding of gender in sexual health issues;
 - h) Demonstrated analytical skills.

Roles and Responsibilities of the team

The Team Leader will:

- a) plan, guide and develop the overall approach and methodology for the evaluation;
- b) be responsible for managing and directing the evaluation's activities, representing the evaluation team and leading consultations with government officials and other donor agencies; and
- c) be primarily responsible for the reporting outputs including managing, compiling and editing inputs from other team members to ensure the quality of outputs.

The Sexual Health/STI/HIV specialist, under the direction of the Team Leader will:

- a) provide advice to the Team Leader on the GoPNG's policies in the sexual health, STI and HIV sector; and
- b) assist the team leader during evaluation activities and meet reporting outputs.

Other team members will:

- a) work under the overall direction of the Team Leader;

- b) provide advice, relevant documentation from the GoPNG, and an understanding of GoPNG processes; and
- c) contribute to the required dialogue and analysis.

Outputs

The following reports are to be provided:

- a) Evaluation Plan - for agreement with AusAID before mission commencement.
- b) Evaluation Aide Memoire - to be presented to AusAID Port Moresby, GoPNG and other stakeholders at the completion of the evaluating mission, before departure from PNG.
- c) Draft Evaluation Report - for consideration by AusAID, within 10 working days of completion of the field study to PNG to the Evaluation Officer, Performance Quality and Review Section, AusAID Canberra. Feedback from AusAID will be provided within two weeks of receiving the draft report, followed by a peer review.
- d) Final Evaluation Report - final document incorporating advice from evaluation peer review. The report will be up to 25 pages. Lessons and recommendations should be clearly documented in the report.

All reports will be submitted in Word format using AusAID's templates by email to the Evaluation Manager and according to the following timeline (exact dates to be set out in the Evaluation Plan):

Reports	Format	Length	Due
(a) Evaluation Plan	As advised by AusAID evaluation manager	No more than 5 pages	At the completion of the desk review and prior to the evaluation mission
(b) Evaluation Aide Memoire	In accordance with AusAID Aide Memoire template	No more than 5 pages	At the end of the in-country evaluating mission
(c) Draft Evaluation Report	In accordance with AusAID Independent Progress Report template	No more than 25 pages plus appendices	Within 10 working days of completion of the evaluation mission. Feedback from AusAID will be provided within three weeks of receiving the draft report
(d) Final Evaluation Report	In accordance with AusAID Independent Progress Report template	No more than 25 pages plus appendices	Within 5 working days of receiving peer review feedback from AusAID

Duration

Date	Task	Location	Input (days)	
			Team leader	Sexual Health/HIV Specialist
2 - 4 November	Document review	Home office	3	3
5 & 8 November	Evaluation Plan	Home office	1	
11 - 12 November	AusAID briefings and presentation of methodology and AusAID Approval of Evaluation Plan	Canberra	2	1
15 - 29 November	Evaluation mission including Preparation and presentation of aide memoire	PNG	17	17
2 - 10 December	Draft evaluation report	Home Office	7	3
15 December	Peer Review		1	1
	Redrafting after feedback from AusAID and other stakeholders Final Report	Home Office	2	1
Travel			3	?
	TOTAL DAYS		36	26

Reference Documents

The team will need to read the following reference documents:

- PASHIP Design Document
- Australia-PNG Partnership for Development
- AusAID's Guidelines 'Managing an independent evaluation'
- Request for Capacity Statements
- PASHIP Concept Note
- Five final Project documents (Anglican Board of Mission, Burnet, Caritas, Save the Children and Sexual Health and Family Planning Australia)
- Research Framework (PNG Institute of Medical Research)
- Assessment and recommendations – PASHIP research
- Program Management Guidelines

- Progress Report template
- Progress Acquittal template
- M&E framework for PASHIP
- M&E Report
- National Strategic Plan HIV AIDS 2006 – 2010
- PASHIP projects Fact Sheets (ABM, Burnet, Caritas, SCA and SHFPA)
- Subsidiary Arrangement
- Contractual Documents - Service Orders (ABM, Burnet, Caritas, SCA and SHFPA)
- Funding Agreement (PNGIMR)
- PASHIP projects Fact Sheets (ABM, Burnet, Caritas, SCA and SHFPA)
- National Health Plan 2010 – 2020
- National Health strategic Plan 2006 – 2008
- PASHIP Monitoring & Evaluation Brief, Program Technical Monitoring Writer, 22 February 2010
- Independent Review Group on HIV/AIDS, Report from an assessment visit 22 April – 5 May 2010

TOR Attachment A: Questions for an Independent Progress Report

Relevance

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

Effectiveness

- Were the objectives achieved? If not, why?
- To what extent did the activity contribute to achievement of objectives?
- Did the activity represent value for money?

Efficiency

- Did the implementation of the activity make effective use of time and resources to achieve the outcomes?

Sub-questions:

- Was the activity designed for optimal value for money?
- Have there been any financial variations to the activity? If so, was value for money considered in making these amendments?
- Has management of the activity been responsive to changing needs?
- Did the activity suffer from delays in implementation? If so, why and what was done about it?
- Did the activity have sufficient and appropriate staffing resources?
- Was a risk management approach applied to management of the activity (including anti-corruption)?
- What were the risks to achievement of objectives? Were the risks managed appropriately?

Impact (if feasible)

- Did the activity produce intended or unintended changes in the lives of beneficiaries and their environment, directly or indirectly?
- Were there positive and/or negative impacts from external factors?

Sustainability

- Do beneficiaries and/or partner country stakeholders have sufficient ownership, capacity and resources to maintain the activity outcomes after Australian Government funding has ceased?
- Are there any areas of the activity that are clearly not sustainable? What lessons can be learned from this?

Gender Equality

- What were the outcomes of the activity for women and men, boys and girls?
- Did the activity promote equal participation and benefits for women and men, boys and girls?

Sub-questions:

- Did the activity promote more equal access by women and men to the benefits of the activity, and more broadly to resources, services and skills?
- Did the activity promote equality of decision-making between women and men?
- Did the initiative help to promote women's rights?
- Did the initiative help to develop capacity (donors, partner government, civil society, etc) to understand and promote gender equality?

Monitoring and Evaluation

- Does evidence exist to show that objectives have been achieved?
- Were there features of the M&E system that represented good practice and improved the quality of the evidence available?
- Was data gender-disaggregated to measure the outcomes of the activity on men, women, boys and girls?
- Did the M&E system collect useful information on cross-cutting issues?

Analysis & Learning

- How well has the current design addressed previous learning and analysis?
- How well was learning from implementation and previous reviews (self-assessment and independent) integrated into the activity?

