



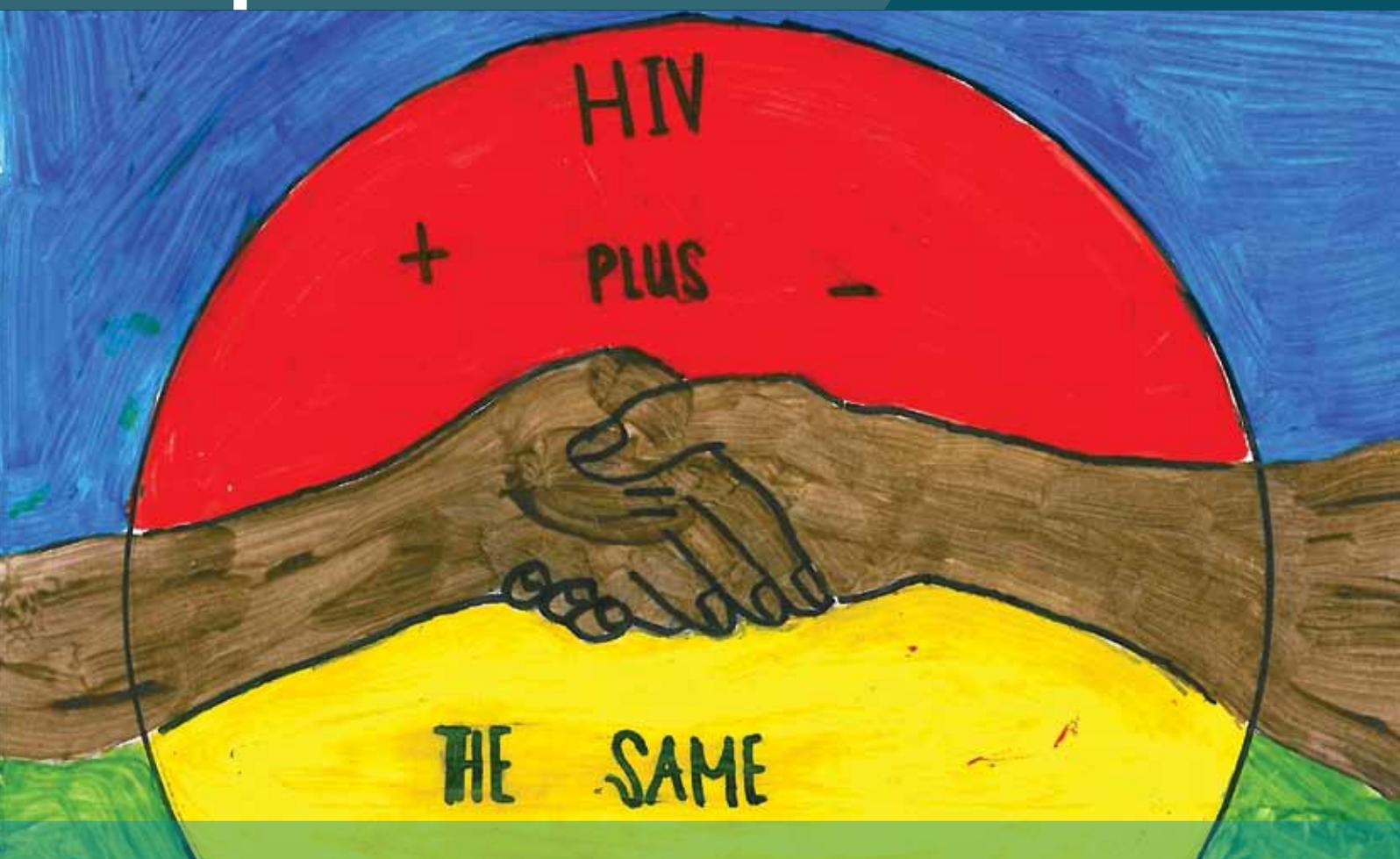
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Responding to Crisis

EVALUATION OF THE AUSTRALIAN AID PROGRAM'S
CONTRIBUTION TO THE NATIONAL HIV RESPONSE
IN PAPUA NEW GUINEA, 2006-2010



ODE EVALUATIONS & REVIEWS

AUGUST 2012



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**EVALUATION OF THE AUSTRALIAN AID PROGRAM'S
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IN PAPUA NEW GUINEA, 2006-2010**

Cindy Carlson | Emily Rudland | Katherine Lepani | Marjorie Andrew

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Cover image: Detail from: “Being HIV Positive: Doesn’t mean that’s the end of everything under the sun!”
Poster by participant of training on HIV stigma and discrimination, which was organised by AusAID’s PNG-Australia HIV and AIDS Program. See page 26 for full image.
Photo: AusAID. Image taken by John Gould.

Office of Development Effectiveness

The Office of Development Effectiveness (ODE) monitors the performance of the Australian aid program, evaluates its impact and contributes to the international evidence and debate about aid and development effectiveness.

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Acknowledgements

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The evaluation team

The evaluation team comprised a mix of international health and PNG specialists:

- **Team Leader:** Ms Cindy Carlson, a public health and evaluation specialist, has almost thirty years of public health and development experience. She has worked with non-governmental organisations, academia, the United Kingdom National Health Service and as a consultant to government, United Nations and non-governmental agencies in a range of capacities that include HIV, sexual and reproductive health program planning and evaluation as well as organisational change and development. Ms Carlson led the team of consultants and facilitated the design of the overall evaluation methodology. She provided inputs on AusAID's technical response and analysis of organisational development and national ownership.
- **PNG HIV Specialist:** Dr Katherine Lepani is a long-term resident of Papua New Guinea, where she has been involved in community-based, public sector, and academic work in the areas of primary health care, HIV, and gender and development. She coordinated the development of Papua New Guinea's first national multi-sectoral strategy for HIV in 1997, and the current National HIV Prevention Strategy 2010–2015. Dr Lepani contributed her experience and knowledge of the HIV epidemic and response in Papua New Guinea, including a historical perspective.
- **PNG National Consultant:** Ms Marjorie Andrew was engaged to provide short term inputs, and coordinated in-country preparations for the evaluation missions including arranging schedules of meetings with key informants at the national level and in three provinces. Ms Andrew conducted interviews and contributed to analysis and report writing, in particular relating to the Family and Community Support focus area. Marjorie has worked with the Department of National Planning as the First Assistant Secretary, with AusAID as Senior Program Officer, and as National Project Coordinator for various institutional strengthening donor funded projects. Ms Andrew has headed the Consultative Implementation Monitoring Council Secretariat for the last four and a half years, facilitating dialogue between government and civil society on selected development issues, policies, and implementation problems.
- **ODE Evaluation Manager:** Dr Emily Rudland is a member of the Office of Development Effectiveness (ODE) in AusAID. ODE is an independent unit within AusAID that reports to the Director General. Dr Rudland participated in the team to support an evaluation process that is relevant to AusAID and builds ownership and understanding of the evaluation findings. Dr Rudland contributed a strategic understanding of AusAID's priorities and operations, as well as relevant skills from her background in research, performance audit and program evaluation.

All effort has been made to ensure that this evaluation has been carried out as independently and objectively as possible. It is therefore important to note that three of the team members could be perceived to have had conflicts of interest as regards their inputs into this report. Katherine Lepani has been involved in the Papua New Guinea HIV response for many years, has done research into the HIV epidemic in the country and was involved in developing the Papua New Guinea HIV Prevention Strategy. Emily Rudland is a staff member of AusAID, though she has no direct connection with the AusAID program in Papua New Guinea. Marjorie Andrews lives in Papua New Guinea and works with many of the stakeholders interviewed during this evaluation.

These potential conflicts of interest have been managed by having an independent team leader, Cindy Carlson. Her role has been to ensure general objectivity and to mediate any disagreements within the team (of which there have been few). Other team members have made important contributions on context and background.

Acronyms and abbreviations

ABC	Abstinence, Be Faithful and Use Condoms
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
AusAID	Australian Agency for International Development
AUD	Australian Dollar
BAHA	Business Coalition Against HIV and AIDS
DCT	Development Cooperation Treaty
DRC	Democratic Republic of Congo
FA	Focus Area
FHI	Family Health International
GIPA	Greater Involvement of People Living With AIDS
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
GoPNG	Government of Papua New Guinea
HAMP Act	HIV and AIDS Management and Prevention Act 2003
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HIV Program	PNG–Australia HIV and AIDS Program
ICR	Independent Completion Report
IMR	Institute of Medical Research
IRG	Independent Review Group
ISP	Implementing Service Provider
JTAI	Jane Thomason International
LNG	Liquefied Natural Gas (PNG LNG project)
LSI	Leadership Support Initiative
M&E	Monitoring and Evaluation
MTP	Medium Term Plan on HIV/AIDS 1998–2004
NAC	National AIDS Council
NACA	National AIDS Coordinating Authority
NACS	National AIDS Council Secretariat
NCAO	National Catholic AIDS Office

NDOH	National Department of Health
NGO	Non-governmental Organisation
NHASP	National HIV and AIDS Support Project
NHPS	National HIV Prevention Strategy
NHS	National HIV and AIDS Strategy 2011–2015
NSP	National Strategic Plan on HIV and AIDS 2006–2010
ODE	Office of Development Effectiveness
OECD	Organisation of Economic Cooperation and Development
PAC	Provincial AIDS Committee
PACS	Provincial AIDS Committee Secretariat
PASHIP	PNG Australia Sexual Health Improvement Program
PGK	Papua New Guinean Kina
PMTCT	Preventing Mother to Child Transmission
PNG	Papua New Guinea
IMR	Papua New Guinea Institute of Medical Research
PNGSF	Papua New Guinea Sports Foundation
QAI	Quality at Implementation
SNS	Sub-national Strategy
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
UNGASS	United Nations General Assembly Special Session
US	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Note: \$ refers to Australian dollars unless indicated to the contrary.

List of supporting annexes

Detailed evidence and analysis supporting this report is available in further annexes, available online at www.ode.ausaid.gov.au.

Reference annexes

- Annex 6: Terms of reference
- Annex 7: Evaluation plan
- Annex 8: List of references
- Annex 9: People interviewed
- Annex 10: Theory of change: AusAID's multisectoral contribution to the national HIV response in PNG
- Annex 11: Evaluation inception report

Analytical annexes

- Annex 12: Historical analysis of the Australian aid program's contribution to the national HIV response in PNG
- Annex 13: Budget analysis of the Australian aid program's contribution to the national HIV response in PNG
- Annex 14: Good practice related to development assistance effectiveness of national AIDS responses
- Annex 15: AusAID's support to HIV mainstreaming in PNG

Evidence annexes

- Annex 16: Summary of programmatic contribution
- Annex 17: Summary of capacity-building contribution
- Annex 18: AusAID's contribution to Focus Area 1—Treatment and Care
- Annex 19: AusAID's contribution to Focus Area 2—Education and Prevention
- Annex 20: AusAID's contribution to Focus Area 3—Epidemiology and Surveillance
- Annex 21: AusAID's contribution to Focus Area 4—Social and Behavioural research
- Annex 22: AusAID's contribution to Focus Area 5—Leadership, Partnership and Coordination
- Annex 23: AusAID's contribution to Focus Area 6—Family and Community Support
- Annex 24: AusAID's contribution to Focus Area 7—Monitoring and Evaluation
- Annex 25: Efficiency and effectiveness of program management
- Annex 26: AusAID's contribution to social risk mitigation of the PNG LNG project

Provincial response case study annexes

- Annex 27: AusAID's contribution to the Western Highlands Province HIV response
- Annex 28: AusAID's contribution to the Sandaun Province HIV response
- Annex 29: AusAID's contribution to the Madang Province HIV response



In Papua New Guinea, a member of Anglicares STOPAIDS theatre group is dressed for a performance. The group, which is supported by AusAID, stages plays at local markets, schools and other community places to help educate young people about HIV/AIDS. Photo: AusAID. Image taken by Rocky Roe.

Executive summary

HIV remains one of the major development challenges in Papua New Guinea (PNG). The country has the largest epidemic in the Pacific. In 2009 it had an estimated 34,100 people living with Human Immunodeficiency Virus (HIV), which is 0.92 per cent of the adult population.

The Australian aid program has a long history of support to the HIV response in PNG. Total funding for a series of programs between 1995 and 2010 was approximately \$250 million. *Australia remains the lead partner in the HIV response*, a role agreed upon with the other partners in the early 2000s. The scale of Australian support has increased steadily over the past ten years, from \$1.8 million in 2000 to \$47 million in 2010. In that year, Australian Government funding represented 76 per cent of the total funding for the HIV response, with the remainder provided by the Papua New Guinea Government and other donors.

Between 2007 and 2010 AusAID contributed approximately \$174 million for HIV through all its country programs, led by the PNG–Australia HIV and AIDS Program (the HIV Program). The HIV Program started in 2007, following a year of transition from the National HIV and AIDS Support Project (2000–2005). Its budget allocation grew from the initial \$100 million over five years to \$185 million over seven years. A further \$25 million was allocated for the PNG–Australia Sexual Health Improvement Program over six years to 2013.

This is the first independent evaluation of AusAID’s current HIV program in the country. The evaluation, which covers the period 2006–2010, assessed whether the aid program’s approach to supporting the national HIV response was effective for the context, and of a scale appropriate to the needs.

The HIV response needs to be understood in the broader country development context. PNG has the lowest health status in the Pacific, low literacy and school enrolment rates, and a rapidly growing population mostly living in rural areas. Maternal mortality rates are among the highest in the world, reflecting low levels of development and weak health, education and other social services. The country’s rugged and diverse terrain makes it difficult to reach populations scattered in remote areas with such services. Other specific challenges faced by the HIV response have included patchy commitment to deal with HIV, corruption, declining government investment in social services and weak national capacity for coordinating the response and delivering HIV services.

Evolving knowledge about the epidemic has helped shape the response. The first HIV case in the country was detected in 1987. By 2003 it was estimated that there were 150 new cases per month, and it was projected that the total number of cases would reach 5 per cent or more of the adult population. These figures prompted fears that the epidemic would reach sub-Saharan African proportions. *Donors reacted to what appeared to be an emergency situation*—the risk of HIV rapidly spreading across the general population if nothing was done, with potentially devastating social and economic consequences. Although this worst-case scenario did not materialise, HIV remains an important health and development concern. With the expansion of HIV testing services it has been possible to gather more and better data, understand better where HIV infection rates are particularly high (both in terms of geographical areas and population groups) and where more targeted support is needed.

The evaluation took place in an evolving context over one year in 2010. During this time, the Australian aid program was beginning to respond to the 2010 review of the PNG–Australia Development Cooperation Treaty (DCT). Findings from the evaluation are consistent with the directions outlined in the review. At the same time, the country response was entering a new phase, with the development and then implementation of a new national HIV strategy. In early 2011 AusAID was conducting a scoping review of options on management of the HIV Program, which has also been informed by the evaluation findings.

Box 1: AusAID’s approaches in support of the HIV response, 2006–2010

The long term goals of the Australian aid program are consistent with those of the PNG Government: to minimise the social and economic impact of the epidemic; to prevent new infections; and to improve care for those affected by HIV. The HIV Program leads in working towards these goals, and coordinates the contributions of other Australian development programs in the country that have HIV components.

The HIV Program

Activities: The HIV Program supports the PNG Government in leading and managing the national HIV response, mainly through technical assistance. It also supports civil society organisations to deliver HIV prevention, treatment and care services through capacity building and grants. These grants represent the largest proportion of funding, and are largely directed to organisations that deliver HIV services. In 2010, the HIV Program was funding 20 international and national implementing partner organisations through the national strategic planning process, and a further 21 partners for the PNG–Australia Sexual Health Improvement Program.

Approach: The HIV Program places emphasis on building the capacity of partners, and on facilitating the adoption of internationally recognised best practice in programming. For example, it stresses the importance of generating and using evidence, involving people living with HIV in the response, and promoting gender equality. In practice, this means engaging with national planning processes and building relationships with partners, rather than just implementing activities.

Program design: The HIV Program has been specifically designed so that it can be flexible, and easily adapt to a changing context; its specific objectives are reviewed and refined every year. The HIV Program is directly managed by AusAID. The Program Director is a senior technical expert who understands HIV well, and has strong credibility among all stakeholders. This position is supported by a limited number of advisers and program managers.

Other AusAID programs contributing to the HIV response

A number of AusAID programs in other sectors are relevant to the HIV response. These include the health, education, law and justice, transport sector and rural development programs. HIV is included in other sector programs either through specialist advisor support or integration into program activities. The HIV Program’s role is to coordinate these contributions as part of a coherent approach.

For example, the education sector has supported the development and introduction of an HIV curriculum across the country, accompanied by teacher training and materials. The Sports for Development Initiative has facilitated HIV training initiatives among sporting groups.

Was AusAID's contribution relevant to the PNG context?

The evaluation team finds that the principles and policies underpinning AusAID's contribution were relevant when the HIV Program was designed in 2005–2006. *In its lead role, AusAID responded to signs that the epidemic was becoming an emergency by establishing a dedicated HIV program and significantly increasing its funding.* At the same time, it took care to keep its focus aligned with evolving national priorities, which included HIV treatment, care, education, and prevention. In line with international best practice, it promoted the involvement of people with HIV in the response, and gender sensitive approaches. When it became clear that the public sector would struggle to implement key interventions, AusAID sought to achieve greater impact by shifting its efforts towards implementing organisations outside the public sphere with greater capacity and commitment. Efforts to expand testing and treatment services led not only to greater access to HIV services across the country, but also to better knowledge about who was particularly affected, and where. *Overall the evaluation concurs with the consensus among stakeholders that much of the HIV policy, strategy and programming that exists in the country today would not be there without AusAID's support, and the response would be far less advanced.*

Box 2: Views of national stakeholders in the response

'Without AusAID we wouldn't have come this far. From the beginning AusAID has been the force behind our response.'

'From the start, AusAID support basically laid the foundations of the response ... It was critical from the beginning.'

'If AusAID hadn't put the money into HIV there would be very, very few programs here. Even if the programs aren't effective enough at least they are there.'

The evaluation, however, also notes that the exclusive focus on HIV through a separate program—although driven by the need to respond quickly to a potential emergency—meant that *the HIV Program did not make the most of other important opportunities to address crucial development challenges together with HIV.* This was largely because, as a stand-alone activity, it did not communicate or coordinate effectively with programs in other sectors. For example, HIV shares with health the challenge of addressing sexual and reproductive health issues. It would have been more relevant to the broader health context (with high rates of sexually transmitted infections and maternal mortality, and poor access to basic health care) to seek to deliver HIV services as part of a broader package of sexual and reproductive health services, working in concert with AusAID's health programs.

New challenges and opportunities are now offered by large-scale infrastructure and extractive industry projects, such as the Liquefied National Gas (LNG) project, which will be integral to the development of the country's economy over the coming decades. Such projects carry the risk of increased transmission of HIV and other sexually transmitted infections through large movement of workers. Here, *forging closer partnerships with industry programs to mitigate their potential impact on HIV and health would enhance the relevance of AusAID's program as a whole.*

Recommendations

1. **Focus resources on increasing and improving the integration of HIV services into basic primary care, sexual, reproductive and maternal health services, especially in high prevalence areas of Papua New Guinea.**
2. **Take a pro-active approach to mitigate the expected negative impact of large extractive and infrastructure projects, such as the Liquefied National Gas project, on sexually transmitted infections and HIV in affected provinces.**

Was AusAID's contribution effective?

The evaluation finds that AusAID can be credited with success in improving processes and increasing access to HIV services, not just during the evaluation period, but throughout its long engagement with HIV in the country. AusAID was crucial to keeping attention on HIV for the last 15 years, and increasing HIV awareness. It assisted in developing progressive national policy and legislation, and supported the expansion of testing and counselling services. Support to civil society organisations is a particular achievement because it enabled the delivery of HIV prevention, treatment and care services throughout the country, as well as civil society involvement in shaping the response. This involvement is also helping reduce stigma and discrimination. AusAID's contribution to policy development and service expansion supported partners to put in place the building blocks for improving the impact of HIV related interventions.

AusAID has helped to keep coordination going when other mechanisms were not functioning. The National AIDS Council (the leading body in the national response) was suspended for two years during the evaluation period, leaving a governance vacuum. For over two years its Secretariat (the coordinating body) has been in the process of organisational reform, but with little progress to date. The HIV Program provided continuity of coordination during these challenging years. However, *the evaluation team concludes that it is no longer feasible for AusAID to continue supporting the Secretariat until the reforms have been successfully completed.*

Unfortunately, there is little evidence that AusAID's support for process and expansion of services has translated into measurable impact on the spread of the HIV epidemic. Only a few of the interventions supported address directly the main causes of the country's epidemic, as these are now understood. For example, there is no evidence that prevention programs are reducing the number of new HIV infections, since comprehensive data on this indicator is not yet being collected. AusAID has not gathered evidence on the impact of supported behavioural change initiatives. However we know that the rate of new sexually transmitted infections has not declined, indicating that sexual behavioural change is very limited or not occurring at all in many places. This lack of progress is significant because HIV in PNG is predominantly sexually transmitted. AusAID's contribution could increase the evidence of its effectiveness relatively easily by ensuring that the findings of research activities supported by the HIV Program, which include social and behavioural studies and the expansion of surveillance, are more widely disseminated and translated into practice.

The HIV Program funded a number of interventions that appear to have performed well, such as certain community-based prevention and treatment services, and work taking place at the provincial level, where there is strong commitment to the HIV response. *Focusing efforts on these proven successes or promising initiatives would help achieve greater impact.*

A single overarching consideration made by the evaluators is that because of the way the HIV Program reports, it can be difficult to attribute specific successes or good practice directly to AusAID's contribution. This can be addressed first by being explicit about what results AusAID hopes to realise, and then by making program reporting more specific about the results that AusAID's funding and partners seek to achieve.

Recommendations

- 3. Invest resources in expanding community-based, integrated sexual health prevention and promotion services, building on the more successful experiences of current projects in this area (for example, Family Health International, Poro Sapot, and Tingim Laip).**
- 4. Suspend support to the National AIDS Council Secretariat until the planned institutional reform takes place and the Secretariat structure is made fit for purpose.**
- 5. Re-focus attention towards provincial and non-state coordination of service delivery, to ensure that the Papua New Guinean population has access to good quality and comprehensive sexual health, reproductive health, maternal health and health promotion services that integrate HIV.**
- 6. Move to performance-based funding mechanisms for all partners.**
- 7. Support initiatives that ensure that research partners and implementing partners come together to identify, review and use the latest local and international surveillance and research evidence for program planning.**
- 8. Make the results of strategies for promoting gender equality and greater involvement of people living with HIV and AIDS part of a new performance framework for managing AusAID grants to government and civil society partners.**

How well has AusAID nurtured sustainability and ownership?

AusAID contributed to the sustainability of the HIV response by helping to build structures and systems that have become embedded in the legal fabric of the country—among these are the National AIDS Council, Provincial AIDS Councils and the HIV/AIDS Management and Prevention Act 2003. The annual planning system that AusAID facilitated provides a useful model for future sustainable planning of the response. Where possible, AusAID made efforts to nurture government leadership. It also raised the profile, capacity and effectiveness of non-governmental partners, who are particularly important to reaching those affected by HIV where the public sector is unable to do so, and to advocate for their rights.

National ownership is considered a pre-requisite for ensuring a sustained response, however in PNG this has not been fully realised. Ownership is stronger among non-state partners, some provincial administrations, at the community level, and among some national-level champions of the response. It is much lower at national government level and in the public sector, where national and coordination bodies have not met expectations.

Stakeholders interviewed for the evaluation had no doubt that without AusAID's support the HIV response would not be as extensive as it is today. However this may have come at the cost of fostering greater national ownership. *It is possible that by stepping in and pushing for attention to HIV as it did, AusAID left less space and time for the country's HIV community to develop its own analysis and direction for the response. High dependency of the Government of PNG on donor funding for HIV, and AusAID's prominent position in the response over a long period, poses a challenge to the sustainability of the response.*

The evaluation proposes a number of ways to address the variable levels of ownership. One way is through a gradual shift of direct management and long-term capacity development responsibilities to those in PNG who have the ability to take on such roles. Another way to ensure long-term sustainability is by looking at how HIV prevention, treatment and care could be delivered as part of the health response, focusing on partners or levels of government that have demonstrated leadership. Moving away from separate planning for HIV and health would also have the potential to generate better value for AusAID's resources. Finally, AusAID could begin a more serious dialogue with the Government of Papua New Guinea about how a greater proportion of HIV activities will be funded from domestic resources in the next five to ten years.

Recommendations

9. **Enable greater Papua New Guinean ownership of the HIV response by clearly delineating respective Papua New Guinean and AusAID roles and responsibilities in the HIV response.**
10. **Change the strategic approach to how HIV services and interventions are supported and managed, through greater use of international non-governmental organisation contractors to manage grants and build capacity.**
11. **Invest capacity building efforts in strategies and approaches for civil society and public sector organisations that are shown to be most effective at leading to a sustained, integrated health response encompassing sexual and reproductive health, HIV and maternal health.**
12. **Prioritise funding and support for HIV mainstreaming where it facilitates greater Papua New Guinea ownership of HIV mainstreaming, by focusing resources where government departments and other partners have already demonstrated leadership.**

Was AusAID's contribution efficiently managed?

The decision to keep the management of the HIV Program 'in house' within AusAID was intended to provide continuity of leadership, high level engagement with the response, ensure greater flexibility to adapt to the context, and lighten the load of reporting. This management model has had benefits and drawbacks.

The Program Director, a senior technical expert, has been in a position to advocate for HIV with the government and partners, and has helped drive the response. This feature of the model is very important and much appreciated by stakeholders. However, the HIV Program has had to take an increasing role in facilitating coordination due to low national capacity. Consequently, the respective roles and responsibilities of the PNG Government and Australian assistance in the response have become blurred.

Another drawback is that, although managed in-house, in some respects the HIV Program continues to have the characteristics of a 'contracted' operational program, and its complexity places a significant management burden on AusAID's staff. At the same time program reporting is less detailed than might be the case under a contractor, and not sufficiently detailed to give senior managers, or the evaluation team, a clear sense of efficiency or value for money.

Recommendations

13. **Move to a program management model that combines strategic technical HIV capacity within AusAID and implementation through a managing contractor (international non-governmental organisation, national organisation or private sector).**

AusAID management response

1. AusAID welcomes the findings of this evaluation of the PNG-Australia HIV and AIDS Program. As the HIV and AIDS Program has been integrated with the Health Program in 2012, it is now referred to as the Health and HIV Program. The Health and HIV Program operates in the context of a fragile health system and has evolved in response to performance feedback, policy and clinical research and evidence about effectiveness. This evaluation makes an important contribution to improving the effectiveness of this program.
2. AusAID agrees with, and is already implementing, the majority of recommendations of the evaluation. AusAID fully accepts ten of the thirteen recommendations and partially agrees with recommendations 3, 4 and 12.
3. AusAID management would like to highlight three key aspects of the evaluation findings for clarification:
 - a. AusAID agrees that promoting **country ownership and leadership** on HIV must be a priority. The Health and HIV Program was designed with the long term aim of building the commitment and institutions needed to lead and manage the response to the HIV epidemic, whilst supporting local civil society organisations to fill immediate gaps in service delivery. However, promoting country ownership and leadership has been a challenge, due to factors such as political instability, weak health systems and entrenched social drivers of the epidemic, such as gender inequity. The Health and HIV Program has responded to this fragile operating environment by balancing the immediate need for HIV services, with longer term institution building.
 - b. **Support to the National AIDS Council Secretariat (NACS):** In line with the findings of the evaluation, the Health and HIV Program has begun to reduce its support for governance within NACS. However, we believe that a complete withdrawal of engagement with NACS would be counterproductive. NACS is the mandated body for national HIV co-ordination, and is increasingly accepted by government bodies at provincial and local levels. The 2011–12 restructure of NACS is encouraging and we believe that the Health and HIV Program should continue to support NACS via targeted technical support to strengthen key functions, including leadership and advocacy on the highest priorities for action to address HIV, informed by evidence on the epidemic in PNG. The Health and HIV Program will also work closely with the PNG National Department of Health (NDoH) and provincial governments to appropriately integrate HIV services within broader sexual and reproductive health services.
 - c. **The Health and HIV Program’s measurable impact on HIV:** The evaluation found that a major challenge for the Health and HIV Program has been demonstrating a direct impact on the HIV epidemic. The lack of reliable time series country data for the HIV epidemic in PNG adds to this challenge.

The Health and HIV Program has achieved some clear results. These include “tremendous gains” to HIV prevention from testing and treatment, noted by the Independent Review Group (IRG)¹ in 2011. The Health and HIV Program has directly supported more than a third of the country’s 315 testing sites by 2011². The Poro Sapot project reached 74 per cent of sex workers in Port Moresby with condoms, while the PNG Business Coalition on HIV/AIDS was funded to distribute 25 million condoms nation-wide. In addition, the Health and HIV Program has contributed to the emergence of a strong civil society response to HIV;

1 A panel of HIV international specialists who review progress in PNG annually.

2 <http://www.ausaid.gov.au/country/png/hiv aids.cfm>

increased provincial government coordination; and leveraged a significant increase in the Government of PNG budget allocation to HIV measures, through high-level engagement between Australia and PNG. This has resulted in an additional 6 million kina in 2010, and 15 million allocated in the Government of PNG recurrent budget for anti-retroviral treatment in 2011, with the total government HIV budget a record 49 million kina in that year.

AusAID is addressing the broader challenge of obtaining reliable country data which covers all of PNG, in two ways: by making best use of available data and by improving surveillance and data collection. For instance, modelling based on existing data is used by the Kirby Institute, University of NSW, to show the deaths and infections that would have occurred had antiretroviral drugs not been introduced or condom usage not improved.

To improve surveillance and data quality, AusAID continues to support the Government of PNG to collect and analyse strategic information. Building the NDoH capacity in disease surveillance will be a key focus for the Health and HIV Program, and will continue to build the evidence base. Commencing in 2011 and continuing in 2012, AusAID has been funding a large scale Integrated Bio Behavioural Survey through the World Bank which will both survey and test 12,000 people across PNG. This will provide reliable information on HIV prevalence across the different regions of PNG. AusAID is also improving program monitoring and evaluation systems to better track its contribution and achievements.

4. Overall the Health and HIV Program is delivering real improvements for the people of PNG and will benefit from implementing the recommendations from this evaluation.
5. Detailed responses to each evaluation recommendation are outlined in Annex 1.

CHAPTER 1: About this evaluation

The Office of Development Effectiveness (ODE) is responsible for monitoring and reporting on the effectiveness of Australian development assistance. In line with this mandate, ODE commissioned an evaluation of the Australian aid program's contribution to the response to the Human Immunodeficiency Virus (HIV) epidemic in Papua New Guinea (PNG). The evaluation aimed to assess whether the approach was effective in that context, and to inform future program priorities and approaches to supporting the HIV response in the country.

This chapter outlines how Australia's support to the national HIV response in PNG fits within the broader context of Australia's development assistance to PNG. It discusses the purpose of the evaluation and how it has been conducted, and sets out what the reader can expect from this report.

