



**Australian Government**  
**AusAID**

# Evaluation of the PNG National HIV/AIDS Support Project

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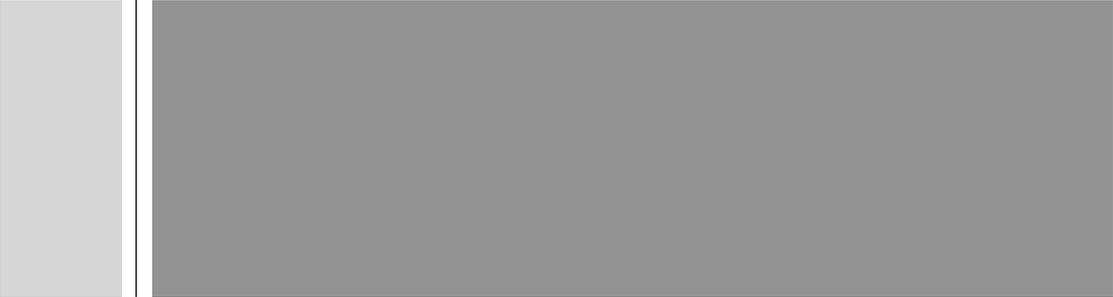
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# Acronyms and Glossary

<b>ABC</b>	'Abstain from sex, Be faithful and use Condoms'	<b>HAMP Act</b>	HIV/AIDS Management and Prevention Act
<b>AIDS</b>	Acquired Immune Deficiency Syndrome	<b>HIV</b>	Human Immunodeficiency Virus
<b>AMC</b>	Australian Managing Contractor	<b>HRC</b>	HIV Response Coordinator
<b>AusAID</b>	Australian Agency for International Development	<b>HRSS</b>	High Risk Setting Strategy
<b>CPHL</b>	Central Public Health Laboratory	<b>HSIP</b>	Health Sector Improvement Program
<b>CSW</b>	Commercial Sex Worker	<b>HSSP</b>	Health Sector Support Program
<b>DWU</b>	Divine Word University	<b>IEC</b>	Information, Education and Communication
<b>EIA</b>	Enzyme Linked Immunosorbent Assay (also known as ELISA)	<b>ILO</b>	International Labour Organisation
<b>ET</b>	Evaluation Team	<b>IMR</b>	Institute of Medical Research
<b>EU</b>	European Union	<b>IT</b>	Information Technology
<b>GFATM</b>	Global Fund for AIDS, TB and Malaria	<b>K</b>	Kina
<b>GoPNG</b>	Government of Papua New Guinea	<b>M&amp;E</b>	Monitoring and Evaluation
		<b>MTDS</b>	Medium Term Development Strategy
		<b>MTP</b>	Medium Term Plan

<b>MTR</b>	Mid-Term Review	<b>SHALOM</b>	Society for HIV/AIDS and Lifeline Operation in Manipur (India)
<b>NAC</b>	National AIDS Council		
<b>NACS</b>	National AIDS Council Secretariat	<b>STI</b>	Sexually Transmitted Infections
<b>NCD</b>	National Capital District	<b>TAG</b>	Technical Advisory Group
<b>NDoE</b>	National Department of Education	<b>TALC</b>	Teaching-aids at Low Cost (UK)
<b>NDoH</b>	National Department of Health	<b>TB</b>	Tuberculosis
<b>NGO</b>	Non Government Organisation	<b>UN</b>	United Nations
<b>NHASP</b>	National HIV/AIDS Support Project	<b>UNAIDS</b>	Joint United Nations Program on HIV/AIDS
<b>NSP</b>	National Strategic Plan	<b>UNDP</b>	United Nations Development Program
<b>PAC</b>	Provincial AIDS Committee	<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organisation
<b>PCC</b>	Provincial HIV/AIDS Counselling Coordinator	<b>UNICEF</b>	United Nations Children's Fund
<b>PCG</b>	Project Coordinating Group	<b>VCT</b>	Voluntary Counselling and Testing
<b>PCR</b>	Polymerase Chain Reaction	<b>VDRL</b>	Venereal Diseases Research Laboratory Test for Syphilis
<b>PDD</b>	Project Design Document	<b>WHO</b>	World Health Organisation
<b>PIN+</b>	Pacific Islands Network for people with HIV		
<b>PLC</b>	Provincial Liaison Coordinator		
<b>PLWA</b>	People Living with HIV/AIDS		
<b>PMGH</b>	Port Moresby General Hospital		
<b>PNG</b>	Papua New Guinea		
<b>PNGTUC</b>	Papua New Guinea Trade Union Council		
<b>RPR</b>	Rapid Plasma Reagin Card Test for Syphilis		
<b>SCF</b>	Save the Children Fund		

# Executive Summary

## INTRODUCTION

The first case of HIV was reported in Papua New Guinea (PNG) in 1987. Since then the prevalence of HIV has risen dramatically. In November 2004 it was estimated<sup>1</sup> that between 25,000 and 69,000 people between 15 and 49 years of age were infected.

PNG now has one of the highest rates of HIV in the Asia-Pacific Region, and is the fourth country in the region to be classified as having a generalized HIV epidemic.

In response to the impending epidemic, the PNG Parliament passed the National AIDS Council (NAC) Bill in 1997, and in 1998 government legislation provided for the establishment of the semi-autonomous National AIDS Council to oversee the PNG response to HIV/AIDS. In 1999 the NAC Secretariat was established. Both NAC and its secretariat were established independently of the National Department

of Health (NDoH), although NAC was initially chaired by the Secretary of the NDoH. In mid-2005 the chairmanship of NAC was moved to the Department of the Prime Minister.

## THE PNG NATIONAL HIV/AIDS SUPPORT PROJECT

Australia is the single largest source of funds for HIV initiatives in PNG. While approximately 90% of funding for HIV initiatives comes from donors, 95% of that donor funding is from Australia. The PNG government budgets approximately K2.3 million per year for HIV activities.

AusAID support to the PNG response to HIV/AIDS began with funding for the PNG Sexual Health and HIV Prevention and Care Project (1995–99). This activity was followed by the National HIV/AIDS Support Project (NHASP), with expenditure expected to total

1 National Consensus Workshop.

about AUD59 million. The implementation of NHASP commenced in October 2000 and was originally expected to finish in October 2005. NHASP has since been extended into 2006.

The goal of NHASP was to 'minimise the impact of HIV and AIDS in Papua New Guinea' and its purpose was to 'support the implementation of the multisectoral PNG HIV/AIDS Medium Term Plan'. Support is delivered through six primary project components which reflect the six focal areas of the PNG HIV/AIDS Medium Term Plan:

- > Education, Information, Advocacy and Behaviour Change;
- > Counselling, Community Care and Support;
- > Clinical and Laboratory Services;
- > Policy, Legal and Ethical Issues;
- > Monitoring, Surveillance and Evaluation; and
- > Management Support for the National Response.

After the 2002 Mid Term Review of the NHASP, another component was added:

- > Cross Component Support and Project Management.

AusAID commissioned an independent evaluation of the NHASP, to commence in early 2005. The goal of the evaluation was 'to improve AusAID's policy analysis and the design and implementation of AusAID's HIV/AIDS activities and programs in the Asia/Pacific region by the identification and adoption of lessons learned from current and prior activities'. The objectives of the

evaluation were 'to assess the relevance, efficiency, effectiveness, impact and sustainability of the PNG National HIV/AIDS Support Project and to draw-out lessons learned'.

The evaluation had three phases. A *Desk Study* in May 2005 reviewed available documentation, identified key informants and potential field sites, and planned the field work component of the study. A *Field Study* took the evaluation team to seven PNG provinces to conduct interviews, inspect activities and locations, and collect documents and other relevant data. *Reporting* consisted of: analysis of information during and following the field visit; debriefing key stakeholders in PNG and AusAID in Canberra; preparing a draft report for peer review; and preparing a final report based on peer review feedback.

The Evaluation Team included: Team Leader, Associate Professor David Plummer; technical expert, Dr Alison Heywood; and PNG counterparts, Ms Margaret Lokoloko (UNDP Programme Analyst on Gender and HIV for PNG) and Mr Albert Bunat (Assistant Secretary (Social Sector) Department of National Planning and Rural Development, PNG). Dr Philip Fradd was the AusAID Task Manager.

## PROJECT RELEVANCE

HIV/AIDS in PNG was classified as a generalised epidemic, when the prevalence of HIV among women in the ante-natal clinic of the Port Moresby Hospital exceeded 1%. HIV prevalence in 'high risk settings' is significantly higher than this. Sentinel data

from STI clinics in 2004 revealed rates of HIV as high as 19.9% in Port Moresby and 6.3% in Mt Hagen. Given the rapid spread of HIV in PNG, and the experiences of nations in analogous situations elsewhere, the NHASP is highly relevant, and urgently so.

The project objectives articulated in the Project Design Document (PDD) accord closely with the PNG national response to HIV/AIDS, detailed in the second PNG HIV/AIDS Medium Term Plan (1998-2002).

## **EFFICIENCY**

Following completion of the PNG Sexual Health and HIV Prevention and Care Project (1995-99), there was a short interim period during which support to the impetus of the response was continued through NACS and NDoH, until NHASP commenced.

Project start-up was delayed, and efficiency was not a strong feature of implementation. While a mid-term review addressed key internal management issues, there was generally slow program rollout and a delayed response to rectify problems. Many important components and outputs appeared to come to fruition late in the project. In addition, rapid turnover of AusAID personnel responsible for the activity may have hindered timely responses to problems.

## **EFFECTIVENESS (BY COMPONENT)**

### **EDUCATION, INFORMATION, ADVOCACY & BEHAVIOUR CHANGE**

The NHASP has contributed to high levels of HIV awareness. The findings are more equivocal for: increased protective behaviour; raised awareness of other STI; reduced HIV-related stigma; and greater accuracy of HIV-related knowledge. The recent shift to a 'high risk setting' strategy is likely to be more influential than generic or individualistic approaches.

There was a notable absence in mainstream health services of HIV health promotion posters and materials. NGOs demonstrated significant levels of awareness. They have had considerable training and have greater knowledge. In the private sector, there was significant engagement of the PNG media with HIV; posters were seen extensively, with materials produced by NACS found in hotels, airports, PAC offices and border posts.

The role of stigma, shame and fear in undermining the response to HIV was a prominent topic of field interviews. Some church-based responses contribute to HIV-related stigma by linking HIV to immorality and punishment. The role of the NHASP Social Marketing Strategies in combating stigma, and the inclusion of anti-discrimination measures in the HAMP Act passed by the PNG Parliament in June 2003, were positive actions. However, stigma is an ongoing, pervasive problem, and there is a strong belief that HIV is due to people's 'own bad behaviour' and that they 'deserve what they get'.

## COUNSELLING, COMMUNITY CARE AND SUPPORT

The development of basic counselling training and voluntary counselling and testing (VCT) services was a high priority. At the time of the evaluation there were 49 health facilities in 17 provinces equipped to provide VCT. In addition, there were 4 non-clinical services that had established VCT sites with the assistance of NHASP. More than 1,000 people had some form of counselling training provided by NHASP. While training appeared to have evaluated well, it required stronger follow-up in two main areas:

- > further training, advanced courses, professional development and skills accreditation; and
- > ongoing supervision, debriefing and professional support.

New initiatives to develop advanced training, accredited courses and minimum standards were noted. The development of a home-based care strategy was less advanced. There were major gaps in care for people with HIV-related disease in the home, community and in hospitals.

## POLICY, LEGAL AND ETHICAL ISSUES

Initiatives facilitated by NHASP during 2003-2005 had assisted NACS to disseminate information regarding the law, workplace ethics, stigma and discrimination. Media involvement contributed significantly to promoting human rights issues in workplaces and communities. The capacity of NACS to influence the public and private sectors and the PNG Trade Union Congress in relation to policy, legal and ethical matters

and HIV significantly improved. Political lobbying extended NACS influence in the PNG Parliament. This created an enabling environment for HIV/AIDS to be treated as a key development issue. However, more attention was needed to reach institutions and organizations in the provinces and to disseminate information widely. In the case of the HAMP legislation, the PACs will need additional support to take the lead in promoting workplace policies.

## MONITORING, SURVEILLANCE AND EVALUATION

The project has developed M&E systems including active surveillance; behavioural surveillance; establishment of the National Surveillance Coordinating Committee (NSCC); and facilitating the establishment of confirmatory sites beyond Port Moresby. An important initiative was the development of the 'Consensus Document', the most definitive report to date on HIV surveillance in PNG. Key difficulties to improved surveillance include: finding sufficient financial support; maintaining the integrity and functionality of the data collection chain; and identifying and supporting a national host body to manage epidemiology and surveillance.

## CLINICAL AND LABORATORY SERVICES

While NHASP made important contributions to clinical care for the 'walking well', notably in the areas of clinical training and in consolidating clinical systems and protocols for syndromic STI care, clinical care in PNG remained weak, particularly for people with HIV. Better services are required for people with clinical illness and

those requiring terminal care. The ongoing reliance on ‘syndromic management’ was not ideal and needed to be reviewed.

## MANAGEMENT SUPPORT FOR THE NATIONAL RESPONSE

The limited development of a multi-sectoral response has been a shortcoming of the Project. People from high-risk settings and people with HIV lack formal involvement in the overall PNG response. The involvement of ‘consumers’ is fundamental to keeping strategies relevant, on-track and vital.

While considerable effort was made to develop the provincial responses through the PACs, NHASP appears to have ‘cut their losses’ on difficult PACs. Rather than trying to overcome their limitations, NHASP has often withdrawn resources, indicating a lack of awareness about the ramifications of non-functional infrastructure in PACs’ offices. NHASP had developed an IT Support Policy and had tried to ensure that basic infrastructure functioned properly, but in many cases this was not sufficient.

Gender influences the response to HIV and in determining women’s vulnerability to the epidemic. Many women are playing an important role in the response to HIV in PNG, although it seems that men dominate in senior positions. In the project there was an inadequate focus on the role of men and male-dominated institutions.

## CROSS COMPONENT SUPPORT & PROJECT MANAGEMENT

While planning for internal management issues was a weakness of the original project design, at evaluation NHASP was found to be staffed by a strong, cohesive team.

The grants program improved after 2003 but significant weaknesses still remained. Timely processing of applications appeared to have improved, and other improvements to the system were occurring late in the project. Despite their shortcomings, the NHASP Research and Project Grants Systems were excellent initiatives and, with improved administrative arrangements, should feature in future support.

Financial administration and project transparency were raised as issues in many field interviews. Most concerns related to peoples’ problems accessing funds at a district and provincial level, the transparency and responsiveness of the NHASP grants system and impressions that funding often failed to go much beyond the National Capital. Most PACs appeared to have poor to moderate financial and administrative skills. There were calls for a much greater reach of resources and activities into high risk-settings and rural and remote locations, to achieve a more meaningful and empowering response to HIV.

## PROJECT MONITORING AND EVALUATION

NHASP invested considerable time and resources into monitoring, evaluating and auditing recipients of NHASP support. A monitoring and evaluation framework for the whole project was developed, but this was

not published until January 2004. Detailed monitoring and evaluation reports were submitted on at least two occasions during the project. The team noted limitations in some reporting areas due to the use of imprecise language or failure to address the evaluation objective. A general lack of clarity about monitoring and evaluation of NHASP was present throughout the project. This could be traced back to the absence of this important element in the original project design, and a failure to focus on monitoring and evaluating the project inputs and their outcomes as an ongoing activity of the project.

## IMPACT

It was difficult to assess the impact of the project at the time of evaluation, but certain activities were considered likely to have sustained effects. Law reforms have set the agenda for approaching HIV in PNG; progress with the role of faith-based organizations is encouraging; and leadership initiatives by NACS, NHASP and UNDP appear to have shifted the PNG political climate.

However, potential positive effects may be compromised by:

- > the failure of key government departments to take up HIV as core business and fully incorporate it into their mainstream activities;
- > deeply ingrained stigma;
- > the failure of people with HIV to be fully represented at all levels of advice, policy and service development;
- > weak financial management and the skills-base at provincial, district and local levels; and
- > limitations to improving health services, including lack of even basic care for people with HIV-related clinical illness across most of the country.

## SUSTAINABILITY

PNG has many limitations in its capacity to control HIV. Strong donor inputs will be required for the foreseeable future. Key sustainability issues included:

- > HIV is a long term threat to PNG, and programs must be maintained and further developed;
- > 90% of funding for the response to HIV/AIDS originates from international donors and is likely to continue to be required even if PNG increases its own contributions;
- > behaviour change and stigma reduction must receive greater priority;
- > mobilising government departments to 'mainstream' HIV into their activities is fundamental to sustainability;
- > there is a considerable deficit in disseminating information, funding and activities to the district and village level; and
- > the lack of people with HIV in the response lends an air of unreality and lack of urgency to HIV. The involvement of people from high risk settings and people with HIV should invigorate the response.

## KEY LESSONS LEARNED AND RECOMMENDATIONS

The future response to the HIV/AIDS epidemic will require a multi- and cross-sectoral approach. The response will have to encompass all levels of government, aid donors, churches, NGOs and communities.

Some of the key elements of a future response will be:

### De-stigmatisation.

- > Stigma, and the associated fear of discovery of HIV+ individuals, compromise the response to HIV.
- > Further work on legislative reform, human rights and HAMP Act education and enforcement should help reduce the incidence of stigma and HIV transmission.
- > Continued development of workplace policies and education programs for workers will also help reduce stigma and infection through increased understanding of HIV/AIDS.

### Prevention

- > A comprehensive social marketing program has contributed to high HIV awareness in PNG, but this has not yet resulted in behaviour change.
- > A greater investment is required in behaviour change, including development of comprehensive materials for low-literacy settings and in major languages.
- > As VCT centres are promoted as sites for HIV prevention, the service providers must ensure that the full range of prevention options is discussed and readily available.

## Identification and treatment of non-HIV STI as well as HIV/AIDS.

- > STI clinics are key components of a comprehensive response to HIV. They have the capacity to provide comprehensive services including VCT and ambulatory HIV care. Clinics that are functioning in PNG are working surprisingly well.
- > The rollout of the remaining STI clinics should be expedited.
- > A National Centre for Sexual Health would provide a reference and training centre to support the STI clinic rollout and would also give PNG a strong academic and training base that could be a model for the region. The Centre could be a home for STI clinical care, HIV ambulatory care, research, surveillance, training and professional development
- > The STI clinic network should be used in subsequent strategies as a base for outreach clinical services to rural and high risk settings. These outreach services should be equipped to operate independently of other health services.
- > There are weaknesses in the current 'syndromic approach' to HIV/AIDS and STI. The progressive introduction of voluntary community screening of all adults (in a village or other target group) for STI is recommended. The benefits include:
  - community screening destigmatises STI because all adults are encouraged to participate regardless of the presence or absence of symptoms;

- community screening identifies asymptomatic STI;
- the identification and treatment of hidden infections addresses key public health issues including ‘epidemiological synergy’ of STI with HIV and maternal and child health risks, and
- a *de facto* trial of community based screening and treatment in an outreach setting has already been shown to be feasible by the IMR as part of its sentinel surveillance research.