Lessons

- What lessons from the activity can be applied to (select as appropriate: subsequent activities/programs [i.e. working in partner systems/environment/fragile stages]).

Annex 3: Guiding Questions

AusAID (HIV program)

Opening question (all respondents)

- What's your experience of PASHIP to date?

Effectiveness

- From your perspective what are the broad strengths and weaknesses of the program?
- What makes PASHIP a program rather than a collection of projects?
- What was the rationale of moving oversight of PASHIP from health to HIV program?
- What lessons have been learned re the achievement of objectives? How are they measured?

Relevance

- Is PASHIP still aligned with Australian and GoPNG objectives i.e. DCT/ Cairns compact/the NHS and NHP? Which areas may need to be amended? When/how?
- How does PASHIP relate to other AA programs (Health, SNS and SPSN in particular)? Are there any unrealised opportunities for synergy?

Governance

- Explain the Secretariat and its functions (composition, functions, performance, and suggestions for change).
- How useful is the program management guide? What needs to change?
- Please can you clarify IMR's role: baseline data?
- Please can you explain the overall M&E structure and whose responsibility it is to manage this?
- What has been your experience of financial accountability from partners?

Sustainability

- Which aspects of PASHIP are most/least sustainable?
- What considerations need to be taken into account when thinking about scale up?
- What evidence is there that GoPNG owns aspects of this program?

Efficiency

- PASHIP is a \$25 million program: in your opinion is it representing good value for money? Describe.
- How has the program changed since its inception to accommodate changing needs?
- Has the program increased both demand and supply of STI services?
- Several partners note challenges to implementation? Could these have been better predicted managed?
- Might LNG impact on the program's efficiency?

Impact

- Are there any concrete impacts so far? Describe.
- Evidence of increased access/increased safer sex/improved government capacity to deliver services/successful referrals.

Gender equality and cross cutting issues

- Are you satisfied with the way these issues are being addressed? What suggestions for change?

Learnings

- Is PASHIP benefitting from lessons learned from other models of STI/HIV service delivery (CHA/Oil search/ADB/FHI etc? How? How might it be improved?
- How do lessons learned from PASHIP get disseminated to other players including NDOH and provincial health? How does PASHIP respond to recommendations from IRG?
- Finally, your suggestions for how PASHIP could be improved up to 2012 and thereafter?

Checklist for field visits

Prevention and management of STIs.

Collect actual numbers seen and treated.

Is it part of NHIS?

Is it sex disaggregated?

Is it can you measure repeat visits?

Data of referrals and actual uptake: how is this verified?

Equipment: who pays running and maintenance costs?

Are there any economies of scale: i.e. multiple use of facilities/curricula etc?

Evidence of innovation?

Why such low HIV testing?

How can you link with HIV sites for increased STI testing?

What are the arguments for and against stand alone clinics/for integrated SRG services?

Risks and risk management (child abuse, rape etc) allied services.

Links with partners across the program.

Evidence of capacity building in Human Resource Management, clinical skills, QA.

Evidence of increased health seeking behaviour.

Risks of scale up (i.e. absorptive capacity/reduced quality) any ideas?

Annex 4: List of People Consulted by PASHIP IPR Team

11-29 November 2010

Name	Position	Organisation
<i>In Canberra</i>		
Octavia Borthwick	PNG Branch Head	AusAID Canberra
Mukii Gachugu	Pacific PNG Divn Performance & Quality Section	AusAID Canberra
Bernard Pearce	Gender Policy Team	AusAID Canberra
Sue Connell	Pacific PNG Divn Ag Branch Head Quality	AusAID Canberra
Alison George	Pacific PNG Divn Performance & Quality Section	AusAID Canberra
Prue Borthwick	PNG branch HIV Adviser	AusAID Canberra
Anna Clancy	NGO Policy Team	AusAID Canberra
Emily Rudland	Office of Development Effectiveness	AusAID Canberra
Margot Morris	Health and HIV Thematic Group	AusAID Canberra
Robyn Biti	Health Adviser	AusAID Canberra
Anna Gilchrist	Pacific Branch Health Team	AusAID Canberra
Kate Fraser	Health and HIV Thematic Group	AusAID Canberra
<i>In Port Moresby</i>		
Martin Korokan	Aid Coordinator AusAID Desk PNG, GoPNG Representative on PASHIP IPR Review Team	Dept of National Planning & Monitoring
Anne Malcolm	Program Director	PNG-Australia HIV & AIDS Pgm
Irene Wettenhall	Deputy Program Director	PNG-Australia HIV & AIDS Pgm
Catherina Habon	Program Manager	PNG-Australia HIV & AIDS Pgm
Clement Totavun	PASHIP Liaison Officer	PASHIP Secretariat
Lydia Butut-Dori	(Prev.) Health Sector Program Manager	Policy & Coordination ,AusAID
Dr Greg Law	STI/Sexual Health Adviser	NDoH
Dr Ururang Kitur	M&E Section	NDoH
Avi Hubert	Health Program Manager	AusAID PNG
Paulinius Sikosana	Health Program Adviser	AusAID PNG
Richard Miria	Clinician	4As Project, Anglicare PNG

Name	Position	Organisation
Janet Tunu	Clinical Nurse	4As Project, Anglicare PNG
Cecilia Vaupin	Clinical Nurse	4As Project, Anglicare PNG
Lorien Vecellio	ABM Australia Ltd, PNG Project Officer	4As Project, ABM
Debra Field	Deputy Director, Finance	4As Project, Anglicare PNG
Kay Nicol	Board Member	4As Project, Anglicare PNG
Marcia Kalinoe	Program Manager	4As Project, Anglicare PNG
Robert Cherry	Nurse Technical Adviser	4As Project, Albion Street Centre
Ulch Tapia	National Secretary	4As Project, Anglican Health Service
Sr Josepha Tametalong	Clinical Nurse	4As Project, Anglican Health Service
Jenni Graves	Snr Project Coordinator/Technical Adviser IHS	Albion Street Centre NSW
Wep Kanawi	Director	PNG National AIDS Council Secretariat
Dr Holly Arawafu	HIV Behavioural Survey Team Leader	National Research Institute, PMG
Sharon Walker	Training Consultant, HIV Counselling & Testing	IEA
Fidelis Bola	Outgoing Provincial Health Adviser	ENB
Nicholas Larme	Provincial Health Adviser	ENB
Mark Nakgai	Provincial Health Adviser	ESP
Dr Likei Theo	Provincial Health Adviser	Morobe
Philip Wanua	Deputy Director, EHP Provincial Health	EHP
Copeland Ihove	Provincial Health Adviser	Oro
Dr John Millan	President	PNG Sexual Health Society
Marie Mondu	PNG Research Officer	Caritas Australia
Margaret Ghunn	Clinician	Catholic Health Services
Clare Andawa	Clinician	Catholic Health Services
Beatrice Tabeu	PNG Project Coordinator	Caritas Australia
Justine McMahon	Project Director	Caritas Australia
Jamieson Davies	International Programs Manager	Caritas Australia
Lisa Natoli	International Project Manager	Burnet Institute, Melbourne
Cathy Beacham	PNG Country Director	Burnet Institute