1.1 Australia's development assistance to PNG

PNG is an important development partner for Australia. Australia is committed to long-term support for development in PNG and is PNG's largest development partner, contributing more than two-thirds of total aid to PNG. Since 1975, Australia has delivered budget and program funding for multiple sectors in support of PNG's medium-term development strategies. *In 2010–11 Australian overseas development assistance to PNG was \$454 million.*

The importance of the aid relationship was emphasised in 2008 by the signing of the PNG–Australia Partnership for Development. The Partnership is a bilateral framework for making progress towards jointly agreed priority development outcomes. It represents a new way of managing the aid relationship through its emphasis on mutual accountability and annual review at the ministerial level.

Australia's contribution to the HIV response has been a major component of the Australian aid program in PNG in the last decade, and formed one of the four pillars of the PNG–Australia Development Cooperation Strategy 2006–2010. The PNG–Australia bilateral meeting in 2010 confirmed HIV as a priority development outcome under the Partnership. Bilateral negotiation of the HIV schedule (to be integrated with the health schedule) was underway at the time of this evaluation. The process of agreeing mutual objectives and commitments on HIV, which is subject to high-level review, provides an opportunity for a different way of working at the bilateral level.

ODE has conducted this evaluation in the context of a major review and reorientation of Australia's aid program in PNG. *A 2010 review of the PNG–Australia Development Cooperation Treaty (DCT) gave the message that 'the status quo is not an option,' and stressed the need to respond to perceptions that the Australian aid program to PNG is lacking impact and value for money.¹ The review pointed to a need for Australia to have more realistic standards by which to judge its impact and focus its efforts, and to make the most of its advantage in a difficult environment by building on successes.*

1 Independent Review Team, 2010, *Review of the PNG–Australia Development Cooperation Treaty (1999)*, Australian Government, Canberra, p. 1.

The findings and conclusions of this evaluation reinforce and build on the directions of the DCT review, as this report will show. The evaluation reflects the relevance of the major themes of the DCT review to Australia's support for the HIV response, particularly:

- There are significant successes that can be built on.
- Reliance on the use of technical assistance for capacity building, which is having limited impact, should be reduced and consideration be given to piloting the use of in-line positions.
- Greater prioritisation of the use of resources is needed to reduce the 'thin spread' of the aid program, including increased focus within each sector.
- There is a need for increased support to lower levels of government, including working with district and local level governments through provincial administrations.
- The Australian Agency for International Development's (AusAID) HIV work in PNG is leading practices highlighted in the DCT review, such as working more with non-state partners and alignment with PNG priorities.

The recommendations of this evaluation are consistent with those made by the DCT review and provide specific directions for future support to the HIV response, in line with the broader directions of reform in the PNG program.

One major contextual difference for the PNG–Australia HIV and AIDS Program (HIV Program) from the wider program should be noted. In terms of the PNG program as a whole, the DCT review observed:

Any influence Australia perhaps once enjoyed through the aid program is sharply diminished in light of PNG's resources boom, and its modest appetite for additional aid. Even in priority sectors where aid funds are concentrated, such as education, health and roads, Australia provides less than 20 per cent of total GoPNG [Government of PNG] resources to these sectors [...] the evidence suggests that one should be careful not to over-estimate Australia's influence.²

In contrast, this evaluation found that the situation in terms of Australia's support to the HIV response is quite different. *Australia's support accounts for the majority of funding to the response in the last decade and has had significant influence over the directions of the response.*

1.2 What the evaluation is seeking to achieve

ODE commissioned this evaluation to assess whether the Australian aid program's approach to supporting the national HIV response in PNG is effective for the context and of an appropriate scale to match the needs. This evaluation arose from dialogue within AusAID in mid-2009 on the need to fill evidence gaps on the HIV epidemic in PNG and assess how well AusAID was performing to support the response. ODE, AusAID's HIV Thematic Group, the AusAID Papua New Guinea Branch and the PNG–Australia HIV and AIDS Program agreed on a set of activities:

- An evaluation synthesis of existing evaluation and reviews of HIV programs in PNG to find out what was already known about interventions that work in the PNG context (led by the PNG–Australia HIV and AIDS Program—completed in 2009).
- A contribution to multi-donor support for the Integrated Bio-Behavioural Survey (led by the PNG–Australia HIV and AIDS Program—in planning at the time of the evaluation).
- An impact evaluation of successful HIV prevention approaches in PNG (led by the HIV Thematic Group, planned for 2011).
- A strategic program evaluation to ensure AusAID's approach to supporting the HIV response is on track (led by ODE).

² Independent Review Team, 2010, Review of the PNG–Australia Development Cooperation Treaty, p. 56.

This evaluation has looked at the Australian aid program's contribution to the HIV response as a whole, with particular emphasis on the effectiveness, relevance and sustainability of that contribution. The evaluation had a selective focus on the key issues of the management approach taken by HIV Program, which will provide valuable information to inform strategic decision-making. It has not focused in depth on any specific components of the Australian aid program's contribution.

The evaluation findings are focused on the period 2006 to 2010, and are informed by a historical analysis of trends in the Australian aid program's support to the HIV response since 1995.

Box 1: Evaluation questions

To what extent are AusAID's program priorities, activities and processes **relevant** for the Papua New Guinea context and why?³

To what extent and in what ways has the Australian aid program been **effective** in achieving its objectives?

To what extent are AusAID's program approach and activities **sustainable** and **facilitating national ownership** of the HIV response?

Is the Australian aid program's contribution to the national response managed and implemented **efficiently**?

The evaluation is primarily targeted at supporting the information needs of AusAID senior managers, who make the decisions on the directions of AusAID's support to the HIV response. For this audience, the *evaluation provides answers to major strategic questions on how well AusAID is performing and how it can adjust its approach to enhance the value of its contribution to the HIV response.*

Secondarily, the evaluation seeks to support the work of AusAID program staff in PNG implementing the HIV programs, and Australia's partners in the HIV response. For these stakeholders the evaluation has aimed to provide detailed assessments on specific aspects of the HIV Program and has contributed to knowledge management in the HIV response by synthesising volumes of existing information into new analysis.

This evaluation is the first independent evaluation of the PNG–Australia HIV and AIDS Program, and the first to consider the contribution to the HIV response from other AusAID sector programs.

1.3 The evaluation process

The evaluation has interacted with AusAID's HIV Program in PNG over a period of almost two years. Planning for this evaluation started in mid-2009 with workshops held by ODE with HIV Program staff. The evaluation team came on board in early 2010. In May 2010, ODE and two of the evaluation team members visited Port Moresby to consult with the wide range of stakeholders from AusAID and the PNG national response on the most important issues for the evaluation to focus on. Based on this input, priority focus areas were identified and used to inform the evaluation questions.

3 The objectives assessed under the effectiveness criterion are two of the three outcomes areas for the PNG-Australia HIV and AIDS Program: support for focus areas contributing to the achievement of the National Strategic Plan and enhanced capacity to lead and manage the national response.

From July 2010, the team started its extensive analytical work, which continued to the end of 2010. The team undertook its fieldwork in September/October 2010, with visits to Port Moresby, Western Highlands Province, Sandaun Province and Madang Province.

Stakeholders in PNG and Canberra were debriefed on preliminary findings of the evaluation by the team leader in October 2010. Stakeholders were given the opportunity to comment on the draft evaluation report during the peer review process held in March 2011.

ODE has focused on engaging with stakeholders throughout the evaluation process to influence change in a timely manner. The HIV Program has not stood still in that time. Its priorities and approaches have evolved, and it has undertaken its own review work that is influencing its future directions. Within the broader PNG Program, the follow up to the DCT review and initiatives by the Minister Counsellor (head of AusAID program in PNG) have affected the directions of the HIV Program, particularly the decision made in late 2010 to re-integrate AusAID PNG's health and HIV programs.

The PNG HIV response has also been evolving, notably with the development and commencement of the National HIV and AIDS Strategy 2011–2015, and a focus by the National AIDS Council (NAC) on completing the reform of its Secretariat.

The fluidity of the evaluation subject has offered challenges to the evaluation team. While the main data gathering for this evaluation was completed in October 2010, this report acknowledges changes that have been made since that time which are relevant to the evaluation recommendations, specifically:

- responses to the DCT review, including the move to the flagship sectors and new ways of managing technical assistance
- a greater focus on integrating HIV and health programs, including the management of these within AusAID
- a stronger focus on accountability for promoting gender equality across the PNG program
- a scoping review of options for the way the HIV program is managed in the future, conducted in March/April 2011.

However, from another perspective, the value of the evaluation has been enhanced by interaction between evaluation and management learning and reform processes. The process of evaluating the HIV Program during a critical point in time has meant that the evaluation influenced change long before the report was completed. From this evaluation, senior AusAID managers have evidence and independent assessment to support the directions they are moving in. It is heartening to the evaluation team that this evaluation, senior management initiatives and the results of the scoping review are all complementary and mutually reinforcing.

The final step in the evaluation process has been the development of the management response.

The management response is AusAID's formal response to this independent evaluation, and sets out management's view on the evaluation findings and how it intends to implement the recommendations. The management response also provides more detail on new directions in the program. In line with good practice, the management response has been integrated into this report. Readers should note the management response is not the work of ODE or the evaluation team.

1.4 What to expect from this report

This evaluation has drawn extensively on existing qualitative and quantitative data, and collected new qualitative data from key informant interviews, facilitated workshops, surveys and site visits.

The evaluation team does not claim that this report is completely comprehensive; even with the strategic focus of the evaluation the scope to cover was very broad. In the document review and fieldwork, the team had to make decisions about where to focus its attention. Therefore, the team acknowledges that it will never fully understand the intricacies of how AusAID's program works, or the PNG context, as well as program staff do. What it offers instead is *an objective perspective on a complex situation, based on a broad range of evidence and professional judgements informed by international experience, PNG experience and experience of AusAID's organisational culture.*

This means that the evaluation conclusions are based on the best information the team could access. However, the evaluation team believes that the evidence base is of sufficient quality and scope to have confidence that the evaluation conclusions broadly represent the current situation. The recommendations have a strong enough rationale to be considered seriously by program managers, who can then bring in their nuanced understanding of the situation to plan how the recommendations will be implemented.

In reading this report and considering the conclusions, the following points should be kept in mind:

- No holistic, comprehensive evaluation has been undertaken of the PNG National Strategic Plan 2006–2010 against which the evaluation team could measure the Australian Government's contribution to the PNG HIV response. The team therefore had to rely on a series of regular reviews done by the Independent Review Group (IRG) and other ad hoc reviews of different aspects of the HIV response.
- The findings are strongly influenced by the combined perspectives of key informants—AusAID staff and contractors, implementing partners, PNG Government officials and other PNG stakeholders. Perspectives from key informant interviews were triangulated with evidence from other sources, particularly program documents, government documents and review reports. Quotes given in this report should be considered illustrative.
- Significant voices who were not accessed during fieldwork were the individuals and communities who are targeted by AusAID's programs. The team was also unable to arrange to talk to other bilateral donors contributing to the HIV response in PNG.
- The extensive analytical work strongly influenced the findings. Much of the analytical work was done after the fieldwork, meaning that there was some impact on the depth of questioning undertaken by the team while in PNG.
- It was not within the scope of the evaluation to undertake a detailed analysis of each intervention supported by AusAID.
- The three provinces visited by the evaluation team were chosen to provide a picture of how AusAID manages its approach in the different contexts. These cases are intended to be illustrative, not representative. Selection of the three provinces was based on advice from stakeholders during the scoping consultations.
- The ownership survey and national workshop, and the self-assessments of mainstreaming effectiveness, had a less comprehensive response from stakeholders than was hoped. The data from these sources is not considered representative, rather illustrative of important perspectives of key stakeholders. For example, the survey captured the views of the NAC Chair, the National AIDS Council Secretariat (NACS) Director and the heads of HIV programs in a number of different agencies.

The report structure is based around answering the evaluation questions. Following a description of the evaluation subject in Chapters 2 and 3, Chapters 4 to 7 respectively address the evaluation questions of relevance, effectiveness, sustainability and efficiency. Chapter 8 summarises the evaluation conclusions and sets out its recommendations.

The annexes attached to this report contain essential information to support the findings and conclusions:

- Annex 1 is AusAID's management response to the evaluation.
- Annex 2 is the assessment and ratings for the Independent Progress Report requirements for the PNG–Australia HIV and AIDS Program, which was integrated into this evaluation.
- Annex 3 provides detail on the evaluation methodology.
- Annex 4 provides a timeline of HIV-related events in Papua New Guinea.
- Annex 5 provides some lessons from other countries.
- Other annexes ('Reference annexes', 'Analytical annexes', 'Evidence annexes' and 'Provincial response case study annexes', available on ODE's website) detail the terms of reference and design of this evaluation, and document the team's detailed analysis and the evidence base for the findings.

CHAPTER 2: Country context

This chapter describes the broader PNG country development context, which is essential for understanding the HIV response and the challenges the response has faced. It explains how understanding of the epidemic changed over time, and how the Government of Papua New Guinea (GoPNG) responded to it. Finally, it briefly outlines the challenges of aid delivery in this difficult environment. This evaluation takes these into account, as much as possible, in judging AusAID's effectiveness.

2.1 PNG's development challenges

The HIV epidemic is among a number of serious development challenges in PNG. The PNG Medium Term Development Strategy 2005–2010 identified major threats to development as the HIV epidemic, high population growth, unplanned urbanisation, dysfunctional service delivery systems and impediments to land reform. It noted that a significant proportion of the population is affected by relative poverty, poor infrastructure and gender inequality, and that underdeveloped health and education services are constraining development.

PNG's geography substantially impedes its development progress, with a rugged topography placing much of the rural population in areas which are difficult to access and making basic service delivery expensive and challenging. Some social factors also make development difficult, including high ethnic diversity, high levels of violence against women and social conflict.

Governance issues, which make these challenges difficult to overcome, are related to the nature of PNG politics and the structures of government. *Service delivery has been affected by unclear division of responsibilities between the different levels of government, leading to underfunding of basic services.* There is significant underfunding of the recurrent budget in priority areas. The National Economic and Fiscal Commission estimated that non-salary recurrent funding was 25 per cent of required levels in health in 2009.⁴

The Service Delivery Determination in 2010, which clarifies the responsibilities of provincial governments, provides an opportunity to improve funding of basic services. PNG also has significant opportunities arising from the expected revenue from the PNG Liquefied Natural Gas (LNG) project, which is expected to begin to flow by 2015.

2.2 PNG's HIV epidemic

The HIV epidemic has been a significant development challenge for PNG for more than 20 years. The first HIV positive case in the country was diagnosed in 1987. Since then the number of new cases appears to have risen steadily.

There are important contextual factors for understanding the HIV epidemic and the response to it.

- The evolving quality of surveillance methods and results has had a major impact on how donors, and AusAID in particular, have tailored their inputs into health and HIV programming.
- HIV is one of a number of major health challenges in PNG.
- The evolution of PNG's national response to HIV has shaped AusAID's contribution.

⁴ National Economic and Fiscal Commission, cited in Independent Review Team, 2010, *Review of the PNG–Australia Development Cooperation Treaty (1999)*, p. 34.

Changing understanding of the epidemic

Early understanding of the epidemic was based on unreliable and erratic epidemiological surveillance. In 2002, the United Nations Program on HIV/AIDS (UNAIDS) announced that PNG was the fourth country in the Asia Pacific region to have a ‘generalised’ HIV epidemic, based on antenatal surveillance data coming from Port Moresby Hospital.⁵ By 2003, it was estimated that PNG had 150 new cases of HIV per month (again based on very limited sample sizes). These findings led to deepening concern within the PNG health community and donors about the potential for the HIV epidemic to attain sub-Saharan African proportions, with projections of prevalence rates reaching 5 per cent or more of the adult population.⁶

Surveillance exercises continued to confirm these trends. The 2007 Estimation Report on the HIV Epidemic in PNG indicated the national prevalence to be 1.6 per cent, with an estimated 59,537 people living with HIV.⁷

Over time, understanding of the scale and nature of the HIV epidemic has improved. The understanding of the epidemic changed significantly in 2009 and 2010 when surveillance data was gathered from a much greater number of health and testing facilities across the country (increasing from 60 sites in 2007 to 178 in 2009 and 250 in 2010). The new data showed that, by the end of December 2008, the cumulative total of reported HIV cases was 28,294,⁸ indicating that the HIV epidemic was not as widespread as previously thought.

While caveats remain about the reliability of some of these data,⁹ the 2010 HIV estimation workshop participants concluded that the 2009 data provided the most complete picture to date. *Surveillance analysis for 2009 found that HIV prevalence was an estimated 0.92 per cent of the adult population.*¹⁰ Therefore, the epidemic is no longer classified as generalised for the country as a whole. However, prevalence rates vary within the country. The 2009 data¹¹ show that *HIV prevalence is highest in the Highlands and Southern regions of the country*, which can be considered to have a generalised epidemic, and lowest in Momase and the New Guinea Islands. With expansion of surveillance and testing sites over the last few years into more rural areas it has become clear that HIV infection is not only an urban phenomenon. It also appears that more women than men are HIV positive, though this finding must be treated with caution given that the vast majority of surveillance data comes from antenatal testing.

Table 1 shows the considerable progress made in understanding the epidemic (as estimates were revised downwards) and expanding essential services.

5 When HIV prevalence rates reach 1 per cent of the adult population, the epidemic is considered ‘generalised.’ When they are below 1 per cent, the epidemic is thought to be concentrated in certain population groups (and therefore known as a ‘concentrated’ epidemic).

6 Milestone 82 2004 National Consensus Workshop of Papua New Guinea, Draft Report submitted to National Agency Council, draft report submitted to NAC Port Moresby (2004b).

7 NACS, 2007, *HIV Estimation Report 2007*, National Department of Health, Port Moresby, Papua New Guinea.

8 NACS, 2009, *The 2008 STI, HIV and AIDS Annual Surveillance Report*, National Department of Health, Port Moresby; NACS, 2010, *The 2009 STI, HIV and AIDS Annual Surveillance Report*, National Department of Health, Port Moresby.

9 For example, not all sites provide regular monthly reports, and reports are sometimes incomplete.

10 *PNG HIV Estimates–June 2009*, National Department of Health, Port Moresby.

11 *PNG HIV Estimates–June 2009*, National Department of Health, Port Moresby.

Table 1: HIV epidemic and response indicators: 2007–2009

	2007	2008	2009
1. Number of new reported HIV infections	5,038	5,084	3,711
2. Estimated number of adults and children living with HIV and AIDS (2010 est. report)	59,537	76,665	27,401
3. Reported number of sites that are providing antiretroviral therapy (ART)	38	52	55
4. Estimated number of people needing ART based on UNAIDS/World Health Organization (WHO) methodology	5,712	7,120	8,790
5. Estimated ART coverage (%) in the country	38%	72%	77.3%
6. Reported number of people receiving ART	2,250	5,195	6,750
7. Number of facilities providing HIV testing and reporting to National Health Department—Surveillance Unit	60	166	250
8. Number of people who have received Voluntary Counselling and Testing	15,341 (2006)	120,667	123,661

Note: 2007–2009 data were sourced from NACS, 2009a and 2010a. Where the team were not able to find relevant data for 2007, data from 2006 were sourced from The HIV Program, 2008, *Quantitative Evidence of Progress 2007-2008*, AusAID, Port Moresby ('2008e').

Understanding of the drivers of the HIV epidemic in PNG remains patchy. The PNG Government and its partners will gain a more complete picture of the epidemic from an integrated bio-behavioural surveillance survey—planned at the time of the evaluation.¹²

A key new potential driver of the epidemic is the LNG project. The project will involve a large workforce of international and national workers. Its main impact will be in the Southern Highland Province and Gulf Province (extraction facilities), Western Highland Province (business centre and regional service hub) and National Capital District (processing plant and port). It will also involve major transport operations on the Highlands Highway, which extends its influence throughout the highlands provinces and Morobe. With a mobile workforce likely to come from around the country, the potential impact of increased HIV transmission related to the LNG project could be widespread.¹³ *The LNG project also brings with it potential positive impacts to support the HIV response, such as new infrastructure providing better access to information and services.*

The evaluation acknowledges how understanding of the epidemic based on limited information has contributed to the directions of the HIV response (and Australian aid to the response). This has been dealt with in this evaluation by historical analysis and by examining the validity of decisions based on what was known at the time (rather than what is known now).

¹² The integrated bio-behavioural surveillance study should give the most complete overview of HIV prevalence in the general population, who the most affected groups are and what the most important risk factors are for acquiring the infection.

¹³ Goldman, 2009, *PNG Liquefied Natural Gas Social Impact Assessment 2008*.

HIV in the wider public health context

HIV is one of a number of major health challenges in PNG and needs to be seen in the wider public health context. In 2004, it was reported that the most important cause of mortality at Port Moresby General Hospital was Acquired Immune Deficiency Syndrome (AIDS). However, other diseases continued to create much greater morbidity and mortality across the country, in particular those associated with pregnancy and delivery, as indicated by high rates of pregnancy and perinatal morbidity and mortality.

PNG has the lowest health status in the Pacific. The top causes of morbidity and mortality in the country are pneumonia, perinatal conditions, malaria and tuberculosis (based on 2004 data of variable quality¹⁴). Issues relating to deliveries are the leading cause of morbidity: less than half of mothers have their delivery supervised by a skilled birth attendant.¹⁵ Women suffer disproportionately from health problems, and maternal health outcomes appear to have worsened since the mid-1990s.¹⁶ Estimates of maternal mortality range from 250 per 100,000 live births (United Nations [UN] data released in 2010) to 733 per 100,000 (Demographic and Health Survey 2006 data).

The quality of the health sector also affects HIV services delivery, as many HIV services are delivered within general health clinics. Underfinancing of the health sector and other problems in the management of public health mean that many rural aid posts (the lowest level of health provision in the public sector) are not operating, and those that are suffer from frequent shortages of essential drugs.

There has been a marked deterioration in access to health services across PNG, especially in rural areas. The new National Health Plan reports that up to 781 aid posts had closed in the ten years between 2001 and 2010, while the number of public hospital beds decreased by around 1,300.¹⁷ The trend has been a general disinvestment in basic health services by government, with the health sector now the lowest funded sector within PNG's Medium Term Development Strategy.¹⁸ Faith-based and other non-governmental services have increasingly become the most reliable providers of prevention, treatment and care services across the health sector.

Due to the close interaction between the HIV response and the public health system, this evaluation has adopted a broader public health lens for analysis of the relevance and effectiveness of AusAID's HIV programs.

The PNG Government's HIV response

The national HIV response is led by the National AIDS Council (NAC) and coordinated by its national secretariat, NACS, and councils in each province. It is implemented by PNG government departments and service providers, provincial administrations, NGOs (international and national), faith-based organisations, businesses, donor-funded private contractors, community groups and volunteers.

14 Health management information systems in PNG remain relatively weak so that all data needs to be treated with a certain degree of caution. However, much effort has gone into improving data collection and analysis throughout the country, including for HIV. The WHO provides significant support to the National Department of Health to help improve their Health management information systems.

15 World Health Organization, *Western Pacific Region Health Databank 2009*, viewed 25 October 2010, <http://www.wpro.who.int/NR/rdonlyres/EFC777E2-7C9D-45A4-AF1F-0D17B6D60AF4/0/29PNGtabo9_final.xls>.

16 AusAID, 2005, 'Evaluation of the PNG National HIV/AIDS Support Project', Evaluation and Review, Series No 38, AusAID, Canberra, p. 30.

17 GoPNG, 2010, *National Health Plan 2011-2020*, National Department of Health, Port Moresby, p. 14.

18 GoPNG, 2010, *National Health Plan 2011-2020*, p. 15.

The national response started in 1986, when the first cases of HIV in PNG were reported. *The national response has gone through different phases over that time, reflecting an ongoing process of learning from and building on experience both outside and within the country context.*

The first decade of the response was a period of advocacy within the health sector to make the case for the HIV response, establishment of the early policy frameworks and structures to manage the national response. *In the mid-1990s, at the time when AusAID became seriously involved in providing support, the response was transitioning out of the health sector with the development of a multi-sectoral strategic framework.* The escalating spread of HIV throughout the country underpinned the decision to pursue a more integrated and multi-sectoral approach which addressed the broader social, economic, and cultural implications of the epidemic for the country's development.

The next phase of the response, approximately 1998 to 2003, was an intensive period of building the organisational structures and systems for the national response, further developing the policy and legal frameworks, and embarking on the major national awareness campaign. It was at this time that National AIDS Council Secretariat (NACS) and the Provincial AIDS Committee Secretariat (PACS) were established with AusAID support. A major milestone during this time was passing the HIV and AIDS Management and Prevention Act 2003 (HAMP Act), which provided the legislative mandate for addressing HIV stigma and discrimination and responding to the HIV epidemic within a human rights framework. This period also saw a significant expansion in the numbers of non-state organisations involved in the response. Less positive developments were the disengagement by other government sectors from the response, and difficulties in establishing provincial responses.

When the current AusAID HIV Program was starting in 2006 the national response was going through a period of expansion, at a time when available evidence presented an emergency scenario that required urgent action to offset the potentially devastating impact of a generalised HIV epidemic. During this time, the numbers of implementing partners and the scope of national HIV program activities grew considerably. Recognition of the importance of understanding the gender-related drivers and impacts of the epidemic was gaining traction. Important steps were taken to build stronger leadership and political commitment to the response, including prioritisation of HIV in the PNG Medium Term Development Strategy 2005–2010. National advocacy bodies were established: Igat Hope (the first formally constituted association to support people living with HIV), the Business Coalition Against HIV and AIDS (BAHA), and the PNG Alliance of Civil Society Organisations against HIV and AIDS.

The National Strategic Plan on HIV and AIDS 2006–2010 (NSP) informed AusAID's contribution to the response for the main period covered by this evaluation. The Government of PNG, donors and implementing partners worked to address the NSP's seven focus areas:

1. Focus Area 1: Treatment, Counselling, Care and Support
2. Focus Area 2: Education and Prevention
3. Focus Area 3: Epidemiology and Surveillance
4. Focus Area 4: Social and Behavioural Change Research
5. Focus Area 5: Leadership, Partnership and Coordination
6. Focus Area 6: Family and Community Support
7. Focus Area 7: Monitoring and Evaluation (M&E).

At the time of this evaluation, the national response was entering into a new phase. AusAID and other donors have supported the Government of PNG to develop a new National HIV and AIDS Strategy 2011–2015 (NHS). *The NHS represents a shift in focus in the national response, with an emphasis on a significantly scaled-up prevention response and addressing the drivers of the epidemic.* As a highly inclusive and well-regarded process, the development of the NHS represents a maturing of the way of working of different partners in the response.

The NHS is complemented by recently completed policies, such as the PNG National HIV Prevention Strategy 2010–2015. In 2010, PNG applied to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) for a Round 10 grant, which was approved by the Global Fund’s Board subject to clarifications and grant negotiation.

The PNG Government is contributing an increasing amount of the national budget to the national HIV response. In order to cover a gap in funding of antiretroviral (ARV) drugs when the Global Fund Round 4 grant expired in mid-2010, the Government of PNG released PGK 6 million (approximately \$2.4 million) to meet the costs of treatment. This was followed up by allocation of a further PGK 15 million for treatment and a substantial increase in the government budget for the HIV response in 2011.

2.3 Challenges of aid delivery in PNG

The evaluation team acknowledges that PNG is a very challenging environment to deliver effective aid. The successes and weaknesses of Australian aid to the HIV response listed in this report should be considered within a context where successes are hard to come by—and therefore are of significant value.

In implementing the aid program in PNG, AusAID is faced with the geographical, social and governance factors outlined above. ODE evaluations looking at service delivery in other PNG sectors also highlight the implications of this difficult operating context.¹⁹ For example, the evaluation of Australian aid to health service delivery in PNG (2009) found that:

*The continuing absence of non-salary operating budgets, and related shortages of drugs and frontline staff, has meant the investments in buildings, equipment and [technical assistance] that account for most of Australia’s aid inputs have inevitably struggled to achieve significant or sustainable input on services delivery. This is not a reflection of the quality of much of the work that was carried out [...]*²⁰

This does not mean that results cannot be achieved in such a context. These evaluations do emphasise, however, that *the decisions that AusAID makes about how to work in this difficult environment have a significant impact on the success or otherwise of programs.* The health service delivery evaluation concluded that ‘...with the benefit of hindsight, different choices about where AusAID inputs should be spent would probably have produced more substantial impact on service delivery.’²¹ This view is consistent with the DCT review, which has focused on how AusAID can operate differently to obtain greater impact.

As much as possible, the findings and conclusions of this evaluation account for the difficulties of the operating environment, and judge effectiveness in terms of factors that AusAID had in its control or could influence.

19 Foster et. al., 2009, Working Paper 1: Papua New Guinea Country Report. Evaluation of Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands and Vanuatu; Steve Packer et.al, 2010, Improving the Provision of Basic Education Services to the Poor in Papua New Guinea; Mick Foster, 2010, Improving the Provision of Basic Services for the Poor: Linkages with Broader Public Sector Reform.

20 Foster et. al., 2009, Working Paper 1: Papua New Guinea Country Report.

21 Foster et. al., 2009, Working Paper 1: Papua New Guinea Country Report.

CHAPTER 3: AusAID support to the national HIV response since 1995

This chapter describes the Australian aid program's involvement in the national HIV response since 2006. It outlines how the Australian aid program fits with other development partners' contributions to the response, and provides historical context to the evaluation subject: the AusAID HIV programs running from 1995 to 2006. It should be noted that the focus of the evaluation goes to 2010; this chapter does not cover subsequent developments (for an overview of recent developments see the Management Response in Annex 1).²²

AusAID has funded three distinct HIV projects to support the national HIV response since 1995. These are:

- the Sexual Health and HIV/AIDS Prevention and Care Project (known as the Foundation Project), from 1995–1999
- the National HIV and AIDS Support Project (NHASP), from 2000–2006
- the PNG-Australia HIV and AIDS Program (initially known as Sanap Wantaim and referred to in this report as the HIV Program), from 2006 to present.

AusAID has also provided support for the HIV response to the National Department of Health (NDOH) through its health program, to provincial governments through its Sub-National Strategy program, and to government agencies through the transport, agriculture and law and justice sector programs.

3.1 Development partner contributions to the HIV response

The national HIV response is led by the Government of PNG and brings together government, civil society and development partners in addressing the epidemic. AusAID is one of many different partners contributing to the HIV response.

AusAID is the lead development partner in the HIV response, a situation arising from the strategic interest of Australia in supporting PNG's development. In the early 2000s, the different development partners agreed that the Australian Government should be the lead partner for HIV.²³ However, important contributions are made by other development partners and PNG partners. One of the prominent partners in funding the response has been the Global Fund, whose funding has been primarily used to purchase and distribute HIV testing kits and ARV drugs. PNG received its first HIV grant from the Global Fund in 2004.

²² Events have continued to develop during the time this report has been drafted, peer reviewed and finalised. While the evaluation team acknowledges these where possible, the evidence base collated for evaluation findings does not go beyond the end of 2010. The management response to this evaluation is an important document for outlining how recommendations will be addressed and for providing up-to-date information relevant to the implementation of the recommendations.

²³ The evaluation team did not see written confirmation of this, but was told of this agreement by three stakeholders who were involved in the agreement.