**Work in high risk settings.**

- > A missing element of the early phases of the project was the recognition of the importance of working with ‘high risk settings’ and the importance of social contexts in behaviour change.
- > A high risk setting strategy should be introduced as early as possible.
- > Formal representation of people from high risk settings and people with HIV is an essential element of a successful response. Places for people with HIV should be reserved on all decision-making bodies at all levels including NAC, all PACs, Grant Committees and the boards of other organisations working with HIV.

Other items discussed in more detail in the lessons and recommendations in the main text (Chapter 10) include:

- > Research and project grants
- > Training, including counsellor training and support.
- > Leadership and advocacy.

- > Gender, including the roles and responsibilities of men and masculinities.
- > Donor, government and NGO coordination.
- > Counterparts.
- > Basic infrastructure requirements, particularly at the provincial level.
- > Modular approach to activity design.
- > Support to provincial, rural, remote, high-risk and grassroots settings.
- > Financial administration.
- > Social marketing programs and research.
- > Project monitoring and evaluation.
- > Information, education and communication resources.
- > Ambulatory, community and home-based care.
- > Clinical care.
- > Voluntary counselling and testing.
- > Laboratory services, STI and HIV diagnosis and monitoring, and partnering.

# 1 Introduction

## SUMMARY

Papua New Guinea has emerged as a 'hot spot' for HIV in the Asia-Pacific Region. In 2002, the country became the fourth in the region to be formally classed as having a 'generalised epidemic', when HIV prevalence in key antenatal clinics passed 1%. HIV has now spread throughout PNG and the next phase of the PNG response will be critical in determining how severe the epidemic will be. To date, the mainstream government institutions in PNG have been limited in their response to the threat that HIV poses. The resources and personnel deployed have fallen short of what is required. Much of the responsibility has fallen on donors. Approximately 90% of funding for HIV initiatives in PNG comes from donors, and 95% of that donor funding comes from Australia. While this support reflects well on international goodwill, it highlights limitations in PNG's internal

capacity to deal with HIV. Donor support will continue to be a critical element in the PNG response to HIV/AIDS for the foreseeable future. This report examines the past 5-year program of Australian support for the PNG response to HIV/AIDS through the National HIV/AIDS Support Project (NHASP).

## DETAILS

### PNG, HIV AND THE CAPACITY TO RESPOND

Papua New Guinea (PNG) occupies the eastern half of the island of New Guinea and the nearby islands of the Bismarck Archipelago. In 2004, PNG had an estimated population of 5,836,000 and an annual population growth rate of 2.6% (1992 – 2002) (UNAIDS 2004: 4).

The capacity of the public and non-government sectors in PNG to deliver services is limited and this holds true for

PNG's capacity to deal with health and HIV. Key social indicators for PNG<sup>2</sup> include:

- > The life expectancy at birth in 2003 was estimated to be 59 years for men and 62 for women.
- > Child (under 5) mortality in 2003 was 96 per 1000 for males and 90 per 1000 for females.
- > The total health expenditure in 2002 was 4.3% of gross domestic product (GDP) or \$136 (International Dollar) per capita.
- > The adult (15+) illiteracy rate in 2000 was 36.1% (29.4% for males and 43.2% for females).

The first case of HIV was reported in Papua New Guinea (PNG) in 1987. Since then HIV prevalence has risen dramatically. By the end of December 2004 the number of people diagnosed with HIV had risen to 11,139, in a population of 5.8 million people. In an attempt to generate a more accurate picture of the HIV epidemic in PNG, the 'National Consensus Workshop' in November 2004 reviewed available data and estimated that there were between 25,000 and 69,000 people between 15 and 49 years of age with HIV in PNG. Papua New Guinea now has one of the highest rates of HIV in the Asia-Pacific Region (NHASP 2004c; see Appendix 1.2 for more detail). Current estimates are 600 new infections per quarter.

From 1995 to 1997 the number of people with AIDS doubled annually. From 1997 the annual increase in diagnosed cases has been around 30% per annum. In 2003, on average 150 new cases per month were reported.

In 2002 PNG became the fourth country in the Asia Pacific region to be classified as having a generalized HIV epidemic, when the HIV prevalence among women seeking antenatal care at the Port Moresby General Hospital exceeded one percent (1% in 2002; 1.35% in 2003). Preliminary data suggest similar scenarios have developed in antenatal clinics in at least some other provinces: Goroka 0.9% in 2002 and 2% in 2003; Daru 0.7% in 2003; and Lae 2.5%. Two of these clinics (Goroka and Daru) are outside of the large urban centres of Port Moresby and Lae.

There is evidence that HIV prevalence rates in 'high risk settings' (transportation, sex work, youth, male dominated industries) are significantly higher than those reported from antenatal clinics. Sentinel data from STI clinics in Port Moresby revealed HIV in 9.6% of clients in 2002 and 19.9% in 2004; and in the Mt Hagen STI clinic the prevalence of HIV was found to be 6.3%<sup>3</sup>. These findings are of particular importance because of the potential for 'epidemiological synergy' between HIV and other sexually transmissible infections (STI), which can greatly amplify the spread of HIV.

The public health implications of the interaction between HIV and tuberculosis (TB) is particularly concerning, in settings where there is multi-drug resistant TB, such as in PNG. Sentinel surveys have revealed HIV prevalence rates among people with TB of 19% in Port Moresby, 15% in Lae, and 12% in Goroka.

2 Data from World Health Report 2005 and World Bank Group – Gender Stats. The Human Development Report 2005 had slightly poorer figures for all indicators except under 5 mortality, which was the same.

3 Most recent findings from the Tininga Clinic, Mt Hagen, indicate 10.99%

## THE PNG RESPONSE TO HIV AND AUSTRALIAN SUPPORT

In 1998 the PNG government made legislative provision for the establishment of a semi-autonomous body, the National AIDS Council (NAC), to oversee the PNG HIV/AIDS response and the development of the PNG HIV/AIDS Medium Term Plan. The NAC is supported by a secretariat (NACS). Both NAC and its secretariat were established independently of the day-to-day operations of the National Department of Health (NDoH), although the Secretary of the National Department of Health chaired NAC until recently (see Appendix 1.3 for details of the corporate structure of the PNG Department of Health). In mid 2005, the chairmanship of NAC was moved to the Department of the Prime Minister.

In terms of financial and technical support, Australia is the single biggest source of funds for HIV initiatives in Papua New Guinea. Approximately 90% of funding for HIV initiatives in PNG comes from donors, and 95% of that donor funding comes from Australia. AusAID funding for the National HIV/AIDS Support Project (NHASP) is expected to total around AUD59 million over the period from 2000 to 2006. In comparison, the Government of Papua New Guinea budgets Kina 2.3 million (approximately AUD1 million) per year for HIV initiatives.

The mechanism identified for the delivery of Australian support for the period 2000 to 2006<sup>4</sup> is outlined in the NHASP Project Design Document. This document sets a framework for supporting the National AIDS Council (NAC) and its secretariat (NACS) by establishing the National HIV/AIDS Support Project (NHASP). NHASP is a large and

complex project which is primarily intended to minimise the impact of HIV/AIDS in PNG by providing support for the PNG national response to HIV/AIDS, as detailed in the second PNG National HIV/AIDS Medium Term Plan (1998-2002). The goal of NHASP is to 'minimise the impact of HIV and AIDS in Papua New Guinea' and its purpose is to 'support the implementation of the multisectoral PNG HIV/AIDS Medium Term Plan'. A summary of key dates is included in Table 1.

**Table 1. Summary of Key Dates**

<b>1995-1999</b>	Sexual Health and HIV/AIDS Prevention and Care Project (the AIDAB / AusAID-assisted 'Foundation Project') Interim assistance 1999 – October 2000
<b>1998-2002</b>	PNG HIV/AIDS Medium Term Plan (MTP)
<b>Late 1998</b>	National AIDS Council (NAC) Act NAC Established
<b>Early 1999</b>	National AIDS Council Secretariat (NACS)
<b>October 2000</b>	National HIV/AIDS Support Project (NHASP) Established (Contract awarded)
<b>January 2001</b>	First payment under the NHASP contract
<b>March 2001</b>	First large payment under the NHASP contract
<b>June 2002</b>	Mid Term Review of NHASP (MTR)
<b>October 2005</b>	Original termination date of NHASP
<b>2005</b>	NHASP term extended to 2006

<sup>4</sup> The Project was initially to run from October 2000 to October 2005 but has since been extended into 2006, pending the development of a replacement initiative.

The NHASP offices and team are co-located with the National AIDS Council Secretariat in the administrative district of Waigani, Port Moresby, with the exception of Component Five: *Clinical and Laboratory Services* which is located within the National Department of Health. The NHASP initiative built on the previous AusAID support project known as the Sexual Health and HIV/AIDS Prevention and Care Project (also known as the ‘Foundation Project’), which ran from 1995 to 1999.

NHASP support has been delivered through six primary project components which reflect the six focal areas of the PNG HIV/AIDS Medium Term Plan. The six components of the NHASP are:

- > Education, Information, Advocacy and Behaviour Change
- > Counselling, Community Care and Support
- > Clinical and Laboratory Services
- > Policy, Legal and Ethical Issues
- > Monitoring, Surveillance and Evaluation
- > Management Support for the National Response

The 2002 Mid Term Review of the NHASP added a component:

- > Cross Component Support and Project Management.

The percentage of the total funding proposed for each component in the original design document is included in Table 2, to provide a rough indication of the relative priority of the first six components.

**Table 2. NHASP Funding by component, based on original project design allocations**

<b>Component 1</b> Education, Information, Advocacy & Behaviour Change	39%
<b>Component 2</b> Counselling, Community Care & Support	11%
<b>Component 3</b> Policy, Legal & Ethical Issues	2.2%
<b>Component 4</b> Monitoring, Surveillance & Evaluation	7.8%
<b>Component 5</b> Clinical and Laboratory Services	29.1%
<b>Component 6</b> External Management	7.7%
<b>Project management</b>	3.3%
<b>Total</b>	<b>100%</b>

During the term of the project, both NACS and NHASP placed high priority on developing the capacity of the PNG provincial authorities and considerable resources and expertise were invested in establishing and supporting Provincial AIDS Committees (PACs).

NACS and NHASP also recognised the importance of supporting non-government organisations and a system of project and research grants was established to provide support for government and non-government activities on a peer reviewed basis.

## 2 Evaluation Method

### SUMMARY

Standard AusAID evaluation methods were used to assess the PNG National HIV/AIDS Support Project (NHASP). The evaluation had three phases:

- (1) *Desk Study*. The desk study was conducted in mid-2005 to review available documentation; to identify key informants and potential field sites; and to plan the field work component of the study. Based on key planning documents (notably the PNG HIV Medium Term Plan, NHASP Project Design Documents, NHASP Mid Term Review, and key project Milestone Reports) a data matrix was developed and study questions were derived.
- (2) *Field Study*. The evaluation team visited seven provinces to conduct interviews, inspect activities and locations and to collect documents and other relevant data that was of value for the evaluation.
- (3) *Reporting*. Analysis and reporting were conducted during and following the field

visits. Reporting consisted of debriefing key stakeholders in PNG and AusAID in Canberra; preparing a draft report for peer review; and preparing a final report based on peer review feedback.

### DETAILS

In 2004 AusAID's Executive requested the assessment of a number of AusAID-funded HIV/AIDS programs to better inform the implementation of Australia's International HIV/AIDS Strategy. Part of the response to this request was to be a cluster evaluation of three large HIV/AIDS projects in the Asia-Pacific region. However, due to the difficulties implementing an evaluation in Indonesia following the tsunami of 26 December 2004, and the potential benefits of evaluating the PNG National HIV/AIDS Support Project<sup>5</sup>, AusAID's Program Evaluation Section undertook an external, independent evaluation of this single activity.

<sup>5</sup> The evaluation has informed the design of follow up activities.

## THE NHASP EVALUATION

The goal of the evaluation was ‘to improve AusAID’s policy analysis and the design and implementation of AusAID’s HIV/AIDS activities and programs in the Asia/Pacific region by the identification and adoption of lessons learned from current and prior activities’.

The objectives of the evaluation were ‘to assess the relevance, efficiency, effectiveness, impact and sustainability of the PNG National HIV/AIDS Support Project and to draw-out lessons learned.’ (The terms of reference of the evaluation are at Appendix 1.1). The methods used in the evaluation follow.

## APPROACH AND ANALYTICAL PERSPECTIVES

Several factors influenced the evaluation team’s strategy. These included:

1. The large size and complexity of the NHASP project – AUD59 million over five-six years for seven diverse components covering the entire country.
2. The progressive modification of the project as it unfolded, including the removal and modification of certain components and outputs and the introduction of new ones.
3. The limited resources and time.
4. The need to expedite a meaningful document to assist planning for the next phase of Australian support for HIV control in PNG.

The team conducted an accurate, balanced, broad-brush evaluation which focused on the macro, structural, design and systemic issues. The team recognised that, with a project of this size, it is always possible to develop an extensive catalogue of implementation ‘errors’, but that this would not be the most useful resource for future planning. The team also recognised that there were inherent problems with evaluating against individual outputs as these changed somewhat during the course of the project and output-based evaluations are already available under the NHASP Monitoring and Evaluation Framework.

The team also decided to modify the standard evaluation *pro forma* report to maintain the integrity of the separate NHASP components and to document the evaluation findings component by component. This approach was taken to increase the immediate usefulness of the report for planners.

The analysis was conducted and the report written with separate chapters for each NHASP component. Within these chapters the team was implicitly concerned with the classic evaluation lenses of relevance, efficiency, effectiveness, impact and sustainability. Each component was assigned a rating of between 1 and 5 by the evaluation team depending on how well the component was executed according to the above criteria<sup>6</sup>. Finally, the team has summarised conclusions, lessons learned and recommendations in a final chapter.

6 Rating scale: 1 = Weak, 2 = Marginally Unsatisfactory, 3 = Satisfactory Overall, 4 = Fully Satisfactory, 5 = Good Practice.

## PREPARATION AND PLANNING

Preparation and planning occurred principally during early 2005.

The members of the evaluation team were Associate Professor David Plummer, Dr Alison Heywood, Margaret Lokoloko and Albert Bunat. (See *About the Authors*). The team was joined for part of the field study by Dr Philip Fradd (AusAID Evaluation Task Manager) and in-country support was provided by Anna Naemon (AusAID, Port Moresby).

Consultations between the team members and support staff commenced in May 2005 and were conducted by e-mail, telephone and face-to-face meetings. These consultations involved reaching agreement on the roles of team members; reviewing key documents (Table 3) and other relevant data; identifying key personnel and stakeholders; and identifying potential sites that could be visited to collect data.

Stakeholders were selected for interview if they had roles relevant to the PNG NHASP and/or had participated in any of the activities established during the project, such as training, staffing or study tours. In particular, the team wanted to obtain rich input from people affected by HIV, and people living with HIV.

Following a Desk Study in May 2005 a draft work plan and activity schedule was prepared. A draft interview guide was also developed. A copy of the study questions, the interview guide and a list of sites visited are included in Appendices 2.1, 2.2 and 2.3. In accordance with established social science research methods, the interview guide was open ended and was intended to be modified

as the study unfolded, and as the preliminary data analysis provided useful leads or suggested possible new explanations (Owen & Rogers, 1999; Sarantakos, 1993; Ritchie & Lewis, 2003; Layder, 1993). The approach constitutes a form of purposive sampling known as ‘theoretical sampling’.

**Table 3. PNG NHASP Evaluation Key Documents**

Government of Papua New Guinea (1998). Papua New Guinea National HIV/AIDS Medium Term Plan 1998-2002. Government of PNG: Port Moresby.
AusAID (July 1999, April 2000 revision). <i>PNG National HIV/AIDS Support Project – Project Design Document</i> . Australian Agency for International Development, Canberra.
AusAID (September 2002). <i>Review of PNG National HIV/AIDS Support Project</i> . Australian Agency for International Development, Canberra.
AusAID (January 2004). <i>National HIV/AIDS Support Project (PNG) – Monitoring and Evaluation Framework (Milestone 9)</i> . Australian Agency for International Development, Canberra.

## DATA COLLECTION

The Field Study took place in June and July 2005. The field study was split into two main components. The first involved interviewing key stake-holders from government and non-government bodies and consumers in Port Moresby. The second involved visiting provincial locations which had special significance for the project. In the context of the present project, special significance meant that sites visited offered case studies of successes and weaknesses of the project, or they illustrated particular aspects of the project which illuminated the evaluation. In each case, interviews were

conducted with multiple personnel, both in focus groups and individually to ensure a comprehensive account and to resolve any differences. Following interviews, sites were visited and documentation was reviewed to confirm (triangulate) the interview data. A schedule of visits and a list of locations is in Appendices 2.2 and 2.3.

Field notes were compiled for all visits, and most interviews were recorded on a digital audio recorder. Participants were given the option of providing confidential or off-the-record feedback and it was explained that if sensitive issues were unearthed, identifying details would not be revealed, and that recordings would be used for analytical purposes only.

## ANALYSIS AND REPORTING

The standard qualitative approach of conducting progressive (preliminary) analysis as the project unfolds, were followed for this study (Owen & Rogers, 1999; Sarantakos, 1993; Ritchie & Lewis, 2003; von Kardorff, 2004). Field notes were collected and supplemented on a daily basis with reflections and the identification of possible avenues of inquiry to pursue. Interview guides were refined in response to emerging data and interview practicalities. In the search for variant and negative cases which required further explanation, new informants were also sought during the project in accord with theoretical sampling principles.

De-briefing of key stakeholders in PNG and Australia was provided at the end of the field study. These sessions provided: rapid feedback of important data which enabled

quick response and informed ongoing activities where appropriate; cross checking of findings and preliminary analysis; deepening the analysis by peer feedback; and mutual education and support of participants and the evaluation team.

The draft report was written in the three weeks following the field study and was submitted to AusAID for peer review. The report was revised, after the team had considered the peer review feedback, and circulated to key stake-holders. A draft final report, which took into account the further feedback, was prepared and submitted to AusAID. After AusAID accepted the final report it was printed and made available to the public.

Project ratings were assigned to each NHASP component and to the project as a whole. However, these ratings should be interpreted with caution. Ideally, in order for ratings to be comparable over time, they should be determined by the same team according to a set of clearly defined criteria. Moreover, ratings conflate and reduce very complex activities into a single whole number value. The dilemma with all ratings in the present evaluation is that each component consisted of very good activities and some weaknesses, the value of which is not done justice in simple numerical ratings.

# 3 Education, Information, Advocacy & Behaviour Change

## (NHASP COMPONENT 1)

**Component 1 Objective:** To strengthen and develop the capacity of government agencies, NGOs, and the private sector nationwide to raise the level of awareness and understanding of HIV and STD transmission and prevention among the general population, with a particular focus on youth, and to promote appropriate behaviour change. **Revised Objective (MTR 2002):** Strengthened capacity of partner agencies to raise awareness of HIV/STD in the population (special focus on youth), to promote behaviour change.