Name	Position	Organisation
Geraldine Wambo	Team Leader	ENBSHIP
Sonia Gawi	Senior Program Manager	Lusa Numuni Project, SCiPNG
Ghanshyam Jethwa	HIV & AIDS Program Manager	Lusa Numuni Project, SCiPNG
Geraldine Maibane	Senior Research Officer	PNG Institute of Medical Research
Dr Claire Ryan	HIV/STI Section Head	PNG Institute of Medical Research
Gevin Edward	Research Officer	PNG Institute of Medical Research
Aloise Ralai	Research Officer	PNG Institute of Medical Research
Anne Kitoneka	PNG Project Manager	COMPASS
Diane Ryan	Coordinator Component 1	Family Planning NZ/COMPASS
Jeremy Symes	PNG Country Program Coordinator	ADB Rural Enclaves
Kel Browne	Technical Adviser	ADB Rural Enclaves
Bill Bowtell	Director, HIV/AIDS Research	Lowy Institute, Sydney
Dr Katherine Lepani	Health Sector Researcher	ANU/Lowy Institute
Julienne McKay	Economist/Public Health Adviser	Lowy Institute
Dr Dakulala	Deputy Secretary of Health	NDoH
Rohoda Yani	Director	HIV/AIDS Desk, DNP&M
Ninkama Moiya	HIV and AIDS Adviser	PNG-Australia HIV & AIDS Pgm
Abraham Opito	HIV and AIDS Adviser	PNG-Australia HIV & AIDS Pgm
Terry Opa	M&E Adviser	PNG-Australia HIV & AIDS Pgm
Colin Wiltshire	Co Located Officer	SNS, AusAID, Central Province
Angela Mandie-Filer	Social Development and Gender Adviser	PNG-Australia HIV & AIDS Pgm
<i>In Eastern Highlands Province</i>		
Moale Vagikapi	Team Leader	AusAID EHP, SNS
Verena Thomas	Communications Course Coordinator	Komuniti Tok Piksa, Uni of Goroka
Ghanshyam Jethwa (Sam)	HIV & AIDS Program Manager	Lusa Numuni Project, SCiPNG
Lucy		Poro Sapot, SCiPNG

Name	Position	Organisation
Sandra (+ 3 clinicians and Lab technician)	Lopi Clinic Coordinator	SCiPNG, Goroka
Sara	Program Coordinator	SCiPNG, Goroka
Sonya	A/g Senior Project officer	Lusa Numuni Project, SCiPNG
Andy Carmone	Director	CHAI Rural Initiative, Goroka
<i>In Morobe Province</i>		
Diane Ryan	Coordinator Component 1	COMPASS
Dr Andrew Roberts	Independent Consultant for QA Component 2	COMPASS
Anne Kitoneka	PNG Country manager	COMPASS
Samson Pisin	Male project officer	COMPASS
Zuabe Tinning	Nurse educator	COMPASS
Micah Yawing	Deputy Provincial Health Adviser	Morobe Provincial Health
Lucy Dally	HIV/STI Coordinator & OIC Friends Clinic	Morobe Provincial Health
Siling Awasa	District Disease Control Officer	Lae District Health Service
Tiureng Tanba	District Disease Control Officer	Tawe-Sisia District Health Service
Adrian Otto	Officer in Charge	Wampar Health Centre
Sinika Daniel	CHW – VCT Trainer & Counsellor	Wampar Health Centre
Tuzi Amakua	CHW - STI Female Nurse	Wampar Health Centre
Andrew Alaweya	CHW - STI Male Nurse	Wampar Health Centre
Wawato Kiwa	Nursing Officer	Wampar Health Centre
Martha Wankeng	CHW - STI Female Nurse	Wampar Health Centre
<i>East New Britain Province</i>		
Anne Sawa	Health Systems Strengthening Officer	ENBSHIP
Sakaia Luana	Community Engagement Worker (CEW)	ENBSHIP
Rebecca Gabong	CEW	ENBSHIP
Elizabeth Norman	Admin Officer	ENBSHIP
Nicholas Larme	PHA	ENB
Hadlee Supsup	CEW	ENBSHIP
Stephanie Losby	Project Management Adviser	ENBSHIP
Ellen Kavang	CEW	ENBSHIP

Name	Position	Organisation
Paul Bridgman	SNS	AusAID ENB
Geraldine Wambo	Project Team Leader	ENBSHIP
Judith Ugava-Taunao	SNS	AusAID ENB
Nicholas Baroro	LLG Manager/Livuan Reimber	At Gazelle HIV Stakeholder Forum
Neville Kunai	LLG Manager/Inland Baining	At Gazelle HIV Stakeholder Forum
Andrew Kusak	LLG President	At Gazelle HIV Stakeholder Forum
Ekonia Wakom	LLG Manager, Toma Vunadidir	At Gazelle HIV Stakeholder Forum
Ronald Sambai	LLG Manager, Lassul Baining	At Gazelle HIV Stakeholder Forum
Grace	Community Health Worker	At Gazelle HIV Stakeholder Forum
Nancy Galoko	Clinician, University Clinic	At Gazelle HIV Stakeholder Forum
Cecilia	Nursing Officer	At Gazelle HIV Stakeholder Forum
Steve Auri	PAC Coordinator	At Gazelle HIV Stakeholder Forum

Annex 5: PASHIP Secretariat Job Description

The PASHIP Secretariat will be central to the coordination and management of the Program.

The Secretariat will consist of a team of two people, jointly selected by NDoH and AusAID:

- A Program Liaison Officer; and
- An Administrative Support Officer

The officers will work closely with the NDoH officers to ensure alignment between PASHIP and the NDoH systems.