The United Nations agencies have also provided funding, either in support of specific programs (for example, United Nations Children's Fund [UNICEF] for the roll out of Prevention of Parent to Child Transmission) or as technical assistance (for example, UNAIDS and United Nations Development Programme [UNDP] for monitoring and evaluation, or WHO for HIV surveillance). The United Nations Country Programme workplans for 2010 indicate that there is not a clear division of responsibilities between the UN agencies and AusAID, with the UN also implementing activities related to prevention, civil society capacity building, and leadership development.

While other donors play a smaller role in the PNG HIV response, they have funded some significant activities—for example, the Asian Development Bank (ADB)-led Rural Enclaves Project. *There are also significant national actors who play a role in financing the response.* The Business Coalition Against HIV and AIDS, which leads on workplace policies, is almost entirely business-funded. The PNG Sustainable Development Program, which implements community mobilisation programs, is funded from the OK Tedi mine. There are also numerous community initiatives that rely on volunteers and donations. For example, a home based care (HBC) program in Western Highlands Province is run out of the home of a community leader and has received some support from the local church.

As a group, donors have played a role in strategic development and monitoring of the response.

For the NSP, NACS formed a steering committee with representation from key donors and implementing partners to guide the development of the NSP implementation plan, aligning it for the first time with the Government of PNG's annual planning and budget cycle. In 2007, a donor-funded Independent Review Group (IRG) on HIV/AIDS was created to support monitoring of the response through annual assessments of progress against the NSP.

The contribution of development partners has been shaped by the limitations of the PNG Government's involvement. As support from donors and development partners increased, along with their increased involvement in management and coordination, political leadership to carry ownership of the response waned and government funding for the national response declined and became sporadic. The disbandment of NAC in 2007 for almost two years, while amendments were made to the NAC Act, meant there was no active governance structure at the helm of the response. Concurrently, *long-standing issues of poor financial management and accountability within NACS created a situation where the government appeared to be rescinding its responsibility for overseeing and coordinating the national response. This left the gap to be filled by donors and implementing partners on the NSP Steering Committee to provide guidance and ensure ongoing support for program activities.* At the time of this evaluation, NACS was in its second year of organisational reform. These reforms were showing little influence on the effective functioning of the organisation. NACS stakeholders expressed increasing frustration, and sought alternatives for coordination of the response.

In addition, during this time the health sector was resuming its central role in service provision with the expansion of HIV testing through voluntary counselling and testing (VCT) services, and the advent of antiretroviral therapy provision through the Global Fund. The emphasis placed by donors on improving surveillance to better target interventions, and improving M&E to measure performance better, resulted in shifting surveillance responsibility from NACS back to the NDOH, and renewing the focus on health sector capacity to manage strategies regarded as essential for an effective national response.

In the two years leading to 2010, the partners of the national response were taking stock and reflecting on achievements and lessons learned as the basis for reframing strategic directions in the national response.

3.2 History of Australian support to the national response to 2006

AusAID has been fundamental to the conceptual and strategic development of PNG's national response to HIV from the beginning, providing essential technical and material support and funding to influence and shape the direction the response has taken, and to activate its implementation. *The contribution, provided through successive programs of support, has been so interwoven into the fabric of the national response that it is sometimes difficult to separate AusAID's roles and responsibilities from those of the PNG government and other partners.*

The Sexual Health and HIV/AIDS Prevention and Care Project, 1995–1999

In response to the increasing prevalence of HIV in PNG in the early 1990s, the Government of PNG requested the Australian Government to extend financial and technical assistance to address sexual health issues, including HIV, in line with the National Medium-Term Programme for the Prevention and Control of AIDS 1989–1995. The Sexual Health and HIV/AIDS Prevention and Care Project, now referred to as the Foundation Project, commenced in 1995 as a bilateral cooperation project jointly funded by Australia and PNG. Its goal was to improve the sexual health status of the people of PNG, prevent the transmission of HIV, and provide quality care for people with HIV and AIDS. The Project focused on supporting the PNG NDOH Sexually Transmitted Disease/AIDS Unit, strengthening clinical and laboratory services, including the refurbishment of 12 clinics for sexually transmitted infections (STIs), building networks with other agencies, and supporting a range of prevention and care activities. The first six PACs were launched with the support of the Project before the Medium Term Plan on HIV/AIDS 1998–2004 (Medium Term Plan) was developed and NAC and NACS established.

Although physically located in NDOH where project officers worked closely with departmental counterparts, *the Foundation Project played a key facilitation role in the transition to the multisectoral approach* that was first envisaged by the National Medium-Term Programme and carried forward through the Medium Term Plan. It actively advocated and supported the establishment of NAC and NACS and played a key role in facilitating the development of the Medium Term Plan. Significantly, the Project organised and conducted two national HIV and sexual health seminars that brought together broad-based representation of organisations and individuals throughout the country to lay the groundwork for further HIV policy and program development and building multi-sectoral partnerships to mobilise the national response.

Management of the Transex Project represented the beginnings of AusAID's close working relationship with NGOs as implementing partners. The Transex Project produced an expanding network of committed volunteer peer educators and outreach workers, as well as staff trained in data collection and analysis and facilitation skills.

A mid-term review of the Foundation Project carried out in May 1997 concluded that, while considerable progress was made in achieving component objectives, the three-year project design was far too ambitious and under-resourced. The review noted that the Government of PNG faced considerable constraints in matching resources to sustain the project, and that the rapid spread of the epidemic required both governments to put in place a longer-term project with expanded scope for supporting the national response.

The National HIV and AIDS Support Project, 2000–2005

The National HIV and AIDS Support Project (NHASP) was developed from the review of the Foundation Project and was *designed to respond to the pressing needs of the rapidly spreading epidemic*, which reached 1,074 newly reported HIV cases in 2000.

The goal of NHASP was ‘to minimise the impact of HIV/AIDS in PNG,’ and its purpose was ‘to support the implementation of the multi-sectoral national HIV/AIDS Medium Term Plan of PNG,’ primarily through the provision of technical and financial assistance to NACS.

NHASP was a complex, multi-sectoral project involving a large number of activities at different levels of engagement. The Project Design Document described an ambitious agenda:

The National HIV/AIDS Support Project is a health, governance, education and community development project. It is designed to work in all sectors and at all levels of the community and will empower a number of groups at national, provincial and local levels to undertake HIV/AIDS prevention and care activities. A sustainable response to the epidemic will be achieved by facilitating community-led responses and ensuring that PNG’s political, legislative and policy environment is supportive of activities to prevent the spread of HIV/AIDS.²⁴

Implemented in all 20 provinces of PNG—although with a heavy focus on activities in the National Capital District and urban areas—it had to be responsive to differences in the magnitude of the epidemic throughout the country, and different logistics and operating environments at the provincial and district levels.

The NHASP model was shaped by frequent requests for support to strengthen NACS’s capacity by the NACS Director while it was being designed. It was managed as a contracted project by a private company, with staff located in the NACS office matched in advisory roles to NACS counterparts.

NHASP made important contributions to the national response. It supported, for example:²⁵

- enhanced levels of HIV awareness across the population as a whole through a phased national media and advocacy campaign
- the promotion of a rights-based response, through a comprehensive HIV policy and legislative reform review, which served as the basis for the HAMP Act
- improved STI and HIV diagnosis and service delivery through health worker training and increases in provincial laboratories and STI clinical facilities
- addressing the gender dimensions of the epidemic, including support for gender-targeted services, research, gender disaggregation of surveillance data and Information, Education and Communication
- community-based initiatives through a small grant scheme
- significant legislative and organisational milestones in national leadership of the response, including the passage of the HAMP Act by Parliament, the establishment of the Special Parliamentary Committee on HIV/AIDS, the relocation of NAC from NDOH to the Office of the Prime Minister, and the appointment of a Minister to assist the Prime Minister on HIV/AIDS.

²⁴ AusAID, 1999, *PNG National HIV/AIDS Support Project: Project Design Document*, AusAID, Canberra.

²⁵ Aggleton and Renneberg, 2007, ‘Papua New Guinea National HIV/AIDS Support Project’, (AusAID AMS Number: 978K21), *Independent Completion Report*, AusAID, Canberra.

The NHASP evaluation²⁶ also highlighted a number of weakness that limited its effectiveness. Some of these were related to its relationship with NACS:

- *NHASP was not as successful in its focus on capacity building of NACS and PACS.* There was an unresolved tension in NHASP's dual focus on capacity building over the long-term while also supporting strategies for an emergency response. This led to NHASP in effect becoming a parallel coordinating and implementing body for the HIV response, often taking the lead in setting priorities and policy directives. Low levels of funding by GoPNG to NACS, and NACS's weak organisational capacity to plan strategically and manage the national multi-sectoral strategy, led to NHASP providing additional financial and staffing resources to enable NACS to function.
- NHASP made little progress on establishing provincial responses despite considerable efforts, and was criticised in the Independent Completion Report (ICR) for withdrawing resources from difficult PACS.
- Opportunities to maximise the impact of the HAMP Act were missed through lack of implementation support and not ensuring NHASP structures facilitated involvement of people living with HIV.
- NHASP's efforts in addressing gender dimensions of the epidemic through strategic planning continued to be problematic in terms of dedicated interest and commitment.
- Despite the massive awareness campaign during this period, there was little evidence to indicate whether strategies were leading to changes in sexual practice.

The difficulties in the relationship between NHASP and NACS, which many stakeholders attributed to the management model, directly affected the approach to the new program of support that started in 2006. This included a change of management approach based on direct management by AusAID to facilitate better relationship management, a deliberate separation from NACS by moving program staff to a separate office, and the stated desire by AusAID to have a 'lighter footprint' in the national response.

The transition to the PNG-Australia HIV and AIDS Program was a staged process during 2006, involving a comprehensive set of strategies for all project components as set out in the HIV Program Implementation Framework.

For further information on the Foundation Project and NHASP, see the historical analysis (Annex 12).

²⁶ Aggleton and Renneberg, 2007, 'Papua New Guinea National HIV/AIDS Support Project', (AusAID AMS Number: 978K21).

3.3 The scale of AusAID's support, 2006–2010

AusAID's goals

The HIV Program goals directly align to the PNG Government's goals: to minimise the social and economic impact of the epidemic, to prevent new infections, and to improve care for those affected by HIV and AIDS. AusAID seeks the following outcomes:

- Outcome 1: support for activities within agreed priority focus areas contributing to achievement of the PNG NSP.
- Outcome 2: enhanced individual, institutional and sector Papua New Guinean capacity to lead and manage a national response to HIV and AIDS.
- Outcome 3: AusAID's PNG Country HIV/AIDS response managed effectively.

The HIV Program does not represent a conventional program design; it is purposely flexible to respond to changing situational factors over its timeframe. The HIV Program is aligned to support the NSP and NHS focus areas.

The intentional flexibility of the HIV Program's design has facilitated changes in strategic direction over the last four years. Objectives are reviewed and refined on an annual basis, with increasing focus since 2007 on provincial engagement, support for civil society organisations, performance monitoring and knowledge management.

Financial contribution

AusAID's financial contribution to the national HIV response has been a significant proportion of total funding. *Australia's aid contributed 56.5 per cent of the total funds committed to the PNG national response between 2000 and 2009.*²⁷

*The Australian aid program has, through a series of programs dating back to 1995, provided total funding to the national response of approximately \$250 million up to 2010. The scale of the Australian financial contribution to the national response has increased steadily over the last 10 years, growing from \$1.8 million in 2000 to \$47 million in 2010.*²⁸ Prior to 2005, the proportion of AusAID's contribution was on average 80 per cent, but was smaller in absolute terms.

Since 2007, the Australian Government has provided approximately \$174 million in support of HIV programming in PNG. The PNG–Australia HIV and AIDS Program is AusAID's main vehicle for supporting the Government of PNG's efforts to address the HIV epidemic, comprising \$27.8 million in 2009. A further \$19.6 million was channelled for HIV through AusAID's program in the health sector and through HIV mainstreaming in other sector programs.²⁹

In 2009, the PNG Government contributed 6.3 per cent of the total funding to the response. In that year, 68.3 per cent of the funding came from AusAID, and the remaining 25.4 per cent came from other development partners. Other primary external donors to the national HIV response include the Global Fund, the ADB and the UN agencies.

Table 2 provides a summary of funding for the HIV response from all sources since 2007.

27 Heijkoop and Piel, 2010, Budget Analysis of the Australian Aid Program's Contribution to the National HIV Response in PNG, p.12 (Annex 13 to this evaluation).

28 Heijkoop and Piel, Budget Analysis of the Australian Aid Program's Contribution to the National HIV Response in PNG, p.11 (Annex 13 to this evaluation).

29 The HIV Program, 2010, *AusAID HIV Sector Performance Report 2009*, AusAID, Port Moresby.

Table 2: AusAID HIV funding compared to all sources of HIV funding 2007–2010

Estimated (AUD) combined resources contribution to the PNG HIV response					
		2007	2008	2009	2010
Government of PNG		\$7,033,142	\$9,039,500	\$4,375,540	\$6,393,555
	NAC—Recurrent	\$2,000,000	\$2,200,000	\$2,300,000	\$2,300,000
	NAC—Development	\$5,000,000	\$6,700,000	\$2,000,000	\$3,900,000
	Education	-	-	-	-
	Health	-	\$59,096	\$72,233	\$193,555
	Transport	-	-	-	-
	Law and Justice	\$33,142	\$80,404	\$3,307	-
	Agriculture	-	-	-	-
	Community Development and Sports	-	-	-	-
Donors		\$45,216,812	\$65,534,439	\$64,954,467	\$63,365,374
	UN Agencies	\$5,400,000	\$6,000,000	\$3,400,000	\$1,300,000
	New Zealand	\$400,000	\$400,000	\$300,000	\$200,000
	United States Agency for International Development (USAID)	\$1,600,000	\$2,100,000	\$3,600,000	\$1,900,000
	Global Fund	\$1,300,000	\$5,300,000	\$4,300,000	-
	Clinton Foundation	\$2,700,000	\$2,300,000	-	\$3,800,000
	ADB	\$2,400,000	\$7,300,000	\$6,000,000	\$5,700,000
	AusAID	\$31,416,812	\$42,134,439	\$47,345,467	\$53,165,374
Total HIV Funding		\$52,249,954	\$74,573,939	\$69,321,007	\$69,758,929
Percentage AusAID to Total Funding		60%	57%	68%	76%

Note: Figures for 2010 reflect budgeted amounts, not those actually expended. While AusAID's expenditure in 2010 is now known to be less than \$53 million, these figures are being used as they provide the best source for comparison with other funding sources.

Where AusAID's contribution is channelled

The majority of AusAID's funding for the national response is dispersed through non-government service providers: 60 per cent of funding in 2009, an increase from 35 per cent in 2007. The HIV Program provides annual grants to 20 international and national non-government partners (as of 2010). These partners submit proposals for funding through the NSP annual planning process, and are then funded by AusAID and other development partners. Funded partners use their grants to deliver services against the various NSP focus areas, including testing and counselling, implementation of HIV prevention activities, and home base care services. A further 21 partners are funded through PNG–Australia Sexual Health Improvement Program (PASHIP).

A much smaller proportion of funds are directed to support activities of the PNG government. This proportion has declined since 2007 in direct relation to the increase of funding to non-government partners. Few of these funds are dispersed directly through the PNG Government. Instead, AusAID has paid directly for procurement of goods on behalf of NACS and funded an external accounting organisation to manage NACS's funds. Where AusAID has supported government operations, this has taken the form of paying for specific contracted positions (in the NACS research unit) and assisting with travel costs of government staff.

AusAID's funding has contributed directly or indirectly to one of the seven NSP focus areas. AusAID has played a larger role in supporting progress in some focus areas than others. For example, while AusAID has led on development partner support for the Leadership, Partnership and Coordination focus area (FA5), it has only played a supporting role in the Monitoring and Evaluation focus area (FA7). In the Treatment and Care focus area (FA1) AusAID has shared the lead, with AusAID instrumental in the rollout of treatment services through its non-government partners, and the Global Fund facilitating the rollout of treatment. Table 3 explores further the Australian contribution to NSP focus areas.

Table 3: AusAID’s relative contribution to NSP focus areas

Focus Area (FA)	AusAID HIV program contribution	Direct HIV program expenditure 2007–09 ³⁰	Other development partner/ government role (not comprehensive list)
FA1 Major role	Lead on expansion of voluntary counselling and testing and strengthening clinical services.	11%	Global Fund lead on treatment rollout. GoPNG role in training and registration of health workers, and delivering HIV and STI services through government clinics.
FA2 Major role	Lead on funding and support to civil society organisations to deliver HIV prevention services. Fund major prevention programs targeted to most-at-risk.	20%	ADB—behavioural and condom social marketing component of Rural Enclaves Program. PNG Sustainable Development Program—community conversations. Projects funded by other bilateral donors.
FA3 Minor role	Support role as member of Surveillance technical committee. Indirectly, support for expansion of testing facilities (FA1) has had an important impact on expansion of surveillance data.	0.3%	Support to NDOH on rollout of surveillance through ADB and UN. Surveillance data collected by government and non-government service providers, and coordinated by multi-stakeholder committees in each province.
FA4 Major role	Lead on supporting government capacity to coordinate social and behavioural research through technical assistance and funding for staff positions and research grants.	4%	Intensive support by AusAID no longer required—now led by NACS Research Unit, and coordinated by the Research Advisory Committee.
FA5 Major role	Lead on supporting government coordination of the response (national and provincial level). Shared role in supporting establishment of coordination bodies and encouraging national leadership.	7%	Some technical assistance to NACS from UN. UNDP and UNAIDS also operate HIV leadership programs. Family Health International funds capacity building of selection PACS. Significant support in establishing Igat Hope from the UN. BAHA primarily supported by its business membership.
FA6 Minor role	Support to family and community care through funding of community based service delivery.	3%	No coordinated lead in family and community care—identified by IRG as a gap. Multiple models by multiple actors.
FA7 Minor role	Support role in technical support to government and capacity building of civil society partners.	1%	UNDP lead on supporting NACS in national response M&E.

³⁰ This does not include all funding from AusAID to the HIV response (for example, it excludes funding to the Clinton Foundation, the HIV Program, NGO grants and some administrative costs) and should be considered as indicative only. See Table 6 for more detail.

3.4 How AusAID's current contribution to the response is managed

AusAID's contribution to the HIV response is led by the PNG–Australia HIV and AIDS Program. Other contributions are through AusAID's support for the health sector, support for HIV mainstreaming in multiple sectors, and policy dialogue by the AusAID Minister Counsellor in PNG and other high-level Australian government officials.

The HIV Program commenced in 2007 as a seven-to-ten-year program of broad-based support for the national response. Its purpose is to 'support the development of leadership and capacity across PNG to promote, design, implement, monitor and review interventions to target agreed HIV and AIDS priorities'. The HIV Program's initial funding allocation was \$100 million over five years, and by the end of 2010, this had increased to \$185 million over seven years. A further \$25 million was allocated for PASHIP over six years to 2013.

The HIV Program is directed by a senior civil servant with technical HIV expertise who reports directly to the Minister Counsellor. In the 2006 HIV Program design this position was to be assisted by a limited number of advisors and administrative staff. This meant that AusAID provided senior level support separately to PNG's health and HIV sectors. A more detailed description of the HIV Program management arrangements can be found in Chapter 7.

Components of the Australian aid contribution to the response 2006–2010

AusAID's activities have a broad reach, with partners in multiple sectors of the national government, provincial governments, and a large number of civil society and faith-based organisations. AusAID HIV Program activities that directly contribute to the HIV response broadly divide into two streams: support to the Government of PNG in leading and managing the national HIV response, and support for the civil society contribution to the response. The way AusAID engages with partners is a critical part of the HIV Program's approach. The HIV Program has been very conscious of how it is perceived, based on learning from the previous program and has sought to have a 'light footprint' in the HIV response. Emphasis is placed on engagement processes, such as the NSP annual planning process, rather than just activities. With civil society partners in particular there is an emphasis on building flexible and strong relationships.

AusAID supports the PNG government's leadership and coordination of the national response through:

- technical support (from Advisory Support Facility and program advisors) and funding of NACS activities, including funding of Financial Management Improvement Unit and Procurement Implementation Unit and the Grants and Research Unit
- support to national condom procurement and implementation
- strategic engagement with government officials on the directions of the national response, and involvement in strategy and policy development
- technical support to the NDOH
- support for HIV mainstreaming in the PNG public sector
- technical support to Provincial AIDS Committees and their secretariats
- co-funding of the IRG.

AusAID's Minister Counsellor is a member of the NAC, as a representative of development partners.

AusAID's civil society partners in the HIV response in 2010 are listed in Box 2. Funding is only part of the HIV Program's support to civil society organisations. The HIV Program also has an extensive focus on technical and organisational capacity building of civil society partners, and on facilitating knowledge management and networking among partners.

Box 2: AusAID's civil society partners in the HIV response in 2010

PNG partners (NSP grants):

Anglicare StopAIDS, National Catholic AIDS Office, Appropriate Technology Projects, Baptist Union PNG, Igat Hope Incorporated, Susu Mamas, Salvation Army, PNG Sexual Health Society, International Education Agency, Friends Frangipani.

International NGOs/foundations:

Save the Children in PNG, World Vision, Family Health International, CARE Australia, Voluntary Services Overseas, National Association of People Living with HIV/AIDS (Australia), Australian Federation of AIDS Organisations, Scarlet Alliance, Tingim Laip (Burnet Institute), Clinton Health Access Initiative.

PNG Australia Sexual Health Improvement Program partners:

Anglican Board of Mission, Albion Street Centre, Anglicare StopAIDS, Anglican Health Services, Caritas Australia, National Catholic Family Life Apostolate of PNG & Solomon Islands, National Catholic Health Services of PNG, National Catholics AIDS Office of PNG and Solomon Islands, Australian Society for HIV Medicine (ASHM), Catholic Health Australia, Sexual Health and Family Planning Australia, Family Planning New Zealand, Canberra Sexual Health Centre, Help Resources, PNG Family Health Association, Burnet Institute, Cairns Sexual Health Centre, International Women's Development Agency, Save the Children Australia, Save the Children in PNG, PNG Institute of Medical Research.

The HIV Program also funds programs that have been designed and contracted by AusAID outside of the NSP annual planning process:

- **Tingim Laip (Value Life):** PNG's largest community-based HIV prevention strategy operating in 36 sites across 11 provinces (as of Phase 1). It focuses on targeted behavioural change interventions for the most vulnerable populations in settings where HIV transmission was known or likely to be high.
- **Porosapot:** co-funding of a Save the Children Fund-implemented project that works with sex workers and men who have sex with men in Port Moresby, Goroka, Kainantu and Lae through a peer-mediated intervention to improve sexual health and reduce HIV and STIs.
- **Clinton Foundation HIV/AIDS Initiative (known as Clinton Health Access Initiative in phase two):** a program to increase access to HIV testing and treatment while strengthening existing national health systems, particularly in rural areas.
- **PASHIP:** a partnership between five consortia of Australian and PNG NGOs, with support from the PNG Institute of Medical Research (IMR), to increase access to integrated, quality STI services in eight provinces.
- **Leadership Support Initiative (LSI):** provision of leadership training and coaching to politicians and government officials.

Cutting across these activities with both sets of partners are AusAID's activities to support best practice in the PNG national response, with strategies for developing evidence for programming, facilitating greater involvement of people living with HIV, and promotion of gender inclusive programming. Key activities in these areas are support for the research agenda and research grants, technical assistance to partners on gender equality, and core funding and institutional support for Igat Hope. The HIV Program also contracts the Australian Federation of AIDS Organisations, Scarlet Alliance (the Australian Sex Workers Association) and the National Association of People Living with HIV/AIDS Australia to provide mentoring to their PNG counterparts.

Capacity building is a major focus of AusAID's contribution, and the most prominent way in which AusAID staff have a presence in the national response. This has been through a variety of types of technical assistance (including short and long term advisory positions), training and support to systems development within different organisations.

One area of the national response where AusAID has little focus is engagement with the private sector, other than contributing funding to the Rural Enclaves Project through its health program.

Geographic focus

Through its implementing partners, the AusAID program coverage extends to all 20 provinces in PNG. In 2009, the HIV Program's Provincial Engagement Strategy defined its priority provinces as Western Highlands Provinces, Eastern Highlands Provinces, Southern Highlands Provinces, Morobe, Western Province, Sandaun Province and the Autonomous Region of Bougainville. These provinces were selected based on the highest reported HIV prevalence rates and Australian national strategic interests.

While the priority provinces have received targeted technical support, *in practice the HIV Program's coverage is determined by where its funded partners are located.* For example, Madang Province is not a priority province but has a significant AusAID-supported presence, with numerous funded partner implementing activities and visits by HIV Program technical advisors accompanying NACS teams or in support of program partners. A number of the partners funded through the NSP process (a proposal driven process) are clustered in certain provinces and/or urban areas, and are reluctant to go to the more remote and underserved areas. The HIV Program has had some success in encouraging some funded partners to focus on locations with the greatest need, but is hindered by the nature of the funding process.

How other AusAID programs contribute to the HIV response

A focus on HIV mainstreaming is applied across most of the PNG country program, and forms a significant part of the Australian aid program's contribution to the national HIV response. AusAID supports HIV mainstreaming through the GoPNG agencies it works with, as well as its non-state partners in the Democratic Governance Program (for example, the Media Council and the Sports Foundation). All programs in PNG are mandated to support HIV mainstreaming. AusAID programs provide support to their government counterparts for internal (workplace) and external (community) mainstreaming to varying degrees.

Implementation of support for HIV mainstreaming is based on two broad models: targeted advisor support, and integration into program activities. *Most of AusAID's support is based on specialist HIV advisors from Implementing Service Providers (ISPs) providing capacity-building and technical assistance on HIV mainstreaming.* This is the case for the HIV Program, the education sector program, the law and justice program, the transport sector program, the rural development program, and the Sports for Development Initiative.

Less common is the approach to promote HIV mainstreaming through a program's existing resources and staff, focusing on strategic entry points. This is the case for the sub-national strategy (SNS) program, the democratic governance program with most of its non-state actors, and the multi-sectoral Incentive Fund.

At the time of the evaluation, AusAID's health program was not playing a major role in supporting the government health sector HIV response. The health program does not have a focus on HIV mainstreaming. However, it has some significant inputs including funding technical support for the NDOH's Disease Control Program, and funding of the construction of STI clinics. AusAID also contributes to the Health Services Improvement Program, a multi-donor pooled fund, which finances provincial disease control programs.

The HIV Program has a role in coordinating and supporting AusAID programs to implement HIV mainstreaming. However, this role is unclear, with program staff uncertain as to what level of authority they have to fulfil their role. The HIV Program has drafted an HIV mainstreaming strategy for the AusAID PNG program, but this has not been finalised.

In the absence of an overall strategy, strategic direction on HIV mainstreaming is limited, and varies by sector. Some programs have specific HIV mainstreaming objectives and/or an implementation plan integrated into their program design. For others, it is a more ad hoc approach.

3.5 How AusAID expects its activities to achieve change

The Theory of Change exercise conducted by the evaluation team with HIV Program staff in 2010 confirmed that *they see their role as building government and civil society capacity to respond to HIV.*³¹ The team see the direct outcome of their activities as helping the key PNG organisations involved in the national HIV response to implement their activities more effectively through:

- having the funds they need to implement services and programs
- being able to work more effectively through greater technical and organisational capacity
- being more evidence-informed in policy and programming
- having processes for better coordination and information sharing among the response partners.
- Through the activities of its partners, AusAID indirectly contributes to progress against NSP (and now NHS) goals.

The logic of how AusAID's HIV Program activities will lead to the desired outcome rests on a number of assumptions about the operating environment and the actions of other actors in the national response. For example, *a major assumption inherent in the 2006 program design was that the HIV Program's main operating partner, NACS, would be able to develop its capacity quickly, to coordinate the HIV response effectively.* This is evident in the 2006 Program Implementation Framework, which stated 'it would be good to be able to report in early 2008 that NAC and NACS were becoming the acknowledged effective coordinator on HIV/AIDS.'³²

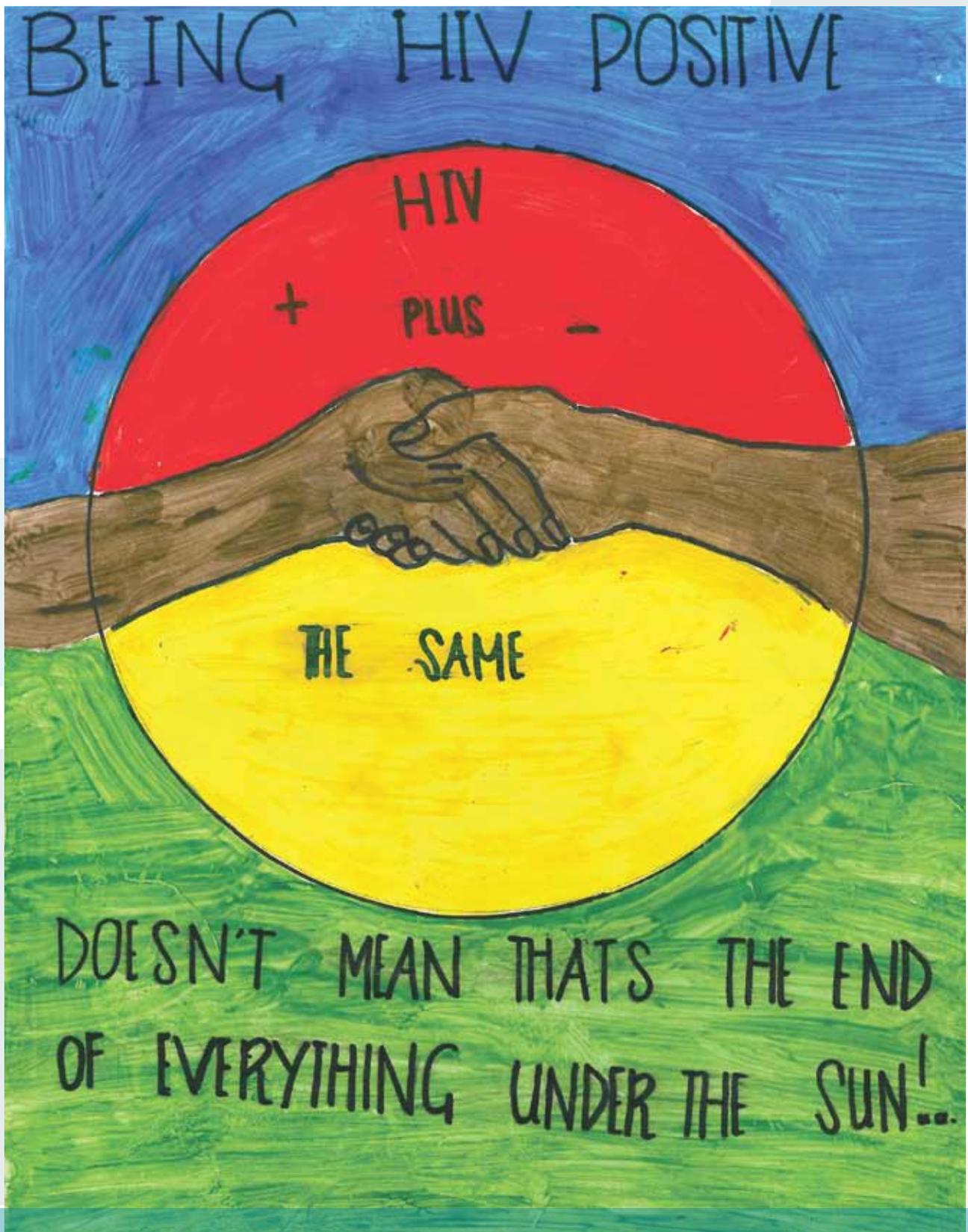
Another assumption identified by HIV Program staff in the Theory of Change exercise was that knowledge about the epidemic and how programs work in the PNG context, where it exists, would be applied effectively into policy and programs and drive decisions.