### SUMMARY

There is evidence of generally raised HIV awareness in PNG covering the five-year period of NHASP. However, the findings are equivocal for: raised awareness of other STI; reduced HIV-related stigma; greater accuracy of HIV-related knowledge; and protective behaviour changes. While there was some evidence of strengthened capacity in NACS to raise awareness, the transfer of capacity was limited. This was largely attributable to the lack of a counterpart to the NHASP Health Promotion Adviser and to limited resources. Strengthened capacity was not evident in the NDoH, and capacity of other government agencies remained severely limited. There was a notable absence in mainstream health services of health promotion posters and materials addressing HIV. Among relevant NGOs there are significant levels of awareness. They have had considerable training and have greater knowledge. In the private sector, engagement of PNG media with HIV was

significant. Posters were seen extensively, with materials produced by NACS in hotels, airports, PAC offices and border posts.

### DETAILED FINDINGS

#### RELEVANCE

HIV is a preventable epidemic given appropriate levels of awareness and behaviour change. PNG has been assessed as vulnerable to a severe epidemic. The objectives of the NHASP Component 1 are therefore relevant. However, the focus on youth in the objective, while relevant and appropriate, risked understating the importance of high risk settings and vulnerable populations in the evolution of the epidemic.

## EFFICIENCY & EFFECTIVENESS

### **Behaviour change to reduce the impact of HIV/AIDS and other STI**

The Project has a database of all resources distributed during each year of the project, including the number of female and male condoms (see Appendices 3.1 and 3.2). There is now a fairly extensive condom distribution system in place that extends well beyond the health sector. Condom dispensing machines capable of providing a total of 3 million condoms were to be launched in PNG in late July 2005.

NHASP market research indicated increased demand for condoms, with a 5-fold increase since 2003.

There was insufficient data for the team to make a confident assessment of whether significant behaviour change has occurred as the result of NHASP activities. While informants repeatedly acknowledged high awareness of HIV in PNG, there was no convincing evidence that there were corresponding levels of behaviour change. The team noted that the NHASP social marketing surveys did not show sustained or dramatic changes in key behavioural parameters, such as numbers of partners, from the baseline survey data. Reports did not indicate whether increases in condom use were statistically significantly higher than baseline figures, as confidence intervals and statistical significance levels were not reported. The evaluation team was disappointed in the lack of rigour applied to the social marketing surveys, and the absence of information to indicate whether behaviour is improving.

## **Youth**

The team noted the engagement of PNG youth with HIV education, and were made aware of clusters of very active young people, but whose activities were hampered by a lack of resources (Wewak, Daru). This engagement was seen in the activities of theatre groups and peer education programs, much of which was on a voluntary basis, and much of which was not supported by NACS/ NHASP (but see Appendix 5.1). The team met with young people committed to health promotion, condom distribution and safe sex. However, there were often reservations during interviews about the magnitude of protective behaviour changes. The team noted the commendable involvement of the EU in peer education.

The team was concerned that many activities were happening only in the vicinity of the PAC offices, with exceptions, such as in East Sepik Province, where theatre groups were reaching remote communities (see Appendices 3.3, 3.4 and 3.5).

The recent development of the High Risk Setting Strategy (HRSS) by the Project was welcomed. This strategy has the potential to reach further into communities to people who are at particular risk. NHASP staff were fully engaged in the development of the high risk settings strategy, in outreach to these settings, and in developing resources to support this program (see Appendix 3.6).

### **Partnerships and networks**

Engaging partners through networking and meetings has been achieved, and is evident in: requests from government departments for talks by the Health Promotion Adviser;

outreach visits by the Adviser and her staff; and requests for materials for distribution and display at special events, health centres, educational institutions, private enterprise etc. Engagement of the private sector (Appendix 3.8), women and youth (Appendix 5.1) was evident.

A significant achievement was the engagement of church leaders. Initiatives included:

- > training programs for church leaders and clergy throughout the country;
- > airing of a TV spot using leaders of four churches to speak out against stigma;
- > two half hour TV panel discussions with church leaders;
- > the roll out of a 1-week major HIV awareness campaign for the Catholic Church (“The Lenten” Program) in the 63 dioceses in Port Moresby which included the training of clergy and the development of a range of educational materials and merchandise (badges, pamphlets etc);
- > the beginning of a Red Ribbon Churches initiative, and the development of a poster; and
- > the development of the Faith Community Leader’s Covenant on HIV/AIDS (See Appendix 8.2).

There has been increased use of advocates from the sports and music arena, featuring as role models in preventive media campaigns, using events and networks to raise awareness, and shifting towards education and interactive, interpersonal community approaches. Sporting organizations were increasingly engaging with NHASP.

NHASP funded a number of significant national meetings on HIV and AIDS. The 2003 PNG Medical Symposium was supported totally by NHASP, the focus of the whole symposium being HIV/AIDS and sexual health. In 2005 the Project expected to support a half day focus in the same symposium. The HIV/AIDS Consensus meeting with 85 delegates was fully funded by NHASP (2005c). NHASP also supported the 2005 PNG Nursing Symposium.

NHASP funded and organised numerous meetings to engage stakeholders and partners, to share information and to report on achievements and progress of the project. There was feedback that some meetings did not encourage dialogue and debate about program issues, with suggestions of lack of transparency, but it was unclear just how widespread this view was.

There were significant limitations in the engagement with other departments at the national level, particularly with Health Promotion in NDoH, and the Departments of Community Development and Correctional Services.

The National Department of Education (NDoE) exhibited strong leadership. There were clear and direct benefits from NHASP (see Chapter 8) and, through its representation on the NAC and participation in forums, NDoE has indirectly benefited from NHASP. Many of their achievements have been largely attributed to the efforts of UNICEF and UNDP.

In the private education sector the project supported the Port Moresby Grammar School’s major teacher education and student peer education program and the International School’s teacher training.

### **IEC materials and training packages developed**

A range of IEC materials (total 114: pamphlets, posters, teaching cards, flipcharts, videos) have been developed at the national level (Appendices 3.1 and 3.2). The development of materials and training packages has been evidence-based. Information has been used from formative research and reference to international literature to identify behaviours and groups as the focus for specific health promotion interventions and to inform the content of materials.

A database of health promotion materials has been established, and a re-order form listing all materials available included in every mail-out of resources (Appendix 3.1). Video materials have been developed by the resource centre, with the pool being reviewed and selectively culled and gradually converted to DVDs in response to demand.

While pamphlets were produced in English, Motu and Pidgin, a criticism encountered during the field trips was that current pamphlets were not appropriate for use in low-literacy settings. While theatre groups (Appendices 3.4 and 3.5) have a significant role in a community education/behaviour change strategy, and play an important role in the dissemination of information to groups with low literacy levels, pamphlets still have a role to play. The team was informed that the project was developing pamphlets with greater pictorial content, but was unable to confirm that this was happening. Translation of pamphlets into local languages had not occurred. Attempts were made to do this for language groups

with over 10,000 speakers (Enga, Western Highlands Province), but these provinces have apparently not responded to NHASP requests for translations, last attempted in late 2003.

Production of appropriate IEC resources at the provincial level has not occurred, despite attempts by NHASP to do so through four Regional workshops. The Health Promotion Adviser planned to establish provincial committees to oversee the production of resources, but abandoned this when it was found provincial capacity was generally insufficient for the task. NHASP also made a deliberate decision to not provide electronic templates of IEC materials, due to concern that messages would be modified and could become distorted and inaccurate. The team noted that the role of aid programs such as NHASP is to take a strategic approach to developing that capacity. Counterpart arrangements with NACS for the Health Promotion Adviser have not been sustained, which severely limited any building of capacity in NACS.

### **Nationwide coverage of HIV/AIDS and behaviour change strategies**

All provinces conducted basic HIV awareness. Fifty-one drama groups (of the target of 60) in 16 provinces have received training by trainers (Appendices 3.3, 3.4 and 3.5). The Project has encouraged the training of district-based theatre groups to widen the potential coverage of community education through theatre. Forty-nine of the 58 districts (84%) in 16 provinces have project-trained theatre groups. All provinces were reported to have at least one youth group that had been involved in awareness activities.

The evaluation team was concerned about the content of prevention messages, particularly those being disseminated by certain faith-based organisations. Some actively promote ambiguous and misinformed messages about protective behaviours, including re-configuring the 'ABC' prevention message, to promote the A (Abstinence) and B (Be faithful) components of the message, while equating C with Church doctrine. It is the team's opinion that this misinformation (at worst) and ambivalence (at best) is undermining HIV prevention in PNG and denying people a full range of proven protective choices.

#### **The NACS/NHASP Resource Centre**

The NACS Resource Centre has been established to house and distribute materials to project beneficiaries. The Centre has a high utilisation rate by the public, including students. The Centre holds all the Project IEC resources, plus additional reference material on HIV, including an electronic mini library obtained through TALC UK. One hundred sets of the mini library have been distributed to all PACs, major institutions including tertiary institutions, nursing schools, medical schools, teachers colleges, DWU, national fisheries authority, libraries, etc. Nine thousand were distributed to schools within the Education Department.

Distribution of HIV/AIDS resources, including condoms, is made to all PACs on request and commercial merchandise is sent quarterly. PACs subsequently distribute supplies to their networks. All distributions include a re-order form. Additional resources can be requested at any time. Distributions are also made through HSSP, with 740

health centres having received HIV resource packages since 2003. Repeat orders have been many, with more emanating from teachers than from the health sector. It is the responsibility of the PACs to monitor the use and coverage of materials. NHASP has reported that this is problematic, reflecting weaknesses in the PACs as a result of inadequate staffing. NHASP officers follow up PACs which are ordering low amounts of materials and resources.

Spontaneous interest in educational resources by the private sector has increased in recent years (Appendix 3.8). For example, the 'RH' logging company requested resources for distribution at their camp sites and Papindo requested resources for their shopping outlets, as have Shell and British Tobacco. Mining companies were requesting resources well before the HRS Strategy commenced. Papindo offered to erect billboards at their shopping centres, knowing NHASP was having problems getting permission to do this.

Since 2003 NHASP had supported mini campaigns that focussed on the core themes of World AIDS Day. This included TV advertisements, newspaper articles, radio, and materials development. In addition, NHASP funded provincial activities and assisted provinces with suggestions for their own activities. NHASP also supported activities associated with International Women's Day.

### **Active participation of priority groups**

The project's main priority groups were: women, youth, sex workers, CSW clients, truckers, seafarers, disciplinary forces, high-risk private-sector workers (such as miners and cannery workers), PLWAs and home-based carers. In addition to being routinely invited to NHASP/NACS seminars, all these groups actively participated in NHASP supported activities (Appendices 3.6, 5.1 and 9.1). Members of these priority groups engaged in diverse activities to raise participation of their own members.

An important later development in the project was the strengthened focus on 'high risk settings'. This shift in strategy (the HRSS) was important because under this approach:

- > resources are directed to priority sites where transmission is particularly likely;
- > prevention messages are tailored to the life patterns, needs and meanings of important populations who are more likely to identify with and own the message; and
- > prevention activities respond to the social contexts in which risks occur.

For these reasons, the 'high risk setting' strategy is more influential than more generic or individualistic approaches. The team noted the potentially valuable *de facto* recognition given to important populations by this strategy – such as youth, sex workers, male dominated commercial settings and men who have sex with men.

The NHASP HRSS component supported NACS to facilitate a workshop for the Trade Unions on the development of workplace initiatives in collaboration with the UNDP HIV Support Project. A draft Workplace Toolkit was put in place for certification by ILO.

### **Distribution of condoms strengthened through social marketing**

The 100% Condom Use document informed the condom social marketing for the project. Six million and six hundred thousand condoms had been distributed by the project at the time of the evaluation; an additional three million condoms were to be distributed by the end of 2005 (Appendices 3.2 and 3.7). The focus of a media campaign upcoming at the time of the evaluation was condom use. The Save the Children Fund (SCF) is a major distributor of female condoms; condoms are distributed to hotels; and an agency had been contracted to go into nightclubs to distribute condoms and display posters. The distribution was being strengthened through the HRSS; some distribution was occurring through the HSIP (Health Sector Improvement Program); and Area Supply Stores had access to supplies.

During the team's provincial visits the availability of condoms was found to be variable. In Sandaun province they were clearly available in one hotel (in clear view at the reception counter and in guest rooms) and at the border in clear view at the front desk. The latter were provided through the HSSP. The team did not see supplies in many health facilities, particularly not in faith-based facilities, nor in government

facilities. The team was told of condoms delivered to government health facilities being removed by some churches. The team met with sex workers in Goroka who reported good access to condoms and increased skills to negotiate their use with their clients, with support by SCF (New Zealand). Sex workers in Morobe reportedly had access to condoms. The Project has recently begun distributing condom dispensers to increase access to condoms and lubricants.

### **Home Care strengthened through stigma reduction activities**

There was no sound information on the extent to which stigma had been reduced. While evidence from the social marketing component indicated some apparent decrease in stigma, it suggested that stigma remained a significant problem in PNG. The team found variable evidence in field visits, but the over-riding impression was that more work was needed to reduce stigma, building on prior activities.

### **Increased political commitment to HIV/AIDS at the highest level**

Shortly after the evaluation the NAC moved from the auspices of the NDoH to the PNG Department of Prime Minister and Cabinet. With strong leadership from NAC and NDoH, PNG has secured US\$29 million over a five-year period for a large HIV/AIDS and STI Project, to be funded through GFATM. HIV/AIDS has been mainstreamed in four sectoral strategies and the MTDS. The Prime Minister featured in a key HIV/AIDS poster. The obvious developments in high-level leadership in HIV in PNG were

an important sign of progress. However, a major hurdle which remains is translating changes in high-level leadership into an effective bureaucratic response and grassroots action.

### **IMPACT**

The evaluation team felt that it had gathered sufficient information and evidence to enable it to anticipate likely impacts. There was fairly widespread awareness of HIV in PNG, at least in urban and provincial centres. While some of this awareness predated NHASP, the NHASP activities had contributed to, and helped consolidate, awareness of HIV in PNG. However, the evidence for widespread behaviour change was not compelling, and the team was not confident that behaviour change will be sufficiently consistent or widespread to have the impact that is needed to curtail the epidemic. The (relatively late) development of the 'high risk setting strategy' was impressive. This strategy had the potential for focussed and important impact providing there was ongoing support and development for this and similar strategies.

### **SUSTAINABILITY**

In view of the leadership emerging at the political levels, and regular reporting of HIV in the press, it is likely that the levels of awareness reported above are sustainable in the short to medium term. Additional support will be required to guarantee ongoing awareness in the longer term, particularly if HIV fatigue emerges, as it has in other countries. With the current approach, sustainable behavioural change is unlikely to occur at levels sufficient to

contain the epidemic, and a substantially increased focus will be required in future strategies. The high risk settings strategy offers an important model for effective, focussed intervention and behaviour change, but this or similar programs will require ongoing support.

## RATINGS

Component 1	Rating 3	While there is high awareness of HIV in PNG, and NHASP was active in providing training, the principal concern is a lack of substantial behaviour change
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# 4 Counselling, Community Care and Support

## (NHASP COMPONENT 2)

**Component 2 Objective:** To strengthen and extend HIV/AIDS counselling services to ensure national coverage and to establish home based care as the chief means of delivering health care services to people and their families affected by HIV/AIDS. **Revised Objective (MTR 2002):** Strengthened and extended counselling, care and support services to people, families and communities affected by HIV/AIDS in collaboration with NACS and civil society partners.

### SUMMARY

NHASP gave priority to developing basic counselling training and voluntary counselling and testing (VCT) services in PNG (NHASP 2003b). At the time of the evaluation there were 49 health facilities covering 17 provinces that were equipped to provide VCT. In addition, there were 4 non-clinical services that had established VCT sites with the assistance of NHASP. More than 1000 people had received some form of counselling training provided by NHASP. NHASP counselling training consisted of basic short courses with very few pre-requisites. Later, there were moves in conjunction with NACS to develop more advanced counselling courses and to accredit counselling services. While NHASP had developed a National HIV Counselling Network (NAG), it appeared that this initiative provided benefits for a core network of people, but that most people who had received training were in need of additional support, professional development and supervision. The

development of a home-based care strategy was less advanced than the development of counselling services. There were major gaps in care for people with HIV-related disease in PNG in the home, community, and in hospitals.

### DETAILED FINDINGS

#### RELEVANCE

The objective of strengthening and extending counselling for HIV/AIDS was appropriate and relevant and, with certain limitations, had generally been fulfilled by NHASP and partner organisations. While some progress had been made towards extending home-based care for people with HIV-related illness, the home-based care element of the objective of Component 2 was more problematic. While the objective of enhancing home-based care was a desirable outcome, and was clearly designed with the limitations of the PNG health system in mind, it failed to take into account the

complexities of providing that care; the low levels of skills available in the home-based care setting; and the importance of providing sufficient skilled support.

## EFFICIENCY & EFFECTIVENESS

### Counselling training

Prior to, and during 2003, basic HIV counselling training was provided by NHASP in the form of a one-week short course, consisting of basic HIV information and basic counselling. From early 2004, improvements were achieved when the counselling course was increased to 2 weeks with a pre-requisite of completion of a basic HIV information module.

Up to April 2003 more than 1000 participants completed the short course. After that time NHASP provided counselling training for approximately a further 600 people. Around two-thirds of these trainees were women. At the time of the evaluation NHASP had far exceeded its target for training in HIV counselling.

Training had been extended to multiple sectors: churches, health facilities, provincial authorities, PACs, police, corrections officers, the military and the private sector. It was reported to the team by NHASP officers that NHASP training courses had also resulted in the development of new services, notably services for orphans in Mt Hagen and Lae.

The courses offered by NHASP were basic and would not be sufficient to qualify a person to work in HIV counselling in many other countries, not least in Australia. This approach was a reflection of the basic needs of PNG. However, being equipped with

basic skills is unlikely to prepare workers to confront the epidemic, given that they can be isolated, have minimal professional backup and be regularly confronted with complicated illness, death and dying as well as extreme stigma and anti-social reactions.

The team heard about moves to develop accredited, advanced training in HIV counselling in PNG through a partnership with Australian TAFE providers. Although this was a very important development, the team noted that this initiative came fairly late in the project.

HIV counsellors were regularly subjected to extreme pressures and they had only basic skills. The team considered that support for people with basic counselling training was not yet adequate and that future assistance should include development of systems for supervision, professional networking, support, advanced training and continuing skills development at a local level. The establishment of the National HIV counselling network was a welcome development. However, this network primarily benefited high level workers and probably had little value for many, if not most, people originally trained by NHASP.

With the support of NHASP, most Provincial AIDS Committees had been able to appoint Provincial Counselling Coordinators (PCC). The PCCs were intended to establish a collaborative network of counsellors and service providers. While officially there were 15 provinces said to have such a network:

- > five provinces (in some cases very disadvantaged and needy ones) did not have sufficient infrastructure to benefit from this system; and

- > in some cases where these networks were said to be established, it was unlikely that they were functioning well.

### **Voluntary Counselling and Testing (VCT)**

An important achievement of the years that NHASP had supported the PNG HIV effort was the increased availability of voluntary counselling and testing (VCT) centres.

These centres are largely located in clinical services settings, but there are also notable centres that are not attached to clinical services (Appendices 4.1 and 4.2). According to NHASP, there were (at the time of the evaluation) 49 health facilities covering 17 provinces with staff who had received basic training in HIV counselling.

By July 2005, four non-clinical Church-based centres were to have been established to provide on-site HIV testing: Anglicare, Port Moresby; Shalom Care Centre, Western Highlands; Mendi Diocese, Southern Highlands; and Bethany Care Centre, Madang. The Wewak Centre for Hope was also due to start VCT services in the near future.