The Secretariat's responsibilities will be as follows:

- Program Management Contact Point for NGOs
 - Contact point for Program issues;
 - Provide coherence of activities under PASHIP, with a focus on monitoring and evaluation;
 - Receive, collate and distribute materials;
 - Ensure strong linkages with NDoH's overall responsibility for STI service delivery;
- Annual Activity Plans
 - Coordinate review of draft Annual Activity Plans;
 - Provide feedback to NGOs on draft Annual Activity Plans, including raising any relevant sectoral or regional issues and/or recommending changes to the Annual Activity Plans as deemed necessary;
 - Circulate reviewed, and if required, revised Annual Activity Plans to members prior to Program Reference Group meetings; and
 - Provide a recommendation to the Program Reference Group regarding the endorsement of individual Annual Activity Plans.
- Organise 6-monthly Program Reference Group meetings
 - Set meeting dates (in line with the Program Timetable below) and notify members;
 - Manage meeting logistics;
 - Formulate and circulate agendas:
 - Receive and circulate relevant papers, including Annual Activity Plans and Progress Reports; and
 - Record and circulate minutes.
- Arrange ad hoc meetings for the Program on request from Partners (i.e. regular clinicians meeting)
 - set meeting dates and notify relevant partners
 - manage meeting logistics
 - formulate and circulate agendas
 - record and circulate minutes

Annex 6: Stakeholder recommendations and feedback

- Can the NGO HIV Forums be timed to coincide with PRG meetings?
- Some concerns about the qualitative research from IMR – or at least the articulation of findings e.g. finding re traditional social control - sex offenders stoned. Recommendations presented included encouragement of traditions.
- PASHIP at EHP – We are seeing very positive outcomes in our project. Particularly the joint partnership implementation and improvement of STI services. Can AusAID fund extension of the program into other six Districts in the Province.
- Failure of IMR to deliver Baseline reports in a timely fashion so as to inform project approach. I understand that there are good reasons for the lab delays, but issues around qualitative data are totally unacceptable. We did plan our own baseline studies but told we couldn't do it because IMR would.
- Dysfunctionality of PASHIP Secretariat.
- Lack of genuine engagement with partner on setting agenda for PRG meetings. These meetings are a huge missed opportunity for sharing and learning from each other's experiences. Also, valuable discussions don't get documented and shared.
- Generally poor administration/communication by AusAID:
 - Huge delays from design to mobilisation.
 - Slow responsiveness to questions.
 - Changing conditions e.g. changes to AAP templates, reporting requirements, 5PRGs to 9 etc.
- Frustrations were so great early on that ACFID was engaged to represent issues and assist with mediation.
- Engagement and integration with provincial health – for sustainability post 2012.
- Timing of IMR follow-up survey – do it 12 months after completion of PASHIP to help assess impact, or not at all if IBBS provides sufficient data.
- How to make best use of data already collected by IMR.
- Lessons on gender approaches.
- Return of IMR test results to people tested – have they been counselled appropriately? – duty of care issues?
- Exit strategies – Save the Children example.
- Capacity building approaches – including issue of inappropriateness of study tours to Australia.
- Standalone STI clinics VS integrated clinics – pros and cons.
- Challenges – from IMR presentation, it was obvious that most of the challenges they faced were around Human Resource related, especially coordination and communication with Partners.
- The Lesson seems to be that there is a need to ensure, at the planning/project development stage, that planning is realistic, has a leadership position built in – and budgeted – for effective communication and coordination with partners. In other words, it is more efficient and effective to invest adequately (time, money and expertise) at the planning level, because

the implementation otherwise becomes extremely difficult, costing a lot more, end even affecting quality of work.

- I wonder at the accuracy of comment from AusAID that they struggled to extrapolate relevant useful material from PASHIP partners' reports. With the extremely high turn over of AusAID staff and their lack of response to queries and requests if they were able to put the effort into what would be required to do this well e.g. every PASHIP we request a more useful format for meetings – never happens.
- See the Secretariat as a missed opportunity to provide useful productive services (beyond a bit of admin) to the PASHIP partners. The history of the Secretariat reflects a lack of logistical and financial support from AusAID. I think the Secretariat could act as a valuable venue for sharing of information/ideas and a lot more.
- A lesson learned for me in the COMPASS Project has been how difficult it is to manage from another country. Very difficult for in-country manager, line managing four men in 3 different sites with me managing from a distance. If I was involved in design in future I would make my position (Coordination Comp. 1) in country.
- Achievement – Local staff ability to cope with ongoing challenges, weather, power cuts, uncooperative local partners, security and getting their work done well.
- I appreciate it would have been difficult to predict this at the design stage but it has negatively impacted on COMPASS project. Rectifying ongoing problems very time consuming and frustrating. I don't know what the lesson learned is here – it is a major risk. Other in-country partner is going through great difficulties governance wise.

- Transcriptions recorded as received -

Annex 7: List of References

- Accra Agenda for Action (September 2008)
- AusAID Draft Health Delivery Strategy in PNG (August 2010)
- AusAID Evaluation of the PNG HIV/AIDS Support Project
- Australian Aid to Health Service Delivery in PNG, Solomon Islands, Vanuatu (June 2009)
- Cairns Compact on Strengthening Development Coordination in the Pacific (August 2009)
- Intensifying the Response – Halting the Spread of HIV: Australia’s International Development Strategy for HIV (2009)
- Minimum Standards for STI Service Delivery in Papua New Guinea (NDoH 2008)
- Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability (March 2005)
- Partnership for Development between the Government of Australia and the Government of Papua New Guinea (August 2008)
- PNG-Australia Development Cooperation Treaty Review (2010)
- PNG HIV Prevalence: 2009 Estimates (WHO, UNAIDS, AusAID)
- PNG-Australia HIV and AIDS program; civil society engagement (Sept 2010).
- PNG Development Strategic Plan 2010-2030
- PNG Medium Term Development Plan 2011-2015 (Oct 2010)
- Responding to HIV/AIDS in PNG: Australia’s Strategy to Support PNG 2006-10
- Service Delivery for the Poor – Lessons from Recent Evaluations of Australian Aid (November 2009)
- Sik Nogut o Nomol Sik – A study into the socio-cultural factors contributing to sexual health in the Southern Highlands and Simbu Provinces, Papua New Guinea, by Philip Gibbs and Marie Mondu (Caritas Australia 2010)
- Transforming Power Relations; Equal status of women and men at the family level in the Pacific (SPC 2009-10)
- Turning the Tide – An open Strategy for a Response to AIDS in the Pacific (December 2009)
- UNAIDS PCB. Integrating Sexual and Reproductive Health Services with HIV Interventions in Practice. (June 2010).
- Violence Against Women in Melanesia and East Timor (ODE November 2008)

PASHIP specific documents

Early PASHIP/Integrated Sexually Transmitted Infection Management and Prevention Program ISMPP Background Documents