The evaluation has also identified other assumptions inherent in the HIV program's approach, for example, that the new management model would better facilitate PNG ownership of the response than the NHASP model. The Theory of Change exercise raised a question for the team about how program staff understand what is under the direct influence of the HIV Program (and can be held accountable for), and what it contributes to, alongside with other players.

Comparison of the 2006 Program Implementation Framework and the 2010 Theory of Change exercise suggest that *the HIV Program team's understanding of how their activities achieve change has evolved over the last four years.* Why changes are made in the program priorities and approach over time, how the HIV Program has managed the assumptions inherent in their Theory of Change, and how it has understood its position in the HIV response, are core to the relevance of AusAID's priorities and activities for the PNG HIV response. These will be discussed in the next chapter.

³¹ See Annex 10 for a detailed description of the Theory of Change.

³² Mooney, Malcolm and Winter, 2006, *Program Implementation Framework*, Papua New Guinea-Australia HIV and AIDS Program, AusAID, Canberra, p. 47.



“Being HIV Positive: Doesn’t mean that’s the end of everything under the sun!” Poster by participant of training on HIV stigma and discrimination, and basics in poster art development. The training was organised by AusAID’s PNG-Australia HIV and AIDS Program. Photo: AusAID. Image taken by John Gould.

CHAPTER 4: The relevance of AusAID's contribution

Relevance: The intended results, and the processes for achieving them, are evidence based and meet the needs of Papua New Guineans.

This chapter provides an overview of how relevant the AusAID contribution to the PNG HIV response has been for the period 2006–2010. The relevance of AusAID's contribution has been reviewed against the question: to what extent are AusAID's program priorities relevant for the PNG context and why? It considers whether the program design decisions and selected activities were 'the right things to do' in the given context.

Relevance is examined in light of the knowledge, understanding and assumptions made at the time of program design, and how these may have shifted to meet changes in knowledge of the epidemic, partner governance and effectiveness and other contextual factors. As mentioned in Chapter 2, the current HIV Program design took place when surveillance data indicated that the level of HIV infection was becoming an emergency, with potentially devastating social, health and economic consequences. At the same time, HIV coordination structures remained weak and the political landscape was changing with elections due. Finally, the impact of the LNG project was beginning to be felt as more people began shifting to the Western and Southern Highlands in search of work.

4.1 Key trends in the relevance of AusAID's contribution

A number of key trends in AusAID's efforts in the PNG context from 1995 onwards influenced the relevance of AusAID's contribution to the HIV response. These trends have also had an effect on the current program design.

- 1. Program objective alignment with government priorities:** *AusAID has consistently tried to ensure that the projects and programs it funds are aligned with government priorities and objectives. These efforts have increased over the last 15 years. The current phase of support under the HIV Program takes the most flexible approach in order to be responsive to changing national needs. These have been captured in annual planning processes that attempt to plan the contributions of all partners, not just AusAID. The evaluation team agrees that alignment with priorities and taking a flexible approach have been relevant approaches.*
- 2. Continued dominance of AusAID in the HIV response:** *AusAID has consistently been the dominant donor for HIV and AIDS activities in PNG. Table 2 in Chapter 3 provides an overview of all spending on HIV and AIDS programming from 2007 to 2010, including the Government of PNG and other donors. The Australian Government contribution increased over this period, from 60 per cent of total HIV funding in 2007, to 76 per cent of total HIV funding in 2010. The Australian Government has also dominated much of the HIV policy and strategy development since 1995, through technical assistance for planning and drafting of various documents. The Australian dominance in the sector has led to a fair amount of conflation in stakeholders' minds regarding the respective roles of the Government of PNG and AusAID in the HIV response. AusAID had been requested to take a dominant role by other donors (see section 3.1) and its growing influence was seen as necessary by AusAID staff and contractors when GoPNG leadership remained weak. The evaluation team considers that AusAID dominance has had an impact on how strongly owned the national HIV response is by national actors, a theme that is explored more thoroughly in Chapter 6.*

- 3. AIDS exceptionalism and program verticalisation:** *The HIV response in PNG has been increasingly verticalised in the last ten years. Some element of this was in line with an international push to treat AIDS as an ‘exceptional’ disease, especially where the epidemic became more generalised, because of the potential social and economic impact of HIV. The setting up of major AIDS-related organisations, such as UNAIDS, the Global Fund and the United States President’s Emergency Plan for AIDS Relief, all reflect this trend. When stakeholders in PNG began to see data indicating a significant increase in HIV infection they also felt exceptional, emergency efforts were required, which included setting up special testing and treatment centres outside of the normal health system, as well as separate systems and structures at national level. AusAID, in response to this sense of urgency and in line with the international context, decided to set up its own vertical program of direct support for the national HIV response. This approach may have appeared relevant in 2005 when the HIV Program was designed but in hindsight the evaluation team feels it was not appropriate. The consequences of this decision are explored in this chapter and in the next three.*
- 4. Shifting balance between prevention, treatment and care:** *Over the last 15 years, AusAID has shifted its investment in HIV programming away from treatment and care and more towards education and prevention. The early days of AusAID’s support emphasised a more integrated approach by funding HIV care as part of STI clinical services, improved laboratory capacity and health worker training. Much of this approach was continued in the second phase of AusAID’s support, through NHASP, although with increased investment in HIV awareness raising and advocating the Abstinence, Be Faithful and use Condoms (ABC) approach to HIV prevention. Starting with NHASP, and continuing in the HIV Program, AusAID has funded the rapid scale up of HIV testing and treatment services, putting money into training and infrastructure as a complement to Global Fund financing of testing kits and antiretrovirals (ARV). Since 2006, a much greater investment has been made in education and prevention, representing 21 per cent of AusAID funding through government and non-governmental organisation (NGO) partners (compared to 9.7 per cent for treatment and care). This does not include the contribution that AusAID continues to make to HIV clinical services through funding for the PNG health sector. A large amount of funding has gone to support people living in high-risk settings (such as main truck routes and market areas) or those more vulnerable to HIV (such as sex workers). Rapid scale up in testing and treatment was a relevant response to what was understood of the epidemic’s progression from 2004 to 2010 and has assisted with improving HIV surveillance.*
- 5. Continuity of support to specific provinces and urban centres:** *AusAID has been fairly consistent in focusing its funding for activities in its own priority provinces and providing substantial support to national institutions, such as NACS.³³ Limited surveillance data showed that HIV was more concentrated in urban centres, particularly Port Moresby, and most technical support has been concentrated in these areas. At the same time, AusAID has funded ongoing efforts to expand services out to rural areas, especially through its funding to faith-based health service providers and to groups doing HIV prevention work. For the last five years, program documents acknowledge that activities need to be much more decentralised. However, little support has been provided to decentralised government offices to facilitate this. The principle of supporting decentralised structures was and continues to be highly relevant. AusAID support to its SNS program is where this principle has best been translated into action for the HIV response, rather than through the HIV Program.*

33 Certain provinces in PNG are of particular strategic importance to the Australian Government.

- 6. Increasing support to non-governmental partners:** In many areas the gradual decline in public service provision across the country has seen non-governmental actors, including faith based organisations, increasing their services to fill the vacuum. As many of the development partners, including AusAID, scaled up their support to the HIV response to address what seemed to be a rapidly expanding epidemic, non-governmental and civil society actors were often the only ones available to take up the call to increase their level of activity. *The direct support to civil society organisations/NGOs has been very relevant as it has helped to increase the range of services provided and the geographical coverage, particularly for testing, treatment and raising awareness.*

4.2 Relevance of contribution to the National Strategic Plan focus areas

Contribution to treatment and care

Based on the surveillance information available in 2005, *AusAID's strategy to work with partners to scale up testing and treatment services across PNG was highly relevant.* More recent surveillance data now indicates that the earlier data had HIV prevalence at higher rates than should have been the case. Therefore, the predictions of PNG heading towards an 'African style' HIV epidemic were over-estimated. The evaluation team notes that this *improved understanding of the epidemic has come about precisely because there are far more testing services available, largely due to AusAID support*, a further factor that points to the relevance of expanding services.

While AusAID support to the expansion of testing, treatment and care services has been relevant, the evaluation team finds that AusAID support to the verticalisation of these services has not been appropriate. In the evaluation team's view, even if HIV infections had been proven to be increasing at the levels predicted, *AusAID's funding of 'stand-alone' HIV testing centres that were not integrated into wider primary care provision was not relevant or appropriate.* This also ran counter to the HIV Program's own objective of improving access to quality primary care services that integrated HIV and sexual health treatment and care. Other service reviews have also commented on this, including the review of the National Catholic AIDS Office (NCAO), which is AusAID's largest implementing partner for HIV treatment and care services. The review found that the NCAO had a preference for setting up specialist HIV services despite the PNG government policy to support integration of services.³⁴ This finding is consistent with an analysis of the Global Fund in PNG and how its funding has contributed to the development of parallel systems within the PNG health sector.³⁵ The verticalisation of HIV services appears even less relevant now that there is a better understanding of the concentrated nature of the epidemic and its relative importance to other major health concerns, especially the significance of sexual and reproductive health problems in the country.

Overall, the findings on the relevance of the AusAID contribution to the HIV treatment and care response have been mixed. Expansion of services has been relevant, but the way that these services have been expanded, primarily through vertical programming, has not been relevant or appropriate in the PNG context. Nor has it been consistent with PNG government policy of supporting integrated service delivery.

³⁴ Lowe, 2009, *Synthesis of HIV Reviews and Evaluations in Papua New Guinea 2006–2009*, AusAID, Port Moresby.

³⁵ Rudge, Phuanakoonon, Nema, Mounier-Jack and Coker, 2010, 'Critical interactions between Global Fund supported programmes and health systems: a case study in Papua New Guinea,' *Health Policy and Planning* 25(1), p. 48–52.

Contribution to education and prevention

AusAID support for education and prevention activities has been highly relevant in principle, but the approaches and interventions supported have been of poor relevance compared to the specific needs of PNG. In order to understand the relevance of the current AusAID assistance to the Education and Prevention focus area (FA2), it is important to consider the evolution of this support since 1995.

The principle of increasing HIV awareness across the PNG community was relevant when AusAID began its more formal contribution to the HIV response in the mid-1990s. Raising awareness is an important first step of promoting better health and healthier behaviours. Early phases of AusAID support were instrumental in supporting awareness raising activities through mass media and community education sessions. However, critics of some of the early work suggest that too much content was ‘imported’ from elsewhere and was not grounded in PNG social concepts of sexuality, reproduction, and illness. For example, emphasis on ‘high risk’ groups and the message were inappropriate for the PNG context.³⁶ This in turn has had a potentially damaging impact on perceptions of HIV generally, and of people living with HIV and AIDS specifically. As one PNG stakeholder put it, the general attitude to HIV in his community today is that ‘Only bad people get HIV, and no one sees themselves as a bad person’.³⁷

To be effective, awareness raising needs to be institutionalised through integration with ongoing activities, such as school health programs and workplace programs, and support for more targeted behavioural change activities. AusAID support to the Education Sector to improve its ‘life skills’ curriculum has therefore been highly relevant, as have AusAID efforts to support public sector organisations to put in place workplace policies and other mainstreaming activities. However, raising awareness on its own is not sufficient to change behaviour.³⁸ As reported by UNAIDS:

According to the available evidence from these and other studies, effective strategies pursue a combination of behaviour change approaches that are delivered with sufficient coverage, intensity, and duration, and that are tailored to address the main drivers of HIV transmission in national epidemics. Effective HIV prevention addresses the specific needs and circumstances of the target population and aims to affect multiple determinants of human behaviour, including individual knowledge and motivations, interpersonal relationships, and societal norms. Community engagement and strong political support have been key ingredients of successful national efforts to change behaviour to prevent HIV infection.³⁹

Despite a wide body of evidence about the limited relevance and effectiveness of most general information and awareness raising activities, most interviews with the HIV Program partner organisations carrying out HIV education and prevention work revealed that *general awareness raising persists as the main approach used by many AusAID-funded partners.*⁴⁰ *There are exceptions to this, where AusAID has funded larger NGO work (Save the Children’s Poro Sapot project, Family Health International’s Continuum of Care project) or the Tingim Laip program, all of which are grounded in the communities they work in and attempt to address the main determinants of HIV infection in those communities. However these approaches remain project based and have not been adapted across AusAID’s partners, nor more widely by most other national response partners.*

36 Evaluation Stakeholder Interviews August–October 2010.

37 Evaluation Stakeholder Interviews August–October 2010.

38 Kesterton and De Mello, 2010, ‘Generating demand and community support for sexual and reproductive health services for young people: A review of the Literature and Programs,’ *Reproductive Health* 7(25) <http://www.reproductive-health-journal.com/content/7/1/25>

39 UNAIDS, 2008, Behaviour Change and HIV Prevention: (Re) Considerations for the 21st Century, UNAIDS, Geneva.

40 UNAIDS, 2008, Behaviour Change and HIV Prevention: (Re) Considerations for the 21st Century.

AusAID's support for condom procurement has been highly relevant, as access to condoms is a critical pillar in HIV prevention.⁴¹ However, the way that the HIV Program chose to support condom procurement and distribution has been less appropriate and relevant. The HIV Program shipped over 40 million condoms to PNG for distribution by the NACS to its partners in 2009. While the condoms were purchased on behalf of NACS as agreed, the weakness of the public sector supply chain has been a major constraint on their distribution. The HIV Program's implementing service provider (ISP) has begun work with the AusAID funded Procurement Implementation Unit within NACS to improve systems to ensure condom supplies already warehoused in Port Moresby start to be distributed throughout the country. The evaluation team questions the appropriateness of setting up a separate procurement and distribution system through NACS for condoms when there is an existing condom procurement and supply system within the NDOH. It would be better to focus on improving the NDOH systems rather than attempting to set up a separate system in a different organisation that also suffers from weak capacity.

On the whole, AusAID's contribution to prevention and education has not been very relevant. Opportunities have been missed by not working to promote safer sexual and reproductive health behaviours more broadly. Both results might have been achieved through integrating improved sexual health diagnostics and prevention counselling with greater emphasis on tackling other drivers of poor sexual health (such as gender based violence, alcoholism, pressures faced by migrant and seasonal workers and so forth).

Contribution to epidemiology and surveillance

AusAID's limited contribution to epidemiology and surveillance has been relevant.

The overall AusAID funding contribution to HIV surveillance, in terms of improving NDOH surveillance systems, has been very limited. However, *its contribution of an advisor to work on surveillance within the NDOH, alongside other WHO advisors, as well as AusAID support to increasing and improving HIV testing centres and laboratory diagnostics, has been relevant for improving understanding of how widespread the HIV epidemic is.* As with clinical services more generally, the emphasis on HIV testing and diagnostics on its own, and not integrated into wider sexual and reproductive health, has not been appropriate.

Contribution to social and behavioural research

AusAID's investment in social and behavioural research since the 1990s, and particularly since 2006, has been highly relevant and appropriate.

Much of this research has been critical for determining what the drivers of poor sexual and reproductive health are, including the drivers of the HIV epidemic. The increased emphasis on improving research capacity and outputs in PNG over the last five years has been particularly relevant. AusAID's contribution to the development of a national HIV research strategy and the provision of funds to conduct research has been a very relevant and appropriate activity, especially in an environment where there is a need to develop a sophisticated understanding of the drivers of the epidemic. *The main challenge in relation to this focal area is not so much its relevance to need and the national response, but how well the findings of the research that has been supported have been used.*

⁴¹ Kesterton and De Mello, 2010, 'Generating demand and community support for sexual and reproductive health services for young people: A review of the Literature and Programs'.

Contribution to leadership, partnership and coordination

AusAID's contribution to leadership, partnership and coordination has been fairly relevant, though this relevance is tempered by the weaker relevance of the approaches taken, especially in support to leadership and coordination.

AusAID has put considerable staff time and funding into supporting the various HIV coordination structures in PNG as well as into leadership training more generally. In principle, these were relevant initiatives, in the sense that international evidence indicates that strong national and community leadership is required for an effective HIV response. In practice, the evaluation team suggests that the AusAID's LSI was duplicative of the HIV leadership training offered by UNDP and others, and there was no indication that the HIV Program attempted to assist with coordinating or harmonising these different leadership approaches.

AusAID's support to partnership for the HIV response has been highly relevant. Through AusAID funding and technical assistance, a wider group of government and civil society partners have increased their engagement in the HIV response in the last four years. This in turn has increased the opportunity for reaching out to a wider section of the population with different HIV related activities. The HIV Program's approach to building partnerships with different types of organisations is seen as a model for other AusAID programs in the country in order to maximise the coverage of AusAID's development assistance more generally.⁴²

As far as coordination is concerned, one of the critical underlying assumptions of the HIV Program was that it would work as a support structure to a functional NACS. The HIV Program's support for NACS over the last four years has been based on the premise that it would keep the basic functions running until a point where the GoPNG's reforms resolve the issues in NACS. A restructuring process for NACS commenced in 2008, and was continuing at the time of the evaluation team visit in October 2010. At that point, many stakeholders in the national response had lost faith that the restructure would achieve its intended results. In the end, the HIV Program has had to develop mechanisms to shore up, substitute for, and by-pass NACS as a coordination body.

In the evaluation team's judgement, the substantial investment by the HIV Program in a verticalised leadership initiative was not relevant. Furthermore, investment in time and funding in a NACS that clearly needed substantial reform, without conditioning its support on seeing that reform take place, was inappropriate.

Contribution to family and community support

AusAID's very limited contribution to family and community support activities has been relevant, though the level of contribution has been low compared to need.

The HIV Program has provided minimal financial support to this strategic area. The 2009 IRG report highlighted the lack of models in PNG that provide outreach services linking facility based health services to family and community support, including HBC. Family and community support is characterised by multiple approaches by multiple players, often with poor design and capacity.⁴³ This being said, some of AusAID's funding has been used by Family Health International to pilot models of international best practice in 'continuum of care,' ensuring that people living with HIV have services that cater for their needs from clinic through to their communities and into their homes.

⁴² Independent Review Team, Review of the PNG–Australia Development Cooperation Treaty, p. 56.

⁴³ Aggleton, Bharat, Coutinho, Drew, Dobunaba and Saidel, 2009, Independent Review Group on HIV/AIDS: Report from an assessment visit 23rd April-6th May 2009.

However, this model has not been tested for how appropriate it would be in facilities that see high numbers of HIV positive patients and would need further examination to determine its relevance to the whole of PNG. Given AusAID's emphasis on prevention, and the expansion of clinical services to respond to what was thought to be an 'HIV emergency,' the relatively weaker support to, and emphasis on, family and community support could appear to be appropriate. However, the evaluation team found that some of the strongest community mobilisation related to HIV is occurring around community care initiatives. Given that many of the different ethnic groups in PNG traditionally provide care and support for people and families affected by illness, it would be very appropriate and relevant to use these community customs as part of a continuum of prevention to treatment to care in the community.

Contribution to monitoring and evaluation

AusAID's limited contribution to M&E has been relevant both in its support for a routine independent review process, and where good coordination between stakeholders has occurred. However, it has missed opportunities to ensure better coordination with the health sector.

The current HIV Program's design assumed a minimal role for AusAID in supporting the M&E of the national HIV response, and that any support would be part of a joint program of support to the NACS M&E unit, as well as support for a regular independent review of NSP progress, through an Independent Review Group.

AusAID's funding for the IRG has been relevant and is consistent with international best practice, as has been AusAID's support to the Government of PNG to fulfil its global commitment to report on its HIV response every two years through the UN General Assembly Special Session (UNGASS) Progress Reports.

The joint M&E program within NACS finished in 2008. From 2009 when activities changed from those set out in the 2006 design, the HIV Program has been operating 'off-strategy,' without specific objectives and prioritisation guiding its attention on this strategic area compared to other areas of the national response. This is particularly notable in the more informal support to NACS since 2008, which appears to be based around being responsive to requests for technical support, including capacity substitution. While the change in the way the HIV Program has supported NACS and NDOH has been responsive to the changing operating context, the ad hoc nature of the approach may not be supporting the most appropriate activities for HIV M&E. Indeed, the major issues hindering progress in M&E, as outlined later in Chapter 5, would suggest that the HIV Program's support through the government structures is not well targeted. For example, it does not appear to have targeted major implementation issues, such as coordination issues between the NACS M&E unit and the NDOH surveillance unit. Given that AusAID has invested in technical assistance for NDOH surveillance as well as for NACS M&E, it could have made greater use of its leverage with both organizations to ensure better cooperation for improved data collection, quality and use.

4.3 Relevance of support to cross cutting issues

Support to policy and strategy development and dialogue

AusAID's support for policy and strategy development and dialogue has been highly relevant as far as need and output is concerned. However, the dominant role played by AusAID in the policy arena has been less relevant as far as encouraging PNG decision makers appropriating policies and strategies as their own.

Through each phase of AusAID's support to the PNG HIV response, successive programs have provided technical assistance and funding support for the development of HIV related legislation. This has included the HAMP Act, and the development of national strategies such as the Health Sector Strategic Plan for STI, HIV and AIDS 2008–2010, NHS and the National Gender Policy and Plan and HIV Prevention Strategy. These policies and strategies are highly relevant and useful for providing a more positive environment within which to work on HIV, even if their implementation continues to be challenging for the Government of PNG.

The Minister Counsellor, Program Director and other AusAID staff have played influential roles in several aspects of the national HIV response, including within the NAC. This is understandable given the lead role that other development partners asked AusAID to play. This influence would appear relevant given how weak other forms of national leadership and coordination have been. However, genuine questions have been raised by PNG stakeholders about how appropriate AusAID's dominance has been, and the degree to which this has left little space for other actors, either country partners or development partners, to take on leadership roles in the national response. There was a tendency among both HIV Program staff and other stakeholders to confuse the role of AusAID as a bilateral donor in the response and the role of the government. The evaluation team heard views about failures in the response that are seen as a responsibility of AusAID, even by NACS staff. There is a need for clarifying those aspects of the HIV response for which it is relevant and appropriate for AusAID to be accountable.

Strategic shift in support from national to provincial and non-government structures

AusAID's decision to change the balance of its HIV contribution towards non-governmental actors has been highly relevant, though the delay in putting increased emphasis on provincial level actors was not appropriate.

The AusAID support to improve coordination and management within the non-governmental sector and at provincial level has been a relevant strategic response to the substantial challenges experienced in working through national bodies. The significant support given to improve non-governmental and civil society capacity has been entirely appropriate, as these organisations have carried out the lion's share of national HIV response. The evaluation team questions why the HIV Program waited almost three years to develop a provincial support strategy, especially when the previous AusAID program (NHASP) evaluation had suggested that much greater investment and support needed to be given to decentralised coordination.

Support to promotion of gender equality in HIV activities

AusAID's support for improving gender analysis and gender sensitivity in program activities has been highly relevant in the PNG context.

AusAID has consistently made gender sensitivity an important feature of its HIV programming in PNG. Successive phases have helped to increase awareness of the gender-related dynamics of the epidemic and the HIV response, and a number of stakeholders have indicated this as a real achievement. NHASP in particular was noted for having assisted with the development of the National Gender Policy and Plan. The current HIV Program's gender advisers have provided gender sensitisation training for implementing partners and developed a number of audit tools to help guide program development. While perhaps not sufficient, it does provide a basis for action that is highly relevant in the PNG context, where gender inequality and gender-based violence are considered to be important drivers of the HIV epidemic. The Minister Counsellor (at the time of the evaluation) initiated a targeted implementation plan for gender where each sector is being held

accountable for specific actions, including HIV. Given the degree to which gender relations, and especially gender-based violence, are an important driver of the HIV epidemic in certain parts of PNG the emphasis on improving the gender sensitivity of program has been highly relevant.

Increasing the involvement of people living with HIV

AusAID's support and advocacy for greater involvement of people living with HIV has been very relevant for efforts to improve program design and reduce HIV related stigma and discrimination.

Ensuring greater involvement of people living with HIV and AIDS is very relevant both in terms of providing knowledgeable support for people who have just learned about their positive status, and for ensuring they are in a position to advocate for more adherence to anti-discrimination legislation and better access to treatment. *From the early days of AusAID's support for the national HIV response its programs have highlighted the needs of people living with HIV and AIDS.* AusAID's programs have sought to support legislation to reduce HIV related discrimination, and helped to set up organisations to care for and support people infected and affected by HIV. NHASP and now the HIV Program together with UNAIDS, have supported the set-up of Igat Hope, the first formally constituted association to represent people living with HIV. The HIV Program directly funds Igat Hope as an implementing partner and supports the National Association of People Living with HIV/AIDS, an Australian organisation, in a technical partnership with Igat Hope. The HIV Program has also funded and provided technical input for the first research project in PNG on the experience of living with HIV and the social aspects of treatment adherence. The design of the research involved people living with HIV, who were also engaged in disseminating research findings. AusAID support to these efforts has been relevant and in line with international best practice.

Support to HIV mainstreaming

It is highly relevant for AusAID to be supporting HIV mainstreaming but relevance could be increased through greater prioritisation and strategic management of this support.

HIV mainstreaming is a critical aspect of PNG's multi-sectoral response, and AusAID's support for HIV mainstreaming in the public and non-state sectors is an important part of its contribution to the response. In most cases AusAID is working in a difficult context where there is limited sector ownership for HIV mainstreaming. *In general AusAID has not been fully effective in adapting to obstacles in the operating environment.* The relevance of AusAID's HIV mainstreaming is limited by an ad hoc approach to mainstreaming with inadequate oversight and strategic direction from the HIV Program and senior managers. This, and lack of prioritisation of where AusAID's HIV mainstreaming efforts are directed, has resulted in a wide but shallow spread of HIV mainstreaming resources that is overly reliant on individual advisors and a sector-focused approach. This approach limits the ability of AusAID to achieve sustained impact in this area.

Where AusAID has been most successful in this area, it has built on and supported existing leadership for HIV mainstreaming and good entry points for mainstreaming. This is the direction for prioritisation going forward.

Engaging in new partnerships with the private sector

AusAID has not had a specific strategy for engaging with the private sector. Its absence weakens the overall relevance of AusAID's approach in an environment where private sector investment continues to expand, with potentially critical implications for HIV and health programs.

It is not necessarily the responsibility of bilateral development assistance to give support to private sector HIV interventions. In keeping with this AusAID has provided minimal support for private sector mainstreaming, with BAHA being the main partner for promoting and coordinating private HIV workplace policies and programs. However, official government aid needs to link with private sector investment where that investment might have a negative impact on social and environmental development. *The evaluation team was concerned to find that the HIV Program's planning for the mitigation of HIV risks related to the LNG project are in very early stages, with little concrete information on plans.* Annex 26 discusses the PNG LNG project in some detail.

The capacity of the HIV Program's partners to scale-up to meet demand is an issue. Stakeholders do not have the capacity to expand. Skilled staff are in shortage across the country, and the provincial governments and non-state service providers have already started losing their skilled staff to the LNG project. This poses a significant dilemma for AusAID, and for PNG in general, especially in light of the extra strain the LNG project is likely to place on both potential new HIV infections and the capacity to provide prevention and treatment services.

Given that large-scale infrastructure and extractive industry projects are now integral to the future development of the PNG economy, it will be incumbent on all stakeholders, including AusAID, to find ways to engage with the companies running these projects to ensure potential negative impacts are mitigated.

4.4 Relevance of levels of AusAID funding

The Budget Analysis indicated that the total estimated funding needed for the HIV response was more than met from all sources of funding from 2007 onwards. Figure 1 provides an overview of estimated funding needed compared to funding allocated between 2000 and 2009.⁴⁴

Figure 1: Total HIV response funding required, funding contributed and AusAID funding



44 Hiejkoop and Piel, Budget Analysis of the Australian Aid Program's Contribution to the National HIV Response in PNG, 10 (Annex 13 to this evaluation).

Looking at the future need for HIV funding, the new National HIV and AIDS Strategy estimates a total of PNG Kina 3,262 billion. Table 4 provides the estimated costs for the NHS 2011 to 2015.

Table 4: Cost Summary by Major NHS Priority Areas⁴⁵

NHS Priority Areas	2011	2012	2013	2014	2015	Total (PNG Kina)
HIV Prevention	656,039,622	553,904,176	679,682,628	579,094,110	562,325,651	3,031,046,186
Treatment, care and support	11,188,805	14,496,661	20,166,416	14,786,414	17,279,175	77,917,471
System strengthening, capacity building and enabling capacity	30,206,759	28,585,071	29,927,613	31,177,188	33,215,261	153,111,893
Total	697,435,185	596,985,908	729,776,658	625,057,712	612,820,088	3,262,075,551

It is noted that this was an early cost estimate (August 2010), which was the only one available to the evaluation team at the time, and that this version was done in a rush by external contractors to meet the deadline for the new National HIV Strategy completion. The team understands that further work has been done to the NHS budget, so that the numbers in this report may not reflect the most recent version. That being said, what is significant about these estimates is that the total budget for the new national health strategy for the same period comes to PNG Kina 6,697 billion. Thus *the budget for implementing the new HIV strategy is roughly half of the total estimated budget required for the health sector. Given the growing understanding of the epidemiology of HIV in PNG compared to the country's other public health problems this seems a highly disproportionate ratio.* The annual estimates of funding also represent an almost five-fold increase over current funding requirements, which again appear disproportionate to actual need.

It would therefore appear that AusAID would need to consider where to invest its HIV-related resources going forwards to ensure that it does not contribute to a further skewing of public health priorities in PNG.

⁴⁵ NACS, NHS Cost Narration, National AIDS Committee Secretary, National AIDS Council Secretariat, Port Moresby, 2010.

CHAPTER 5: The effectiveness of AusAID's contribution

Effectiveness: Australian aid is achieving the results it intended to achieve.

This chapter provides an overview of how well AusAID has been able to meet its intended objectives in relation to support to the PNG HIV response. It also considers the effectiveness of AusAID's support to the cross cutting priorities supported by the HIV Program, including gender sensitivity, greater involvement of people living with AIDS (GIPA) and mainstreaming of the HIV response. The section is divided into a review of the effectiveness of programmatic interventions (testing and treatment, education and prevention, epidemiology and surveillance, social and behavioural research, leadership, partnership and coordination, family and community support and M&E), cross cutting issues (gender sensitivity and equality, GIPA and HIV mainstreaming), as well as capacity building interventions. The chapter covers only the main headlines. Further explanation and synthesis of the evidence relating to this section can be found in Annexes 16 and 17 of this report, as well as in the more detailed Evidence annexes.

Caveat: One limitation of analysing the AusAID HIV program's effectiveness is that most of the program objectives relate much more to processes (for example, 'to support' or 'to ensure') rather than results. This leaves analysis of program impact or effectiveness more open to interpretation, and it is very difficult to attribute successes, or failures, to the AusAID contribution.