While the wider availability of HIV testing is endorsed, and the involvement of faith-based organisations in HIV care welcomed, important issues remain about the role of some church organisations in VCT. These concerns are addressed in Chapter 7: 'Clinical and Laboratory Services'.

Moves by NACS, supported by NHASP, to develop and promulgate VCT guidelines were a welcome development, albeit occurring late in the 5-year NHASP term.

### **Home-based care**

Clinical care for people with HIV in PNG is very limited and often extends to counselling but little more. The reasons for this shortfall do not lie principally with NHASP, but reflect the systemic problems in health care services in PNG. Nevertheless, the team would have liked to see NHASP articulate a clearer vision for community and home-based care, and to take a more strategic approach to achieving it. This is important: there is a growing need for clinical care in PNG and HIV care is steadily improving elsewhere in the region. A development aim for future strategies should be to raise the minimum standard of care available to people with HIV and STI.

The team welcomed the initiatives taken by NHASP to develop home-based care (NHASP 2004b). These included:

- > strategic meetings in 2003 and 2004;
- > a study tour to Africa by key stakeholders;
- > the development and distribution of a home care kit by 'Appropriate Technologies' which was commissioned and sponsored by NAC/NHASP;
- > support for PCCs in most PACs, and
- > the (recent) development of training in home based care.

These initiatives are discussed further in Chapter 7: 'Clinical and Laboratory Services'.

To the time of the evaluation, NHASP had trained 113 people (64 females, 49 males) from the four regions of PNG in basic home-based care. Thirty-three of these were trained as trainers (21 females, 12 males)

in the expectation that they would continue developing the skills-base locally. There was no evidence of the outcomes of this strategy. The team had significant concerns because AIDS is a complex, multi-system disease that can cause respiratory distress, nutritional depletion, dementia and severe pain syndromes and these present severe challenges for home based carers with minimal skills.

### IMPACT

As with the rest of this report, there are limits to the assessment of impact during a project. However, the team noted that NHASP had been very active in training counsellors, and there were NHASP-trained counsellors located around the country. The impact of this training was mitigated by two key factors: the level of training was fairly rudimentary, given the complexity of the issues involved; and the level of ongoing support, supervision and professional development was insufficient and the benefits of training were likely to be dissipated.

### SUSTAINABILITY

HIV care is complex and can be extremely draining. HIV/AIDS counsellors are regularly exposed to intense suffering, death and dying, particularly in settings where clinical and palliative care are generally not available and where counsellors are isolated. The benefits of NHASP (and other) counsellor training are only likely to be sustainable if there is ongoing support, supervision and professional development for people who have been trained.

Training consumes considerable resources which are unlikely to be available internally in PNG to the level provided by NHASP.

Home based care was rudimentary and the development of a sustainable system will require skilled support (probably from the health and NGO sectors) in order for it to be more than a token response.

### RATINGS

Component 2	Rating 3	While counselling training, networking and services were developed, there were shortcomings in ongoing support for counsellors, and in developing community care beyond counselling.
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# 5 Policy, Legal and Ethical Issues

## (NHASP COMPONENT 3)

**Component 3 Objective:** To strengthen the capacity of the NAC and other government and private sector agencies to facilitate the development of relevant policies, codes of ethics and enabling legislation regarding HIV/AIDS and STD prevention and care. **Revised Objective (MTR 2002):** Strengthened capacity of NACS, other government and private sector agencies to facilitate the development of relevant policies and enabling legislation regarding HIV/AIDS and STI prevention and care.

### SUMMARY

Workshops, consultative meetings and sessions facilitated by NHASP during 2003/2005 assisted NACS to disseminate information regarding the law, ethics in the workplace, stigma and discrimination. Involvement of the media contributed significantly to promoting the issues of human rights in workplaces and in the community. The capacity of NACS to leverage the public and private sectors and the PNG Trade Union Congress in matters relating to policy, legal and ethical matters and HIV was significantly improved. Political lobbying extended NACS influence in the PNG Parliament, thus creating an enabling environment for HIV/AIDS to become a key development issue.

More attention should be directed at reaching institutions and organizations in the provinces to disseminate information more widely (for example, promoting the Defence Force Workplace Policy to military institutions outside of Port Moresby). In the

case of the HAMP legislation, the PACs will need additional support if they are to take the lead in promoting workplace policies.

### DETAILED FINDINGS

#### RELEVANCE

A comprehensive approach to the challenges posed by the HIV epidemic invariably requires institutional adaptation and institutionalisation of HIV-related responses. Effective HIV strategies typically require updated public health laws and human rights protection as pre-requisites. A review of existing legislation and promulgation of new laws is therefore relevant to HIV control in PNG. The development of HIV-related policies at political, government and institutional levels is also necessary if institutions are to adapt to the needs of the epidemic and to respond accordingly.

## EFFICIENCY & EFFECTIVENESS

### **Policy, a multi-sectoral response and mainstreaming of HIV**

NHASP facilitated the integration of sectoral HIV policies into the PNG Medium Term Development Strategy (MTDS) 2005-2010, thus ensuring the formal recognition of HIV/AIDS as a development issue requiring a multi-sectoral response (NHASP 2003a). In the process, NHASP maintained close consultation with key Government partners, namely the Department of National Planning and Rural Development (the focal point for MTDS), and the Public Sector Reform Unit based in the Prime Minister's Department. The MTDS, including the references to HIV/AIDS, was launched by the Minister for National Planning in early 2005.

Similarly, NHASP/NACS staff were involved in consultations on the Population and Development Policy and the National Youth Strategy and lobbied for HIV/AIDS to be mainstreamed into them.

NHASP, in conjunction with NACS and UNDP, promoted 'good practice' materials in CD form such as the Draft Workplace Policies Toolkit, quarterly stakeholder reports, draft National Strategic Plan and ILO documents. Further workshops with other public service organizations were expected to test the toolkit before ILO certification in August/September 2005. NHASP's facilitation led to amendments to the Public Service General Orders in the light of HAMP.

NHASP designated a Provincial Liaison Coordinator specifically to support the private enterprise response to HIV in key

provinces. The target industries include mining, logging and agriculture. NHASP worked closely with the Chamber of Mines by funding two streams of assistance – through the PNG Trade Union Congress (PNGTUC), including the distribution of IEC materials and condoms, and by funding the HIV coordinator in the office of the Chamber of Mines. The PNGTUC also supported unions to develop HIV policies, for example, by assisting with the development of policies for the Airline Workers Union and the Energy Workers Union.

### **Gender**

HIV/AIDS has well recognised gender ramifications, and PNG is no exception (Appendix 5.1).

PNG women are subjected to significant sexual risks including frequent violence and rape. These risks are markedly exacerbated by the generally weak position women find themselves in PNG gender-power relations, including limited negotiating power (for sexual safety). These dynamics translate into HIV epidemiological patterns in which young women are documented to be at particular risk.

Women bear a disproportionate responsibility for HIV care. This burden extends to families, relatives, children, partners and community members, as well as being carers in the 'formal' sector as health professionals.

Traditional culture in PNG adds a further dimension to the burden that PNG women carry. For example, the (gendered) impact can be demonstrated in customary practices

such as 'bride price', polygamy, 'widow inheritance' and child custody, all of which affect, and are affected by, HIV.

The relatively hidden role of men, masculinities and male peer groups needs to be more transparent and men, as drivers of the epidemic, need to be engaged. For example, it is men's financial power that sustains the sex industry; yet it is the female sex workers that are targeted for interventions and for surveillance. It is male peer groups that drive sexual assault, yet it is women who carry the burden of the assault and the interventions. While women often rely on having one partner (often their principal means of protection against HIV), their male partners are often not monogamous and, if they do not use condoms, then the women can become infected too.

In the long term, these issues must be addressed by achieving greater power for women and greater equality between women and men. However, despite policies of 'mainstreaming' gender issues into HIV programs, and HIV and gender into a range of sectoral activities, this approach is generally not in the foreground and has been widely neglected.

UNDP conducted a 'gender audit' of the PNG National HIV/AIDS Strategic Plan for 2004-2008 (UNDP 2005). The team agreed that higher priority must be placed on gender in the next strategy, including maintaining a key focus on women, but also developing a focus aimed at researching, engaging and changing men and dangerous masculinities. A gender advisor whose job is to advocate for gender and HIV will be

needed to ensure that gender is maintained as a priority. In the absence of such a designated person, the usual experience is that gender drifts into the background.

### **Involvement of people with HIV and people at risk**

There is an absence of people with HIV in key positions in the PNG response to HIV. The two common explanations given for this absence were that the prevailing HIV-stigma has resulted in people remaining hidden and that people with HIV with sufficient skills have not been available. While the team accepted these explanations in part, it noted that:

- > A systematic approach to destigmatising HIV is required so that people are free to participate fully;
- > Some skilled persons with HIV, who appeared to have been available for permanent positions, were met by the team;
- > There should be a systematic approach to supporting and developing the skills of people with HIV; and
- > Important symbolic actions should be taken, such as designating seats on advisory and management bodies at all levels for people at special risk and people with HIV, and designating staff positions for people with HIV.

The lack of routine formal inclusion of people with HIV in the management structures of the response to HIV suggested that there was a weak commitment to human rights and an effective response.

Like gender, HIV should attract specialised targeted initiatives as well as being 'mainstreamed' into other sectors.

An HIV 'mainstreaming advisor', whose job is to advocate for the involvement of people with HIV, for people from high-risk settings, and for mainstreaming HIV across sectors, would ensure that people with HIV, and those at special risk, are increasingly involved.

### **Law reform**

A key milestone for the PNG response to HIV was the development of the HIV/AIDS Management and Prevention Act (the HAMP Act) (NHASP 2002). The HAMP Act was passed by the PNG Parliament in June 2003; was gazetted in September 2003 and became law in October 2003. The Act provides a comprehensive basis in law to: support public health provisions for the control of HIV; provide guarantees for the protection of human rights; and to provide a legal framework for situations where people are placing others at risk of contracting HIV.

Further reforms are needed before the PNG laws meet with international expectations regarding HIV control. In particular, there are outdated colonial laws concerning sex work and homosexuality, which intensify stigma and interfere with prevention. Future assistance should extend the excellent early law reform work and amend these laws so they conform with the demands of HIV control.

Stigma is a key impediment to effective HIV prevention and to the implementation of constructive strategies. Stigma deeply impinges on human rights and entrenches denial. The HAMP Act has considerable

educational potential for overcoming stigma, but promotion of the details of the act to magistrates, health workers and to the public appear to have been limited. The team also noted misconceptions about the Act during interviews. For example, personnel in key NGOs were under the impression that the act provided little protection for people whose partners have HIV but are not taking precautions.

### **IMPACT**

The law reform work facilitated by NHASP, and the work with religious leaders, have had important positive impacts on PNG society. The promulgation of the HAMP Act marked an important milestone in the PNG political and legal responses to PNG and is a testimony to good leadership. Likewise, the publication of the covenant on HIV by PNG faith-based organisations also provided a long needed lead to the community from religious leaders, along with ethical guidance. Both of these approaches mark the early stages of destigmatising HIV, at a point when stigma is a major barrier to progress in dealing with HIV in PNG.

The impact of the work of NHASP/NACS on the major institutions of government has been more variable. While there were good initiatives, for example in the PNG Defence Force and the Education Department, other departments and institutions were slow to respond and the influence of NHASP has not been nearly as apparent. In addition, the team observed a declining impact the further they went from Port Moresby. Socially and geographically isolated populations remained needy and vulnerable and the impact of NHASP work was less apparent.

## SUSTAINABILITY

PNG law reforms, being legislated by the PNG Parliament, are durable. The impact of these reforms will depend on the education of officers charged with administering the law, notably the police and the judiciary. Moreover, the education of the public about the law will only be significant if there is comprehensive awareness raising. These educational tasks were still to be done at the time of the evaluation, and in the meantime there were deficits in grassroots understanding and practice in institutions and in the community.

Sustained progress among religious leaders is tenuous. While the goodwill of the leaders who endorsed the HIV covenant is not in doubt, there are other religious leaders who did not participate or who appear to dissent from the spirit of the covenant. There are still major sections of the PNG bureaucracy which have not acted on HIV. A strategic approach to ‘mainstreaming’ and institutionalising HIV is necessary if the PNG bureaucracy is to play a sustained and valuable role in the PNG response to HIV/AIDS.

## RATINGS

Component 3	Rating 3	There have been important developments in law reform and in leadership in HIV/AIDS in PNG.
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# 6 Monitoring, Surveillance and Evaluation

## (NHASP COMPONENT 4)

**Component 4 Objective:** To strengthen the public health surveillance of HIV/AIDS and STDs and related behaviour change through improvements to case definitions, data collection, reporting, analysis and feedback mechanisms including sentinel surveillance sites. **Revised Objective (MTR 2002):** Public health surveillance of HIV/AIDS and STI strengthened.

### SUMMARY

Despite being titled ‘Monitoring, Surveillance and Evaluation’, this component focused on epidemiology. Monitoring, evaluation and research grants will be addressed in Chapter 9. Disease and behavioural surveillance is difficult in PNG because of gaps in the systems that underpin surveillance: testing, data collection and collation, IT support and sufficient designated personnel. An important initiative was the development of the definitive report to date on HIV surveillance in PNG: the ‘Consensus Document’ (2004c). This outcome was auspiced and supported by NACS, the NDoH, NHASP and the WHO. A key difficulty has been to identify and support a national host body to manage epidemiology and surveillance in PNG.

### DETAILED FINDINGS

#### RELEVANCE

This component focused on surveillance of the HIV epidemic and therefore the objective does not accord well with its title. Surveillance of the epidemic is a key objective of HIV control. However, surveillance alone will only document, but not control, the epidemic. Surveillance must be strongly linked with feedback activities and outcomes for the surveillance to be meaningful and relevant.

There was progress in surveillance of the AIDS epidemic in PNG during the term of NHASP. However, there were notable weaknesses and surveillance remains vulnerable.

## EFFICIENCY & EFFECTIVENESS

### **Behavioural and disease surveillance**

Surveillance is difficult in PNG because of the general weaknesses of the systems that underpin surveillance: availability and access to testing, data collection and collation systems, IT support and sufficient designated personnel.

At the commencement of the project there was no HIV surveillance system. Surveillance activities have progressed well over the last 4 years with continued strong support from NHASP and collaboration between NACS and NDoH.

An important milestone was the production of the 'Report of the 2004 National Consensus Workshop' (2004c). This report was the most definitive document at the time on HIV surveillance in PNG. The process of arriving at this consensus and producing the document was underwritten by NACS, the NDoH, NHASP and the WHO.

The PNG Institute of Medical Research (IMR) has undertaken surveillance and epidemiological research in various provinces around PNG. This is an important initiative and has contributed significantly to mapping the extent of HIV in PNG. This research was based on offering counselling and screening during field visits to locations across the country. Screening involved multiplex PCR on urine for several STI and testing a blood sample for HIV and syphilis. Testing was done at the IMR in Goroka. Subsequent visits were conducted to provide the results and treatment for infections that were detected by the survey. This research was commissioned by the project.

In addition to its important surveillance value this research provided a key 'test of concept', including a *de facto* costing study for outreach-based STI programs.

NACS/NDoH collaborated with IMR in their nationwide STI/HIV/AIDS community based surveillance as well as the molecular study on HIV virus typing in the country.

Training on surveillance was provided for nursing officers working in antenatal clinics, STI clinics, medical and TB wards/clinics, labour and post-natal wards in nine provinces (Daru, Lae, Mt Hagen, Wewak, Buka, Vanimo, Goroka, Kundiawa, Rabaul and Port Moresby). One hundred and forty-five staff from 9 provinces received training on HIV/AIDS surveillance guidelines. In October 2004, the project trained 60 data collectors (50 male; 10 female), including 20 Directors, Laboratory Managers and Provincial Disease Control Officers. The team noted that, in addition to training, surveillance depends heavily on having effective data management systems in place. The requisite systems have not yet been achieved.

Passive surveillance in PNG was limited to collating test results and clinical conditions that fulfil standard clinical criteria for AIDS. The results were subject to access to services, testing patterns, clinical practices and reporting systems. The Port Moresby CPHL, Mt Hagen Hospital and Lae Hospital provided confirmatory HIV testing. All twenty provincial hospital laboratories and the CPHL submitted testing data for NACS/NDoH quarterly reports.

Active surveillance was being upgraded with the assistance of NACS and NHASP. NHASP supported a laboratory scientist and a data manager at the Port Moresby STI Clinic. Twenty-six sentinel surveillance sites, including TB, antenatal and STI clinics, were established across 13 provinces (Appendix 6.1). During 2005, the key STI clinics in Port Moresby, Lae, Mt Hagen and Goroka conducted both sero- and behavioural surveillance, and there were sero- and behavioural surveys in the PNG Defence Force (160 soldiers) and some correctional facilities (390 prisoners).

Sero-surveillance has been expanded into four district level facilities and behavioural surveillance has been conducted at the PMGH, Ht Hagen, Goroka and Lae STI clinics. Behavioural surveillance was conducted in 2005 at Bomana prison in Port Moresby and in the Papua New Guinea Military at Taurama and Murray barracks.

The National Surveillance Management Group was successfully established at a meeting on the 17<sup>th</sup> of June 2005 between NDoH, NACS and facilitated by NHASP. This group is responsible for surveillance activities, monitoring, evaluating, and will guide research and the dissemination of HIV and STI epidemiological information. It comprises membership from NDoH, NACS, IMR, CPHL and NHASP and also representation from the School of Public Health. It is chaired by the Director of the Disease Control Branch of NDoH, and will jointly determine the directions of the annual planning process, review and select surveillance sites and population groups for surveillance activities. A strong link with

NDoH service delivery is necessary to ensure a sustainable surveillance system.

The National Centre for Sexual Health is developing into the centre of excellence for STI management, the ART program, STI and HIV sero- and behavioural surveillance, VCT and data management. The standards and practices from the Centre will be rolled out to the provincial STI clinics and ART centres. The National Centre needs to be supported and developed to meet the increased needs of its services.

As the new STI clinics are built, staff will be trained in computerised STI case management, STI and HIV sero- and behavioural surveillance including data management.

A large volume of market research data was produced from a baseline survey and four subsequent surveys of knowledge, attitudes, behaviours and beliefs in four regions of PNG using samples of up to 2000 participants (Appendix 3.7). These data were generated by the NHASP social marketing program and provided a very important resource for planning and research. However, the team found that academic inputs into designing the market research and its subsequent analysis were not transparent and were probably minimal. Any academic partners were not acknowledged in the documentation of results that the team examined, and the style of reporting did not meet basic statistical and academic standards. The credibility and utility of the data was therefore compromised. This was far from ideal for such potentially important data.

Further development and consolidation of surveillance in PNG will depend on the establishment of a suitable host institution and sufficient support for this activity. The team was aware of the current debate about whether the future host institution of HIV and STI surveillance should be NACS or the Department of Health. Surveillance will benefit from the development of an STI clinic network, especially if it is accompanied by an STI outreach screening program as described in Chapter 7. The development of a National Reference Centre for STI may also make a suitable future host institution for STI surveillance under the auspices of the NDoH. Partnering that institution with similar institutions in Australia should also be explored.

better handling of existing data. Behavioural surveillance was introduced in certain high risk settings and at sentinel clinics.