- PNG ISMPP Concept note (March 2006)
- PNG ISMPP Request for Capacity Statements (March 2006)
- PNG ISMPP PDD Specifications (Oct 2006)
- Minute: ISMPP Design & Implementation Strategy Update (Sept 2006)
- PASHIP Program Management Guidelines (May 2008)
- PASHIP NGO Locations (Sept 2010)

PASHIP Partners' PDDs

- PDD: CARITAS (Oct 2006)
- PDD: The 4As Partnership Program (June 2007)
- PDD: Burnet (ENBSHIP) (Feb 2007)
- PDD: SHFPA (COMPASS) (June 2007)
- PDD: SCA (June 2007)

PASHIP PDD Appraisals (Mar 2007)

- SCA
- ADRA
- The 4As
- Burnet (ENBSHIP)
- Caritas
- SHFPA (COMPASS)
- Introduction to Appraisals
- PASHIP Appraisal Outcome Minute (AusAID Internal)

Service Orders

- Burnet (ENBSHIP) (n.d.)
- Caritas (May 2008)
- IMR Funding Agreement (Apr 2008)

Monitoring & Evaluation

- PASHIP M&E Final Milestone Report (Apr 2008)
- M&E Assistance to PASHIP Final Report (Sept 2007)
- PASHIP M&E Framework (Jan 2008)
- PASHIP M&E Brief (Feb 2010)
- Assessment & Recommendations on Research Component of PASHIP (Evelyn King) (Sept 2009)
- Lusa Numini Project. Monthly Monitoring Report (Oct 2010)

Other Related Documents

- Reviews & Evaluations Synthesis Report 2006-2009 (David Lowe)
- IRG Report (Apr-May 2010)

- National HIV Strategy (NHS) 2011-2015
- NHS Implementation Framework 2011-2015
- NHS Monitoring & Evaluation Framework 2011-2015
- Subsidiary Agreement between Government of Australia & GoPNG for PASHIP
- Partnership for Development between GoA & GoPNG (Aug 2008)
- PNG National Health Plan Vol 1(NDoH; Jul 2010)

PASHIP Progress Reports

- SCiPNG LNP Year 1 Progress Report (Oct-Dec 2007)
- 4A's Year 2 Quarterly Progress Report (Oct-Dec 2008)
- Caritas Year 2 Annual Progress Report (Jan-Dec 2008)
- Burnet ENBSHIP Year 2 Annual Progress Report (Jan-Dec 2008)
- SHFPA COMPASS Year 2 Annual Progress Report (Jan-Dec 2008)
- SCiPNG EHSCIP Year 2 Progress Report (Jan-Dec 2008)
- 4As Year 3 Quarterly Progress Report (Jan-Dec 2008)
- IMR Baseline Research Progress Report (Aug 08-Apr 09)
- SCiPNG EHSCIP Year 3 Progress Report (Jan-Dec 2009)
- IMR PASHIP Research Component Update (Feb 2010)
- IMR Baseline Research Progress Report (Apr 2009)
- 4As Year 3 Annual Progress Report (Jan-Dec 2009)

PASHIP Annual Activity Plans (AAPs)

- SCiPNG EHSCIP AAP (planning period Jan-Dec 2008)
- Caritas STIMP AAP (planning period Jul-Dec 2008)
- SHFPA COMPASS AAP (planning period Oct-Dec 2008)
- Anglican Board of Mission 4As AAP (planning period Oct-Dec 2008)
- SCiPNG EHSCIP AAP (planning period Jan-Dec 2009)
- Burnet ENBSHIP AAP (planning period Jan-Dec 2009)
- SCiPNG EHSCIP AAP (planning period Jan-Dec 2009)
- Caritas STIMP AAP (planning period Jan-Dec 2009)
- SHFPA COMPASS AAP (planning period Oct-Dec 2009)
- ABM 4As AAP (planning period Jan-Dec 2009)
- Caritas STIMP AAP (planning period Jan-Dec 2010)
- SHFPA COMPASS AAP (planning period Oct-Dec 2010)
- ABM 4As AAP (planning period Jan-Dec 2010)
- Burnet ENBSHIP AAP (planning period Jan-Dec 2010)

PASHIP Program Review Group (PRG) Minutes

- November 2008
- May 2009
- November 2009
- May 2010

PASHIP Financial Acquittals (2008)

- SCiPNG (Lusa Numini)

- ABM (The 4As)
- Burnet (ENBSHIP)
- Caritas (STIMP)
- SHFPA (COMPASS)

PASHIP Financial Acquittals (2009)

- SCiPNG (Lusa Numini)
- ABM (The 4As)
- Burnet (ENBSHIP)
- Caritas (STIMP)
- SHFPA (COMPASS)

Other Documents

- Aide Memoire: Clinton HIV and AIDS Initiative. (n.d.)
- AusAID Health Delivery Strategy (draft) (June (2010)
- Research Support to IMR – Draft IPR (Jul 2010)
- Research Support to PNG National Research Institute – Draft IPR (Aug 2010)
- Ministerial taskforce of Maternal Health in PNG (NDoH; May 2009)
- PNG Australia HIV and AIDS Program: Civil Society engagement – Case Study Report (Sep0t 2010)

AusAID Templates

- Guidelines for Managing the Independent Evaluation of an Aid Activity
- Outline for an Evaluation Aide Memoire
- IPR Template
- Standard Evaluation Questions

Annex 8: Summary of NGO Partner Comments on the IPR

Partner NGO	Report Reference	Partner NGO Response	AusAID / NDoH Response
4As	Staff numbers at St Margaret's in Oro Bay (p10, last paragraph)	While the 4As Program Design Document envisaged a number of PASHIP funded staff at St Margaret's Health Centre in Oro Bay, this has not been feasible to date, due to insufficient accommodation available for staff near the site. Discussions have been held about employing two additional staff to conduct STI awareness/prevention activities, but this idea has been put on hold due to a lack of staff accommodation. We are exploring options for peer educators to assist the Oro PASHIP Program Officer with STI awareness/prevention activities.	Noted
	Recommendation 6	<p>The 4As supports this recommendation. The 4As have organised local clinical placements. Two local placements have been undertaken to date, with Anglicare PNG staff working with Poro Sapot (2010) and Anglican Health Service staff working with Anglicare PNG's Begabari Clinic (2011).</p> <p>Participants and their Managers/ Board Member have reported positive results from the STI Service Management and Clinical Placement undertaken in Australia (2010). Results include the development of a Client/ Service Promotion card to provide to sexual health clients to encourage partners to attend clinic, a new collaborative style of management and a new emphasis on client approach, particularly in regards to vulnerable population groups.</p>	<p>Noted</p> <p>Noted. NDoH has advised that a Client Service Promotion Card is already in use at some government health centres</p>
	Institutional capacity (p11, 3 rd paragraph)	The 4As consortium is providing an STI response that is firmly centred within the institutional structures of the Anglican Church of PNG (ACPNG), and specifically Anglicare PNG and Anglican Health Services. As such we are strongly committed to providing a variety of capacity building measures to Anglicare PNG and Anglican Health Services, as they deem appropriate and necessary. With technical support from Albion Street Centre, a wide range of	Noted