5.1 Effectiveness of support to the National Strategic Plan focus areas

This examination of the effectiveness of AusAID's contribution to the PNG HIV response must be understood in the light of how very significant Australian support has been. *Many of the stakeholders interviewed indicated that, had the Australian Government not provided such a large amount of funding over so many years the HIV situation could be much worse.*

If AusAID hadn't put the money into HIV there would be very, very few programs here. Even if the programs aren't effective enough at least they are there.

Without AusAID we wouldn't have come this far. From the beginning AusAID has been the force behind our response.

From the start, AusAID support basically laid the foundations of the response... It was critical from the beginning.

While others might argue that the dominance of AusAID in the response has let the Government of PNG 'off the hook' (see Chapter 6) *there is no doubt in the minds of those interviewed for this evaluation that much of the HIV policy, strategy and programming that now exists in PNG is due to Australian support. Based on the evidence gathered the evaluation team agrees with this view.*

HIV treatment and care

11 per cent of total AusAID HIV Program funding

NSP Focus Area	Objectives ⁴⁶	Activities supported
Treatment and Care	<ol style="list-style-type: none"> 1. Improve men and women's access to quality primary health services that incorporate HIV and sexually transmitted infection treatment and care. 2. Support for the scaling up of HIV/AIDS treatment services, including ART and treatment of opportunistic infections. 	Roll out of expanded HIV testing and ARV treatment services through: <ul style="list-style-type: none"> • training clinical and counselling staff • building and rehabilitating infrastructure • improving laboratory services • supporting management and supervision costs.

The AusAID HIV Program has been effective in providing support for the scaling up of HIV and AIDS testing and treatment services, but has been ineffective in improving men's and women's access to quality primary health services that incorporate HIV and STI treatment and care.

During all three phases of AusAID support there has been a significant emphasis on improving HIV service delivery. In the era prior to easy diagnostic testing and effective ART, AusAID placed more emphasis on treating STIs and opportunistic infections. These early efforts have continued to run as more or less vertical service provision through successive phases of support to HIV services.

In the last four years, AusAID support for HIV testing capacity (in conjunction with the Global Fund financing of testing kits) has contributed to a 260 per cent increase in testing between 2007 and 2009 (see Table 1 in Chapter 2). It is estimated that two-thirds of all voluntary counselling and testing (VCT) clients are seen through the Catholic network of VCT centres, the majority of which are funded by AusAID.⁴⁷ Access to treatment has been similarly enhanced through AusAID's support to clinical services of mainly non-governmental partners, again in conjunction with Global Fund financing of ART.

However, many of the HIV clinical services supported by AusAID (primarily testing and counselling) are funded as stand-alone services and not integrated into broader primary health care services. Furthermore, the IRG has raised concerns that the rapid expansion of services has not been accompanied by attention to the quality of these services. The areas of concern highlighted in the 2010 report are ongoing themes of the previous IRG reports: poor roll out of rapid 2-test algorithm and ARV initiation without CD4 counts.⁴⁸ In addition, tuberculosis/HIV testing remains weak, as does HIV testing of STI cases (only 8 per cent reported in 2009).⁴⁹

⁴⁶ Mooney, Malcolm and Winter, 2006, Program Implementation Framework, Papua New Guinea-Australia HIV and AIDS Program.

⁴⁷ The HIV Program, 2010, *Annual Program Plan 2010*, AusAID, Port Moresby.

⁴⁸ Aggleton et. al., Independent Review Group on HIV/AIDS: Report from an assessment visit 23 April-6 May 2009; Aggleton et. al., Independent Review Group on HIV/AIDS: report from an assessment visit 22 April-5 May 2010.

⁴⁹ Aggleton et. al., Independent Review Group on HIV/AIDS: report from an assessment visit 22 April-5 May 2010.

This verticalised support has been given in a context where PNG health services have continued to decline more generally. Recent work in PNG indicates that the verticalised approach to the HIV response has probably weakened wider health systems. For example, a case study of Global Fund-supported programs in PNG reveals that while the Global Fund has made a significant contribution to scaling up the national HIV response, including the strengthening of civil society engagement, it has also ‘skewed human resource capacity within the health sector’ and reinforced the establishment of parallel systems.⁵⁰

The evaluation team believes the same criticism can be levied at how AusAID has supported a verticalised HIV program. *Related to the verticalisation of the HIV response, the team found that there appeared to be little interaction between AusAID’s HIV program and its health program.* IRG reports⁵¹ and key stakeholders interviewed during the evaluation suggested that there were poor relations between NACS and NDOH, which was hampering better coordination of the health response and its fit with the overall strategic direction of the national HIV response.

As AusAID provides substantial funding for both HIV and the PNG health sector, and has advisers based in both NACS and NDOH, it is in a prime position to facilitate greater dialogue between these key national partners. The Health Sector Wide Approach provides a substantial opportunity for influence, but has been under-exploited. This appears to be a combination of the immaturity of the Sector Wide Approach structures, and a lack of interest (until recently) in pursuing support for the HIV response through AusAID’s health program. The AusAID PNG Program is now working on ways to improve communications and ways of working between the Australian health and HIV programs. It is important that this includes strategising on how best to enhance and integrate the health sector HIV response into sexual and reproductive health services more generally, and in particular exploring how to build synergies between programs to improve maternal health, which was emerging as a priority for AusAID and the Government of PNG at the time of the evaluation. Annex 5 provides an international perspective on how HIV and maternal health services can be better integrated.

Thus, while AusAID funding has been effective in increasing a rapid expansion of services, the evaluation team thinks insufficient attention has been given by some partners to VCT service quality, and therefore overall effectiveness. Furthermore, *the verticalisation of HIV treatment and care has resulted in substantial missed opportunities for improving sexual, reproductive and maternal health services offered by both government and non-governmental partners more generally.* This could almost certainly have had a more important impact on the leading causes of morbidity and mortality in PNG, especially among women.

50 Developments in surveillance, testing, and treatment have reinforced a weakly integrated, vertical approach to HIV services within the existing health system, while establishing parallel systems for monitoring and evaluation, and procurement and supply to meet Global Fund demands for performance-based management. Rudge et al, ‘Critical interactions between Global Fund-supported programmes and health systems: a case study in Papua New Guinea,’ *Health Policy and Planning*, vol. 25, issue 1, 2010, p. 48–52.

51 See IRG reports from 2008 and 2010, which look primarily at progress in improving coordination of HIV monitoring and evaluation. Stakeholders in both NACS and NDOH acknowledged that their working relationships could be better, though there was no clear mechanisms, other than through HIV surveillance and M&E, through which coordination could be improved.

Education and prevention

20 per cent of total AusAID HIV Program funding

NSP Focus Area	Objectives	Activities supported
Education and Prevention	<ol style="list-style-type: none"> 1. Support community, civil society, business and church groups develop effective, rights-based prevention initiatives. 2. Reduce stigma associated with HIV/AIDS. 3. Address underlying causes of gender inequality and sexual violence through the HIV/AIDS response. 4. Ensure HIV/AIDS prevention efforts are gender sensitive and address factors such as sexual violence towards women. 	<p>Support to the development of the National Prevention Strategy.</p> <p>Focus on community engagement including:</p> <ul style="list-style-type: none"> • support to the National HIV and AIDS Training Unit as key repository for education and prevention training and resources • support to a number of international NGOs (Save the Children, Voluntary Services Overseas, Family Health International, Anglicare Stop AIDS, CARE Australia and Baptist Union) to carry out general prevention activities • support to Tingim Laip, PNG's largest community prevention program working specifically with at risk populations • funding for condom procurement and distribution • limited support to BAHA to institute workplace policies and prevention programs • non-HIV Program support to the Department of Education to develop and implement HIV based curriculum.

Note: The assessment of the effectiveness of AusAID's contributions to gender-related activities can be found in section 5.2.

There is no empirical evidence of a fall in new HIV infections in PNG, which is the most important indicator of prevention program effectiveness. There is insufficient evidence to demonstrate whether the HIV Program interventions have reduced stigma association with HIV and AIDS. The AusAID HIV Program has been partially effective in ensuring that HIV and AIDS prevention efforts are gender sensitive but has not been effective in reducing the underlying causes of gender inequality and sexual violence, nor in ensuring that non-governmental partners are all developing effective, rights based prevention initiatives.

The 2010 Annual Program Plan reports significant scaling up in HIV training and support for prevention, including condom procurement and distribution. It reports that 4,000 peer educators were trained, and over 120,000 people and 60,000 schoolchildren attended formal HIV training and awareness programs. The Annual Program Plan reports a noticeable increase in community mobilisation activities, especially in areas that are most affected by the epidemic, although this is not clearly mapped in the available documentation. Credit is given to Tingim Laip for providing structure and support for community engagement and local leadership initiatives (see Box 3).

However, it should be noted that most of the HIV Program information on education and prevention is output oriented and, as noted in Chapter 3, focused on general awareness raising. The most important indicator of the effectiveness of HIV education and prevention strategies is whether the number of new HIV infections is falling. While recent estimated new infection rates are lower than those for previous years, it should be noted that the downward trend in the reported number of new cases and estimated number of adults and children living with HIV need to be treated with circumspection, as it might be more due to artefact than reality. Reductions are almost certainly more due to improvements in the expanding scale and quality of data rather than an actual decline in new infections.

In contrast to improved reporting showing fewer HIV infections than previously, STI incidence and prevalence appear to remain unchanged or getting worse. STI services are poorly resourced and generally not integrated into more general family health services. Reported increases in those clinics that do provide STI services would indicate that the prevention activities to reduce STI incidence and prevalence is failing miserably.⁵² In other words, there has been almost no impact on the drivers of sexually transmitted infections, including HIV. Without available bio-behavioural surveillance data and findings from social research conducted in areas where program implementation occurs, it is difficult to draw direct associations between program activities and prevention outcomes. Some NGOs use program baseline data as the means to assess progress on specific objectives and increasingly there is an interest in using qualitative methods to capture most significant change stories as a means to evaluate effectiveness. While the concept of evidence-based interventions is widely accepted, there is insufficient data to support the design and implementation of effective program activities and there are few opportunities, apart from the NGO Forums, to share local lessons and establish networks of best practice.

A few programs funded by AusAID that provide integrated, 'continuum of care' services, such as Poro Sapot and Family Health International (where behavioural change communication is linked to access to testing, treatment and care) are considered to represent best practice internationally.⁵³ However, their effectiveness in reducing infections still needs to be evaluated more fully in the PNG context.

The problems with condom distribution described in Chapter 3 have meant that the HIV Program's support to improving condom access had been ineffective at the time of the evaluation. This was likely to have a significant impact on other areas of encouraging positive behavioural change.

The 2010 UNGASS Report found little evidence of improved protective sexual behaviours among the general population and specifically among youth. Significantly, the extent to which people are enabled to practice protective behaviour is directly hampered by the continued poor supply of condoms.⁵⁴ *Based on the UNGASS findings, reports of prevention activities by most partners and the ongoing problems with condom availability, the evaluation team finds that the majority of HIV education and prevention activities funded by AusAID have been ineffective. This should be of significant concern to program managers as the majority of the HIV Program funding is allocated to this focus area.* Box 3, which describes the mixed effectiveness of one of AusAID's flagship prevention programs, illustrates these issues.

52 Aggleton et. al., 2010 Independent Review Group report and UNGASS 2010 Country Progress Report.

53 Lowe, 2010, Synthesis of HIV Reviews and Evaluations in Papua New Guinea 2006–2009.

54 NACS, UNGASS 2010 Country Progress Report Papua New Guinea, National AIDS Council Secretariat, Port Moresby, p14.

Box 3: Harnessing the energy of communities—the example of Tingim Laip

Tingim Laip is PNG's largest community-based HIV project, operating in 36 sites across 11 provinces and covering a population of over 200,000 people. It was designed to respond to the need for targeted behavioural change activities, focusing on the most vulnerable populations in settings throughout the country where HIV transmission was known or likely to be high. Managed by an Australian contractor, the project incorporates partnerships between NACS, PACS, government agencies (Defence, Police, Correctional Services), and private sector stakeholders (mining and petroleum, palm oil industry, fisheries, the sugar industry). It also includes a number of implementing agencies supported by the HIV Program, each responsible for different aspects of the project, which include Family Health International (FHI), World Vision, the International Education Authority, and Save the Children in PNG.

Tingim Laip aims to empower vulnerable communities to develop, implement and monitor their own responses to HIV by supporting the capacity development and training of volunteers from participating communities. The project is based on four 'pillars,' which are the promotion of condoms, STI treatment, VCT services, and treatment, care and support for people living with HIV.

Two independent evaluations of Tingim Laip have been conducted. These have indicated mixed findings regarding effectiveness and relevance, but both studies highlighted the potential of the project to make a valuable contribution to the national response. Significantly, the evaluations indicate that despite an ad hoc approach to community mobilisation, Tingim Laip has effectively harnessed the energy and commitment of many people, including volunteers, to become involved in the response. The absence of an effective reporting system against baseline data limits the findings of both evaluations. However, qualitative data collected through Most Significant Change stories suggests that Tingim Laip activities have resulted in increased awareness and understanding of HIV and related sexual health issues, and the social factors that contribute to HIV risk and vulnerability. It is less clear whether this has in turn led to positive behavioural change.

Key issues affecting the project include the lack of coordination of work plan activities between implementing partners, as well as communication regarding accountability and recruitment. There are inadequate links between prevention and the continuum of care strategies. The weakest aspects of the project are the activities to address stigma and discrimination, and to develop care and support services. In addition, training has not been used strategically. There has been no assessment of training needs, no clear links between the timing of training and the development of programs, no competency assessment of participants in skills-based courses, limited post-training support, and minimal ongoing technical support.

At the time of the evaluation Tingim Laip was about to enter Phase 2 in 2011 under a new contractor, with Madang the new headquarters for the management team. There was a strong expectation at the provincial and community levels for more skilled personnel, resources, and services to be put in place to expand the project. However, the transition to the new management created uncertainty about future directions and arrangements, which was affecting program continuity and sustainability where community relationships have been established and activities are being implemented.

Epidemiology and surveillance

0.3 per cent of total AusAID HIV Program funding

NSP Focus Area	Objectives	Activities supported
Epidemiology and Surveillance	<ol style="list-style-type: none"> 1. Support research and surveillance to better inform prevention, treatment and care interventions. 2. Improve the availability and dissemination of research and surveillance findings, locally and internationally. 	<p>Limited support provided within the HIV Program, as it was expected that Asian Development Bank and WHO would lead on HIV surveillance. Activities include:</p> <ul style="list-style-type: none"> • NACS grant scheme and M&E unit to identify epidemiological research priorities • technical advisory inputs to develop a research and surveillance data dissemination strategy • non-HIV Program funding for a HIV surveillance adviser in the National Department of Health • funding provided to World Bank for an Integrated Bio-Behavioural Survey.

The HIV Program has not been very effective in meeting its objectives to disseminate and use surveillance and research findings.

It is critically important to understand the nature, scale and scope of a country's HIV epidemic in order to ensure an appropriate response. *AusAID's inputs here have been effective as far as ensuring that research is conducted that can improve understanding of the nature of the HIV epidemic in PNG.* AusAID funding has contributed to improving the effectiveness of HIV surveillance through expansion of HIV testing services, alongside advisory surveillance support to the NDOH also provided by the WHO and the ADB. In general, AusAID funding through the HIV Program in this particular focus area has been minimal, as other development partners have taken a lead role. AusAID has not been very effective in using research and surveillance data to inform NSP interventions by partners. The Integrated Bio-Behavioural Survey, though planned to take place each year since 2007, had not yet been carried out at the time of the evaluation. The study is being organized by the World Bank, which has experienced delays in negotiating the details of conducting the study with the Government of PNG.

Social and behavioural research

4 per cent of total AusAID HIV Program funding

NSP Focus Area	Objectives	Activities supported
Social and Behavioural Research	1. Support social and behavioural research and improve the availability and dissemination of findings, locally and internationally.	<p>AusAID's emphasis has been to provide technical advisory support to NACS and other PNG institutions involved in HIV research, plus fund some research activity, including:</p> <ul style="list-style-type: none"> • funding a Social and Behavioural Research Adviser (later Senior Research Advisor) based in NACS reporting to the NACS Director • funding three positions in the NACS Research Coordination Unit • support for development of the National Research Agenda 2008–2013 • funding of national research capacity assessments and of the development of a national research capacity development plan • grants for research (currently funding three medium sized research projects) • core funding for the National Research Institute and for the IMR for their HIV research activities.

The AusAID HIV Program has been effective in building capacity and in improving understanding of HIV in PNG through its support to research activities. However, it has been relatively ineffective in improving the dissemination and use of research findings for policy and practice.

Social, behavioural and epidemiological research has provided much needed data for understanding the HIV epidemic. AusAID support to the National HIV Research Strategy, to the Research Advisory Committee and to the NACS Research Coordination Unit, as well as to research institutes and researchers themselves, has ensured that HIV research remains a key activity. Between 2007 and 2009, 82 social/behavioural studies were submitted to Research Advisory Committee. However, less than 50 per cent were approved or funded, mostly due to poor quality. Completed and on-going HIV research from 2007–2010 includes 30 social/behavioural studies out of 47 funded studies. This represents a significant increase from 2006 to 2007, when only two out of eight social/behavioural research proposals were approved for funding by Research Advisory Committee.⁵⁵

55 AusAID, The HIV Program Annual Program Plans 2007–2010, AusAID, Port Moresby.

As mentioned in the previous section (epidemiology and surveillance) *while successive AusAID HIV programs in PNG have always placed a strong emphasis on research M&E, they have been less adept at translating the evidence it has helped to generate into strategy or program interventions.* HIV Program staff and partners have not consistently integrated the use of evidence—primarily in using the results of research into the social and behavioural factors—which could underpin prevention programming.

The IRG has found that progress in Focus Area 4 (FA4), Social and Behavioural Research, contributed to ‘a positive climate for social research as part of the national HIV response, and has built significant interest in key national research institutions and universities’.⁵⁶ However, initiatives to utilise these sources for informing policies and strategies have been limited to the point where some stakeholders felt that social research is not valued, or that only social research conducted under the NAC grants program is valid for informing the national response. The National Research Institute HIV Seminar Series has sought to address this oversight and encourage conceptual engagement with the wider literature.

Furthermore, *active knowledge of and engagement with FA4 is not apparent at the provincial level,* with the majority of research studies conducted in National Capital District or urban settings in the provinces. Only a few provincial AIDS committees (PACs) are involved in reviewing research grant proposals for studies in their provinces, but there is no available evidence of social and behavioural research activities being coordinated at the provincial level or incorporated into program activities. Voluntary Services Overseas Tokaut AIDS is the only project that provides evidence of developing strategies and program content based on formative research. Some NGOs and community based organisations have contributed to operational research, primarily baseline data collection to inform M&E, but many have expressed an interest and need for skills building in participatory action research. There is potential for linking HIV Research Cadets Program graduates with NGOs to conduct community-based research projects with seed money provided by NACS.

The 2009 Stocktake Workshop provides some insight into the effectiveness of HIV Program research initiatives. The Workshop identified the need for further review, analysis, and dissemination of research results to ensure stakeholders have better access to research findings and recommendations. There is also a need to pitch research findings persuasively to leaders so they engage with and act upon findings. Dissemination of research results to a broad range of stakeholders in PNG has been both challenging and limited. Furthermore, there has been limited response by implementing partners to research findings. *More support needs to be provided at the community and provincial levels to support community based research, to develop skills for capturing case studies and most significant change stories, and to understand and translate research findings.*

56 Aggleton et. al., 2008, Independent Review Group on HIV/AIDS: Report from an orientation visit, 12–25 April, p. 17.

Leadership, partnership and coordination

7 per cent of total AusAID HIV Program funding

NSP Focus Area	Objectives	Activities supported
Leadership, Partnership and Coordination	<ol style="list-style-type: none"> 1. Support leaders at National, Provincial and grassroots levels to advocate for, and participate in, an expanded response to the epidemic. 2. Strengthen coordination of efforts to implement the NSP. 3. Support improved mainstreaming of HIV/AIDS across all sectors. 	<p>AusAID funding has focused on leadership training, strengthening coordination and management capacity of NACS, PACs and NGOs as well as advisory support for mainstreaming HIV activities. Support includes:</p> <ul style="list-style-type: none"> • support to NACS and NAC to begin to decentralise management of the response to Provincial Authorities • strategic engagement with Provincial Governments to build ownership for HIV response • engagement with Department of Provincial and Local Government Affairs, National Economic and Fiscal Commission to link NACS/HIV to broader decentralisation reform and strengthen policy environment for decentralisation of HIV • funding for the LSI targeting Parliamentarians and senior public servants with HIV leadership training and coaching • funding for the Catholic Diocesan leadership program covering 20 provinces in 2007 • HIV Program director and Minister Counsellor inputs into policy dialogue • advisory support to Provincial AIDS Committees and their planning processes • funding support for networks of people living with HIV (for example Igat Hope), and business community network (for example BAHA) • facilitation of quarterly NGO meetings for those receiving AusAID HIV related funding • funding of some NACS costs, of the Financial Management Improvement Unit and the Procurement Improvement Unit in NACS, plus support to management advisers for NACS.

Note: The assessment of the effectiveness of mainstreaming efforts is covered in section 5.2. This section focuses on support to leadership, partnership and coordination efforts.

The AusAID HIV Program has been effective in underpinning national coordination of the HIV response through the provision of substitute, operational coordination when national structures have failed. It has not been effective in strengthening the national HIV coordination secretariat nor in strengthening decentralised coordination structures. The efforts to shore up NACS may in fact have been counterproductive in that they may have delayed much needed reform and hampered a rethink as to what type of NACS is necessary for the PNG response. The HIV Program has been fairly ineffective so far in translating its support for leadership capacity development into longer-term institutionalisation of national and local leadership. The HIV Program has been effective in strengthening partnerships with civil society and faith based organisations.

Strengthening leadership skills for the HIV response

LSI has been the HIV Program's most direct input into building leadership for the national response, allowing it to access over 300 potential HIV champions in politics and national and provincial government. One of the target groups included the Special Parliamentary Committee on HIV and AIDS. LSI participants have reported that action plans have been implemented, and workplace policies developed. *LSI appears to have helped motivate HIV mainstreaming efforts in a number of departments. It has been reported that politicians have been advocating in their electorates, and individuals advocating to their families and communities.*

On the other hand, LSI was delivered as an isolated intervention. Even the contractor responsible for delivering LSI acknowledged it could not have much sustained impact in the way it was set up. Some factors that detracted from the effectiveness of LSI included:

- Loss of momentum between LSI phase 5 (LSI5) and LSI phase 6 (LSI6) while the Leadership Strategy was being developed.
- No action taken by NACS on implementation of leadership strategy, which was meant to guide LSI from 2007.
- The coaching component of the Initiative was underdeveloped, with the contractor reporting it 'clearly needs much more development if it is to become an effective strategy for developing leaders... the experience of the LSI coaching pilots in LSI 5 and LSI6 has not indicated the positive benefits that can be achieved from coaching'.⁵⁷

While there were some positive results from the workshops, sustained results of the Initiative are difficult to see. Partly this is because the LSI approach, while having value, needs more high level GoPNG political commitment and follow up activities to be in place to have a significant impact. *As a result, most AusAID supported leadership activities have been fairly ineffective in fostering sustained national leadership of the HIV response.*

Facilitating increased civil society involvement and capacity to respond to the epidemic

AusAID's support to civil society involvement in the HIV response is a defining feature of its current approach to partnership, and a significant achievement. Through funding (grants, core funding and contracted projects) and technical assistance, the HIV Program has contributed to the increased capacity of civil society partners to play a role in the response. AusAID's civil society partners deliver a large proportion of HIV prevention, treatment and care services across the country and contribute an important voice in the response. The expansion of HIV services through AusAID-funded partners has been instrumental in increasing access to VCT and ART. The importance of AusAID's engagement with civil society is that it goes beyond funding to a range of capacity-building activities. Some partners (such as Igat Hope and Anglicare StopAIDS) have particularly benefited from institutional capacity building.

⁵⁷ PNG–Australia Targeted Training Facility, 2009, Leadership Support Initiative (HIV & AIDS): Activity Completion Report October 2009, p. 9.

Looking forward, other important areas of focus in support to civil society include building the quality, relevance and complementarity of partners' activities, and developing a formal strategy and performance measures for capacity building activities. *Neither the ODE evaluation of the HIV Program's civil society engagement,⁵⁸ nor this evaluation, was able to clearly measure increases in partners' capacity due to a lack of baseline and monitoring data.*

Improving planning and partner coordination capacity

AusAID has put substantial efforts into improving national level coordination of the HIV response since the early days of its involvement. *It has been most effective in its co-facilitation with NACS of a national annual planning process for all partners in the national response as well as in bringing together AusAID's own implementing partners to share and review the work they are doing.* This has been particularly important as the number of actors in the PNG HIV response has increased over the last decade due primarily to the increased funding made available through AusAID and other donors. Improving coordination of these actors has been highly relevant. One possible consequence of this way of working is the highly participatory methodology used in planning the next phase of the national HIV response, resulting in the National HIV Strategy (2011–2015), which is generally felt to be the best and most inclusive national HIV strategy so far produced in the country.

Support to national coordination structure

The foundations for NACS, the secretariat of the main national AIDS coordinating body, have been relatively insecure since its set up as little government funding was committed to the organisation. It has therefore always been heavily dependent on external funding and technical support to operate, much of which has been provided by AusAID. Annexes 16 and 17 detail the efforts successive AusAID programs have gone to in order to help the NACS be more functional. Annex 5 includes a brief overview of international evidence on NACS institutional arrangements.

These continued efforts to shore up NACS have been at some risk to AusAID's reputation. The 2009 review of the HIV Program (commissioned by management) highlighted the risks of a close association between the AusAID Program and NACS.

There is a strong perception among stakeholders that NACS has absorbed too much of the Program's management focus, resources and policy effort, despite the scaling down of this support in 2008. Over the last three years, resourcing to NACS from all sources has increased, while performance has deteriorated in the near unanimous views of stakeholders. Now NACS's poor performance is seen as the responsibility of the AusAID Program and it reflects on Australia's ability to engage more broadly, a problem recognised by Program management.⁵⁹

One of the main strategies AusAID has used to support the NACS is to provide advisers to work alongside PNG counterpart staff. However, in many cases, these counterpart staff have never materialised or there is so much turnover that medium to longer-term training becomes extremely challenging. Therefore, instead of capacity 'building' the HIV Program has been more effective through capacity substitution, which has played an important role in keeping certain functions of NACS in operation.

⁵⁸ Kenyon and Rudland, 2010, *Papua New Guinea–Australia HIV and AIDS Program: Civil Society Engagement Component. Case Study Report*, AusAID, Canberra.

⁵⁹ Mooney and Wheeler, 2009, *Review of the Papua New Guinea–Australia HIV and AIDS Program*, p. 14.

The HIV Program has been effective in keeping the core coordination structures of the response operating, through its involvement in the NSP Steering Committee and technical working group. The NSP annual planning process, which commenced in 2007, involves development partners, provincial governments and civil society organisations involved in the HIV response. The planning process aims to coordinate activities in support of the NSP focus areas through submission of annual activity plans by partners. One of its major achievements from its technical support to NACS appears to be the development of the national response policy framework. In many cases, this is from direct technical input rather than capacity building. Similarly, AusAID advisers recruited through the Capacity Building Service Centre program provided major technical inputs into writing the new NHS and the Global Fund Round 10 proposal.

Support to coordination at decentralised levels

Successive AusAID reviews of previous phases of support to the HIV response have highlighted the need to focus more attention on and provide support to decentralised levels of administration. After two and a half years of operation, the current phase of AusAID HIV support reached the same conclusion and made 'Provincial and Rural Response' a focus of the HIV Program.

Two years later, the evaluation team's visits to Western Highlands, Sandaun and Madang provinces showed that *coordination of provincial responses remains under-resourced, both in terms of staff and funding, as well as under-appreciated by many of AusAID's implementing partners.*

AusAID's other programs that provide more direct support to provinces, such as the SNS program and the Democratic Governance program, are making some gains on HIV coordination in those provinces where leadership is stronger. Interviews with the SNS program, Department of Provincial and Local Government and NACS stakeholders suggest that PACs have not always been the most relevant or effective organisation through which to promote HIV coordination and this has caused some tension with provincial authorities. In some provinces, with other AusAID program support, there are effective Provincial Coordination and Monitoring Committees. These committees are responsible for provincial development planning and integrate HIV response planning where relevant. The HIV Response Coordinator usually also sits on the Provincial Coordination and Monitoring Committees. *There would be much value in supporting closer links between NACS and the Department of Provincial and Local Government to assist them in developing flexible HIV strategies at the sub-national level.*

Family and community support

3 per cent of total AusAID HIV Program funding

NSP Focus Area	Objectives	Activities supported
Family and Community Support	1. To support community-based groups to care for those living with HIV/AIDS.	<p>AusAID funding has been primarily for NGO activities including:</p> <ul style="list-style-type: none"> activities targeting HIV related stigma and discrimination through Friends Frangipani and the International Development Law Organisation to ensure the rights of people living with HIV are understood and respected, and through Tingim Laip, which works to reduce stigma more generally. Also support for people living with HIV networks through building the capacity of Igat Hope HBC, through improving local HBC kits with Appropriate Technology Project to provide HBC training (Family Health International, National HIV and AIDS Training Unit), guidelines (Family Health International) and supporting HBC initiatives (Salvation Army, Anglicare Stop AIDS, Catholic dioceses) community activities to promote sustainable livelihoods (Baptist Union, Voluntary Services Overseas, World Vision, CARE Australia) developing counselling referral networks and databases in the provinces (FHI) support for orphans and young people (Save the Children, Catholics and Salvation Army).

The AusAID HIV Program support has helped with the development of some, limited, effective programming for community based care and support for people living with HIV/AIDS. Support in this area appears to have been more effective in reducing stigma and discrimination than support for prevention activities, though this needs further investigation to demonstrate why, to what degree, and how this has been so.

Prior to the current AusAID HIV Program, counselling training, networking and services were developed, but there were shortcomings in ongoing support for counsellors, and in developing community care beyond counselling.⁶⁰ Since 2007, over 3,000 people have been trained in community HBC and have provided services to many sites. Thus there has been an increase in access for people living with HIV throughout PNG. The National HIV and AIDS Training Unit and FHI have training courses and provide training in the provinces on HBC, with FHI supervising delivery to selected sites.

⁶⁰ AusAID, 2005, 'Evaluation of the PNG National HIV/AIDS Support Project', *Evaluation and Review Series* no. 38 and appendices, AusAID, Canberra.

One of the areas where funding for community and HBC support has been effective has been the fostering of greater ownership of the HIV campaign by the churches and NGOs, who are now able to speak publicly about the issue.

Increasingly, non-state actors are engaging communities to identify factors contributing to HIV and AIDS. Stigma and Discrimination of people living with HIV is higher in communities even though significant efforts have been made over the years. However, there are some signs of progress in pockets of communities due to continuous and constant engagement and awareness.⁶¹

However, there have also been a number of drawbacks in support to this focus area.