### SUSTAINABILITY

Surveillance typically depends on maintaining the integrity and functionality of complex chains of command that cut across organisations. Sustainability of PNG surveillance systems cannot be guaranteed and will require constant work. Most of the capacity for surveillance can be undertaken by existing staff, however, support is clearly required at the national level for data management, analysis and appropriate dissemination of results.

### IMPACT

There was no surveillance system at the start of the project. Certain refinements in surveillance capacity were achieved during the life of the project (training, data collection systems, surveillance research, and trials of rapid testing kits). Additional testing sites were introduced (VCT centres) and 3 provincial laboratories were upgraded to undertake HIV confirmatory testing. No new diagnostic tests were introduced during the life of the project, so the impact of NHASP work was largely limited to

### RATINGS

Component 4	Rating 3	Systems for monitoring, surveillance and evaluation were developed. However, the capacity of lead agencies such as the Department of Health remains weak and sustainability of surveillance is fragile. Apart from the consensus statement on HIV, the epidemiology of HIV in PNG is unclear. Commissioned work by the IMR is commendable.
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# 7 Clinical and Laboratory Services

## (NHASP COMPONENT 5)

**Component 5 Objective:** To improve the quality and delivery of STD and HIV/AIDS services through enhanced diagnosis, clinical management, and community care.

### SUMMARY

NHASP made important contributions to clinical care for the 'walking well' over the 5 years of the project, notably in the areas of clinical training, consolidating clinical systems and protocols for syndromic Sexually Transmitted Infections (STI) care. However, clinical care in PNG remains an area of considerable weakness and great need, particularly for people with HIV. There were notable areas of clinical and laboratory strengthening in the Project Design that were not achieved during the life of the project. Not all of these shortfalls were attributable to NHASP. During the project some key clinical activities were removed from NHASP to be administered separately. This was the case for the rollout of the STI clinic infrastructure. The rollout of STI clinics commenced during the 'Foundation Project': the predecessor of NHASP. During the Foundation Project 12 STI clinics were established or significantly upgraded and many more were planned. During the 5 year period of NHASP no new clinics were

opened although design and tendering progressed and additional clinics were to be constructed in the near future. The team found that NHASP helped develop clinical services for the walking well, although much less progress was made for people with clinical illness or requiring terminal care. The team believed that the ongoing reliance on 'syndromic management' was not ideal and needed to be reviewed.

### DETAILED FINDINGS

#### RELEVANCE

The control of sexually transmitted infections (STI) is a fundamental element of the HIV response. Well developed, basic, STI services can provide sorely needed clinical leadership in: counselling, prevention, health promotion, testing, screening, HIV monitoring, ambulatory care, clinical outreach, clinical support, public health and professional development. As such, STI clinics constitute a strong focal

point for HIV initiatives in the community and are a key professional counterpart to community-based and NGO HIV activities. STI services also provide a bridge between hospital, community and home-based care and act as a valuable resource for clinicians who are generally ill-equipped to manage sexual health problems. The objective of this component was highly relevant to achieving an effective response to HIV in PNG.

## EFFICIENCY & EFFECTIVENESS

### Context, Infrastructure, Skills Base and Training

Significant achievements facilitated by the Sexual Health Adviser included: capacity building with the Curriculum Unit of the HR Branch of NDoH; the upgrade of curricular materials in sexual health, STI, HIV, AIDS for pre-service health worker training; training of pre-service trainers from all the health worker training institutions in PNG in the areas of sexual health, STIs, HIV, AIDS and counselling; the capacity building and training of NDoH staff from the Family Health Unit; and involvement in the training run by Elisabeth Reid's group for clinical care teams from the Catholic Health Services.

There were severe sector-wide limitations to providing STI and HIV-related diagnosis and treatments in PNG. The reasons for these limitations included, but were not confined to:

- > The separation of the PNG response to HIV from the service delivery role of the Health Department. This separation was detectable all the way from the National level through to the provincial and

service delivery levels, with the exception of diagnosis and treatment of STI and HIV. Capacity was slowly improving in these areas.

- > Weaknesses in government and non-government services in terms of basic treatments and investigations for people with HIV-related illness.
- > The general lack of capacity of VCT centres to provide for anything but the most basic of clinical needs.
- > The almost complete absence of basic STI diagnostics, opportunistic infection diagnostics and HIV monitoring, including CD4 cell counts.
- > Limited resources (such as consumables, rubber gloves, masks, sterile needles and syringes, sterilisers) to ensure a consistent working system of Universal Infection Control Precautions.
- > Problems with the reliable supply of basic drugs, including Amoxicillin and Cotrimoxazole.
- > Logistical difficulties in providing outreach, treatment supplies, 'cool chains' and specimen transport in a difficult environment

At a national level, it did not seem that the Health Department (among other Government Departments) had yet found its role in HIV. Although the epidemic has been underway for the better part of a quarter of a century the PNG Department of Health did not appear to see HIV as 'core business'; did not seem to have integrated HIV into all areas of its activities; and did not have a Department of Health HIV Strategic Plan. While these issues were not directly relevant

to the evaluation of NHASP, they were indirectly relevant:

- > It was not clear that NHASP did enough to stimulate and support the development of a response by the Health Department, given that NHASP was intended to support the development of multiple sectoral responses;
- > The shortfall in the response of the PNG Department of Health affected the ability of NHASP to deliver outcomes; and
- > Weak counterparts have significant implications for future support programs.

Other Australian programs could have made a stronger contribution to developing the Department of Health's capacity to respond to HIV. For example, the AusAID-funded Health Sector Support Program (HSSP) Advisers were well placed to assist PNG's response to HIV as a 'mainstreamed' part of their duties. That this was not the situation reflected that HIV in PNG was not mainstreamed even by the nation's Health Department.

There are difficulties involved in stimulating government departments to respond to HIV, but as this was one of the original intentions of the project it had to be evaluated accordingly. However, it was notable that the Department of Health created a disease control branch, although it appeared to be severely under-staffed; and that NHASP advisers were co-located with their counterparts in the Health Department. As noted elsewhere, problems with counterparts seem to have been compounded by 'public sector reforms' in the early 2000s.

### **Clinical Management for the walking well: STI Clinics and VCT**

A strategy that has considerable potential to contribute to HIV control in PNG is the Australian-funded rollout of new and upgraded STI clinics in all provinces. As noted earlier, this strategy was initiated under the 'Foundation Project', the Australian-funded predecessor of NHASP. At the completion of the 'Foundation Project', 12 STI clinics had been completed and the team understands that evaluations of these clinics were highly favourable. However, while further work on this rollout was originally planned for NHASP, this role was subsequently moved to come under the Health Sector Improvement Program (HSIP) where it was subject to the PNG Government tendering system. No new clinics were opened during the life of NHASP, in part because these clinics were not linked to an identified health priority under the PNG Medium Term Development Plan.

NHASP directed considerable resources into training clinicians to work more effectively with STI. As noted elsewhere, the strategy relies heavily on 'syndromic management'. This approach was understandable and the training provided by NHASP was commendable. However, there are important public health limitations to syndromic management which are relevant to PNG: these limit the utility of relying on VCT and 'syndromic management' in PNG in the future.

The shortcomings with syndromic management can be summarised as follows:

- > Syndromic management directs the focus to people with symptoms. This can intensify stigma and lead to a false sense of security by implying that STI are managed adequately if infections with classic symptoms are treated.
- > Syndromic management misses asymptomatic infections. All STI share the ability to cause infections in the absence of symptoms, and many important STI do so during substantial periods of their natural history and in substantial proportions of those infected.
- > Asymptomatic STI continue to be transmissible and contribute to 'epidemiological synergy'. Epidemiological synergy is the amplified risk of HIV transmission to, and from, a person with an STI.

The lack of a strategy to address the asymptomatic pool of STI constitutes a major weakness in the public health response to STI and HIV.

The rollout of VCT centres with the support of NHASP, the extensive delivery of clinical training programs, and the standardisation and promulgation of clinical protocols, have made important contributions to the clinical care of the 'walking well' and people with symptomatic STI, and were one of NHASP's strengths. However, significant gaps remained. These included: moving beyond syndromic management; improving infection control training and logistics; systematic management of HIV in pregnancy and antenatal care; and deployment of post-exposure prophylaxis.

### **Clinical Management: care for the sick and dying**

The project funded the only hospice service in PNG and was rapidly developing Home Based Care (ongoing research, hygiene kits and training) which addresses the reality of dying in PNG, mostly at home rather than in a hospital. However, reaching minimal standards of care for people with HIV-related illness was a major weakness in the capacity of PNG to respond to HIV, and the evaluation team repeatedly found evidence that care for the sick and dying did not receive sufficient priority. This deficiency reflected nationwide problems and was not solely attributable to NHASP. However, the team would have liked to have seen greater leadership from NHASP and an attempt to articulate a vision for care in PNG that went beyond working within the *status quo*, a near-total reliance on counselling, and 'syndromic management' and services for the walking well.

NHASP took some important initiatives to address the difficulties of people working with clinical illness in PNG. In particular, in an attempt to respond to the needs of people with AIDS for care in home and community settings, Provincial Counselling/Care Coordinators (PCC) posts were created in most PACs, and were given the responsibility of coordinating the development of home based care services in their respective provinces. In addition, NHASP convened home care workshops in August 2003 and April 2004 and organised and funded a study tour to South Africa, Zambia, Kenya, Uganda and Senegal in November 2003 for 9 key stakeholders to examine home care experiences (NHASP 2004b).

There were very few options for care for people with complicated disease and for palliation in the terminal phases. In Port Moresby, there were pressures on the Port Moresby General Hospital and extreme pressures on people with advanced illness, including finding money for basic needs like food and bus fares to attend clinics. The lack of realisation of the full vision for the National Centre for Sexual Health in the grounds of the Port Moresby General Hospital compromised the development of ambulatory care services in the National Capital District, a site of significant growth in HIV clinical illness and of significant overlap between poverty and risk. The team commended NHASP for supporting the development and free distribution of home-based care kits by Appropriate Technology Projects from 2002 onwards.

Quality care for people with HIV was also compromised by a weak diagnostic base. The lack of STI and opportunistic infection diagnostics and HIV monitoring facilities (including CD4 counts) adversely affected: the management of infections that are linked to 'epidemiological synergy'; the prevention and treatment of intercurrent infections; and the introduction of anti-retrovirals.

These weaknesses in clinical services occurred in an environment with growing numbers of people requiring ambulatory care and with clinical illnesses, not least in the Capital, and the advent of the Global Fund on AIDS, Malaria & TB and the 3 x 5 program. Both of these programs are designed to facilitate/fund access of people to anti-virals in development settings. NHASP has provided support for HIV medicine and ARV training in partnership

with the Australian Society for HIV Medicine (ASHM). However, evaluations of the courses suggested that there were severe limitations to being able to implement what was learned in PNG, apart from at the Port Moresby General Hospital where there were about 184 people on ARV treatments.

### **Diagnostics & Laboratory Services**

Weaknesses in laboratory facilities for the monitoring of HIV infection and the definitive diagnosis of opportunistic infections and STI, means that heavy reliance is placed on 'syndromic management' of STI at all stages of illness. The result is that clinicians in PNG generally find themselves 'flying blind' when they are managing scenarios where diagnostics would be particularly useful: namely (1) highly complicated AIDS-related presentations; (2) managing ARV treatments; and (3) asymptomatic infections.

NHASP procured test kits for syphilis screening and confirmation, test kits for HIV screening and confirmation, plus the associated consumables. Improvements were largely limited to streamlining and consolidating existing approaches rather than introducing a wider range of basic tests. NHASP supported a laboratory advisor for the first couple of years of the project and subsequently provided some funding for diagnostic kits, and basic reagents and consumables. The streamlining of testing benefited HIV and STI surveillance and NHASP initiatives led to the expansion of 'passive' surveillance for AIDS as well as active surveillance through 22 sentinel surveillance sites in 13 provinces. NASHP also funded a laboratory scientist and a

data manager based at the Port Moresby STI Clinic.

As already noted, diagnosis of STI was usually clinical, sometimes supplemented with microscopy if available. Rapid, on-the-spot testing for HIV has been introduced at key VCT sites. Positive rapid screens are subsequently confirmed by a combination of EIA tests done at a central laboratory. Until recently, confirmation was available only at the Central Public Health Laboratory (CPHL) at the Port Moresby General Hospital. However, with the assistance of NHASP, confirmatory testing was extended to Lae, Mt Hagen and was soon to be available in Rabaul. In addition, turn-around times for HIV confirmation were reduced from weeks to days as a result of the initiatives taken by NACS/NHASP. NACS/NHASP also took a lead in ensuring that the rollout of HIV testing was done with due attention to accreditation and quality-control.

Syphilis serology is available fairly widely, generally using VDRL or RPR. There were discussions about introducing rapid syphilis testing in a similar way to HIV. The team agreed that this should be pursued and noted that protocols for the interpretation of syphilis serology will need to accommodate this development (interpreting syphilis serology is known to be tricky).

Gonococcal sensitivity monitoring is not routine in PNG. Instead, periodic surveys are undertaken in 4 key clinics to confirm the best antibiotics to be used as first line treatment in syndromic management. These gonococcal sensitivity studies conducted by IMR were funded by NHASP. Ironically, the chronic shortage of basic drugs probably

helped to keep the gonococcus sensitive to traditional agents in PNG. The IMR is the designated WHO gonococcal sensitivity monitoring lab in the country.

### **The role of faith-based organisations**

HIV poses major challenges for any faith-based organisation. Not least of these are the moral prevention issues, particularly whether or not abstinence should be the only prevention method sanctioned or whether the use of condoms should also be promoted. The PNG Churches have a significant role to play in helping PNG to cope with the HIV epidemic. In particular, churches provide around 60% of health care services in the country and are well placed to provide compassionate care for people who are sick and dying. A key distinction exists between the approaches of the major denominations in HIV prevention: the Catholic Church officially remains opposed to the use of condoms for HIV prevention, while the other major denominations are more open to promoting condoms where necessary. Evidence from elsewhere in the world, and the advice of UNAIDS, is that the use of condoms is one of several valuable and effective tools available to stem the epidemic. Therefore, an approach that does not give a balanced view of condoms runs the risk of denying vulnerable populations life saving measures. (The team also noted that to deny persons access to the full range of options for HIV prevention is probably illegal under the HAMP Act.)

The theological position taken by the Catholic Church is unlikely to change in the foreseeable future. This has implications for effective prevention of HIV in PNG which

need to be taken into account in future programs. The following might provide a way forward on this issue:

- > Catholic support should focus on areas that the church traditionally does well: in particular there is a growing gap in PNG in care for the sick and dying.
- > VCT centres are considered premiere sites for prevention education, and given the dilemma that some churches have with prevention, funding agencies should revisit support for the rollout of VCT centres run by certain church organisations.
- > Where church organisations are involved in VCT they should be partnered with organisations that take a more inclusive approach to prevention.

### **Extending clinical models and the future of HIV care in PNG**

A recurring theme in the interviews conducted by the evaluation team was the serious deficit in the capacity to provide clinical care for people with HIV in PNG, and that the current national HIV strategy and donor support have a notable deficit in addressing clinical issues. This prompted the evaluation team to explore alternative clinical models that might be feasible in the PNG context. What lies beyond the current approach to VCT? Can outreach and ambulatory care be readily enhanced in PNG? These considerations seemed particularly relevant given that there is a pressing need to provide clinical support for home care providers and non-clinical VCT sites. In addition, the roll-out of antiviral drugs was imminent at the time of the

evaluation, although access to antivirals was restricted, for all practical purposes, to Port Moresby (there was limited access in Lae) despite there being a national epidemic. Enhancing existing clinical services, including ambulatory and home-based care, which was a stated aim of the NHASP project, is an appropriate development role for major donors.

A *de facto* model for ambulatory care had already been trialled during the NHASP-funded STI epidemiology research conducted by the PNG IMR. This research commenced with visits by a team to various provincial sites to offer counselling and testing for various STI including HIV. Specimens were transported back to the IMR for multiplex PCR and serology analysis and the team then returned to the sites several weeks later to provide results to participants and to treat infections. This research contained costings that could guide planning for similar activities conducted on a service basis. (For further details on potential models see Appendix 7.1.)

### **IMPACT**

NHASP had key impacts on STI care in PNG: training was provided for health workers at all levels, including surveillance, anti-viral prescribing, and syndromic management.

However, the positive benefits of the NHASP activities were mitigated by: growing weaknesses in PNG clinical facilities; removal of responsibility for the rollout of STI clinics from NHASP; excessive reliance on 'syndromic management'; and, while HIV testing was refined and streamlined, no new tests for STI were introduced.

Greater impact would have been achieved if there had been more progress on:

- > the rollout of STI clinics (including the use of these as the basis for HIV ambulatory care and to develop the clinical infrastructure to support GFATM rollout of anti-virals);
- > the development of a strategy to move beyond 'syndromic management' for STI; and
- > the establishment of the National Reference Centre for Sexual Health.

## SUSTAINABILITY

Reliance on syndromic management and a limited number of STI clinics is 'sustainable'. However, significant improvements in HIV control will require that the more difficult option is taken to substantially enhance the STI clinic/ ambulatory care infrastructure. While the shift of the STI clinic rollout to the HSIP might have made development sense, its delay compromised HIV control. The threat to PNG posed by the HIV epidemic is such that priority should be given to enhancing the STI clinic and clinical support infrastructure in the short and medium term, regardless of longer term sustainability considerations.

## RATINGS

<b>Component 5</b>	<b>Rating 3</b>	There has been training on syndromic management but there has been a failure to move beyond it.
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# 8 Management Support for the National Response

## (NHASP COMPONENT 6)

**Component 6 Objective:** To strengthen the capacity of the NACS to coordinate multi-sectoral planning and implementation of the MTP and to monitor and review progress towards its achievement.

**Revised Objective (MTR 2002):** Strengthened capacity of NAC and other program partners to facilitate multi-sectoral planning and implementation of the MTP and to monitor and review progress.

### SUMMARY

While the creation of NHASP as a separate body might have had administrative and accountability advantages for the donor, the evaluation team found the creation of a parallel model (NACS – NHASP) did not always favour the PNG response to HIV.

Analysis of this arrangement suggested that there were tensions in working relationships where one party (NACS) was vested with the political authority while the other (NHASP) exercised considerable financial power. This binary arrangement is not an invariable feature of Australian aid.

The limited development of a multi-sectoral response was an important shortcoming of the Project, and a more strategic and concentrated approach will be required in the future. While acknowledging that many HIV+ people do not declare their status, the evaluation team was concerned about the lack of visibility of people with HIV and the lack of formal involvement of people from high-risk settings and people with HIV, in

the overall PNG response. The involvement of ‘consumers’ is a fundamental way to connect strategies with the epidemic and to keep the strategies relevant, on-track and vital.

### DETAILED FINDINGS

#### RELEVANCE

The PNG HIV Medium Term Plan (Government of Papua New Guinea, 1998) was the guiding document for the PNG response to AIDS. Strengthening the PNG capacity to plan, implement, monitor and review progress towards achieving the aims of the PNG HIV Medium Term Plan was a relevant and highly appropriate role for donor support.