		<p>capacity building programs have been conducted, tailored to the identified needs of staff and the institutional context, alongside individual mentoring to staff as required. We have integrated PASHIP activities into the institutional structures of ACPNG and are confident of the church's capacity to maintain these activities beyond the end of PASHIP funding – as the Independent Progress Report notes on p20.</p>	
<p>ENBSHIP: comments from Burnett Institute</p>	<p>Training of Stret Tokers on basic HIV technical issues</p>	<p>In the design of ENBSHIP, HIV was excluded from the training curriculum for stret tokers. This decision was made to avoid duplication and allow a focus on previously neglected issues, such as boarder STI prevention. Training on HIV was to be provided using the existing mechanism via the East New Britain Provincial AIDS Council (ENB PAC). Names of our stret tokers are routinely provided to the PAC, and in Kokopo and Gazelle districts stret tokers have participated in PAC-led training. We will follow-up with the PAC regarding the provision of training to remaining districts.</p>	<p>Noted. Since the IPR was conducted, some progress has been made and Stret Tokers are being trained on basic HIV information by the ENB PAC.</p>
	<p>Concern in relation to sustainability of Stret Tokers</p>	<p>Several comments referred to concern about the sustainability of the Stret Toker component of ENBSHIP. We would like to add that ENBSHIP was designed to use the 'Stret Tokers' activity as a catalyst or 'spark' for starting community conversation about sensitive topics, raising awareness about STIs and breaking down the barriers that exist between villagers and health facilities. The program is not designed to train multiple cohorts of Stret Tokers. To this end, the role of a Stret Toker is to talk with their peers locally and in a way that is routine for their community and utilises existing networks. For example, a woman talks to another woman sitting next to her at the market or a young Stret Toker talks with their peer when they meet via the Church youth group. As such, awareness about STIs and understanding of safer sex and appropriate health seeking behaviour should become 'normalised'; and issues should continue to be discussed as part of everyday life.</p> <p>Remuneration of Stret Tokers is guided strictly by existing government guidelines.</p>	<p>Noted</p> <p>Noted</p>

		<p>In Districts where ENBSHIP has completed engagement with Stret Tokers, communities have lobbied for Stret Tokers to continue their work, and in some LLGs we see indications of ownership and sustainability in some sense. Stret Tokers have formed their own 'association' in a number of LLGs or joined forces with existing CBOs. Several LLGs, Ward Development Committees and Churches have budgeted for Stret Toker activities in their annual plans, and the old Butuwin STI clinic has been handed over to Stret Tokers as a 'drop in centre'. Stret Tokers are achieving community respect and being asked to take on additional responsibilities. Many have been given roles in church congregations, Ward committees, women's committees and school committees. The kudos that comes with being a Stret Toker seems to propel Stret Tokers into such leadership roles, and they become known for having knowledge on STIs.</p> <p>Given this development, we will discuss with the Provincial Health Office how support to active Stret Tokers may be provided and document this in our Exit Strategy.</p>	<p>Noted</p> <p>Noted. At the PRG in Kokopo in June, ENB Provincial Health indicated strong commitment.</p>
	<p>Lack of provincial health operational commitment to health system strengthening (specifically supervision and mentoring of staff)</p>	<p>It is well understood by ENBSHIP that potential impact at the health system level is being constrained by the lack of provincial commitment (human and financial resources) to providing supervision and support to health facilities. The project will endeavour to seek support from NDoH and AusAID's Sub-National Program to enhance this commitment.</p>	<p>Noted</p>
<p>Caritas</p>	<p>General comments</p>	<p>Acknowledging that security concerns were the main reason that the reviewers could not visit Caritas sites, these are the conditions that our partners operate in all year round. It is hoped that any future reviews would allow adequate time and take whatever they consider appropriate measures to deal with those concerns. Caritas workers would be happy to host review teams at our sites.</p>	<p>Noted</p>

		<p>We believe that there is value in having a review, particularly of a program of the size and complexity of PASHIP. However we feel that it would have been more effective if the review could have been conducted at the half way mark. The program now has 18 months to go in total. This includes an exit period. As such we would query the value of instituting any major changes now.</p>	<p>Noted however the IPR is part of AusAID's mandatory quality processes and will be helpful in considering options for AusAID future support for STIs.</p>
		<p>As above, with a short time to go before the end of AusAID funding it seems that to develop and work to a joint action plan at this stage would run the risk of taking resources away from implementation and exit.</p>	<p>A joint action plan was developed at the Program Reference Group meeting in Kokopo in June and includes PASHIP partners developing a handover and exit strategy to present to the next PRG meeting in November.</p>
		<p>It is regrettable that the IMR data will only be available at the end of 2011. On several occasions Caritas Australia went directly to AusAID to ask for assistance with obtaining information on baseline data, particularly so we could link IMR's work with our own research. This did not prove helpful.</p>	<p>Noted but IMR delays were beyond AusAID's control.</p>
		<p>While acknowledging that LNP is a fine model, our program is completely integrated into, and implemented by, existing health and social services in PNG. It seems unusual that this did not warrant mention in the Independent Progress Report.</p>	<p>The IPR report states under 2.6 (Sustainability) that the church-based IPs have made clear that they have integrated improved STI services into their existing Church health services and that these will continue beyond PASHIP.</p>
		<p>It is acknowledged within the report that each of the projects are managed</p>	<p>Noted</p>