- The HIV program has no adviser with specific terms of reference relating to family and community support. There are some aspects included in the Gender and Social Development Advisor terms of reference but the main emphasis is on gender, human rights and civil society responses. Community based care and support seems to be left to the implementing partner organisations to develop themselves.
- There is a significant lack of focus by the HIV Program on addressing the impact of HIV and AIDS on family well-being, including strengthening families' abilities to cope.
- A number of partners reported during interviews, especially during provincial visits, that they themselves feel they have neglected this area of work. A number indicated that they rely on traditional community support mechanisms to help when someone falls ill with HIV, but that these family and community members remain largely unassisted.⁶²
- As resources and experience are scarce within civil society, they need more support for greater collaboration, networking and skill development among volunteers and community groups involved in supporting and helping affected families.

Monitoring and evaluation

1 per cent of total HIV Program funding

NSP Focus Area	Objectives	Activities supported
Monitoring and Evaluation	<p>1. Support implementation and strengthening of the M&E Framework established under NAC for the NSP.</p> <p>The HIV Program revised and refined objectives for each year from 2007–2010 building on lessons learned and taking into account resourcing constraints. Changes in strategic focus were outlined as 'resourcing priorities' in 2009 and 2010 Annual Program Plans.</p>	<p>Most of the HIV Program's funding has been for the AusAID program's own M&E rather than support to the NACS M&E. The UN and AusAID both provide advisory support to the NACS M&E unit. Activities funded include:</p> <ul style="list-style-type: none"> • funding for the IRG and for the NACS Research Coordination Unit • support for partner participation in quarterly workshops, review meetings and conferences • M&E adviser support working with NACS and with PACs.

61 The HIV Program, 2009, Quantitative Evidence of Progress 2007–2008.

62 Strategic Evaluation Interviews August–October 2010.

AusAID's support to national HIV response M&E has been effective as far as its support to the M&E technical working group and support to the IRG. There is little evidence for assessing the relative effectiveness of AusAID's technical assistance provided to the NACS M&E unit as there are other technical advisors from other agencies also working in the Secretariat unit.

There are two levels at which the HIV Program's M&E contribution needs to be assessed. The first is the contribution the HIV Program is making to the national HIV response's M&E. The second is how well the HIV Program is monitoring and evaluating its own contribution. This second area is covered in Chapter 7.

The 2006 program design identified AusAID's contribution to FA7 as focusing on building organisation capacity for M&E through participation in the M&E steering group, strengthening NACS role to implement the M&E framework through the technical working group, and supporting monitoring of the progress of the NSP through coordination mechanisms.

Based on these original objectives, AusAID's support to FA7 has been effective. The HIV Program's M&E adviser has participated in the steering group and technical working group, which have facilitated various achievements as set out in the following section. The HIV Program has contributed to funding for the IRG, which is the mechanism for regular monitoring of the progress of the national response.

However, these have not been the HIV Program's only activities in relation to FA7. Beyond the original objectives, *the HIV Program has also provided support to the NACS M&E unit in the form of advice and implementation of activities by the M&E adviser, and capacity building support to civil society partners for M&E.* The evaluation team has limited information available to assess the effectiveness of these additional activities.

5.2 Effectiveness in cross cutting issues

Effectiveness of HIV mainstreaming support

NSP Focus Area	Objectives	Activities supported
Leadership and Coordination	1. Support improved mainstreaming of HIV/AIDS across all sectors.	Advisory support to internal and external mainstreaming activities across government departments and programs supported by AusAID.

The AusAID HIV Program has been relatively ineffective in its support to HIV mainstreaming due to the lack of a strategic approach and weak coordination of mainstreaming activities. Some other AusAID programs have been more effective in integrating HIV mainstreaming into different public sector departments.

The effectiveness of AusAID's HIV mainstreaming activities is assessed broadly against the degree to which the PNG country program has integrated HIV mainstreaming into its programs, and the likelihood of AusAID's support to mainstreaming contributing to achievement of NSP objectives. All AusAID programs that are implementing mainstreaming activities could report specific achievements of their counterparts in relation to both internal and external mainstreaming, although the contribution of AusAID's support is not always clear. Common internal mainstreaming achievements include supporting agencies to develop HIV strategies and workplace policies, create and maintain management structures for mainstreaming, and to provide HIV awareness training to staff. *Some standout achievements were noted by the evaluation team in the education, sports and sub-national governance sectors, as outlined in Box 4.*

Alongside these achievements the evaluation team also found that overall there are limitations in the way AusAID is approaching HIV mainstreaming support. At the time of the evaluation there was no agreed set of objectives for AusAID's HIV mainstreaming activities. Therefore different AusAID staff and contractors engaged in HIV mainstreaming did not have a common framework within which to conduct their work nor could they report on the results of their efforts. While all programs implementing activities could report specific achievements of their counterparts in relation to both internal and external mainstreaming, these achievements are at the activity and output levels. *Sustained results in capacity building and partners' external mainstreaming activities are difficult to identify.* The primary approach used to support HIV mainstreaming is adviser support. In some cases, activities are supply-driven and not owned by government partners. Realistic expectations of what individual advisers can achieve within a sector are not always clear. *Significant gaps in support for HIV mainstreaming are the health sector, the HIV Program's engagement with NACS, and a lack of focus on creating demand for HIV mainstreaming, capacity or coordination within the GoPNG as a whole.*

Box 4: A selection of notable HIV mainstreaming achievements

Education sector: AusAID advisers in the National Department of Education were instrumental in supporting the development and rollout of an HIV curriculum across the country, supported by teaching materials and teacher training. This directly contributed to achieving the PNG Government's policy goal for the national education system to participate effectively in the HIV multi-sectoral response.

Sports sector: Through the Sports for Development Initiative, AusAID facilitated the PNG Sports Foundation (PNGSF) to become an active participant in the HIV response. With the support of the Sports for Development Initiative adviser, the PNGSF became the first registered member in the Pacific of the international 'Kicking AIDS Out' network, and worked with the Olympic Committee to form the 'Committee on HIV Prevention through Sport' to represent all key sporting bodies and HIV organisations in PNG. Out of these structures, the PNGSF is supporting the delivery of Kicking AIDS Out training by its regional sports development officers and has integrated the activities into sporting groups. The Committee has secured funding through NACS, has developed a Sports Place Policy and a policy implementation grants scheme, delivered HIV leadership training to sports leaders from across the country, and widely distributed an HIV tool kit for sports communities. As part of the 2010 PNG Games, the Committee conducted a major HIV knowledge, attitudes and access survey with 6,200 completed surveys from all 20 provinces in PNG.

Sub-national governance: Through advocacy at the national level, AusAID has contributed to incorporation of HIV in intergovernmental financial reforms. HIV service delivery was identified as the responsibility of provincial governments, which provided a basis for allocation of service delivery funds to the provincial level. AusAID has also helped to raise the profile of HIV on the government's agenda by encouraging the formation of an HIV sub-committee under the Provincial Local Level Service Monitoring Authority—the inter-governmental coordination and monitoring body. Without building linkages between SNS and HIV Program, a core component of PNG reforms to intergovernmental financing—the Function Assignment Determination—would not have included HIV responsibilities in assigning functions between different levels of government. HIV spending has been showcased in more detail in the 2009 National Economic and Fiscal Commission annual Provincial Expenditure Review and some analysis given as to what can be done to address the issue.⁶³

63 Program input into SNS mainstreaming summary.

Effectiveness of support to promotion of gender equality in the HIV response

NSP Focus Area	Objectives	Activities supported
Education and Prevention	<p>3. Address underlying causes of gender inequality and sexual violence through the HIV/AIDS response.</p> <p>4. Ensure HIV/AIDS prevention efforts are gender sensitive and address factors such as sexual violence towards women.</p>	<p>Support for two gender and social development advisers for the HIV Program, as well as gender advisers in other programs who have HIV within their remits.</p> <p>Support to numerous studies and the preparation of strategies relating to gender and HIV, including reviews of proposed annual plans of implementing partners to check for gender sensitivity.</p>

AusAID support has been effective in maintaining the profile of the gender-related dimensions of the HIV epidemic in PNG. It has not been effective in ensuring the mainstreaming of gender sensitivity and promotion of gender equality in strategic and operational approaches in HIV programs that it supports.

Despite praise for AusAID's efforts to keep gender a visible issue within the HIV response a number of questions have been raised as to the effectiveness of AusAID's approach to promoting gender equality over the various phases of its support. NHASP made a large effort to address the gender dimensions of the epidemic through strategic planning but continued to face problems in terms of dedicated interest and commitment. The Independent Completion Report concluded that NHASP

...lacked a clear conceptual and operational underpinning for its work to address gender inequity and inequality within the context of the epidemic. Gender was not an area of special focus and had a low profile. Ideally, issues of gender should have been addressed in a broad and encompassing manner since gender inequality and gender violence are widely acknowledged as key factors influencing the HIV epidemic in PNG.⁶⁴

Much of the same comment could be made about how gender equality is addressed in the HIV Program. The HIV Program staff concede that despite having a gender policy framework in place, most HIV prevention efforts lack a comprehensive understanding of gender and few programs specifically engage in interventions to address gender-based violence, sexual coercion and rape, gender roles and relations, gender power differentials, and trans-generational sex.⁶⁵ The HIV Program has acknowledged that more work needs to be done to engage men in addressing gender drivers of the epidemic, especially to counteract the general perception that gender means women and that gender strategies are only focused on working with women.

⁶⁴ Aggleton et al., 2007, *Independent Completion Report NHASP Completion Report*, AusAID, Port Moresby, p. 8.

⁶⁵ The HIV Program, 2009, *Annual Sector Performance Report*, p. 11.

Effectiveness of support for Greater Involvement of People living with AIDS

There were no GIPA objectives in the Program Implementation Framework.

The AusAID HIV Program has so far not been effective in ensuring greater involvement of people living with AIDS in policy, strategy or operational decision making in the national response. Nor is there any evidence of the HIV Program taking a strategic approach to support greater involvement of people living with AIDS.

So far AusAID has not been able to influence implementing partners to embrace the GIPA principles more wholeheartedly, with only a few, such as Anglicare StopAIDS and Igat Hope, employing people living with HIV and AIDS to work with and counsel those seeking HIV related services. Instead, most activities that come under a ‘Greater Involvement’ label have focused on the practical aspects of helping people living with HIV and AIDS, rather than genuinely involving them in designing, implementing and reviewing HIV programming. Under the HIV Program, the GIPA principle was not cited in the main program documentation and annual plans until 2009 when the HIV Program created the position of GIPA Advocacy Officer.⁶⁶ The 2010 Annual Program Plan does not provide any follow up information on whether this was implemented, although the GIPA Advocacy Officer prepared a GIPA Position Statement, annexed in the 2010 plan.

Effectiveness of capacity building activities

HIV Program Outcome	Objectives	Main Program Approaches
Enhanced individual, institutional and sector Papua New Guinean capacity to lead and manage a national response to HIV and AIDS	To have been developed after a capacity mapping exercise.	Capacity building with individuals—training approaches to build competencies and abilities for improved performance. Capacity building within organisations—organisational development processes and technical assistance with program implementation. Capacity building within the government and civil society sectors—processes to build viable networks, partnerships and strong civil society.

The evaluation team finds that AusAID’s capacity development efforts have been of mixed effectiveness. The most effective aspect of the HIV Program’s capacity building efforts has been its work with NGO partners, where there has been a willingness to improve management systems and technical skills, and where there are staff to work with. However, the lack of a strategic objective to build leadership and coordination capacity, especially within the public sector, has undermined the HIV Program’s ability to measure and demonstrate what progress it has made to build capacity among its partners.

Each phase of AusAID’s support to the PNG HIV response has emphasised capacity building as part of its overall efforts. PNG has relatively low capacity, both in terms of the numbers of people trained in service delivery and management, as well as the level to which people have been trained. As with many low-income countries, PNG has had trouble supporting its youth to attain education levels beyond primary school, which in turn limits the numbers of people who are

66 The HIV Program, 2009, Annual Sector Performance Report, p. 22.

eligible to carry on into professional training programs. This is an enormous constraint on any program wishing to improve technical, leadership and managerial capacity, and needs to be kept in mind when reviewing how effective AusAID has been in improving HIV leadership, coordination and implementation capacity. Annex 17 provides an overview of the highlights in capacity building for each of the phases of AusAID's program.

Capacity building strategy

The current HIV Program planned to develop a capacity development plan in 2008, which would outline specific targets and inputs. However, this did not occur. Instead, it appears that capacity development approaches evolved in a range of ways, based on the efforts of individual advisers, and specific organisational interventions where needs were identified (for example support to Anglicare StopAIDS in strengthening its financial management systems).

The lack of strategic approach to capacity building creates the impression that there have been few gains or successes in the ad hoc approach currently taken by the HIV Program. As there are no defined outputs, outcomes or ends for capacity building work the evaluation team cannot comment on the overall impact of the capacity building efforts made to date. It also means that there is no consistent follow up to efforts that are being made, such as in the leadership initiative or moving from capacity substitution to capacity building. Nor is there a sense of how AusAID funded capacity development initiatives fit alongside those of other donors.

Improving clinical and counselling capacity of service providers

Since 1996, AusAID has supported the training of numerous clinicians and technicians in sexual health and HIV services, as well as the training of hundreds of HIV counsellors. While various reviews have expressed some concerns about the lack of follow up to this training, there is no question that increasing the clinical and counselling skills of a large amount of the workforce has been vital for scaling up sexual health and HIV related activities in PNG. AusAID has also supported capacity improvement through rehabilitation of infrastructure, and provision of material and equipment so that trained workers had adequate facilities within which to work. One of the most effective capacity building programs, according to program reviews, has been the Clinton Foundation program (now known as Clinton Health Access Initiative, which has combined both infrastructure rehabilitation and laboratory training skills to improve the quality of HIV testing and diagnosis in 30 public sector facilities. One feature of the Clinton Foundation's work is to ensure that its health system strengthening activities extend beyond HIV testing and target wider sexual health and maternal/child health services. Various reviews have indicated that combining the improvement of staff skills alongside improvements to the facilities staff work in is very effective,⁶⁷ especially where there is ongoing support and supervision on the initial training or material improvements have been made.

67 One example is the Clinton Foundation, CHAI Phase 1 Independent Review, 2009. See also Lowe, 2009, Synthesis of HIV Evaluations and Reviews in PNG 2006-2009.

CHAPTER 6: The sustainability of AusAID's contribution

Sustainability: Processes and systems have been put in place to sustain the national HIV response beyond the life of AusAID funding.

National ownership: Partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions.⁶⁸

This chapter answers the evaluation question ‘To what extent are AusAID’s program approach and activities sustainable and facilitating national ownership of the HIV response?’ The discussion reflects the analysis of key issues related to effectiveness of development assistance for national AIDS responses (provided in Annex 14).

National ownership of HIV responses is understood to be a pre-requisite for ensuring a sustained response that meets the needs of a country’s population into the future. Sustainability of any development activity requires long term political and financial commitments by national stakeholders first, supported as needed by reliable funding from their development partners. AusAID has been a committed partner to the PNG HIV response since 1995 and continues to include support to the HIV response as a priority for development cooperation with PNG.

National ownership is seen as a critical factor for underpinning national and local political commitment and leadership, which in turn helps to ensure that HIV programs are prioritised within national development agendas. It is also seen as the key ingredient for ensuring that development and HIV responses will be sustainable over the longer term, with countries providing leadership and coordination of all internal and external inputs into strategy development, implementation and monitoring. The Accra Agenda for Change (2008) recognises that country ownership is the basis upon which the rest of the aid effectiveness agenda is built.⁶⁹ The UNAIDS Global Task Team Report also puts country ownership at the heart of the AIDS response:

The primacy of national ownership of plans and priorities is the overarching rubric that efforts to harmonise and align must support and under which coordination efforts should occur. This principle of ownership requires planning, programming, M&E to be led by national stakeholders. Ownership is grounded in the fact that national partners are accountable to their own societies for the services they provide.⁷⁰

6.1 Key issues in fostering ownership

As indicated in Chapter 5, there is a widely held perception in PNG that AusAID is a critical driver, if not the main driver, of the PNG HIV response. *During the evaluation team’s fieldwork in PNG, a large number of people interviewed as well as survey respondents and workshop participants, indicated that AusAID’s predominance was undermining national ownership and leadership and therefore the possibility of greater sustainability.* This perception was also cited during the 2009

68 Organisation of Economic Cooperation and Development (OECD), 2008, *Accra Agenda for Change*, Paris.

69 Organisation of Economic Cooperation and Development (OECD), 2008, *Roundtable 1: Ownership—Key Points from the Evaluation*, Organisation for Economic Co-operation and Development, Paris.

70 UNAIDS, 2005, *Global Task Team on Improving AIDS Coordination Amongst Multi-lateral Institutions and International Donors: Final Report*, Joint United Nations Program on HIV and AIDS, Geneva.

review of the HIV Program.⁷¹ As in many countries where both political will and capacity to respond to the HIV epidemic is weak, this leaves donors such as AusAID with a dilemma in terms of how much it must intervene for humanitarian reasons versus how much the organisation can stand one step removed and let national processes evolve.

Lessons from the literature and from other countries would indicate that, *to foster greater ownership of HIV responses, it is important to modulate donor actions to fit more with in-country dynamics*. This does not mean being inactive in PNG as there are a substantial number of actors, both state and non-state, who are committed to developing and implementing effective HIV programs. However, it may require facilitating more opportunities and negotiating greater ownership space for these actors to take on a greater leadership role themselves rather than looking to the AusAID program to provide that leadership for them. The types of activities where AusAID is engaged in helping to build the political will, citizen interest and general capacity to ensure greater ownership and sustainability include the following.

- The HIV Program works with civil society groups, especially faith based organisations and associations of people living with HIV, to mobilise community participation in HIV prevention and care and support activities, and to encourage a much more positive discourse around HIV and those who are HIV infected and affected. Local leadership initiatives have been limited but there are a growing number of activities aimed at engaging community leaders and village elders as agents of change. In other countries, this sort of advocacy work is often undertaken by associations of people living with HIV as they seek to improve access to treatment and care. In PNG, the advocacy positions of these associations remain relatively weak and they need support from other, more powerful groups like the churches, to add to their own voice. While steady efforts have been made to mobilise the voices of people living with HIV, to date AusAID's funding and support for these associations has been less focused on actively involving them as service deliverers and decision makers. Fostering a citizen's movement for HIV is expected to gain momentum under the new AusAID program called Strongim Pipol Strongim Nesen, which is a democratic governance initiative where civil society groups will be empowered and mechanisms strengthened for engaging with government.
- The HIV Program has made efforts to nurture leadership in government where it exists at national level. At the same time, along with other AusAID programs in PNG, it has started to put more support into those provinces that have already shown interest and willingness to deliver some form of HIV response with the limited resources available to them. As long as this support is done without overwhelming decentralised levels with too many resources and too much expectation, it should help to build greater momentum for political interest at local levels. Particularly crucial is ownership and leadership by the health sector to integrate HIV prevention, treatment and care activities into training and service delivery. The HIV Program could take greater initiative to work with agencies such as the Department of National Planning and Monitoring to enhance their capacity to fund and monitor NGO HIV activities, facilitated through Memorandums of Agreement with all service delivery NGOs and the Department.

71 Mooney and Wheeler, Review of the Papua New Guinea-Australia HIV and AIDS Program, p. 9.

- The HIV Program's efforts to foster the development of a sustainable coordination structure have been limited by uneven and inconsistent government support for its own AIDS secretariat. As with government leadership, lessons learned on coordinating the HIV response suggest that the PNG NAC has many of the elements of being an effective, high level coordinating body. However, it is clear that its secretariat has yet to find its appropriate form and staff, and, as with other countries, struggles to balance its coordination role with a desire to hold budgets and implement programs. In addition, there are positive coordination efforts within PNG stakeholder clusters, such as in the faith and business communities and in some provinces, such as Autonomous Region of Bougainville and Sandaun. However, more radical and rapid reform is required within NACS to allow it to be more effective in coordinating these other sub-coordination groups, as well as fostering ownership of the HIV response across the public sector more generally.

6.2 National ownership global consultation exercises

Based on the literature reviewed, there would appear to be at least five areas that influence ownership, leadership and coordination of HIV responses: a) government leadership of the response; b) citizen perceptions of and participation in HIV responses; c) the role of NACs; d) capacity to respond; and e) donor impact on ownership.

A UNAIDS global consultation exercise with donor partners found that first and foremost donors feel the role of country partners is critical for leading and driving HIV responses, while at the same time creating an inclusive and enabling environment for other actors to engage.⁷² While the central role of government in leading and owning the response was emphasised, those consulted also acknowledged that ownership was needed by non-state actors who could influence policy and implement and review effective programs. They also acknowledged that *where the state is not providing credible leadership, as is often the case in fragile states or in countries where the epidemic is concentrated in marginalised and politically unpopular groups, then donors need to engage with 'other credible national actors' while considering how to foster the sustainability of the longer term response.* The donor community can go some way in catalysing HIV responses, and in fostering ownership of these responses among some partners, but they can only go so far. What they must be careful of is being seen to drive a country's response themselves, as governments and civil society can form the impression that the HIV response is therefore not their responsibility.

To date, measurements of 'national ownership' have been mostly based on financial indicators, such as the amount of funding governments are prepared to commit to poverty reduction or to HIV responses. UNAIDS, with support from the United States Government and the Rockefeller Foundation, has been looking to understand better what factors influence ownership of HIV responses and how changes in ownership can be measured and monitored more appropriately beyond only financial indicators. The evaluation team distributed a 'national ownership' assessment survey (developed by one of the evaluation team members for UNAIDS earlier in 2010) to around 40 stakeholders in PNG, and conducted interviews with individuals and groups about their views as to how PNG is performing in terms of ownership. The team also explored how AusAID has facilitated or hindered an increased sense of ownership of the HIV response within the country. As noted in Chapter 1, the survey responses and numbers of participants in some of the group discussions were not as large as the team had wanted.

⁷² UNAIDS, 2010, *National Ownership Pivotal to Sustained AIDS Responses*, <<http://www.unaids.org/en/resources/presscentre/featurestories/2010/july/20100702nationalownership/>>.

The survey was sent to 40 stakeholders, of whom 12 responded. However, the survey was able to capture the views of some major stakeholders, including the NAC Chair, the NACS Director and heads of HIV programs in a number of different agencies. Their views were echoed during interviews with other stakeholders both at national and provincial level. The questionnaire asked respondents to rate, on a scale of one to four, how well they felt PNG was doing according to four dimensions of ownership: ownership of policy and strategy, ownership of resources, ownership of processes and contribution to national ownership by development partners. The respondents were also asked to comment on what they felt were the ‘facilitating’ and ‘hindering’ factors in relation to there being strong national ownership of the PNG HIV response.

The current position from the literature suggests that national ownership of AIDS responses should be understood as a *process* that is inclusive of different country stakeholders, with each providing leadership for responding to HIV that is appropriate to the epidemiology and socio-cultural make-up of the epidemic. How well country partners can take up the mantle of ownership depends significantly on their interest and incentives for doing so, as well as having the leadership and resource capacity to negotiate ownership ‘space’ for themselves.

The main findings from the survey and interviews in PNG were that ownership is highly variable across different actors. While there is some evidence of leadership and commitment at all levels, it is currently difficult to find among national political leaders. High levels of stigma and discrimination continue to discourage many communities and politicians from engaging with the HIV response effectively. Some of the barriers to effective ownership of the PNG HIV response were cited as follows.⁷³

‘There is no leadership, it is very weak and defunct.’

‘The church and NGOs are the ones facilitating national ownership and not the government.’

‘NACS has not functioned as the coordination body. Very weak technically. Nil accountability. It’s there in name, yes, but little coordination provided.’

‘Serious issues of police brutality, impunity, such as rape and bashing of sex workers and homosexual men. HAMP Act is strong but never used. HAMP Act implementation/regulation is weak.’

‘Dependency on donors for driving and pushing and funding and [technical assistance], and presence of one big donor that dictates what is done and what is not done.’

For further discussion, see Annex 14.

6.3 Stronger and weaker areas of ownership of the PNG HIV response

How well the HIV response is owned by different stakeholders in PNG varies enormously. All groups, sectors and levels have some individuals who are committed to reducing the levels of HIV infection and helping people who are infected or affected by HIV. At the same time, these organisations can also have individuals who are morally opposed to action on HIV and who continue to see those infected with HIV as being somehow morally ‘bad.’

73 Carlson, 2010, Good Practice Related to Development Assistance Effectiveness For National Aids Responses. (Annex 14 to this report).

Where a sense of ownership is stronger

Ownership is stronger among a few national public sector champions, within non-state coordination mechanisms, among some provincial administrations, and among community-level champions.

Among a few champions in the public sector at national level

Having come through the turmoil of the last few years *the reconstituted NAC now contains some of PNG's most forthright champions for the HIV response in the country*, including individuals serving as Members of Parliament and as directors in government departments and the NACS Director. There is no denying their commitment to the HIV response, though they are not always using their position to counter some of the more negative stories that can be found in some of the country's media. They have worked hard to try to improve the effectiveness of the NACS, which has been beset with problems since 2006, as well as attended national events to raise the profile of HIV.

Other national public sector champions can be found in different national departments and foundations. Examples of strong leadership around HIV can be seen in: the National Department of Education and its work on HIV policy and curriculum development for the sector; the Department of Provincial and Local Government, through putting HIV into the routine provincial reporting mechanism'; some individuals within the Special Parliamentary Committee on HIV/AIDS; and Dame Carol Kidu, Minister for Community Development, and her work on human rights and legislative reform.

Within non-state coordination mechanisms

Stakeholders pointed out that while NACS has remained relatively ineffective as a coordination mechanism due to internal problems, *other coordination mechanisms have developed to support different types of partners, though many of these structures remain nascent.* PNG now has a church based AIDS coordinating body (the Church AIDS Alliance) and a national representative body for people living with HIV and AIDS (Igat Hope), as well as a business coordinating group (BAHA). There is also a donor forum, which serves as the coordinating mechanism among donor partners to ensure their support is aligned with the national strategy and works within the annual planning cycle.

One notable example on non-state commitment to the HIV response is how the Secretary General and Chairperson of the PNG Sports Federation and Olympic Committee has made HIV awareness and prevention an important feature in the work of the federation. This is visible through their partnership with public sector and non-governmental stakeholders in HIV prevention through the Sports Committee. They have demonstrated strong leadership and ensured that all committee members are engaged and take on various responsibilities to lead on HIV activities.

These different coordination mechanisms receive varying degrees of support from AusAID but have been organised through leadership efforts from within their respective constituencies, out of recognition of the need for having a structured means to discuss and coordinate their contributions to the national HIV response.

Among some provincial administrations

A number of provincial administrations, including Sandaun, Madang and the Autonomous Region of Bougainville, have demonstrated a strong commitment to their own provincial HIV response by taking a number of key actions. Such actions include:

- approving provincial funding for HIV activities
- ensuring that planning for HIV responses is included as a priority within provincial plans more generally
- ensuring that monitoring of the response is part of the provincial monitoring and coordination system.

This work will be further assisted by the formation, in 2011, of an HIV sub-committee within the Provincial Local Level Service Monitoring Authority, the multi-agency national monitoring system to which all provinces must report.

Among community level champions

AusAID support for community based programs, such as Tingim Laip, Poro Sapot and faith based outreach programs have stimulated the growth of community level champions. Many of these individuals work as volunteers to provide HBC to people living with HIV or to undertake awareness raising activities. It was not within the scope of this evaluation to be able to assess the levels of community activism around HIV. However, what was clear from the field visits undertaken by the evaluation team is that there are untold numbers of committed activists working in their communities across the country. In some cases, their work is supported through a small grants program (not currently operating) or donations. In many cases, their work is not being supported.

There is apparently tremendous scope for nurturing greater community involvement and activism through using more traditional community structures and building on cultural norms. During field visits, the evaluation team was informed that, despite high levels of stigma associated with HIV and AIDS, many communities continue to help with the care of individuals who have HIV-related illnesses. In the Highlands, local communities are revitalising communal systems to improve hygiene and sanitation in their villages as well as to have a few people trained to educate the whole community on key health issues, including HIV infection. *While AusAID itself cannot directly extend its reach to this level, it could be doing more to examine how effective these initiatives are which partners can help support this work.*

Where a sense of ownership is weaker

Ownership is weaker at the political level, within public sector departments, and within government and communities.

Weak political level ownership and engagement with the HIV response

Almost all stakeholders involved in the ownership consultation exercise and in a number of evaluation interviews expressed exasperation about the low level of attention given to the HIV response, and to public health more generally, by the Government of PNG. *Low political will and low capacity to lead and coordinate were all mentioned as core problems for seeing any real political-level action from government on HIV.* Others cited problems with low accountability of government to its citizens, and a view that donors have stepped in to play too big a role in the HIV response in particular, letting government ‘off the hook.’ This view was echoed in statements that no donor seemed to have proper capacity development plans that would leave PNG with sustained capacity to lead and deliver the national HIV response.

Despite this widely held view, it is heartening to note here that when the Global Fund resources for ART ran out, the new NACS director along with several other stakeholders including AusAID and civil society campaigners were able to persuade the government to provide extra funding to cover the gap. This demonstrates that *the Government of PNG can take action when required and suggests that external donors could be more circumspect about balancing the amounts of money they provide with what the government provides.*

Within public sector departments

Despite the existence of a NAC and a Special Parliamentary Committee on HIV/AIDS, as well as policy initiatives by some national departments, *there is no clear evidence of active ownership of and engagement with the national HIV response across the public sector.* Unlike some countries responding to a national HIV epidemic, the GoPNG has not obligated line departments to commit part of their annual budget for HIV mainstreaming activities. There is no consistent or coordinated approach to HIV workplace policy development. NAC and its secretariat, along with members of the Special Parliamentary Committee, should be able to influence some degree of coherent public sector action on HIV. This has not happened so far, presumably because of the weak political will referred to above. This problem is by no means universal and some public sector departments (such as the National Department of Education), have embraced HIV mainstreaming both in terms of workplace policies and in terms of how they integrate HIV into their service delivery. However, key central and influential departments such as Planning and Monitoring, Treasury, and Department of Mineral Resources have not yet accepted HIV mainstreaming principles. A number of stakeholders interviewed indicated that there are key government actors in influential positions who maintain negative perceptions of HIV, which could hinder mainstreaming efforts as well as wider governmental action on HIV.

Ongoing stigma and discrimination of HIV and people living with HIV within government and communities

Related to the problems of political will is the fact that *stigma and discrimination against people living with HIV and AIDS remains rife at all levels of society in PNG.* Analysis of the factors affecting ownership of HIV responses indicate that general population perceptions of HIV play an important role in shaping government reactions to their epidemic. Stakeholders interviewed who work at national, provincial and community levels, and across different organisations, suggested that much work remains to be done to dispel negative perceptions of HIV among the general population. As noted in Chapters 4 and 5, the way that HIV messages were communicated in the early years of the epidemic may have inadvertently created greater stigma. The work being done by some faith based organisations to try and counter some of the more negative moral messages on HIV is very welcome, but not all faith leaders have accepted the more positive messages being promoted.