## EFFICIENCY & EFFECTIVENESS

### Supporting a multi-sectoral approach

The evaluation team identified insufficient engagement between NACS and the National Department of Health. While this arrangement was not the primary concern of the present evaluation (it is an internal issue for the Government of PNG), it did affect the capacity of NHASP to support the development of a multi-sectoral approach and compromised the PNG response to AIDS: notably in surveillance, health promotion and clinical care.

Appropriate counterparts frequently were not available. This situation led to disparities between positions and activities in both NACS and NHASP. Some NHASP staff successfully sought out alternative counterpart arrangements, but others were less successful.

Indicators that reflect the achievement of Component 6 include the ratings given to Provincial AIDS Committees (PACs) performance. Provincial Liaison Coordinators (PLC) rate the performance of PACs against certain criteria, using a rating scale of 1-5.7 Over 20% of PACs each quarter (commencing in February 2004) achieved satisfactory ratings. While modest, this level exceeded the target set by the project. The following PACs achieved an average rating of 3 or above over the five quarters commencing February 2004 and ending April 2005: Bougainville, Milne Bay, NCD, Morobe, East Sepik, Madang, Oro, and Western Highlands (Appendix 8.1).

While there was considerable effort to develop the provincial responses through the vehicle of the PACs, NHASP appeared to have 'cut their losses' on the difficult PACs and concentrated on the more successful ones. Where provinces were less prepared and less capable, instead of focussing efforts and resources to address these limitations, resources often seem to have been withheld. There appeared to be a lack of awareness about the adverse ramifications of non-functional infrastructure in PACs offices e.g. phones, email and a limited capacity by NHASP to respond to these critical needs in a timely manner. It was the team's view that NHASP did not fulfil its development role in these circumstances.

### Monitoring and review of the NSP implementation

The main achievements, in addition to the development of the National Strategic Plan (NSP), were the development of an M&E plan linked to the NSP, and the ongoing development of district plans (see below).

NHASP supported development of the NSP M&E Framework. The framework was developed over a two-year period through a series of meetings of the NACS M&E Technical Working Group (which includes two NHASP representatives) chaired by the Director of NACS, with UNAIDS, NHASP and AusAID Post providing technical and budgetary support. A highly consultative process was applied, with participants drawn from PNG Government, multilateral and bilateral donors, and the non-government sector.

7 5: Excellent; 4: Very Good; 3: Satisfactory; 2: Poor; 1: Very Poor; 0: Non-Existent (no HRC or PCC or PACs office operating).

### **Provincial level structures and capacity building activities**

PACs are supported by Provincial Liaison Coordinators. The introduction of PLCs was a valuable initiative under the project. Their role was expanded to include monitoring the implementation of grants, given the limited capacity of PACs to take on this responsibility. Each PLC (when there is full capacity of 4 officers) has five provinces to monitor and support. Given the significance of provincial activity in the national response, and the complexity of the PLCs' roles, the evaluation team considered that there were too few skilled PLCs to undertake this role effectively. The evaluation team recommends that this strategy be reviewed and additional resources used to support the approach, should it be carried over to the next phase of AusAID support.

The assessment of capacity at provincial and lower levels should be improved, to identify which local responses are in need of additional support and what support is required. The HIV epidemic is typically amplified in areas where there is weak infrastructure and less than functional systems, and it is these very areas that should be prioritised rather than penalised if they fail to perform.

### **NACS & PACs financial systems; financial management capacity**

By the end of the project, it was planned that 15 of the 20 provinces would meet minimum standards in annual financial audits. The team was unable to get information to demonstrate achievement of this at the

provincial level, and did not undertake an audit of financial systems either nationally or provincially. It is understood that the NACS had only one audit during the Project (2001). While this did not appear to be sufficient, auditing NACS is primarily an issue for the PNG Government (although it will inevitably be of concern to donors). Feedback to the team was that financial management capacity at the provincial level was frequently limited.

### **HIV/AIDS and STI issues in sectoral and provincial plans**

At the time of the evaluation, all districts in 3 provinces had developed District Strategic Plans, and all districts in 5 provinces were to have developed District Strategic Plans by August 2005. The target by the end of the project is for these plans to be developed in all districts in 10 provinces. However, the impact of these plans appears to have been limited as penetration to the grass roots was proving particularly difficult. To achieve a multi-sectoral response NHASP chose to work through key groups, including youth, provincial women and church leaders. It had also: funded an HIV/AIDS coordinator for the private sector; supported theatre groups; and, more recently, developed a High Risk Setting Strategy (HRSS). The extent to which districts/provinces incorporated STI/HIV into provincial planning was variable. The field visits confirmed wide variation in capacity, motivation, strategic thinking and the availability of necessary skills to undertake planning and implementation.

Mainstreaming of HIV/AIDS and STI into national government departments was variable, and generally disappointing. However, in 2005 the Project provided HIV input into the development of: Department of Justice and the Attorney General Plan; Gender Strategy for Law & Justice; Ombudsman's Department Strategic Plan; Correctional Services Strategic Plan; Magisterial Services Strategic Plans; Police Strategic Plan; and Judiciary Strategic Plans.

Direct benefits from NHASP to the National Department of Education (NDoE) included: training at NDoE's request for curriculum writers and ongoing advice to the curriculum unit; training for school inspectors; and, invited input on HIV and AIDS for NDoE's national education conference 2005. In addition, NHASP was to support the launch of NDoE's policy on World AIDS Day 2005 and it supplied all schools in PNG (9,000) with HIV educational resources and all teachers' college libraries with electronic mini-libraries. NHASP and NACS were the only non-education representatives invited on to the NDoE National HIV Policy Group. Through its representation on the NAC and participation in forums, NDoE has indirectly benefited from NHASP. Many of their achievements have been largely attributed to the efforts of UNICEF and UNDP. Other efforts seem to have been largely attributable to the efforts of senior staff, UNICEF and UNDP, more so than NHASP.

Correctional Services showed the evaluation team their 2001 HIV/AIDS and Other Infectious Diseases Strategy, but there was no reference to inclusion of HIV in their 2005 Strategic Plan (see above).

Consultations with the team suggested that, even at the level of senior management, thinking and knowledge was minimal, and some officers expressed attitudes which were of concern to the team. Field trips confirmed these observations: while some top-level personnel had been exposed to HIV-related information and policies, this had had variable (if any) impact further down the ranks.

NHASP has been instrumental in supporting, educating and involving the Minister for Community Development in HIV. She has become a significant advocate for HIV in parliament and in the community. However, hers is an extremely under-resourced Department. NHASP worked with the Women's Division of the Department on HIV policies, and more recently with Youth in the development of a Youth Policy, although (at the time of the evaluation) NHASP was unaware of the status of the Youth Policy. Personal interactions by NHASP with some staff in Community Development saw improvements, but at an organisational level progress was slow, and only recently had the Department appointed an HIV Adviser, who was neither very senior nor very expert in HIV/AIDS.

A Sectoral Response Advisory Committee, formed in 2003, was chaired by the Planning Department. While it was scheduled to meet on a quarterly basis, the last meeting was in December 2004. This committee did not appear to function well, and there was no NAC counterpart to the NHASP Adviser with responsibility to support these activities. NHASP had developed a counterpart

arrangement with people in the Department of National Planning.

The Project acknowledged that it had difficulty engendering genuine interest from other departments to make HIV part of their core business, and continued to examine how this could be better achieved. It was thought important that HIV/AIDS components of Strategic Plans were reflected in Action Plans and that NACS had a strategy for monitoring the implementation of these in the different sectors.

#### **Technical support and resources for the HRSS**

The High Risk Setting Strategy (HRSS) was implemented only shortly before the evaluation (Appendix 3.6). The Project set a target of 75% of 30 HRSS pilot sites to be fully implementing their work plans by the end of the project. At the time of the evaluation, this had not been achieved for any site. However, it was expected that, by mid-July, 12 of the 30 sites would be implementing these work plans, and that at least 24 sites would have completed these work plans by mid-October 2005. As of mid-July, it was considered that the roll-out of the pilot was on track. Twenty-one of the proposed 30 sites had undertaken qualitative data collection. The quantitative baseline survey was only then being designed, to be field tested in August, with plans to roll out in September 2005. While the team considers the HRSS to be a commendable initiative, it is of the view that this strategy was introduced far too late in the project.

Social Mapping was undertaken in 19 of the 20 provinces. Results were yielding extremely useful information to guide provincial and district initiatives. This has been probably one of the key successful NHASP activities. While this activity was initially intended for district strategic planning; it became a database for all donors and others interested in developing programs. While not site specific, the same methodology was to be applied to HRSS. The extent of engagement and capacity building within this activity appears to have been significant. At least one PAC representative had been involved in each Social Mapping training unit.

#### **IMPACT**

The impact of NHASP support was mitigated by shortfalls in funding and availability of counterparts from the PNG Government. The emerging HIV epidemic created pressure on NHASP to compensate for GoPNG shortfalls and to directly provide services. While this achieved short-term impacts, it is not possible to predict any longer term benefits. In the short term, a certain level of commitment and mobilisation of government, NGOs and communities has occurred, but this will need to be sustained and strengthened if there is to be a significant impact on the progression of the epidemic.

## SUSTAINABILITY

Sustainability of the benefits and outcomes of this component, like impact, was largely determined by a lack of sufficient funding and counterpart personnel. While HIV seems to have recently been elevated as a funding and political priority for the PNG Government, it is likely that the capacity of NACS to have an impact on the HIV epidemic will remain dependent on donor support for some time.

## RATINGS

<b>Component 6</b>	<b>Rating 3</b>	There has been extensive support for NACS; however the lack of counterparts has undermined benefit. There has been significant progress in leadership and profile of HIV in PNG.
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# 9 Cross Component Support & Project Management

## (NHASP COMPONENT 7)

**Component 7 Objective (added after the MTR 2002):** Effective implementation of cross-component activities and efficient project management.

### SUMMARY

Planning for internal management issues was a weakness of the original project design, which was preoccupied with responding to and mirroring the components of the PNG HIV/AIDS Medium Term Plan. Teething difficulties with the project meant that some key initiatives were slow to be implemented (for example the late introduction of the HRSS; delays in streamlining the grants program (NHASP 2003c); and late implementation of internal monitoring and evaluation (NHASP 2004a)). Project management was also influenced by counterparting and external capacity problems. At the time of the evaluation, NHASP was staffed by a strong and cohesive team. This team ethos enabled effective internal interchange and integration between components.

While the grants program had significantly improved since 2003 (NHASP 2003c), insufficient attention had been given to working with applicants to prepare and submit applications, and to providing

support and follow up (including not acknowledging receipt of applications). Timely processing of applications appeared to have improved. While the grants database was being enhanced, it was the team's view that these improvements were late in the project, and would be finalised at a time when the enhancements would be of limited assistance for planning and monitoring. Nevertheless, the team considered that the NHASP Research and Project Grants Systems were excellent initiatives and, after refining and streamlining the administrative arrangements, should be a feature of future support.

Monitoring and evaluation are important aspects of all programs, not least for a program as complex as NHASP. NHASP invested considerable time and resources into monitoring, evaluating and auditing recipients of NHASP support. Paradoxically, reflexive monitoring and evaluation of NHASP was not as systematic until late in the program. This appeared to have been a weakness in project design.

## DETAILED FINDINGS

### RELEVANCE

Component 7 was introduced as a consequence of the mid term review of NHASP. Prior to that, NHASP suffered from administrative problems and there were several changes of core personnel. The introduction of a component specifically focussing on internal management issues was needed and therefore relevant to achieving the goals of Australian support. The absence of such a component prior to this was a weakness of the project design.

### EFFICIENCY & EFFECTIVENESS

#### Integration of project activities

A number of factors contributed to ensuring that project activities were integrated. These included monthly combined staff meetings, monthly provincial meetings, and monthly seminars that brought all NACS/NHASP advisers together to discuss cross-cutting issues. These meetings covered a range of topics, promoted discussion and dialogue, and contributed to provincial action. Project Coordination Group (PCG) meetings were held every 6 months, and there were Quarterly Management Meetings.

There was general NHASP team cohesion, and integration and active exchange between project components and activities. The High Risk Settings strategy worked within all components. Component One assisted other components with the pre-testing and development of materials. VCT was being collaboratively developed with Components Two, Four and Five and all Components cooperated in the delivery of training programs to a diverse range of participants.

#### Activity and non-research grant funds management

The grants program underpinned the national response and was the principal mechanism to support HIV/AIDS activities at the provincial and grassroots level (Appendices 9.1 and 9.2). The grants mechanism offered considerable capacity for flexible, responsive approaches to a dynamic and complex epidemic. The team considered this to be a very significant element of the project.

The **grants scheme** was slow to start, and seems to have operated with rudimentary management systems for the first few years. Midway through the project, the program was reviewed and areas for improvement were identified (NHASP 2003c). Additional Project staff were hired to manage the program. Achievements since that time included:

- > An improved grant application handbook;
- > Revised grant application guidelines requiring applicants to better demonstrate that they can manage a grant;
- > Improved grants approval process;
- > Development of templates for letters, evaluation, monitoring, and acquittals;
- > Strong financial oversight;
- > Development of a database for recording successful grants;
- > Workshops for writing applications, and
- > Monitoring of provincial grants by PLCs.

There was a significant increase in **activity** grant approvals, with 144 approved between April 2004 and July 2005. This exceeded the target set by the project. Of the grants approved since April 2004 that have been reviewed, 84% met their objectives, although the team was unable to evaluate the quality of this information. Fifty two percent of the total in that period were visited and reviewed. The other 48% were monitored by reviewing project documents and reports. This has exceeded targets set by the Project.

**Activity and research** guidelines were reviewed throughout the life of the project. The latest revision was in April 2004. The team considered that these guidelines were still too complex, and were not presented well. Guidelines were only available in English; pidgin translations were urgently needed; layout was sub-optimal; Figure 1 (not labelled) was confusing; and both types of grants information (activity and research) were included in both guidelines, rather than there being separate specific guidelines for each stream.

There was a lack of clarity about the grant application and submission process. While the application guidelines indicated that applications should be sent directly to the NHASP Grants Administrator, the team was told on other occasions that grants should be submitted to local PACs. These instructions were not in the guidelines. The team learnt that grants were accepted both via PACs and directly to NHASP, but clarification was required.

The evaluation team's provincial consultations highlighted problems in the management of applications through

PACs offices. A number of interviewees (eg. in Western Province and Western Highlands) indicated that applications had been submitted to PACs, but no response had ever been received from NHASP. The team concluded that in at least some instances these applications were not reaching the NHASP Grants Manager or grants committees.

Frustration with the grants process was notable during interviews. Interest in the grants was likely to wane unless systems and procedures were further streamlined and additional support instituted. The result of an audit by the team confirmed that more than 70% of the applications that were received by NHASP were not acknowledged. At least some HRCs were not providing financial reports on grants to the PAC (e.g. Daru) as guidelines required.

While grant application workshops were provided, the team received feedback during provincial visits that this training had not resolved people's confusion. The situation was problematic if people who had been trained were then expected to assist less informed applicants to submit proposals. More systematic follow up was required to evaluate the effectiveness of the training activity and to identify problems.

Workshops were undertaken at the provincial level to determine that priorities for the province were being addressed through the grants activities. Monitoring of this activity could have been strengthened through enhancements to the grants database. For example, a data field for "sector" being addressed by the project could have been included in the database, so that

the system could automatically generate reports that indicate the extent of coverage of these areas. While no written brief to the AMC for database enhancements was available, the evaluation team trusted that improvements and streamlining undertaken by the AMC would ensure that reports could be automatically generated by province and priority area to enable quick assessment that priorities were being addressed in all provinces.

The evaluation team noted that grant tracking and accountability mechanisms could be strengthened. An enhanced database system could: improve efficiency; streamline some activities, while still maintaining the integrity of the system; improve grant tracking and accountability; and support better strategic reporting on coverage (geographic, priority areas). Work to be undertaken by the AMC needed to incorporate these elements into the enhancements being made to the system.

Some evaluation team interviews in the provinces highlighted concerns about the extent of the monitoring and reporting on technical and financial use of grant funds, and certainty that grant money was being used for the purposes originally stated in proposals. PLCs had been given responsibility for monitoring grant activities, but the team was unable to ascertain how well this was being done, and were concerned that PLCs were already over-committed. The team did not do a financial audit of the grants system but noted the capacity of the NHASP financial manager to investigate suspected misappropriation of funds.

### **Research grants support**

The principal mechanism for NHASP to support HIV-related research in PNG was through the NAC/NHASP **Research Grants Program** (Appendix 9.3). This program provided for both commissioned and independent research. Since early April 2004, 16 research grants had been approved and funded. The target for that period was 12. Evaluation of grant outcomes was part of the reporting requirements for research grants. The evaluation team was informed that assessment of outcomes would continue to be monitored by the research advisory committee.

PNG has a small health and social science research base, which complicates the assessment and awarding of grants. In particular, there were potential problems with conflict of interest because of the close linkages between applicants and assessors.

While the research grants system produced important research results, the team considered that the system had not maximised its development potential. In particular: the research skills base remained largely confined to limited players; fostering new researchers was not a strong feature of the program; and there had been insufficient development of collaborations outside of PNG. The team recommended that stronger partnering with Australia's National HIV Research System should be pursued.

### **Monitoring and evaluation of programs and grants**

Monitoring and evaluation are important aspects of all programs, especially complex programs such as NHASP. NHASP invested considerable time and resources into monitoring, evaluating and auditing recipients of NHASP support. NHASP showed a willingness to take action where recipients were considered to be underperforming or where funding did not appear to be used in the ways that were intended. These actions included rectifying strategies, freezing further payments and repossessing assets.

Given the limited skills-base of many of the recipients of NHASP support, which included small NGOs and provincial authorities, difficulties with meeting the terms of agreement for NHASP support constituted a risk that was predictable. NHASP was often left in the position of having to take a punitive approach once difficulties were well established. A more proactive, systematic approach to supporting recipients might have included enhanced training on accountability mechanisms, and frequent, close, proactive support from an enhanced team of Liaison Officers. These officers could implement and acquit monitoring, evaluation and accountability for each recipient. There are clear cost implications of this recommendation for future programs but there are also development benefits.

### **Monitoring and evaluation of NHASP**

Internal monitoring and evaluation of NHASP was not as systematic as that applied to the recipients of NHASP funding. This weakness did not appear to have been fully addressed until late in the project (NHASP 2004a). A monitoring and evaluation (M&E) framework was developed midway through the project and its development was an iterative process. The M&E framework was not published until January 2004. Detailed monitoring and evaluation reports were submitted on at least 2 occasions during the project. The team notes certain limitations in some reporting areas due to the use of imprecise language or failure to address the evaluation objective. At the time of the evaluation a short-term advisor for M&E was updating the matrix, and had identified that many indicators were on target, or had been exceeded. The team also recognized the important contribution of 'mini evaluations', with some completed and others planned at the time of the evaluation.

A risk in the M&E framework was that its focus on targets may have been at the expense of qualitative assessments and process evaluations. The team noted that *process* was fundamental to achieving development, while an undue focus on outputs could result in activities that had little development benefit and lacked sustainability (because the outputs could be generated entirely by the contractor). An M&E strategy should have explicit process evaluation/monitoring elements.