		<p>separately. We think that the report does not highlight enough the differences in project designs and that comparisons cannot easily be made, especially in cases where some models enabled new clinics to be built and staff hired and others worked on building the capacity of existing health services.</p>	
	<p>Progress towards Objective 1</p>	<p>Chapter 3 of the report <i>Sik Nogut o Nomol Sik</i> does include data that could be considered trend data.</p> <p>Analysis and learning It should be noted that the IMR research was not the only research component in PASHIP. Originally STIMP and IMR were to work together at the STIMP sites but when it became obvious that the IMR research would be delayed, the STIMP research component went ahead and produced the peer reviewed report <i>Sik Nogut o Nomol Sik</i>. That report comes from qualitative research involving over 600 men and women and over 300 hours of transcribed interviews. The report helped inform later interventions. Hence it could be given more recognition in the review, particularly when it comes to analysis and learning. We note a call for IMR to complete their research report. This will be of limited value to STIMP since at no stage did IMR visit the STIMP sites in the Tari area.</p> <p>Relevance As the researchers did not visit any Caritas sites, we believe the report is significantly lacking and its value is diminished. There is no recognition that IPs and local staff located in the Caritas sites deal with security issues all the time and that this influences the development of the program but also community utilisation</p> <p>The section on 'Relevance' highlights the absence of any PASHIP partner</p>	<p>Noted. The Sik Nogut or Nomol Sik study will be a key source for the new M&E consultancy.</p> <p>Under 2.9 (Analysis and learning), the report notes that Caritas has completed its research and published peer reviewed strategies to address emerging issues in its report <i>Sik Nogut o Nomol Sik</i>.</p> <p>Noted. Similarly, not just at Caritas sites but health workers in many locations in PNG (including Government and other church health services) also face these issues constantly.</p>

		<p>working in Western Highlands Province (WHP). We agree that there is a need for some type of intervention in WHP and accordingly our program has started working there. Our AAP had been submitted to AusAID at the time of this review so it is assumed that the reviewers were aware of these plans.</p> <p>Again, this section mentions the need for greater coherence between PASHIP and other AusAID-funded programs. It should be noted that Caritas Australia does try and create linkages between the Church Partnership Program and PASHIP, albeit low key.</p> <p>Acknowledging time and travel constraints of the reviewers, it is regrettable that they identified STIMP’s main achievements as “better record keeping and monitoring statistics.” We feel sure that there have been many other achievements not least the research (<i>Sik Nogut o Nomol Sik</i>), more comprehensive community-based education, the introduction and expansion of the Men’s Clinic at Mingende and increased testing.</p>	<p>Noted</p> <p>Noted</p> <p>It was Caritas itself that noted PASHIP has resulted in better record keeping and monitoring of STI statistics – see page 10 of report. The report acknowledges other Caritas achievements including the research, <i>Sik nogut o nomol sik</i>.</p>
	<p>Progress towards Objective 2</p>	<p>The report states on page 13: “To date there has been no attention to developing a knowledge management system to support PASHIP and this has seriously constrained achievement towards Objective 2.” It should be noted that our program has made significant effort to collect data, monitor and manage knowledge. This has been available to Secretariat.</p> <p>Efficiency Secretariat efficiency – taking into account the difficulties mentioned in the</p>	<p>A participatory end of program evaluation will draw together the lessons and knowledge from individual PASHIP projects. In addition, PRG meetings and the biannual PASHIP updates provide a forum for sharing of knowledge.</p> <p>Noted. The Secretariat has</p>

		<p>Independent Progress Report, this program has suffered from poor communication. It has never been clear why this is the case. Simple questions have been left unanswered; more substantive questions also have either been left unanswered or have taken a very long time to get a response.</p> <p>Project management Page 18 of the report says that there is a “lack of connection between PNG and Australia.” From a STIMP perspective we do not agree with this statement. There is regular communication and visits. Our program is largely based in PNG with significant support from Australia. Planning and implementation is all done in PNG. We do not believe that the statement above is an accurate reflection of our program.</p> <p>Analysis of the PNG and Australian costs seems flawed. Some program personnel in PNG might be funded from other sources with support from Australia; in this case the Australian costs would seem much higher. Other programs could have expatriate personnel based in PNG; in this case their costs would have a more favourable ratio for PNG-Australia costs.</p> <p>In addition, this method does not take into account cost sharing with other grants/programs or the significant differences in models that influence the Australian-PNG ratios of budgets</p> <p>Training and minimum standards The report mentions that COMPASS have developed new training curriculums and QA assessments. Has there been a change to the advice that we are not to deviate from the PNG NDOH Syndromic management</p>	<p>been significantly strengthened over the last six months.</p> <p>Noted</p> <p>Noted. AusAID has requested PASHIP Partners to provide further information about sources of funding from other programs (e.g. AusAID Church Partnership Program or AusAID HIV AIDS Civil Society Grants Program). Reporting needs to be transparent so AusAID can assess economies of scale across civil society programs.</p> <p>There has been no change in this requirement. The material that COMPASS</p>
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		<p>training and to utilise the pre existing minimum standards for STI clinics? We could not see where these two documents are referred to within the report.</p> <p>There does not seem to be much analysis on the effectiveness of the “managing” NGOs and less so on the value-add, or otherwise, of the Australian partners. This is regrettable as it would give a more complete picture of the program.</p>	<p>has developed is not so much a new curriculum as a further development of the existing NDoH materials. It is soundly based on the NDoH training materials and has added a bit more some areas, including diagrams and laminated charts of the existing NDoH material. There has been no change in the Minimum Standards for STI Clinical Services. The QA developed by COMPASS is based on the NDoH Minimum Standards</p> <p>Noted however the report notes under section 2.8 (M&E) that the Australian managing NGOs could have been expected to perform better on M&E given they are fully accredited by AusAID. As part of the accreditation process, they have been assessed as being able to monitor, report and rate the effectiveness of</p>
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		<p>We do not completely agree that the risk matrix was not “well deployed” (page 20). When the program began the global financial crisis had not emerged and the LNG project was not signed off. Both have had an impact, the latter particularly around staff retention and recruitment. We have attempted to manage other risks that we identified as best we can.</p> <p>Child protection We welcome the idea of a child protection process. It is hoped that this can be introduced into all programs at their inception.</p>	<p>activities. Indicators of the M&E accreditation criteria include an understanding of AusAID’s Quality Rating System and evidence of qualitative judgments in monitoring reports.</p> <p>Noted</p> <p>Noted. This was discussed at Program Reference Group meeting in June and PASHIP partners agreed to establish a working group on child protection led by Save the Children. Partners will nominate one representative of each PASHIP project to be on this working group. The WG will review the available guidance and the training materials being developed by Save the Children and report back to the next PRG on</p>
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		<p>Monitoring and evaluation</p> <p>In the design phase AusAID recruited an M&E consultant. The NGOs were not consulted about the suitability of this person. The input from this person was not helpful; it seemed that he had little understanding of the NGOs or the context. This had an impact on following broader M&E plans.</p> <p>The introduction of QAI well into the program was not helpful. It has not reduced reporting workloads and there has been no comment from AusAID about the report submitted to date. Waiting for six months for peer review feedback is too long and can be discouraging to staff. (AusAID response:</p> <p>We note the importance placed on M&E. It is our hope that PASHIP will commit resources to strengthening M&E, including the recruitment of a suitable advisor who can visit and provide practical advice about M&E. Caritas would be happy to work closely with such a person.</p>	<p>recommendations for adoption by PASHIP partners and NDoH.</p> <p>Noted</p> <p>The QAI is AusAID's standard monitoring tool and is used across the aid program as the building block of sector and country performance reporting. Feedback on individual QAIs has been provided to all PASHIP partners. There has been an improvement in reporting of results by PASHIP partners since introduction of QAIs.</p> <p>A six month M&E consultancy has commenced to work with PASHIP partners to strengthen M&E processes among PASHIP partners with a greater emphasis on</p>
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			<p>outcomes and to strengthen the evidence base for reporting results.</p>
	<p>Recommendation 6: Focus on local solutions and cease the practice of overseas clinical placements</p>	<p>We do not agree that it is inappropriate to have a study tour to Australia. Much of the value in this is in increased networking, professional development and much needed morale boosting. Health workers typically suffer from low morale in their work place (a fact supported by our research). The promise of professional development is an important incentive and a valuable learning opportunity.</p>	<p>Noted but this is a matter of opinion. Experience in the past has strongly indicated that PNG health workers returning from overseas trips are often frustrated and disillusioned when returning to the limitations of the local situation – especially related to resources. The STI scene and the generous funding associated with STI management in developed countries are both very different to the PNG scenario. It is agreed that professional development opportunities are valuable but these can be realised by accessing work experience in other venues within PNG, where false expectations are not engendered. The distance education Certificate program in Sexual Health being developed by the</p>