It is clear that more time is needed, and more support to HIV activists at all levels of PNG society, to create the conditions for greater national ownership of the HIV response. Given that the nature of the HIV epidemic varies enormously when viewed in different parts of the country, it is important to weave more positive HIV communications within existing messages that address areas of high priority for the PNG population. Due to the deteriorated state of public health services more generally in PNG, and worsening trends of key health indicators, there is much more acceptance that health services, and specifically maternal and newborn services, require urgent attention and greater commitment of resources. *Strategies that consider HIV prevention in the context of primary health care services and improving parental and infant health may have more traction than continuing to make HIV a stand-alone service and an 'exceptional' issue.*

6.4 Sustainability of the national response

At present, the government and its stakeholders estimate that the HIV response receives 80 per cent of its support from external funding and 20 per cent from within PNG. *The NACS Director would like to reverse this ratio, so that 20 per cent of funding for the HIV response is from external resources and 80 per cent comes from within PNG using new resources that will become available from the LNG project and other large extractive industry programs.* However, there is no apparent strategy in place to make this transition happen, or to look at how donor funding will gradually reduce and be replaced by government and private sector resources. The donors themselves, including AusAID, do not yet have a strategy developed that would facilitate this process. Such a change in the funding make-up of the HIV response seems to be more of an aspiration at this stage and will require a pragmatic approach to make it happen.

AusAID and others have made substantial efforts and devoted large amounts of funding for sustainable structures and processes, including legal frameworks, for the HIV response. However, the findings of this evaluation, along with the 2009 review of the HIV program and the various IRG reviews, indicate that the *institutional structures in place to sustain the coordination and management of the HIV response remain weak, and, in the case of decentralised levels, mostly under-resourced.*

To start redressing the balance between the dominance of AusAID in the PNG response vis-à-vis the Government of PNG, incentives need to be developed and space needs to be made for the Government to own the HIV response and take on a more substantial role itself. The Government of PNG, at both national and provincial levels, could make a notable contribution to the country's HIV response by ensuring adequate staffing and resources for provincial coordination of the national strategy. This would enable the organisational framework of PACS and District AIDS Committees to be adequately resourced without reliance on donor funding. AusAID and others could then take a more strategic and targeted approach to supporting appropriate capacity development of provincial teams, so that they are able to maximise the resources they receive from government.

Sustainability of the PNG HIV response would also be more likely if greater effort were made to build on community level ownership of HIV responses. This would include support to the various initiatives cited in this chapter to integrate HIV prevention, treatment and care into wider community based health schemes, primary health delivery systems and other interventions that build on community expressed needs and experience.

CHAPTER 7: The management of AusAID's contribution

Efficiency: The level and method of investment and method of managing AusAID resources achieve maximum outcomes, and represent Value for Money for the Australian Government and for the Government of PNG.

The fourth question to be answered in this evaluation is whether the Australian aid program's contribution to the national response is managed and implemented efficiently. This also corresponds to the third outcome area of the current HIV Program. This chapter examines the issues of efficiency and effectiveness in HIV Program management, as well as of the overall HIV Program model.

7.1 Background to the current program model and management

The current program model was put in place to reduce problems found with the NHASP 'project' model, which was seen to place too much emphasis on AusAID funding delivering project outcomes. The Program Implementation Framework says:

The Framework proposes the use of a programmatic approach as the aid delivery mechanism, rather than a traditional 'blue print' project mechanism in the style of NHASP. A program approach uses a wide range of flexible approaches to:

- *support partner government policies and direction, such as the NSP*
- *encourage and develop greater partner government ownership of development efforts which in turn should enhance sustainability of outcomes*
- *widen the opportunities for engagement with Non-Government Organisations (NGOs), faith based organisations, civil society and the private sector*
- *support the use of partner government systems and processes, and*
- *encourage partner governments to accept responsibility to systematically pursue national sector strategies and implement institutional change.⁷⁴*

The Framework document goes on to say:

This Framework strongly emphasises:

- *fostering ownership and enhanced engagement with GoPNG through a focus on its development priorities*
- *improving communication with all key stakeholders, including civil society*
- *using incentive based and community driven approaches, especially at the sub national level and,*
- *the quality of the engagement and the achievement of mutually agreed performance targets based upon PNG sector policy and frameworks.*
- *The management mechanism proposed in this Framework supports this approach.⁷⁵*

⁷⁴ Mooney, Malcolm and Winter, Program Implementation Framework, p. 5.

⁷⁵ Mooney, Malcolm and Winter, Program Implementation Framework, p. 6.

The HIV Program management model

The HIV Program is directly managed by AusAID staff, with logistical support from an ISP.

It comprises:

- The Program Director, who is an HIV technical expert contracted as a senior AusAID staff member for this position and reports directly to the AusAID Minister Counsellor.
- Two Deputy–Program Directors, who are generalist AusAID staff rotating in the positions on a three-year basis.
- Technical advisors (six at the time of the evaluation), who are a mixture of international and PNG nationals and provide support to partners and within the HIV Program (up from three originally planned).
- A senior program manager (new position in 2009), who manages the partnerships with civil society partners and oversees grant management.
- Program managers (six at the time of the evaluation), who administer the grants to civil society partners (up from zero originally planned).
- Two administrative support staff.
- Contracted short-term advisors for specific inputs.
- Program administration is supported by the ISP, Jane Thomason International, which provides support in financial and contract management, travel and security, logistics and office management.

*The HIV Program’s focus of attention has been on providing advisory support to NACS as the national coordination body for the HIV response in PNG, and to the implementing partners (mainly non-governmental) of the HIV response. Work with other sectors has been done primarily through other AusAID sectoral advisors working on mainstreaming issues. The exception has been in the NDOH where AusAID has invested considerable resources, both funding and advisory support, to strengthen PNG’s public health-run services. The evaluation team found that while meetings occurred between the HIV Program and AusAID’s health advisors, *there was no strategic approach to considering how AusAID’s investment in health and in HIV could be made more complementary and efficient.* This evaluation considers that one of the factors that allowed this to happen was the structure of the HIV Program management model.*

The HIV Program represents a significant change in the management approach compared to the Foundation Project and NHASP, which were both managed and implemented by contracted companies. The change was made to reduce problems with the project model, which was seen as placing too much emphasis on AusAID delivering project outcomes. The change to a front-line role by AusAID in program management was also seen to offer advantages in direct engagement with key government and non-government stakeholders. By moving staff out of the NACS office and assuming a less prominent support role, the HIV Program was also intended to leave space for the GoPNG to take greater direct responsibility for the HIV response. A major feature of the new approach has been emphasis on developing and adhering to joint annual NSP planning exercises. This reflects good development practice and was a positive shift in direction for AusAID.

This management model is experimental; AusAID was conscious that it meant increased levels of demand and risk for AusAID around program management and accountability. The total cost for program management and the ISP represents 21 per cent of the total funding for the AusAID HIV Program in PNG (see Table 6).

7.2 Monitoring of management effectiveness and efficiency

The 2006 Program Implementation Framework and 2008 M&E Framework set out the third outcome of the HIV Program, that the Australian Government contribution is managed effectively. This outcome is supported by two major thematic areas that define the responsibilities of those managing the HIV Program, as taken from the Program Implementation Framework.

1. Effective management of the strategic direction of the HIV Program within the Australian Government's overall HIV and AIDS strategies as agreed with GoPNG. This is measured by asking: are the inputs and activities contributing to the goal and purpose? Moreover, what benefits were evident from the support provided?
2. Effective and efficient project management of the HIV Program. This is measured by asking: are the inputs and activities delivered according to the design and the contract to the quality required, within the time and resources prescribed?⁷⁶

Having an M&E strategy is fundamental to helping a program and its stakeholders to review whether it is making progress towards some predetermined targets or objectives. The HIV Program developed an M&E framework in 2008 which provides a set of indicators broken down by five outcome areas and 11 indicators.⁷⁷ The main characteristics of the indicators being used to measure program effectiveness and efficiency are:

- their focus on differentiating the relative roles and responsibilities of the HIV Program and other national actors (covered in section 7.3)
- the HIV Program's use of evidence (research, program reviews and reports and so forth) to inform planning and decision making (covered in section 7.3)
- the quality of some of the cross-cutting work (notably HIV and gender mainstreaming—covered in Chapter 4 and 5)
- whether there are financial management systems in place (covered in section 7.3)
- whether risk assessments are done, include mitigating factors (covered in section 7.3).

These are primarily process indicators, which are relevant insofar as management is a process itself. The effectiveness and efficiency of the HIV Program can therefore be assessed in terms of: a) how effective the HIV Program has been at achieving its objectives; and b) how well program funding has been used more generally to achieve program objectives.

Overall, HIV Program management objectives and indicators have all the basic elements that can be used to measure management performance. However, many are not measurable. No targets are set and they are therefore largely open to interpretation. *The HIV Program itself does not do any reporting against its own indicators, nor did the 2009 review⁷⁸ consider these indicators as part of the team's assessment. In terms of a management tool, it would appear that the M&E framework and its outcome areas are not seen as very relevant to the HIV Program team itself.*

7.3 Effectiveness in achieving management objectives

Despite the weak connection between the current HIV Program M&E framework and how it reports on its achievements and challenges, it is still useful to have a look at the HIV Program's management through the lens of the above indicators. These have been regrouped for this discussion into three categories.

76 Mooney, Malcolm and Winter, Program Implementation Framework, p. 48.

77 The HIV Program, 2008, *Monitoring and Evaluation Framework: PNG–Australia HIV and AIDS Program*, Port Moresby, AusAID.

78 Mooney and Wheeler, Review of the Papua New Guinea–Australia HIV and AIDS Program.

Understanding of the relative roles and responsibilities of the Government of PNG and the HIV Program

This evaluation has found that *there remains a good deal of confusion as to what the relative roles and responsibilities are, and should be, between the GoPNG and the HIV Program*. The 2009 review of the HIV Program, the Theory of Change workshops and interviews with stakeholders conducted for this evaluation confirm that this confusion exists. The HIV Program performs a number of national coordination related functions yet at the same time it has put a large amount of financial, time and advisory resource into bolstering NACS, so that the HIV Program remains seen in many stakeholders' eyes as intimately tied to the survival of NACS.

The 2009 Review goes on to see this link as representing a substantial risk for the HIV Program's reputation:

...in the absence of a co-ordinated government effort led by the NAC, or anyone else in GoPNG, the Program (and AusAID) risks being seen as the PNG response to HIV and the main mechanism for delivery of the response. It also risks carrying the responsibility for what may be perceived as failure.⁷⁹

The confusion of roles and responsibilities is also evident in how stakeholders viewed AusAID's responsibilities for the HIV response during the Theory of Change workshops held in 2009 and 2010. A few of the 'Intermediate Outcomes' attributed to the AusAID program by stakeholders, such as 'strengthened enabling environment' and 'integrated multi-sectoral planning', are more appropriately within the responsibilities of the GoPNG. Laying these responsibilities at the door of the HIV Program as well indicates a sense that the HIV Program must somehow substitute for the GoPNG in these areas.

The GoPNG needs now to work with the NAC and other partners to 'redefine the roles and responsibilities for NACS and the support it needs'. At the same time *AusAID can and should be much clearer on which roles and responsibilities must be centred within the GoPNG and organise its support accordingly. The HIV Program should look to transition progressively from direct engagement in implementation, such as provincial support activities or communications, and set up mechanisms for national partners to take on these responsibilities*. This could achieve multiple objectives:

1. It would provide a model of contracting out and partnership relations that a future, more functional NACS could take over managing.
2. It would remove AusAID from having to manage multiple partners and different sizes of grants (by contracting this out to a set of few, but larger and more capable NGOs) so that it could focus its attention more on advocacy with the national government, integration of health service HIV interventions with the AusAID health program and redirection of funding and support to provinces and districts with higher HIV prevalence.
3. The larger NGOs could work closely with provincial governmental and non-governmental partners to build capacity on an ongoing basis more effectively than the AusAID program team is able to do (due to the fact they are relatively few in numbers and have to cover many provinces at present). The AusAID program could then focus on ensuring capacity-building strategies are developed, sound and achievable, and monitor their progress.

79 Mooney and Wheeler, Review of the Papua New Guinea-Australia HIV and AIDS Program, p. 29.

Using information and evidence to inform program planning and implementation

‘Information and evidence’ is used here to denote information that comes from research, international good practice, reports of implementation experience and program reviews. This section explores how all these different sources of evidence are being used to inform the HIV Program.

The annual planning process introduced in 2007, and the Quality at Implementation (QAI) process introduced in 2009 by the HIV Program for its funded partners, are seen as promoting cross organisational learning (planning) and internal organisational reflection. Partner evaluations have also provided points in time for learning to occur. However, the *HIV Program’s M&E approach is based on an assumption that it is not possible or necessary to measure the HIV Program’s contribution to the high-level goals of the national response*. Instead, the HIV Program appears to rely on IRG reviews as proxies for review of AusAID funded activities—another indication of the blur between what the GoPNG response is and what the Australian contribution is to the response. The evaluation team disagrees with this assumption. *By building its M&E approach around this assumption, the HIV Program has put itself in a position where it cannot report on what it has ultimately achieved over the last four years.*

At the same time, the evaluation team noted a tendency for HIV Program staff to over-attribute achievements. For example, a HIV Program report on ‘Quantitative Evidence of Progress’ implies that the rise in access to testing and treatment can be fully attributed to Program-funded service providers, as it does not discuss the contribution of other factors such as the Global Fund grant, PNG Government funding to church health services, and so on.

Concerns have been raised that AusAID does not have a clear view of what is happening on the ground. In Madang, stakeholders expressed concerns that AusAID does not have a good understanding of the local context and the effectiveness of its funded programs. This included concerns that some partners are providing misleading information to AusAID that is not being verified.

I don’t see that AusAID understands what types of programs they’re funding, what kind of impact it’s having. Lots of money is being used, the results of the projects has to reflect that. I don’t know if AusAID has learned from that, and changed the way funds are being used.

AusAID needs to come down here and see the physical evidence.⁸⁰

These comments reinforce the relevant recommendation made in the 2009 review of the HIV Program saying:

There is an urgent need to improve information flow on the effectiveness of [NGO partner] activities. It is therefore essential that this large part of the Program be monitored through regular visits to organisations and sites by Program management, the advisers and Program officers. The current monitoring and evaluation support from the Program is appreciated, but it needs to be intensified in a way that is appropriate, cost effective and simple for these partners.⁸¹

80 Evaluation stakeholder interviews August–October 2010.

81 Mooney and Wheeler, Review of the Papua New Guinea-Australia HIV and AIDS Program, p. 25.

There were also a range of stakeholders expressing concern that AusAID is not learning from its experience. For example, stakeholders are wondering if the recommendations from various evaluations have been implemented and used to guide decision-making. A review of recommendations from evaluations over the last five years (by the evaluation team) shows recommendations repeatedly being made on the same themes over that period, suggesting that there are obstacles to the HIV Program's ability to feed lessons into its ongoing management. As long as the HIV Program is not examining what it is achieving and how well it is performing, it is not going to be able to improve on the interventions it supports.

One area of particular concern to the evaluation team is that there does not appear to be any oversight by the HIV Program team that would allow them to ensure grant funding is being used as effectively and efficiently as possible. One example is where AusAID funding supports two separate VCT services in Vanimo, the provincial capital of Sandaun Province, which is a low prevalence province with a small population. These services are mostly underused, yet a third VCT service, also funded by AusAID, was due to open in late 2010. These are not necessarily issues that would be picked up in the IRG reviews of the general national response.

The failure to translate evidence into practice in the HIV Program may also be due to unclear lines of responsibility in terms of advocating for evidence-based practice between the HIV Program's activity managers and program advisers. The 2009 review of the HIV Program found that:

...the advisers need to be an externally focussed resource accessible to partners, agencies and AusAID sectors. These key stakeholders are hungry for technical support, which they feel strongly they are not receiving. Full utilisation of all advisory staff (health and non-health) to assist in the process of mainstreaming of HIV at all levels is a priority.⁸²

Program implementing partners continued to query the role of advisers during interviews with the evaluation team, while activity managers (each of whom has direct responsibility for monitoring a number of different partners) indicated that their management and mentoring role does stray into technical support, with which they feel increasingly able to assist.

The translation of evidence into program and practice needs to be the responsibility of all stakeholders. However, it would make sense to have responsibility for monitoring, whether and how this is being done, within a more clearly defined remit of the HIV Program team members so that there can be more general dialogue about the effectiveness of the HIV Program's interventions. This work is already being done by the gender adviser(s) on the team, who have done a review of partners' annual activity plans to see how gender sensitive these are.⁸³ A similar assessment could be made by activity managers, with support from technical advisers where possible, to see how well current evidence and guidance on prevention and education, treatment and care, as well as gender and GIPA, are being integrated into NGO partner activities.

Program financial and risk management

Program financial management

Up to 2010, the HIV Program has written its financial reports according to the requirements of the AusAID's AidWorks program, which was designed to be AusAID's financial management tool. However, AidWorks records information at too high a level to make it suitable for managing individual program finances. When similar programs are managed by contractors, they have developed their own systems to monitor grant performance. It would appear that the HIV Program

82 Mooney and Wheeler, Review of the Papua New Guinea-Australia HIV and AIDS Program, p. 29.

83 Abirafeh and Mandie-Filer, 2009, Comments on NGO Proposals 2009 (internal program documents).

team felt that existing AusAID financial systems would be sufficiently detailed. However, their use severely limits the amount and usability of financial management information. *It took the HIV Program three years of operation, pushed by the 2009 review of the HIV program, to undertake a financial management risk analysis, which subsequently found that the HIV Program was seriously exposed.⁸⁴ The Budget Analysis exercise (see Annex 13), and work done by this evaluation team, also found that getting useful information about how grants were being spent in relation to the HIV Program's goal and objectives was problematic. This has required extra effort by the HIV Program team and the ISP to put the information together, even though much of the information requested is critical for routine reporting. Not knowing how funding is being directed by partners across the grants program indicates a curious lack of program management oversight.* In light of the findings of these various reviews the HIV Program has now developed a financial management and monitoring framework (draft at the time of the evaluation fieldwork) and has engaged an auditor following the financial management risk analysis.

Beside the difficulty of retrieving financial information that is meaningful in terms of assessing the relative benefits or return on investments, the 2010 financial management risk review also noted that *up to March 2010 no one had responsibility for analysing the full set of partners' financial statements. In addition, no one was following up with partners to ensure that they were complying with the contractual requirement for annual audited financial statements to be provided.* The activity managers indicated they had neither the time or skills to carry out a proper financial analysis of the documents they were sent, while the ISP Finance and Audit Adviser does not have this responsibility as part of his job description. As noted by the author of the report:

The review considers that current Program management arrangements do not adequately monitor Implementing Partner financial management. Consequently, the review considers that Program grants administration is not sufficiently defensible.⁸⁵

Key risks identified and measures in place to address them

Each annual sector program report includes a description of the risks the HIV Program faces each year, as well as how these risks have been or will be mitigated. Given the management weaknesses within the HIV Program's main government partner, NACS, this has been an area of risk dominating much of the risk analysis. *The HIV Program has put in place numerous means of trying to reduce the risk of working with NACS, such as funding a Financial Management Information Unit and Procurement Support Unit within NACS (run by contractors).* The HIV Program has also supported the placement of management advisers to provide support to the NACS Director. All of these efforts have worked to ensure that NACS funds are being used for the purpose intended. It is also clear that unless there is a substantial reform within NACS, good governance of national HIV funding will remain dependent on external oversight and independently funded units.

Procurement, recruitment and sub-contracting in line with GoPNG and AusAID policies

The 2009 review of the HIV program highlighted the one-year grant cycle for implementing partners as being particularly problematic:

One matter raised by the partners was the difficulty and transaction costs (i.e. losing staff) on the current one-year contracts for funding. Longer contracts would enable the providers to plan and resource activities with more certainty and provide staff training and career progression.⁸⁶

84 Heijkoop, 2010, The HIV Program Financial Management Risk Review Report, AusAID, Port Moresby.

85 Heijkoop, 2010, The HIV Program Financial Management Risk Review Report, p. 17.

86 Mooney and Wheeler, Review of the Papua New Guinea-Australia HIV and AIDS Program, p. 26.

The HIV Program did put in a submission to seek approval to provide multi-year funding in 2009. Even though AusAID had approved funding for the HIV Program only through 2012, it is unclear to the evaluation team why the HIV Program was not permitted to provide at least two-or-three year grants to partners within this period.

The ISP (JTAI) is very familiar with both GoPNG and AusAID policies and works within the framework of both. Most contracting and procurement occurs through JTAI, which is responsible for some of the financial management and reporting. The 2009 review recommended that financial management of implementing partners be taken on by the ISP. If the recommended changes are made to how the AusAID program organises itself in future, then it is likely that one role of the ISP will be to help with financial management of implementing partners. *Given the wide spread of duties that the activity managers have, and their lack of specific training in financial management or contract management, it makes more sense that the ISP plays this role, freeing up the activity managers' time to focus on bringing evidence into practice and program quality and effectiveness more generally.*

7.4 Program management strengths and weaknesses

An analysis of efficiency needs to identify: a) where the HIV Program is doing the right things (strengths); and b) the weaknesses in program management. The evaluation team found that while there are a number of key strengths in the program's management, there are also a significant number of weaknesses. In the evaluation team's view, this may be due to certain miscalculations in the management model, which are covered in more detail in Section 7.6.

Program management strengths

Based on the various reports reviewed for this evaluation, an understanding of the context the HIV Program works in, and interviews with HIV Program staff and other stakeholders, *the areas in which the HIV Program team are doing well as far as management is concerned include:*

1. **Joint annual planning process:** the process that has been put in place provides a good model for future HIV planning as and when NACS can take on coordinating this process itself. At present, this process appears to be facilitated by the HIV Program staff, which probably adds to stakeholder confusion as to whose planning process this actually is.
2. **Improving NGO financial and program reporting:** over the last three years staff have been able to determine where implementing partners need to increase their financial and reporting capacity and have provided the means for them to do so, for example, by introducing QAI reporting formats and training in financial management systems. Those partners who have benefited from these inputs feel that their organisation has been strengthened more generally.

Program management weaknesses

1. **Program planning and improved reporting** are all positive additions to effective and efficient program management. They have been put in place to try to model how annual planning could be done through leadership from the NACS in future. However, at present it appears that the size of AusAID's funding portfolio makes it a dominant force in national planning work. Despite the fact that annual planning includes all partners in the national response (not just those funded by AusAID) there remains confusion about how each group is contributing to the response.

We don't know how much each partner contributes to the response. Even NACS doesn't know.

How are projects being formulated in terms of national priorities?⁸⁷

As noted earlier this confusion extends to understanding what, exactly, AusAID is funding or how much of a contribution it is making to larger programs it is part funding. Annual Activity Plans are not reviewed for progress against agreed outputs and outcomes in a joint process with partners. Therefore, there is no systematic means of capturing how well the HIV Program as a whole is performing against annual targets, challenges or lessons learned. This lack of oversight extends to weak follow up of how effectively and efficiently AusAID resources are being used by implementing partners as noted above.

2. *Reporting remains AusAID-centric with little incentive to report to government coordinating bodies.* In the same way, as indicated above, NGO financial and program reporting is generally submitted to AusAID. A number of partners working at sub-national level indicated that they do not provide reports of their activities to provincial AIDS coordination bodies or the province more generally. Rather, they send them directly to their own Port Moresby based headquarters, leaving it to their headquarter staff, or to AusAID, to transmit the necessary information back to provincial authorities. While this might improve the efficiency of reporting for AusAID specifically, this practice contributes to frustration among provincial officials who are trying to monitor activities in their provinces.

We don't report regularly to the PAC [Provincial AIDS Committee] (or provincial department of health) but sometimes share our annual reports. Monthly statistics go straight to our national office.⁸⁸

3. *Advisory resources are not being used effectively.* As noted earlier, there was fairly widespread concern from different stakeholders (government and implementing partners) about how little support they received from program advisers, with a common refrain being 'we don't know what they do'.⁸⁹ Other issues raised were that the advisers' approach to capacity building was often not appropriate for the organisational contexts and the way that Papua New Guineans learn. Some stakeholders also commented that AusAID's approach lacked tack and sensitivity, with some advisers being directive and dominating meetings. In addition, it was felt that the approach taken could be overly technical rather than focusing on process and relationships.

Early in Sanap Wantaim the concept of capacity building came to the fore, but they had no idea what they were talking about.⁹⁰

To build capacity at the provincial level you have to do things differently.

AusAID needs to provide longer-term support.

The model is OK to get results, but how to build local capacity? It's a gap.⁹¹

Some stakeholders raised concerns that some of the HIV Program advisers do not have the right skills for their positions, including a good understanding of how to apply international evidence in the PNG context. *While some individuals were singled out for praise, several stakeholders expressed negative perceptions of the adviser group:*

Advisers not performing attract criticism of the Program and overshadow its achievements.

We never see the Program advisers except at Sanap Wantaim meetings. They never come to see us.

87 Strategic Evaluation Stakeholder Interviews August–October 2010.

88 Strategic Evaluation Stakeholder Interviews August–October 2010.

89 Strategic Evaluation Stakeholder Interviews August–October 2010.

90 'Sanap Wantaim' was the original name for the HIV Program but is not longer used by AusAID. However, many stakeholders in PNG still use this name when referring to the AusAID program.

91 Evaluation Stakeholder Interviews August–October 2010.

I'm not sure what achievements have been made by the Sanap Wantaim advisers.

I expect the Sanap Wantaim advisers to provide support and backup for stakeholders, I don't see it happening.⁹²

These views were raised in the 2009 Review of the HIV Program, which found that advisory support from the HIV Program team was not accessible at all levels and there is a strong desire for it to be available and engaged.⁹³ Some stakeholders expressed the view that advisers are not in the right positions to influence, and should be based within NACS or out in provinces.

In general it would appear that the Program Director and activity managers are much more visible, and appreciated, by different partners. The HIV Program has indicated verbally that advisors have been involved in annual planning processes, the NSP Steering Group, provincial engagement and the development of the new National HIV Strategy. However the evaluation team did not verify the scope and scale of advisory activity. It is possible that there is greater appreciation for the strategic and operational management support provided by these project staff. However, the technical advisory role remains elusive for many of the partners interviewed. *Part of this problem may relate to the fact that the capacity building objectives (versus program outputs) that advisers need to deliver are not clear, neither within the HIV Program team itself nor to external stakeholders.*

7.5 Program funding and efficiency

HIV Program expenditure—2007 to 2010

The scope of this evaluation has not allowed the evaluation team to do a proper calculation of value for money, and the HIV Program itself has not yet undertaken such a study. Table 5 provides an overview of the best estimate of how funding has been split between different categories, in Australian dollars. As the implementing partner costs were reported in PNG Kina, the average exchange rate for each year 2007–2009 was calculated⁹⁴ and used to provide the equivalent Australian dollar value.

As noted earlier, a substantial amount of funding goes towards salaries and operational costs, both of the HIV Program team itself and of implementing partners. Given that quite a large part of the HIV Program is grant management, there is certainly a strong justification for the funding of the activity managers, and it is clear that these staff are providing a valued service to partners.

It is also clear that activity is happening and that progress is being made in a number of the HIV Program's priority areas. However, *the lack of genuine oversight of how program funds are used does not allow for comment on whether program funds are being spent efficiently.*

Tables 5 and 6 provide an overview of all AusAID funding from 2007 to 2009. These tables give an overview of program funding broken down by various administrative costs versus funding for activities contributing to different NSP focus areas (Table 3). The tables also provide a breakdown of what funding went to program management and to partner organisations, as well as long term and short term technical and advisory assistance.

⁹² Evaluation Stakeholder Interviews August–October 2010.

⁹³ Mooney and Wheeler, Review of the Papua New Guinea–Australia HIV and AIDS Program, p. 21.

⁹⁴ Using data from the Bank of PNG website which gives weekly historical exchange rate data.

See <http://www.bankpng.gov.pg/index.php?option=com_content&task=view&id=360&Itemid=1>.

Table 5: Program budget breakdown by program area and operational costs (AUD)—imprest fund managed by JTAI and grants to civil society organisations⁹⁵

For Year Ending 31 December	CY 2007			CY 2008			CY 2009			TOTALS	%
	NACS/ NDOH	NGO grants	HIV Program operations	NACS/ NDOH	NGO grants	HIV Program operations	NACS/ NDOH	NGO grants	HIV Program operations		
Salaries	-	3,141,513	762,578	136,114	4,300,159	1,675,958	129,686	5,574,714	2,144,254	17,864,976	21
Staff Development	-	242,824	-	-	461,098	-	-	1,042,644	-	1,746,566	2
Administrative Costs	-	-	1,577,095	-	-	2,545,368	-	-	2,377,190	6,499,653	8
Operational Costs	-	3,305,246	497,504	-	3,503,220	1,465,492	-	5,107,887	619,018	14,498,367	17
Travel Costs	52,189	-	196,227	67,540	-	541,649	42,980	-	538,525	1,439,110	2
Capital Costs	-	1,196,528	-	-	1,878,742	-	-	1,015,925	-	4,091,195	5
Costs by NSP focus areas											
1. Treatment, counselling, care and support	-	2,119,447	-	-	3,514,627	480,046	45,920	2,603,656	392,535	9,156,231	11
2. Education & prevention	411,533	1,584,928	-	3,149,464	4,132,528	163,763	2,640,606	4,951,104	270,449	17,304,375	20
3. Epidemiology & surveillance	-	-	-	190,058	-	-	35,223	-	-	225,281	0.3
4. Social and behavioural change research	595,176	-	10,089	1,107,458	-	249,919	841,332	-	209,813	3,013,787	4
5. Leadership, partnership and coordination	58,257	881,653	146,739	722,138	1,395,901	377,451	1,367,147	981,245	244,399	6,174,330	7
6. Family & community	-	353,522	67,254	21,109	863,694	17,478	71,844	610,242	159,064	2,164,207	3
7. Monitoring & evaluation	-	261,207	-	45,652	315,635	120,230	-	404,316	12,146	1,159,186	1
Total Program Expenditure	1,117,115	13,086,868	3,357,486	5,439,443	20,365,604	7,637,354	5,174,738	22,291,735	6,967,393	85,437,734	

⁹⁵ Sources: The HIV Program financial report, spending by funding area and recipient through imprest account managed by JTAI, 2006–2010; HIV Program financial report, spending by funding areas and recipient—civil society grants, 2006–2010. Note: Included in imprest account: funding to NACS (through FMIU), funding to NDOH, program activities (for example, travel to provinces, workshops, quarterly forums, conferences), program M&E, partner audits, design costs, program office and running costs, program adviser salaries, administrative staff salaries, staff travel, ISP fees, and some funding for LSI and IRG. Not included in imprest account: Program director salary, LSI (through Papua New Guinea-Australia Targeted Training Facility), advisers to NACS (through Advisory Support Facility), desk travel, some post travel, NGO grants, Clinton Foundation, PASHIP, IRG, some staff related costs.