The lack of attention to a NHASP M&E framework was a design issue that originated from the original NHASP Project Design Document, primarily because the target components of NHASP related to the components of the PNG HIV/AIDS Medium Term Plan. It was not until the mid-term review that an additional component (Component 7) which focussed on internal management issues was added to the NHASP Design.

**Training impact**

NHASP developed, supported and delivered comprehensive training programs. This training was one of NHASP’s most significant achievements. A training database was established; and training packages developed for over fifteen programs. Courses included basic HIV information, counselling, home-based care, syndromic management of STI, peer education and management. More recently, there were moves to develop certified advanced training in conjunction with external bodies such as TAFE. NHASP also provided support for the development

of minimum standards, guidelines and accreditation procedures for counselling and for VCT. These developments were welcomed by the evaluation team.

There is room for improvement. With some exceptions, follow-up, professional support, continuing education, supervision, involvement of people with HIV, and assistance with implementing training were not adequate. Field trips confirmed that follow up and support of trainees was not a strong feature of the NHASP approach, and the team recommended improvements. Many training packages were not yet available in pidgin, and it was suggested that this be addressed.

**IMPACT AND SUSTAINABILITY**

The introduction of Component 7 to address the internal management of NHASP appears to have led to improvements in NHASP functioning and impacts. As this component was principally designed to improve the operations of the project, there was no requirement for an impact of this component beyond the life of the project.

**RATINGS**

<b>Component 7</b>	<b>Rating 3</b>	Several excellent initiatives and refinements emerged late in the NHASP project.
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# Conclusions, lessons learned and recommendations

This section summarises the overarching outcomes of the evaluation. The lenses of evaluation are: relevance, efficiency, effectiveness, impact, sustainability and lessons learned.

In brief, the subject of the evaluation, NHASP, was a large, ambitious, complex project with many successes to its credit. There are also lessons to be learned and recommendations that flow from the evaluation.

## EVALUATION CONCLUSIONS

### RELEVANCE

NHASP's provision of technical assistance and financial support for the PNG AIDS response, by supporting each key component of the HIV/AIDS Medium Term Plan, was appropriate and highly relevant. The PNG HIV/AIDS Medium Term Plan represents the aspirations and aims of the people and Government of Papua New Guinea and the support of that plan represents a textbook approach to development assistance. The evaluation team found that the principles underpinning the NHASP strategy were well founded and that NHASP provided a mechanism to direct considerable amounts

of funding into key national initiatives. However, this approach had two main limitations:

- > NACS did not receive the support that was originally envisioned through national government mechanisms and imbalances in counterparts and implementation capacity emerged. As a consequence, NHASP moved from its original support and development role to become increasingly implementation and outputs oriented.
- > The relevance of the NHASP strategy was compromised by geographic distance and skills deficiencies in regional PNG. The further away from Port Moresby, the less immediate NHASP and the national mechanisms became. The decline in relevance and accessibility was amplified by the poor quality of leadership, technical expertise, skills-base and financial capacity of communities in the provinces and villages.

To be more widely relevant, future strategies should aim for much greater grassroots, consumer and rural impact.

## EFFICIENCY

The goal of efficiently rolling-out a single, complex, multi-million dollar project to achieve an urgent and effective response, was optimistic. Even in the presence of the best plans, efficient implementation is dependent on individual personalities, power politics and the coordinated response of disparate bureaucratic elements. These elements patently affected the efficiency of NHASP implementation. Teething and personality problems delayed project start-up and it required a mid-term review to address key internal management issues.

The evaluation team found a cohesive NHASP staff team, but many important goals and outputs appeared to be just coming to fruition late in the project. NHASP had difficulties with support and development roles and was much more effective as an implementation body. Widespread difficulties in PNG with accountability, skills deficits, distance and isolation, and insufficient staff for support, monitoring and evaluation, made the deployment of resources less efficient. A more discrete, autonomous modular approach with good communication but little inter-dependence might have made for a more efficient deployment of resources. While there was pressure to cap the NHASP bureaucracy, and the evaluation team endorsed the need to limit the development of 'top heavy' administration, greater administrative support further down the line would have improved efficiency if it

strengthened financial management and implementation capacity at the provincial, village and grassroots levels.

## EFFECTIVENESS

Not surprisingly, some NHASP activities were more effective than others. The dissemination of a wide range of materials and extensive social marketing was highly visible and effective in raising community awareness and the profile of HIV in PNG. What was less clear, in part because of a lack of available data, was the extent of development of protective behaviour.

Devising and delivering a wide range of HIV-related training and courses was also a prominent achievement of NHASP. The quality of training, its impact and the extent of ongoing support for graduates of these programs could not be assessed.

The eventual organization of the research and project grants schemes was considered to be effective on the whole, but would have benefited from a greater investment in administration and support.

The establishment and activities of the NACS/NHASP resources centre was also a prominent achievement.

Among the least effective of the NHASP activities were: the dissemination of information, resources and support for activities to the district and village levels; mobilisation of key government departments to play their core role in HIV; involvement of people with HIV at all levels; and reduction of HIV-related stigma to ensure an effective response.

## IMPACT

Impact is difficult to assess close to the end of a project. By definition, impact refers to the long term effects of the project. However, the team noted certain changes likely to promote beneficial impacts, for example:

- > Law reforms have set the agenda for approaching HIV in PNG;
- > Progress with the role of faith-based organizations is encouraging; and
- > Leadership initiatives by NACS, NHASP and UNDP appear to have shifted the PNG culture.

Challenges remaining to the achievement of beneficial impacts include:

- > The failure of key government departments to take up HIV as core business and to fully incorporate it into their mainstream activities;
- > Deeply entrenched stigma (and the fear it engenders) which will continue to undermine progress in HIV programs;
- > The failure to fully include people with HIV at all levels of advice, policy and service development, which means that programs will continue to risk being out of touch with the epidemic;
- > Weak financial management and skills-bases at provincial, district and grassroots levels; and
- > Limitations to the upgrading and development of health services, including an inability to provide the most basic care for people with HIV-related clinical illness across most of the country.

## SUSTAINABILITY

The sustainability of benefits is almost a moot point. PNG has many limitations to its capacity to control HIV, and strong donor inputs will be required for the foreseeable future. The evaluation team identified key issues of sustainability, including

- > HIV is a long term threat to the people of Papua New Guinea and programs must be maintained and further developed;
- > Ninety percent of funding for the PNG response to HIV/AIDS originates from international donors and this is likely to continue even if PNG increases its own contributions;
- > Behaviour change and stigma reduction must be given higher priority;
- > Mobilising government departments to 'mainstream' HIV into their activities is fundamental to sustainability, but is not yet adequate;
- > There is a considerable deficit in the dissemination of information, funding and activities to the district and village level; and
- > People with HIV are not yet integrated into the response to HIV in PNG, and this lends an air of unreality and lack of urgency to HIV. The involvement of people from high risk settings and people with HIV will go a long way towards invigorating the response.

## COST EFFECTIVENESS

A comprehensive cost-effectiveness study of a complex and expensive program like NHASP was beyond the capacity, expertise, resources and time-frame of the present evaluation. Nevertheless, the team offered the following observations on cost-effectiveness. In addition, details about the potential economic impacts of the HIV epidemic in PNG are available in the publication by the Centre for International Economics (2002).

The priority for any HIV program, not least for a rapidly evolving epidemic such as that in PNG, is prevention of infection. Approximately 39% of the total NHASP budget was allocated for 'Education, Information, Advocacy and Behaviour Change'. However, during the lifetime of NHASP, HIV infection progressed and PNG became the fourth country in the Asia Pacific region to be classified as having a generalized HIV epidemic. While there is evidence that awareness of HIV is high in PNG, some of which is attributable to NHASP activities, NHASP social marketing baseline surveys suggest that some of this awareness preceded and occurred independently of NHASP. Moreover, there is no conclusive evidence that there has been a widespread protective behaviour change in PNG. This is partly because of weaknesses in behavioural surveillance, but the progression of the epidemic suggests that behaviour change has been insufficient and there are significant reservations about the cost-effectiveness of this component.

With the progression of the epidemic come clinical developments and a growth in the number of people with clinical illnesses requiring care. Just over 29% of NHASP funding was allocated for clinical and laboratory development, making this the second largest NHASP component. Nevertheless, the evaluation team identified a significant ongoing deficit in the development of clinical services for people with HIV in PNG. While the deficit is multi-dimensional and multi-factorial, a key issue is that it leaves PNG with poor capacity to take advantage of diagnostic and treatment advances, such as the rollout of anti-viral drugs by the Global Fund on AIDS, TB and Malaria and the WHO. It also leaves people with HIV disadvantaged as their illness progresses. Moreover, while the public health/preventative importance of the phenomenon known as 'epidemiological synergy' has been known for many years (Wasserheit, 1992), the failure to move beyond 'syndromic management', or to roll out any additional STI clinics in PNG, during the NHASP period, has been a significant weakness of the joint Australian/PNG response. The evaluation team noted that this outcome does not appear to be the result of NHASP activities (or lack thereof) but is the result of policy and program changes within AusAID and between AusAID and the PNG Government.

The development of the High Risk Setting Strategy in the latter stages of the project was recognised by the team as potentially extremely valuable. Focussing and intensifying prevention activities in high risk settings is likely to be both effective and cost effective.

The lack of formal involvement of people with, and people at risk of contracting, HIV at all levels of the response to the epidemic leads to a separation of the response from the epidemic. Such a situation risks disenfranchising potentially important participants, isolates the response from the epidemic, and reduces the sense of immediacy and urgency in the response. The team believes that the PNG response to HIV would be more effective and more cost effective if people with HIV, and people from high risk settings, were formally involved at all levels of the response. The grassroots intelligence these people can provide to the response is potentially valuable and should be tapped.

Access to services has emerged in many locations (including in Aboriginal Australia) as a crucial factor in HIV and STI control. The evaluation team noted calls for greater outreach of the response to HIV into rural, isolated and high-risk settings, and the implication of these requests is that access to services and resources in key settings is not adequate. Moreover, previous comments about weaknesses in clinical care add to the picture of poor access. A similar situation was noted for access to project grant funding and the involvement of people at risk of HIV. The team considers that greater cost effectiveness would be achieved if access to services and resources was improved.

## **LESSONS LEARNED AND RECOMMENDATIONS**

### **LESSON 1: THE ROLE OF LEADERSHIP**

Leadership emerged as an important issue for people working at all levels of the PNG response to HIV. The team agrees that leadership at the national level will be crucial for PNG's capacity to respond to HIV. The team acknowledges the work done by UNDP on leadership and HIV in PNG. The team found evidence that leadership at the national level was developed during the life of the NHASP and that NHASP played an important role in supporting many of these developments (most notably in support for the HAMP Act and the Churches Covenant – see Appendix 8.2). Additional evidence of growing momentum and leadership in PNG included the creation of a Parliamentary Committee on HIV/AIDS Advocacy and the decision to move NAC and NACS to the Department of the Prime Minister. There were also examples of good leadership at the provincial level. On the other hand, the team identified a need for a greater focus on leadership in the following areas: most national government departments; to ensure effective prevention, including the full range of prevention options; clinical, ambulatory and terminal care; de-stigmatisation of HIV/AIDS; ensuring formal representation of people with HIV at all levels; and, consistent, pro-active leadership at the provincial level.

- > **Continued attention to leadership and advocacy will be required in future strategies, including comprehensive attention to enlisting other government departments, provinces, districts, local government and traditional leaders in the fight against HIV.**

## LESSON 2: THE IMPORTANCE OF CONSUMER INPUT

Consumer input is a basic human right and provides a mechanism to ensure that strategies are transparent, vital, meaningful and respond effectively to the needs of those most affected. It is through the involvement of people at risk and people with HIV that responses are deeply and meaningfully connected to the realities of the HIV epidemic. While NHASP provided support for groups such as 'Igat Hope', the open and formal involvement of people with HIV in the PNG AIDS response was the exception rather than the rule. The most frequent reasons given for the lack of visibility of people with HIV were that they were hidden or that they lacked the skills and qualifications. However, the team observed one case of a person who was open about her HIV+ status and who was very skilled, but who had been in a temporary position for at least 2 years. The reason why people with HIV are relatively invisible in the response is largely because their involvement is still not considered essential, nor has it become a matter of routine, in PNG. The formal involvement of people with HIV, and those at risk of infection with HIV, at all levels of the response, will be an important symbol in the fight against the oppressive role of stigma. There were calls from 'Igat Hope' representatives for: formal representation of people with HIV at all levels, including as staff members; greater attention to developing clinical care for people with HIV at all stages; greater attention to reducing HIV-related stigma; and support for a Pacific Islands Network for people with HIV (PIN+).

- > **Formal representation of people from high risk settings and people with HIV is an essential element of a successful response. Places for people with HIV should be reserved on all decision-making bodies at all levels including NAC, all PACs, Grant Committees and the boards of other organisations working with HIV.**

## LESSON 3: THE IMPORTANCE OF GENDER

Gender roles are important in structuring women's vulnerability to the epidemic and gender must influence the response to HIV. The evaluation team heard frequent accounts of women who became infected with HIV without ever realising that they were at risk, and HIV-positive women who suffered severe discrimination, including violence. The team is also aware of many women who are playing an important role in the response to HIV in PNG, although it seems that men dominate in senior positions. There also has been an inadequate focus on the role of men and male-dominated institutions, including: men's role in subordinating women and subjecting them to a range of risks, such as HIV; the role of men as central organising agents in terms of HIV risks; men taking due responsibility for HIV prevention and care; men being 'vectors' of infection; and men orchestrating anti-social reactions to people at risk from HIV.

- > **The empowerment of women should continue to be a priority in future strategies.**
- > **Future strategies should also focus on the roles and responsibilities of men and masculinities in the AIDS epidemic.**

#### LESSON 4: STIGMA COMPROMISES THE RESPONSE TO HIV

Stigma erodes a nation's ability to fight HIV because it:

- > Keeps the epidemic concealed and sustains denial;
- > Isolates people with HIV and compromises their ability to access social supports and quality care; and
- > Tacitly supports anti-social reactions to HIV.

Discussion of the role of stigma, shame and fear in undermining the response to HIV was a prominent feature of field interviews. Stigma is a significant problem in PNG, and field visits indicated a greater focus was needed in this area. Even some church-based responses (presumably unwittingly) were contributing to HIV-related stigma by linking HIV to immorality and punishment. The team notes the role of the NHASP Social Marketing Strategies in combating stigma and the inclusion of anti-discrimination measures in the HAMP Act passed by the PNG Parliament in June 2003. This outcome was made possible in part because of strong support from NHASP. However, stigma was confirmed to be an ongoing problem, with the most recent NHASP social marketing surveys seen by the team showing that more than half of the respondents believed that infection with HIV is due to people's 'own bad behaviour', and that they 'deserve what they get'.

- > **Strategies to comprehensively combat HIV-related stigma are an essential component of an effective response to HIV.**

- > **The focus on stigma needs to be closely monitored for evidence of constructive change.**

#### LESSON 5: DONOR, GOVERNMENT AND NGO COORDINATION

Multi- and bi-lateral donors requested better coordination of PNG HIV assistance. Both NACS and NHASP were relied on and their roles were widely respected by the donor communities.

- > **Future strategies should improve stakeholder mapping and donor coordination.**

#### LESSON 6: ACHIEVING A MULTI-SECTORAL RESPONSE

A multi- and cross-sectoral response to HIV is recognised by international authorities to be an essential aspect of all national HIV strategies. There was evidence of mixed success by NHASP in fostering and supporting multi- and cross-sectoral approaches at a national government level. There was better evidence of multi- and cross-sectoral outcomes at a provincial level, largely through the mechanisms of the Provincial AIDS Committees. NHASP invested considerable resources and expertise into supporting the development and functionality of PACs in all 20 provinces. The evaluation team found that some PACs were more active and more effective than others. There are complex reasons why this is the case, including: leadership; commitment of the provincial governments; links with the health sector; personalities; skills and organisational capacity; financial management skills; and quality of basic infrastructure such as

electricity, telephones, office accommodation and equipment. NHASP also played an important role in supporting and developing the capacity of non-government organisations to respond to HIV and in stimulating local activities through the NHASP grants program.

- > **Future project designs should direct greater attention to supporting effective multi- and cross-sectoral responses, particularly at the national government level.**
- > **Consideration should be given to supporting 'HIV mainstreaming advisors' in key government departments. The advisors would advocate for a strong sectoral HIV response and coordinate the development of sectoral strategies (but not be burdened with sole responsibility for the response of the sector).**
- > **Future projects should:**
  - **Prioritise support for provincial AIDS committees;**
  - **Direct special attention and support to PACs that appear to be under-performing; and,**
  - **Ensure that there are alternative avenues for the provision of support to provinces where PACs are weak.**

## LESSON 7: COUNTERPARTS

While the original *modus operandum* for the NHASP was to advise and support NACS, the team found that there was constant pressure on NHASP to take more of a direct service delivery role. These pressures resulted from:

- > Restraints on the PNG Government, which prevented the appointment of the counterparts that were originally agreed to in the project design, and the consequent need for NHASP to 'work around' their absence;
- > The impact on NACS of Public Sector Reforms in 2000-2002;
- > The recognition that the AIDS epidemic was dynamic and rapidly developing and that direct service delivery expedited the response, even though it might not be the best approach to development and sustainability;
- > Most of the financial resources for the national response flowed through NHASP and accountability was simplified by direct management approaches; and,
- > There was heavy pressure on the managing contractor to deliver outputs and outcomes.
- > **The lack of a full complement of PNG counterparts for NHASP compromised the original project design, put pressure on agreed roles and impacted on the relationship between NACS and NHASP.**

## LESSON 8: THE SPECIAL ROLE OF THE DEPARTMENT OF HEALTH

There was insufficient engagement between NACS and the National Department of Health. While this connection is not the concern of the present evaluation (it is an internal issue for the Government of PNG), it did affect the capacity of NHASP to support the development of a multi-sectoral approach and compromised the PNG response to AIDS: notably in surveillance, health promotion and clinical care.

- > **Future projects should direct greater attention to building links with the NDoH and between NACS and the NDoH and to supporting an appropriate role by the NDoH in the PNG response to HIV/AIDS.**

## LESSON 9: DEPENDENCY ON BASIC INFRASTRUCTURE

Effective and functional responses depend on the integrity of basic infrastructure such as electricity, telephones and office equipment. The team observed numerous situations where the failure of basic infrastructure severely compromised the ability of groups and organisations to respond effectively to HIV. Examples included disrupted telephone services due to billing problems as well as computer and printing failure due to power and software failure. NHASP has developed an IT Support Policy and has gone to some lengths to ensure that basic infrastructure functions properly. However, in many cases further improvement is required.

- > **Future projects would benefit from strategies to ensure that basic infrastructure is available, maintained and funded.**

## LESSON 10: DONOR SUPPORT AND PEAK BODIES

While the creation of NHASP as a separate body had administrative and accountability advantages for the donor, the creation of a parallel model consisting of NACS and NHASP set dynamics in train that did not always favour the PNG response to HIV. Further analysis of this arrangement suggests that tensions in working relationships were a predictable outcome of parallel bodies where one (NACS) is vested with the political authority while the other (NHASP) exercises considerable financial power. This binary arrangement is not an invariable feature of Australian aid.