			COMPASS partners is soundly PNG based and it is anticipated, will in the future be upgraded to Diploma / Degree status.
	Recommendation 12: Support IMR to write up their data analysis (quantitative and qualitative) and determine where and how best it can be used; abandon next surveys.	While we are pleased to see IMR getting assistance, we encourage AusAID to review the process that led to IMR's involvement. There did not appear to be the same rigour around IMR's proposal as there were for the other program participants. While the streamlining may have facilitated IMR's inclusion in the program ultimately could it have contributed to the difficulties it is now experiencing?	Noted. Under section 2.3 on Research, the IPR reflects on process which led to IMR's engagement and subsequent issues.
	Recommendation 11: engage a participatory specialist for six months to begin collecting and collating key lessons learned from PASHIP implementation so far.	<p>Recruitment of additional staff at this late stage is not helpful. While we can see the value in getting someone to collect stories beyond that it seems that it stretches limited resources and could take focus away from the completion of STI activities.</p> <p>We note that the report's timeframes have already fallen behind significantly. Together with a short period of time remaining, we suggest that the report's recommendations be looked at in this light.</p>	AusAID has not accepted this recommendation. A participatory end of program evaluation will draw together the key lessons learned from PASHIP implementation.
	Working with Provincial Government	Attempts have been made through ongoing discussions with Provincial Government Health Services to improve relationships between Catholic Health and Government Health Services, especially in the Southern Highlands Province. However these efforts have not proved fruitful. However, other attempts have been made, and in some cases been	Noted and for future discussion.

		<p>successful, to involve government staff in training with staff from Southern Highlands and Western Highlands Provinces attending STI Syndromes Management workshops. Requests to the provincial governments to engage in clinical mentoring support have not been taken up. Other areas have proved more successful. These include: planning (for example being involved in HIV/AIDS planning meetings; reporting (monthly statistics) and working through Provincial Health Advisors; procurement from area medical stores and dialogue between Disease Control Officers; staff rotation (health workers gaining experience in government/CHS facilities, as rural lab attachments, doctor's practicals and nurses rotations); sharing of limited resources such as IEC materials, vehicles and important staff training.</p>	
	<p>Recommendation 28: Establish and formalise a Technical Advisory group (TAG) to oversee approvals of QAs and AAPs submitted by IP. The TAG membership should include key expertise from NDoH, PNG Sexual Health Society, private sector, AusAID's SNS Program, the HIV Program and the Health Team. At least one member of the TAG must have demonstrated</p>	<p>We question the value of instituting a TAG at such a late stage in the program, particularly as there is only one more planning cycle left. AusAID already engages the NDoH in the assessment of AAPs. The introduction of additional actors who are not familiar with the program or the way that each project works would further delay already long processes. If a TAG is to go ahead how will PASHIP members be represented.</p> <p>It is pleasing that the review team have picked up our point on the significance of gender based violence and note the importance of follow-up on this matter.</p> <p>The report gives no clear indication of the future of PASHIP.</p> <p>The reviewers do not seem to have realised the complete Caritas program including:</p> <ul style="list-style-type: none"> • The collaboration with other funding systems: the Clinical improvement section works in conjunction with the Collaboration for Health in PNG 	<p>AusAID has accepted this recommendation. The TAG may also act as a reference group for design of a new program of support for STIs following completion of PASHIP.</p> <p>The report has identified several options to inform the design of future support for STIs post PASHIP.</p> <p>Noted</p>

	<p>gender expertise in the PNG context. Other</p>	<p>(CHPNG) providing cost benefits, utilisation of varied expertise, and developing the Catholic health system as a whole within a province rather than STI alone. Oil Search Limited also supports Pureni and Hiwanda in Southern Highlands;</p> <ul style="list-style-type: none"> • There is no mention of Pureni in the report; • The report specifically mentions that the Det STI clinic does not meet NDOH standards. The report neglects to mention that Caritas' attempts to discuss and resolve issues, including with site visits, have not been successful; • In Annex 1 the objectives and outputs are not complete for Caritas, missing 2.4 Strengthening Catholic health systems and supporting government health systems; and • Taking into account that this report is for the whole of PASHIP rather than individual projects, we regard it as unusual that there was no mention of laboratory strengthening and little mention of the men's clinic, antenatal services development, increases in number of patients. To say that some of Caritas' main achievements are "better record keeping and monitoring of STI statistics" does not give the full picture. 	<p>NDOH advises that a major issue here is that there was no involvement of NDoH in the planning stages for the new "clinic" at Det. NDoH could have provided eg sample floor plans / approved designs, focused at the fulfilment of Minimum Standards. NDoH did not know the new Det clinic construction was underway until it was already built.</p> <p>It was Caritas itself that noted PASHIP has resulted in better record keeping and monitoring of STI statistics – see page 10 of report. The report acknowledges other Caritas achievements including the men's clinic and the research, <i>Sik nogut o nomol sik</i>.</p>
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