- > **Future projects should review the need to create parallel bodies as these may run different agendas.**

## LESSON 11: MODELS FOR DELIVERING DONOR SUPPORT

The NHASP was a large and complex project and while there were many positive outcomes of the project, and advantages that came from economies of scale and project coordination, the outcomes might have been improved by separating certain discrete elements, rather than maintaining a single large entity.

- > **Future projects should consider the advantages and disadvantages of a more modular approach to project design.**

## LESSON 12: EXTENDING THE REACH OF DONOR SUPPORT

Calls for a greater reach of resources and activities into high risk-settings and into rural and remote locations in PNG was a recurring feature of the evaluation team's field interviews. Greater 'outreach' of resources and activities into such locations would make the response to HIV more personal, immediate, meaningful and empowering. Such an approach would also be more in accord with a strong pro-development agenda. While NHASP invested considerable time and resources into outreach, the team considered that even greater resources are required; that many provincial and rural workers struggled to make an impact because of insufficient support; and that complaints that resources were disproportionately concentrated in Port Moresby may have had some basis.

- > **Future activities should include strategies to increase the efficient flow of support to provincial, rural, remote, high-risk and grassroots settings.**

## LESSON 13: LAW REFORM

NHASP actively supported HIV-related legal and policy initiatives in PNG. A major achievement for NACS and the project was the passage of the HIV/AIDS Management and Prevention (HAMP) Bill by the PNG Parliament in June 2003. This act provides public health provisions for managing HIV and includes action to be taken against people knowingly transmitting HIV, while simultaneously protecting human rights and confidentiality. Despite the legislation, stigma, discrimination and violence continue, indicating that public education

and enforcement measures are necessary adjuncts to legislative reform. In addition, outdated colonial laws concerning sex work and homosexuality remain on the books in PNG. This legislation perpetuates stigma and scapegoating in relation to HIV, and interferes with prevention and care. Additional reforms would include the repeal of these and similar provisions.

- > **Further work on legislative reform, human rights & HAMP Act education and enforcement would assist in the control of HIV.**

## LESSON 14: WORKPLACE INITIATIVES

NACS and NHASP were involved in the delivery of workshops for union representatives from the PNG Trade Union Congress in 2003. Further work has been undertaken with the International Labour Organisation. Workplace activities have been undertaken by the private sector, particularly mines and agriculture (notably, the Palm Oil Industry). This work has been supported by NHASP, which has a designated liaison officer for the private sector. The PNG Defence Force was one of the first organisations in PNG to develop an HIV workplace policy, also with support from NHASP. Educational levels in parts of PNG are low and the workplace represents an important opportunity to deliver HIV/AIDS education. Moreover, experience in PNG and elsewhere confirms that working adults are at particular risk of HIV. Despite high-level workplace policy activity, the team found evidence, at least in custodial and military settings, of substantial grassroots misinformation and educational needs.

- > **Priority should be given to finalising workplace policies and providing education programs to workers.**

## LESSON 15: FINANCIAL ADMINISTRATION

Financial administration and project transparency arose as issues in many field interviews. While there were hints of financial irregularities, the team did not conduct a financial audit and notes that NHASP undergoes annual auditing. Most concerns about financial administration related to problems accessing funds at a district and provincial level; the transparency and responsiveness of the NHASP grants system; and impressions that funding often failed to go much beyond the National Capital. With few exceptions, the provincial AIDS committees had moderate to poor financial and administrative skills. There were also requests from grant applicants for improved feedback from NACS and NHASP concerning outcomes/decisions of grant applications.

- > **Future projects should consider: simplified acquittal systems; support for basic financial administration; strategies to increase access to funding and small grants; and streamlined and simplified grants systems, at provincial and district levels.**

## LESSON 16: GRANTS ADMINISTRATION

NHASP funded and supported a system of research and project grants. This was a key initiative that provided substantial and flexible responses to the PNG HIV epidemic. The development and efficient administration of this system was a relatively late development in the life of the project

and some weaknesses remained in the grant system. PACs and applicants in the provinces requested:

- > Improvements in access;
- > Simplified paperwork better suited to people with little grant experience and less developed language skills
- > Paperwork in *tok pisin*;
- > Additional support for preparing applications;
- > Timely correspondence and routine acknowledgement receipts; and
- > Support and feedback for unsuccessful grants.

A repeated finding was that these organisational issues led to frustration and attrition of people being prepared to apply for further grants. Some of these problems may not be due to failures of NHASP. The team emphasises the importance of ensuring that grant application guidelines are appropriate for the target population. Future grant programs should consider a two stage application process, with an abbreviated first stage application that is submitted for short-listing followed by a supported approach to developing a full proposal. There should also be more systematic and more intensive support and follow-up for grant submission, mentoring, support for outcomes, and monitoring and evaluation. Training must be undertaken as a matter of course.

- > **Future support should contain an expanded and more streamlined grant system with enhanced secretariat and field support. Consideration should also be given to:**

- Increased support for the grant process at the provincial or regional level, including: publicising grant availability; mentoring applicants, ensuring efficient handling and acquittal of funds; monitoring implementation and evaluating outcomes.
- Separate allocations for larger NGOs, prevention initiatives, care initiatives and research.

### LESSON 17: RESEARCH GRANTS

NHASP supports a system of HIV-related research grants. This system runs parallel with, and is similar to, the HIV-related Project Grants. PNG has a small health and social science research base, which makes the assessment and awarding of grants difficult, as there is the potential for conflicts of interest. While quality research has been undertaken as a result of the grant system, there does not appear to have been a concurrent development of the health and social research capacity beyond the existing field.

- > **The research grant system appears to have worked well. However, the evaluation team would have preferred to have seen the identification of new researchers and the development of additional research capacity in PNG along with twinning arrangements with relevant HIV research institutions in Australia and elsewhere.**

### LESSON 18: SURVEILLANCE

Surveillance continues to be difficult in PNG. Nevertheless, to NHASP's credit, the definitive document on HIV surveillance to date was produced through the collaborative efforts of NACS/NDoH/NHASP/WHO. This document is known as the '*Report of the 2004 National Consensus Workshop*'. Much of the epidemiological data referred to in this evaluation comes from that consensus statement. Surveillance can be greatly improved, but this will depend on finding a suitable host institution and sufficient support. Surveillance will also benefit from the development of an STI clinic network, especially if it is accompanied by an STI outreach screening program. The development of a National Reference Centre for STI may also make a suitable future host institution for STI surveillance under the auspices of the NDoH. Partnering that institution with similar institutions in Australia should also be explored.

- > **The PNG capacity for surveillance would be greatly improved with the development of an STI screening outreach strategy.**

### LESSON 19: SOCIAL RESEARCH

The PNG National HIV/AIDS Social Marketing Campaign included a market research component which conducted a baseline survey and four subsequent surveys to monitor knowledge, attitudes, behaviours and beliefs in four regions of PNG using samples of up to 2000 participants. The apparent lack of formal academic collaboration and advice into that market research raised concerns about the scientific validity of such research. Nevertheless, this social marketing research provided a valuable resource for planning.

- > **Greater academic collaboration in future market research is recommended, to ensure integrity, validity and reliability of methods, analytical approaches and results. The aim should be to publish key social research in peer-reviewed journals.**

## LESSON 20: PROJECT MONITORING AND EVALUATION

A monitoring and evaluation framework (for the project) was developed as part of the NHASP, although this was not published until January 2004, midway through the project. Detailed monitoring and evaluation reports were submitted on at least two occasions during the project. The team noted limitations in some reporting areas due to the use of imprecise language or failure to address the evaluation objective. A general lack of clarity about monitoring and evaluation of NHASP is present throughout the project. This can be traced back to the absence of this important element in the original project design, and a failure to focus on monitoring and evaluating the project inputs and their outcomes as an ongoing activity of the project.

- > **Monitoring and evaluation would have been more systematic if it had started at the beginning of the project.**

## LESSON 21: COMMUNITY AWARENESS

A sophisticated and comprehensive Social Marketing Campaign was supported by NHASP, and was one of NHASP's key achievements. The initiative was split into four phases over the 5 year period and was underpinned by an informative market research component (See lesson 19). There was evidence from across the country,

including from urban, rural and border areas, of the availability of materials produced by the NACS/NHASP program. Market research findings confirmed that there is a high level of HIV awareness in PNG, in one survey exceeding 90%.

- > **A comprehensive social marketing program has contributed to high HIV awareness in PNG.**

## LESSON 22: BEHAVIOUR CHANGE

Behaviour change is a premiere outcome of any response to HIV. Unfortunately, there was insufficient data to make a confident assessment of whether significant behaviour change has occurred as the result of the NHASP activities. Informants acknowledged high awareness of HIV in PNG but were not confident of a corresponding level of behaviour change.

The NHASP social marketing surveys do not show sustained or dramatic changes in key behavioural parameters such as condom use or numbers of partners.

- > **A much greater investment in behaviour change is needed in future strategies.**

## LESSON 23: THE IMPORTANCE OF WORKING IN HIGH RISK SETTINGS

An important later development in the project was the renewed and enhanced focus on 'high risk settings'. This shift in strategy was important because:

- > Resources were directed to priority sites where transmission was particularly likely;
- > Prevention was tailored to the life patterns, needs and meanings of

important populations who were more likely to identify with and own the tailored message; and

- > Prevention responded to the social contexts in which risks occurred.

For these and other reasons, the evaluation team was convinced that the ‘high risk setting’ strategy was likely to be much more influential than more generic or individualistic approaches. The team noted the potentially valuable de facto recognition given to important populations by this strategy – such as youth, sex workers, male dominated commercial settings and men who have sex with men.

- > **The strength of the ‘high risk settings’ approach is recognised, as is the implicit recognition of the importance of social contexts in behaviour change.**
- > **Future programs need much stronger social research and behavioural surveillance.**
- > **It is recommended that the HRSS be introduced as early as possible in future strategies.**

#### LESSON 24: INFORMATION, EDUCATION & COMMUNICATION RESOURCES

The Project developed a comprehensive range of IEC materials, and established the Resource Centre to house these materials, as well as to serve as a reference centre for stakeholders. Some limitations were seen in the availability of printed materials appropriate for illiterate populations.

- > **The value of a Resource Centre for both accessing IEC materials and publications needs to be recognised in the development of further programs.**

- > **Future programs must develop comprehensive materials for low-literacy settings and in major languages.**

#### LESSON 25: TRAINING

Training was one of NHASP’s most significant achievements, having developed, supported and delivered comprehensive training programs. Moves to develop certified advanced training in conjunction with external bodies such as TAFE were commended. NHASP also supported the development of minimum standards, guidelines and accreditation procedures for counselling. With some exceptions, follow-up, professional support, continuing education, supervision, involvement of people with HIV, and assistance with implementing training were limitations of the NHASP approach to training. The evaluation team would have liked to see greater attention to follow-up and support of people trained by NHASP.

- > **Comprehensive training programs are an essential part of an HIV response.**
- > **Training should involve people with HIV and people associated with high-risk settings, and include follow-up and ongoing support for trainees.**

#### LESSON 26: COUNSELLOR TRAINING

The central activity of the NHASP counselling strategy was training. NHASP delivered extensive basic counselling training courses to workers and volunteers around PNG. These courses appear to have evaluated well, although there were limitations in relation to follow-up. These limitations were in two main areas:

- > Further training, advanced courses, professional development and skills accreditation; and
- > Ongoing supervision, debriefing and professional support.

As noted above, NHASP moved to develop advanced training, accredited courses and minimum standards. These initiatives were significant because HIV counselling can be difficult and isolating, with regular exposure of counsellors to stressful situations, including death and dying.

- > **Future strategies should emphasise follow-up to maintain and further develop counselling skills and to support trained counsellors.**

## LESSON 27: AMBULATORY, COMMUNITY AND HOME-BASED CARE

Community care is rudimentary in PNG. NHASP supported some initiatives for the development of community and home-based care for people with HIV-related illnesses, but these were not as advanced as NHASP's approach to counselling. A notable home care initiative supported by NHASP was the development of home care kits by 'Appropriate Technologies'. While NHASP made a commendable effort in training and developing protocols for basic clinical care, this did not extend to advanced care in either STI or HIV. This was probably because of the weaknesses in services, which limits the application of such training. Clinical care, including home based care, lagged behind other HIV-related initiatives in PNG and constituted a significant limitation in the national HIV response. This situation echoed the limitations of clinical care

available in PNG in the formal health sector more generally.

- > **Home-based, community, ambulatory, hospital and terminal care are all under-developed in PNG and should be prioritised for improvement, but not at the expense of other important elements of the response such as prevention, high-risk setting initiatives, de-stigmatisation, outreach and project and research grants.**

## LESSON 28: CLINICAL CARE

A sector-wide gap in the PNG response to HIV over the past 5 years has been clinical care for people with AIDS. The reasons for this gap include:

- > Separation between the principal public health service provider (NDoH), and the principal HIV bodies (NACS and NHASP);
- > Traditional care providers, such as the churches, focus on VCT services, which are well suited to earlier infection, but have limited capacity in the presence of advanced disease;
- > Delays in the rollout of the AusAID sponsored STI clinics; and
- > Shortcomings in diagnostic and clinical services in the public sector.

The team also noted the imminent rollout of combination anti-retroviral treatments by the Global Fund for HIV and the WHO '3 x 5' Strategy.

- > **This report recommends a review and refocussing of the clinical care components of subsequent strategies including VCT, treatment, diagnostics,**

**ambulatory care, enhanced diagnosis and management of clinical illness and terminal care. Greater priority should be given to improving clinical services in future strategies.**

## LESSON 29: VOLUNTARY COUNSELLING AND TESTING

Considerable effort has been invested in development of voluntary HIV testing and counselling centres (VCT). The rollout of VCT centres was another key NHASP outcome. The evaluation team visited several VCT clinics supported by the project. While these services had the potential to play a valuable role, the team noted some problems:

- > VCT services are best suited for services for the ‘walking well’;
- > On one occasion staff without health training appeared to be dispensing medical treatments;
- > On another occasion VCT was delivered in the absence of formal HIV counselling training;
- > A case was observed where the funded VCT component risked being overtaken by other activities;
- > No centre was equipped to provide care for people with advanced clinical illness. Indeed, some centres were not prepared to develop care for people with clinical illness, despite there being few alternatives.

VCT centres provide particular challenges for the Catholic Church. In particular, it is the policy of the Church not to promote condoms as a means of HIV prevention. While the team understands the theological reasons for this approach, it is inconsistent with expert public health advice.

- > **The rollout of VCT centres should be revisited. It is recommended that further attention be directed to VCT standards, and that the role of VCT centres in caring for people with illness be reviewed.**
- > **As VCT centres are promoted as a site for HIV prevention, the choice of service provider must ensure that the full range of prevention options are canvassed.**

## LESSON 30: STI CLINIC ROLLOUT

The AusAID-supported ‘Sexual Health and HIV’ project, which preceded NHASP, commenced the rollout of sexually transmitted infection clinics around PNG. This rollout was a phased strategy, with rollout intended to continue until all 20 provinces had quality STI services. The ongoing rollout of clinics appeared to have been written into the original project design for NHASP. However, the role of NHASP in the rollout of STI clinics was subsequently curtailed, with the role of NHASP reduced to undertaking a situation analysis and providing clinical training. The funding for STI clinic construction was moved to the Health Sector Improvement Program (HSIP). The evaluation team considered this to be illogical given that funding for related facilities, such as VCT services, remained with NHASP. The rollout of STI clinics moved slowly under the HSIP, which did not

reflect the priority AusAID attaches to HIV control in PNG.

- > **STI clinics are a key aspect of a comprehensive response to HIV and have considerable capacity to provide comprehensive services including VCT and ambulatory HIV care. Clinics that are functioning in PNG are working surprisingly well.**
- > **The rollout of the remaining clinics is too slow and all efforts should be made to expedite this process.**
- > **The STI clinic network should be used in subsequent strategies as a base for outreach clinical services to rural and high risk settings. These outreach services should be equipped to operate without being dependent on other health services, but strongly encouraged to collaborate with NGOs, health patrols and high-risk setting workers, among others.**

### LESSON 31: NATIONAL SEXUAL HEALTH REFERENCE CENTRE

The aim to develop a National Sexual Health Reference Centre in conjunction with the Port Moresby Hospital STI Clinic has not been achieved. This is a key weakness of the national response and may have occurred for the reasons mentioned in the point above.

- > **A National Centre for Sexual Health would provide a reference and training centre to support the STI clinic rollout and would also give PNG a strong academic and training base that could be a model for the region.**

- > **The Centre could be a home for STI clinical care, HIV ambulatory care, research, surveillance, training and professional development. The development of the Centre is a keystone priority for the next strategy.**

### LESSON 32: WEAKNESSES OF THE 'SYNDROMIC APPROACH' TO HIV, AIDS AND STI

PNG has relied on a 'syndromic approach' for managing STI. While it is clear why this strategy is used, it is acceptable on an interim basis only and should be revised. The main reasons for this are:

- > All STI share the property that there is always a significant pool of people who are infected but who do not exhibit symptoms;
- > Being asymptomatic, these people will usually not come to the attention of syndromic treatment programs;
- > Despite being asymptomatic, people with these STI are infectious and can amplify HIV spread through the mechanism of 'epidemiological synergy'.

People are regularly infected with more than one STI.

- > **Reliance on 'syndromic management' of STI is not satisfactory.**
- > **The progressive introduction of voluntary community screening of all adults for STI is recommended. The benefits include:**
  - **Community screening destigmatises STI because all adults are encouraged to participate regardless of the presence or absence of symptoms;**

- **Community screening identifies asymptomatic STI; and**
  - **The identification and treatment of hidden infections addresses key public health issues including ‘epidemiological synergy’ of STI with HIV and key maternal and child health risks.**
- > **The team notes that a *de facto* trial of community based screening and treatment in an outreach setting has already been shown to be feasible by the IMR as part of its sentinel surveillance research.**

### LESSON 33: LABORATORY SERVICES

The original project design aimed to enhance PNG’s capacity for laboratory-based diagnosis and monitoring of HIV and STI. While professional development activities have been undertaken under the auspices of NHASP, the development of the diagnostics capacity in PNG has been limited to refining existing testing. Clinical care continues to depend too heavily on ‘syndromic’ diagnosis. Most hospital laboratories outside Port Moresby offer only microscopy, if that. There is no availability of CD4 counts in the public sector anywhere in PNG, nor is there a capacity to diagnose pneumocystis pneumonia. While multiplex PCR for STI is available at the Institute for Medical

Research in Goroka, this is only used for surveillance/research purposes.

- > **Greater priority needs to given to improving the diagnosis and monitoring of STI and HIV in PNG. Capacity for multiplex PCR exists only at the IMR. In recent years STI diagnosis has become more robust and increasingly automated. These developments potentially make STI diagnosis and treatment more accessible in remote settings.**
- > **Future support should consider partnering arrangements between the National Public Health Laboratory and the IMR and Australian laboratories, to improve the diagnostic capacity of the health system in PNG.**

### CLOSING COMMENT

During the course of NHASP, the HIV epidemic in PNG officially became a generalised epidemic. The next 5 years will be critical in determining whether PNG experiences a modest or a severe generalised epidemic.

### RATINGS

<b>Overall project rating</b>	<b>Rating 3</b>	Significant improvement occurred late in the course of the project
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