Table 6: The HIV Program expenditure, CY 2007-2009⁹⁶

	CY 2007	CY 2008	CY 2009	Total	%	Notes
Program management:						
Program technical assistance (advisers)	913,000	1,408,000	1,780,000	4,101,000	6	
ISP—fees and salaries	1,577,000	2,545,000	2,585,000	6,707,000	10	
Program office running costs	516,000	526,000	935,000	1,977,000	3	Includes administrative staff salaries
Reviews, designs and audits	-	1,023,000	365,000	1,388,000	2	
Service delivery support:						
Civil society partner grants	11,422,873	13,732,762	13,849,720	39,005,355	56	
PASHIP	-	-	-	-	0	Note: funded under health program until 2010
Clinton Foundation	-	-	-	-	0	Note: funded under health program until 2010
Leadership Support Initiative	-	-	146,948	146,948	0	
Support to NACS					0	
Small grants	520,000	878,000	-	1,398,000	2	
National condom distribution	365,000	3,144,000	2,500,000	6,009,000	9	
Financial Management Improvement Unit	8,000	426,000	1,115,000	1,549,000	2	
Research coordination unit and research grants	-	372,000	790,000	1,162,000	2	
Support to priority provinces	-	-	128,000	128,000	0	
Information, Education and Communication	-	-	147,000	147,000	0	
Advisory Support Facility (ASF) advisers	-	-	1,174,380	1,174,380	2	Note: funded under ASF until 2009
Other:						
IRG and NSP review	-	13,000	1,000,000	1,013,000	1	
Technical capacity inputs (gender, GIPA, M&E)	67,000	50,000	567,000	684,000	1	
Technical capacity inputs—short term advisers (grants, reviews, etc.)	224,000	611,000	303,000	1,138,000	2	
Quarterly forums, conferences, workshops	184,000	745,000	409,000	1,347,000	2	
Total	15,769,873	25,482,762	27,795,048	69,074,683	100	

⁹⁶ Source: The HIV Program, 2010, *AusAID HIV Sector Performance Report 2009*, Annex C. Note: Program Director, deputy program managers and activity managers' salaries are departmental costs.

Limitations of analysis of program funding

The evaluation considered how well program reporting and funding levels matched each other. This was found to be highly variable across different grant recipients of the HIV Program. As stated earlier *program reports lack sufficient disaggregation to allow the reader to understand what aspects of the response AusAID funds, including its specific contribution to funded partners' overall activities*. A number of the various activity reports and summary reports provided to the evaluation team appeared to attribute all partners' HIV activities to AusAID funding. While this is true in a few cases, it is by no means true in all, and it is misleading that it appears as such. This problem is exacerbated by not producing program financial reports against any breakdown of cost areas.

An example of inadequate financial reporting is the HIV Program report for Susu Mamas. It provides an overview of all of Susu Mama's activities, but the HIV Program's contribution to these is minimal according to the record of grants provided. The majority of the 2008 and 2009 grants were for salaries and operational costs, but this is not reflected in any reporting. Similarly the NCAO is one of the largest recipients of AusAID HIV funding. The majority of this funding has been used on construction of infrastructure for VCT sites (46 per cent of overall NCAO funding), with further funding for VCT (18 per cent) and prevention (13 per cent). The HIV Program report indicates that VCT kits and ARVs are received from the NDOH but there is no reflection that many facility staff salaries are also paid from NDOH.

To give a further example, all of Poro Sapot's activities in the financial report⁹⁷ are included as 'Prevention and Education'. However, the project has other activities that include providing clinical services for sex workers and men who have sex with men. It is not clear from the report if these are also funded by AusAID.

Overall, the HIV Program would appear to have been somewhat vague in how it reports partner activities against AusAID funding. *This reporting could be made much more transparent by providing, on a regular basis, not only the HIV Program portfolio that implementing partners offer, but also specific mention of which aspects of the portfolio AusAID contributes to.* The analysis in Table 5 provides an annual aggregate breakdown of all spending by the HIV Program—both spending through JTAI for HIV Program operations, and spending through implementing partners. This analysis indicates that a fairly substantial amount of HIV Program funding (over 50 per cent) goes to supporting the operational costs of HIV Program and partners' supporting salaries, office costs, staff training and so forth. This is not necessarily a bad thing if the areas that AusAID is funding can be seen in the context of the whole portfolio of work that is happening. For example, the NCAO uses a substantial amount of its AusAID funding to pay for staff salaries, training and capital works (building of stand-alone clinics). The Catholic Church more generally receives substantial resources from the GoPNG through the Church Medical Council to run its mission health centres and hospitals, as well as receiving donations from other organisations for health related project work or contributions in kind from drug companies. As HIV services cannot run without having trained staff and equipment, the AusAID contribution is entirely appropriate. However, most of HIV Program's reports on the NCAO's work do not make it clear what specifically is being financed and why.

97 Implementing Partner financial information prepared for the strategy evaluation team October 2010.

7.6 Analysis of the HIV Program's model

The evaluation team finds that the HIV Program management model was set up according to good aid effectiveness principles around country ownership, harmonisation and alignment, while also in response to what stakeholders in PNG understood to be an emerging HIV epidemic crisis for the country. Furthermore the HIV Program model was a direct response to previous evaluation criticisms of the NHASP model, particularly its relationship with NACS.

A significant assumption underlying the model was that the NAC Secretariat would take on an increasing amount of coordination of HIV response implementation, with AusAID playing an advisory and supportive role, very much in the background. The original intention of organising the HIV Program as an internal AusAID program was to provide senior, official, bilateral input in HIV strategy discussions in PNG as well as to provide advisory support to the NAC Secretariat, which was assumed would be a robust, well managed institution.

Those involved in deciding the program design also felt that working through a managing contractor would not give HIV the profile it needed, both with PNG counterparts but also across other AusAID programs that needed to pay more attention to how HIV would affect their work. The new model was intended to address the criticisms of the NHASP model—that by having staff sitting within the NAC Secretariat it had not provided sufficient space for NACS staff to take on greater responsibility, and that NHASP's frequent turnover of project staff, including the project director, had disrupted smooth operations of the program. It was felt that by bringing the management of the HIV program 'in house' AusAID could assure greater continuity of leadership of its own program, and that by setting up a program separate to, but continuing to provide close support to NACS, the new HIV Program would be able facilitate the emergence of a well-functioning national coordination body. *The HIV Program model has helped achieve greater continuity of leadership but its assumptions about the NAC Secretariat have turned out to be flawed.*

In practice the NAC Secretariat has not been able to take on a lead role in any significant manner. The evaluation team found that NACS has remained mostly dysfunctional and not capable of taking on many of the responsibilities that the design team had envisaged. This was compounded with the dissolution of the NAC itself for almost two years, which left a governance vacuum for the Secretariat. As a result, *HIV Program staff found that they needed to have a more pro-active role with implementing partners and other stakeholders to ensure that HIV activities continued to expand, requiring a more operational management style.* However, the HIV Program management have held to the initial principles guiding the program design, even though the design assumptions were proven to be overtaken by the reality of NACS management and capacity issues.

As mentioned in Chapter 4, NHASP, and now the HIV Program, were also developed on the global assumption that a great deal of attention needed to be given to HIV as more than 'just a disease'. A related assumption was that it needed to be managed separately from a purely health sector response. The HIV Program took this separation further by creating a very senior civil service post where the post holder is a technical expert (the Program Director post), while also separating HIV and health advisory teams. This has had the *unintended effect of reducing communications and synergies between AusAID's health and HIV programs*, where they should be working hand in hand.

The evaluation team considers that there has been an increasing mismatch between the HIV Program's strategic approach and the operational reality. This mismatch requires improved coordination and integration with other AusAID-funded programs, notably the health sector program, as well as increased capacity building and oversight of implementing partners. Effort now needs to be made to create greater synergies between AusAID-funded health and HIV programs, to strengthen direct and indirect management of AusAID funded implementing partners, and to increase the space for other development partners (especially UN partners). These actions would be aimed at improving PNG national coordination systems and mechanisms in order to reduce the need for AusAID to play the substantial role it has played to date.

Strengths of the HIV Program model

The major strengths of the program model are its high-level technical engagement and capacity to substitute for weak national structures.

High-level technical engagement: The original program model is based on the need to have a senior technical person who understands HIV well and who can liaise with the different stakeholders in PNG based on a firm technical grounding in HIV responses. Stakeholders indicate that this has been an important and appreciated feature of the model, and that AusAID should continue to place people with technical understanding in these types of senior positions. *The Program Director has strong credibility with HIV stakeholders across PNG. The evaluation team feels that it is correct to have a senior level director with a technical background in health and HIV to manage the AusAID portfolio in this area, though not necessarily as director of a vertical HIV program.*

Capacity to substitute for weak national structures: It is natural, though not inevitable, that the AusAID program stepped in to fill the coordination gap in the absence of any credible PNG coordination. As the major external donor to the HIV response and with a high ethical and programmatic stake in making sure that processes and interventions continued, AusAID, through its Program Director, has become a fundamental part of the HIV landscape in PNG. *The HIV Program has had the capacity to put some advisory support in place and has succeeded in keeping things going, with a number of stakeholders stating that ‘without AusAID we would be nowhere’ or ‘without AusAID the house of cards would come tumbling down.’*

Weaknesses of the HIV Program model

The main weaknesses of the program model are its contribution to the confusion about AusAID’s roles and responsibilities in the national response, its reliance on the capacity of NACS to coordinate the national response, and its capacity and accountability systems.

Confusion of AusAID role and responsibilities in the national HIV response: AusAID is seen as primarily responsible for maintaining HIV coordination, through its support to NACS. The risks of this close association have already been outlined above. Having the Australian Government as a dominant force behind the PNG HIV response is likely to have consequences on how Papua New Guineans perceive HIV more generally and what their responsibilities are for addressing their HIV epidemic. As some of those interviewed stated, ‘Leadership training for HIV is not coming from NACS or national organisations but from outside, so we ask ourselves ‘why do people from outside come and tell us how to do our jobs?’

The AusAID dominance may have inhibited others from stepping forward to share the load. The discussions in 2002 that AusAID should be the lead development partner in the HIV response need to be revisited. For example, in a number of countries where there is weak government capacity (or willingness) to address HIV, UNAIDS or UNDP take on significant roles in assisting HIV coordination, both of local and donor partners. Bilateral donors, such as AusAID, play important roles in supporting implementation. The UN system, through UNAIDS, should be able to provide greater support for these areas. As multilaterals, UN agencies are likely to be seen as more neutral actors by the Government of PNG and other stakeholders.

Some in PNG also argue that AusAID has not left much space for the Government of PNG itself to take on greater leadership.

Too closely tied to the capacity of the NACS to coordinate the national response: The assumptions of the original program model included a strong assumption that the NACS structures would be solid enough to work with as the lead counterpart agency in the national response. This expectation has not been met and the HIV Program appears to have been less effective in achieving its objectives as a result.

The focus on national level coordination has also continued to divert energies and attention away from strengthening decentralised levels. Many of the NHASP evaluation comments made in 2005 and 2007, on the need to focus more on provincial coordination and community capacity, continue to be highly relevant in 2011.

Weaker capacity and accountability systems: Having the HIV Program as a directly managed AusAID program has lightened the amount of reporting needed (as compared to a contracting agency). However the HIV Program has had to become increasingly operational to fill some of the vacuum created by NACS, but has done so without adapting the role of its advisors or putting in place stronger reporting systems. The main differences between this current model and previous contracting models appear to be that the HIV Program has greater flexibility in deciding how funds will be used to support shifting objectives, and less need for accountability as far as demonstrating how AusAID funds are spent. This has led to other weaknesses as already described in the program management section.



Children from Kaugere, an urban settlement in Port Moresby, congratulate each other after taking part in a World AIDS Day 2011 early morning walk. Photo: AusAID. Image taken by Anna Awasa.

CHAPTER 8: Conclusions and recommendations

This evaluation has found that *AusAID has been instrumental in the development of the PNG HIV response*. AusAID support has helped to shape PNG HIV policy and strategy, develop coordination mechanisms, expand capacity to deliver services, shine a light on those who are most vulnerable to HIV infection and raise awareness of HIV more generally across a broad spectrum of PNG society.

The assistance provided by the Australian Government, in terms of funding, technical assistance and other material support, is so interwoven into the fabric of the PNG response that it is at times difficult to see where the Australian contribution ends and the PNG-led response begins. Other reviews, including for past programs, have suggested the same and have consistently recommended a more thorough separation of roles and responsibilities of Australian assistance from those of the GoPNG and partners. So far it would appear that it has been very challenging for both the Australian and the GoPNG to put this recommendation into practice.

This evaluation took place within the context of the recently completed DCT review. The evaluation team's conclusions are very much consistent with those of the DCT in the areas of refocusing interventions on service delivery and decentralised levels, and reorienting the role of advisors in the PNG program. The dominance of the Australian Government's contribution to the national HIV response is the only area of divergence from the DCT's general conclusion that Australian influence is waning in PNG. The evaluation team finds, though, that *Australian influence within the HIV response could be more effectively directed if better integrated with other Australian programs in PNG, and if used to open opportunities for increased leadership and ownership by PNG stakeholders*. The new National HIV and AIDS Strategy's priorities provide an ideal opportunity for realigning and intensifying support for greater community and decentralised-level leadership of the HIV response.

8.1 Was AusAID's contribution relevant to the PNG context?

The evaluation team finds that the *AusAID contribution to the PNG HIV response has been relevant in terms of its principles, policies and in some of its strategic interventions*. The original HIV Program design was relevant to what was understood about the HIV epidemic in PNG in 2005 and 2006. The HIV Program's decision to shift the balance of its contribution to the non-state sector, once it realised that the public sector would struggle to implement key interventions, was a very appropriate and strategic response to the situation at the time. Other appropriate decisions, given the priorities in the national response at the time, include: the HIV Program's focus on funding treatment and care, education and prevention, and leadership, partnership and coordination; as well as the HIV Program's promotion of gender equality and greater involvement of people living with HIV and AIDS.

Where the HIV Program has fallen short in being entirely relevant is through not ensuring that appropriate policy and strategy was translated into interventions that were equally appropriate. The three highest funded focus areas cited above are also the ones the evaluation team has found to be most problematic. Treatment and care interventions have been funded primarily as stand-alone, non-integrated services. These interventions have created parallel systems and added transaction

costs in service delivery systems. By focusing only on HIV and AIDS and not looking at its fit with the wider health context in PNG, AusAID has missed opportunities to make both its HIV and health money work more effectively and be more relevant to the population of PNG. Education and Prevention interventions have, for the most part, not been grounded in local behavioural research evidence or an understanding of the deep social influences on people's behaviours. Far too much attention has continued to be given to trying to make NACS work when all indications were that its structure and systems were not fit for purpose.

At a strategic level, the relevance of the Australian Government's support depends to some extent on the perspective from which it is viewed. From the Australian perspective, and considering the best information on the PNG HIV epidemic between 2003 and 2009, *AusAID was justified in thinking it had both a moral and strategic responsibility to significantly scale up its funding for HIV in PNG.* Data at the time showed a real danger that the HIV epidemic could quickly reach general prevalence rates between 5 to 10 per cent, signalling the need for emergency action.

From the perspective of relative needs and priorities in PNG, where delivering education, health and other social services have continued to be highly problematic, the emphasis on HIV has perhaps looked overblown. The verticalisation of HIV services has added strains to an already fragile public health system, as parallel systems have been developed to bypass it where it was not functioning. *The evaluation team agrees that HIV services should continue to be funded. However, the approach to providing and funding these services needs an urgent overhaul so that they are more in line with the needs and capacities of PNG, and emerging evidence of effective investments in HIV.⁹⁸ By supporting the expressed needs of Papua New Guineans, while responding to the challenges of HIV as part of a wider scope of health and social priorities, AusAID support would become more relevant overall to the wider population. This in turn could foster communities and leaders to take fuller ownership of the response and ensure its longer-term sustainability.*

In terms of the overall development assistance portfolio to PNG, now is the time to re-evaluate how much funding should continue to be devoted to HIV alone when seen in the light of other donor and government contributions and relative need across all sectors. This shift would require a change in strategic emphasis for AusAID's support to the PNG HIV response. To date the support provided to policy and strategy has assumed a verticalised response. The technical assistance supported by AusAID to help write national strategy documents has helped to reinforce this tendency. *AusAID now needs to put efforts into relaxing the boundaries created by its own programming. This can be done through AusAID's large program support to the PNG health sector.* By harmonising its own support to HIV and to the health sector, AusAID can reduce the transaction costs it imposes on its PNG partners and improve its contribution to aid effectiveness.

From an operational perspective the relevance of AusAID support has been mixed. Support for scaling up HIV testing, treatment and care has been relevant in that there is much increased accessibility to HIV services across the country, but the 'stand-alone' nature of many of these services is not necessarily relevant in the PNG context, especially in many rural or peri-urban areas, where general primary health care services are severely challenged to meet people's basic health care needs. As PNG continues to struggle with especially high rates of sexually transmitted infections and maternal mortality, *more sustained health sector support across these services, with HIV as part of an integrated package, would help to increase the overall relevance of HIV service delivery interventions.*

98 Investment Framework Study Group, 2011, Towards an improved investment approach for an effective response to HIV/AIDS. *The Lancet*. Vol 377, 11 June 2011, p. 2031–2041.

Recommendation 1: Focus resources on increasing and improving the integration of HIV services into basic primary care, sexual, reproductive and maternal health services, especially in high prevalence areas of Papua New Guinea.

Proposed actions

1. Review and exploit the opportunities for greater integration of HIV interventions into other primary care services and support partner efforts at greater integration (looking at the Susu Mamas model of HIV integration into sexual and reproductive health services).
2. Actively encourage (and fund) other partners to expand HIV specific services to include STI testing and treatment, and STI, reproductive and maternal health counselling.
3. Focus initial efforts on developing strategies for linking sexual and reproductive health, maternal health and HIV policies and service provision to ensure collective outcomes. An example would be a coordinated system of referrals between service providers to ensure continuity-of-care (as has been developed by Family Health International).
4. Develop strategies that join together sexual and reproductive health, maternal and HIV policies and service provision to ensure comprehensive services. For example, developing cross-training of health providers to provide multiple services in one location, or supporting multiple providers to offer services in one location.
5. Incentivise partners, through performance contracts and other means, to seek ways to encourage men as well as women to access sexual and reproductive health services.

The relevance of the AusAID contribution to the PNG HIV response would also be enhanced by addressing the changes currently taking place in the socio-economic arena. To date little attention has been paid to how the LNG project is going to impact on PNG's HIV and STI profile, and by the time of this evaluation the HIV Program had only engaged with the LNG companies to a very limited extent. Direct foreign investment through extractive industries will continue to dominate the PNG landscape for decades to come, and these industries will bring with them both positive and negative social and health effects, including the potential risk of increasing exposure and vulnerability to STI and HIV infections.

Recommendation 2: Take a pro-active approach to mitigate the expected negative impact of large extractive and infrastructure projects, such as the Liquefied Natural Gas project, on sexually transmitted infections and HIV in affected provinces.

Proposed actions

1. Work with partners to plan and implement prevention and clinical service interventions that will address expected drivers of infection and the most vulnerable groups.
2. Actively advocate for greater investment and action by the LNG companies to mitigate the impact related to HIV and sexually transmitted infections that their activities are likely to have.

8.2 Was AusAID's contribution effective?

The evaluation team found a very mixed picture of the effectiveness of AusAID's contribution to the PNG HIV response. It is the view of the evaluation team that AusAID has been effective in helping to keep the spotlight and much needed attention on HIV within PNG for the last 15 years. In particular, AusAID support has assisted the development of progressive national policy and legislation on HIV, has ensured that there has been inclusive strategy development for the HIV response, and has helped to keep some form of coordination operating even when national mechanisms have not been operating well, or at all. AusAID has made important and essential contributions to the expansion of testing and counselling services throughout the country, and has helped to make HIV much more visible to the wider PNG community.

AusAID's support has also helped to boost engagement of non-government groups, including the private sector. Due to AusAID's funding and management support, there are now a number of strengthened civil society actors who are making a significant contribution to HIV counselling and testing, as well as care and support of people living with HIV and AIDS. AusAID's HIV support in PNG has been responsive to what appeared to be needed at different times (perception of rising HIV infection rates), and was in keeping with international trends (HIV as an 'exceptional' disease that required a high-level coordination council and dedicated resources for a multi-sectoral response).

Many stakeholders and program reports also credit AusAID with having ensured that greater attention has been given to the gender dimensions of the HIV epidemic in PNG, including the development of a national gender strategy. AusAID support has helped to ensure that there are now structures and programs in place to support people living with HIV, ranging from home-based care to networks of people living with HIV. AusAID support has been important in improving HIV awareness in PNG and, by bolstering HIV research capacity and outputs, has helped to improve the PNG evidence base. *There is no doubt in most PNG stakeholders' minds, and in the view of this evaluation team, that much of the progress made in tackling the HIV epidemic in PNG would not have been made without AusAID support.* This is consistent with the findings of the 2010 DCT review.⁹⁹

In addition to areas of positive progress, there have also been a number of areas of less effective support and practice. *Analysis of two of the three focus areas receiving the most money from AusAID, 'Education and Prevention' and 'Leadership, Partnership and Coordination', indicates that progress has been relatively poor.*

In Education and Prevention there appears to be little progress on changing behaviours and preventing HIV infections. Many of AusAID's partners continue to focus on outputs (numbers of workshops, numbers of people attending workshops) rather than behavioural change outcomes. New extractive industry and infrastructure projects planned for PNG will put further pressures on PNG communities as well as potentially increase the risk of, and vulnerability to, HIV infection. The new National HIV Strategy has made prevention its primary goal. AusAID should help to ensure that prevention activities are grounded in an understanding of what influences people's behaviour in PNG, what works as far as maximising preventive behaviours, and then put resources into effective interventions.

A number of prevention interventions that appear to be relatively effective, such as whole community interventions and services that emphasise a continuum of care approach, need much more attention, expansion and study to understand whether and why they help to change people's behaviours. All prevention interventions also need to ensure ready access to the means of preventing infection, including a reliable and accessible supply of condoms. This is especially important in existing and new areas where extractive industries are active and migrant labour flows are high.

⁹⁹ Independent Review Team, Review of the PNG-Australia Development Cooperation Treaty, p. 56.

Recommendation 3: Invest resources in expanding community-based, integrated sexual health prevention and promotion services, building on the more successful experiences of current projects in this area (for example, Family Health International, Poro Sapot, Tingim Laip).

Proposed actions

1. Undertake an impact evaluation of community based behavioural change initiatives in PNG in order to understand what strategies they use and develop a view as to 'what works'.
2. Engage advisory support in sexual and reproductive health to design pilot projects that link clinical sexual and reproductive health services with community based sexual and reproductive health promotion and prevention.
3. Work together with NDOH to finance and implement the 2010 Condom Strategy, using both public, NGO and private sector outlets.

Under Leadership and Coordination, *much of the funding and advisory support effort that has gone towards improving national coordination has been notably ineffective.* While much of the fault for this lies with the PNG context—where government institutions struggle to work within a context of low salaries, poor resources and capacity and corruption—NACS appears to have been especially dysfunctional. A number of reports¹⁰⁰ on AusAID's support for capacity efforts in PNG, beginning with NHASP, have made strong recommendations to decentralise coordination but these recommendations have been only partially heeded. Provincial HIV coordination remains severely under-resourced and under-appreciated. *Continuing support to the present NACS without it undergoing a complete reformation will not be an effective use of Australian resources.*

The HIV Program's effectiveness has also been greatly hampered by the organisational problems AusAID advisers have encountered while working with public sector organisations. The evaluation confirmed the findings of previous reviews that *there is too much conflation among PNG stakeholders of the roles and responsibilities of NACS and the HIV Program, due primarily to the HIV Program's genuine desire to step in and fill the gaps left by a non-functioning Secretariat.* The evaluation team acknowledges that action was needed, but also agrees with other reviews that the shoring up of NACS has required too much of the HIV Program staff's attention and time. This has impacted on the support they can give to effective prevention, treatment and care service delivery.

Efforts have also been hampered by the wide difference in pay, working materials and opportunity enjoyed by AusAID funded program staff during all phases and those counterparts whose capacity these advisers were meant to develop. The problems and resentments between NACS staff and AusAID advisers that were noted in the NHASP ICR report in 2007 hold true in 2010.

As noted in Chapter 6, successive AusAID programs have attempted to support reforms by, for example, facilitating functional reviews of the Secretariat. However, as many of these reviews have not considered a radical rethink of the Secretariat function in order to respond to the needs and context of PNG, the recommendations have tended more towards streamlining and 'moving the deck chairs around.' *More radical and rapid reform is now required within NACS to allow it to be more effective in coordinating these other sub-coordination groups, as well as fostering ownership of the HIV response across the public sector response more generally.* This may mean a substantial slimming down of the current form of the Secretariat, and providing support to Council members and the Secretariat executive director to take on more substantial advocacy for attention to HIV at higher levels of government.

100 See, for example: NHASP, Role of Government Study Part One: Government Framework to Respond to the HIV/AIDS Epidemic in PNG, AusAID, Port Moresby, 2005a; NHASP, Milestone 92, Annual Monitoring and Evaluation Report for Year 5 (October 2004 to July 2005) September 2005, AusAID, Port Moresby, 2005b; Mooney and Wheeler, 2009, Review of the Papua New Guinea-Australia HIV and AIDS.

The evaluation team suggests that NAC consider what the minimal function needed for the NAC Secretariat should be, where it should be located and whether AusAID can help ensure that NACS staff have the capacity needed to perform these functions effectively.

Recommendation 4: Suspend support to the National AIDS Council Secretariat until the planned institutional reform takes place and the Secretariat structure is made fit for purpose.

Proposed actions

1. Withhold all support to NACS until there is clear commitment to reform. This may be evidenced by:
 - A rigorous independent functional review of NACS takes place and recommendations, including those related to staffing, are brought into effect.
 - Substantial restructuring of NACS occurs, based on the review, that moves functions currently within NACS to other, better functioning institutions (such as grant management contracted out to an independent organisation; research coordination contracted out to a research oriented NGO or institution; capacity building contracted through NGOs).
 - Once restructuring is complete, assess the pros and cons of including in-line advisory positions to help with renewing an effective management and coordinating culture within NACS (such as in-line advisers modelling good management practice with a view to instilling use of systems and good work ethic within teams).

The attention given to ‘fixing’ NACS has been unfortunate, especially as it appears that the contrast in commitment to, and passion for, working to halt HIV is far greater among some provincial government stakeholders than their national counterparts. Provincial level authorities have significant responsibility for service delivery and coordination in their provinces, but support to provinces to help them carry out these functions has remained low and full devolution to provincial levels has not yet occurred in PNG. *AusAID is in a good position to give greater support to provincial authorities. It already has a substantial program of assistance for decentralised structures and the HIV Program has its own strategy for working with provincial authorities.* Moving in this direction would also be in line with the DCT recommendations that AusAID focus much more on service delivery, including working with those levels and structures in government that facilitate and coordinate improved service provision.

Recommendation 5: Re-focus attention towards provincial and non-state coordination of service delivery, to ensure that the Papua New Guinean population has access to good quality, comprehensive sexual, reproductive and maternal health and health promotion services that integrate HIV.

Proposed actions

1. Build on work already taking place within the provincial and local government planning authorities, with particular attention given to provinces with highest risk factors (such as large economic enclaves) and highest burden of poor sexual and reproductive health.
2. Work together with national and provincial authorities to build a model of effective separation of coordination roles and responsibilities between these two levels.
3. Work with provincial stakeholders to coordinate AusAID funded organisations involved in the provincial HIV response.

Related to the problems of translating policy into action, the current HIV Program's M&E framework should have helped AusAID, and its partners, to monitor and measure the effectiveness of their contribution to the HIV response, as well as specifying what they could be accountable for. Unfortunately it does not achieve this objective. Program reporting is not specific enough about what AusAID funding has contributed to, making it particularly difficult to disentangle what successes or areas of good practice could be attributed to AusAID support, and what may well have happened whether or not AusAID had provided some funding. *Program reporting could be strengthened if there is more emphasis on what partners will achieve, and especially what they wish to achieve using AusAID funds.* In particular AusAID could make its funding more performance based where there are clear descriptions of what funded partners have achieved through their programs, and some delineation of what proportion of this has been due to AusAID support.

Recommendation 6: Move to performance-based funding mechanisms for all partners.

Proposed actions

1. Institute a system of structured activity planning and annual review of achievements of plans for grant recipients and other HIV response partners, to be chaired by a new NACS or other PNG coordination structure.
2. If NACS reforms are carried out, provide operational funding for NACS that is contingent on achieving jointly agreed performance targets that are reported on each year.
3. Incentivise partners, through performance contracts and payments, to address the drivers of poor sexual health, including gender based violence.
4. Performance targets should include information on how they are based on current best evidence, with a focus on outcomes rather than outputs.
5. Put program expansion plans on hold while work is done to improve the relevance, quality and depth of interventions of current partners, and while moving to a more streamlined program management model.

Improving HIV-related evidence through research has been one of the HIV Program's most effective contributions and has helped to improve the PNG evidence base. AusAID support has been fundamental to ensuring that an HIV research strategy was developed, that research has been funded, and that there are mechanisms for prioritising and monitoring HIV research activities into the future. In some cases this research has been helpful for informing certain activities, such as developing the new National HIV and AIDS Strategy. *Unfortunately the effort placed in supporting research capacity has not been matched by consistent and continual efforts to make sure that this research is then disseminated and used.* As such, many program activities are not grounded in evidence, reducing their effectiveness. As AusAID has been very active in promoting and supporting better quality research in PNG, it is in a good position to work with partners to make better use of the evidence generated locally, as well as feed in evidence of international best practice.

Recommendation 7: Support initiatives that ensure that research partners and implementing partners come together to identify, review and use the latest local and international surveillance and research evidence for program planning.

Proposed actions

1. Finance and help to facilitate an annual surveillance and research workshop that presents local and international evidence, and allows for discussion on the relevance of findings for PNG as a whole and for specific communities.
2. Facilitate discussion among government and other service providers on areas that they need researching to engage policy makers and implementers in defining their own research questions and needs.
3. Fund resulting research programs that seek to answer questions posed by PNG decision makers.

Similarly, *notable efforts have been made to raise the profile of the gender dimensions of the HIV epidemic in PNG. However, this only started to be translated into more integration of gender-sensitive approaches* in mid-2010, when each sector team was held accountable for reaching specific gender equality-related targets by the AusAID Minister Counsellor. The role, desires and responsibilities of men continue to be neglected in favour of emphasising women's participation and women's vulnerability. This may inadvertently contribute to beliefs held in many communities that women 'bring HIV into the family and community'. There is no doubt that women are more biologically and socially vulnerable to HIV infection in PNG, with social vulnerability due to the very unequal status between men and women. However, focusing on only one side of this relationship equation is bound to fail.

AusAID has been a driving force behind ensuring there are greater rights for people living with HIV in PNG, both through its support for the drafting of the HAMP Act, as well as through its LSI and through support to Igat Hope. These notable successes have not been matched with equal effort or attention to support for greater involvement of people living with HIV within the interventions that AusAID funds, with a few exceptions. As with gender equality, there has been quite a bit of work on strategy development but much less on actually operationalising this through AusAID funded activities. In all cases there has been almost no effort made to monitor and evaluate the impact of gender or other rights based initiatives on how partners and the wider PNG communities perceive differential gender status or people living with HIV and AIDS. There are a number of innovative initiatives, primarily in sub-Saharan Africa, where tools have been developed to allow stakeholders to monitor changes in discriminatory practices. These could be adapted for use in the PNG context.

Recommendation 8: Make the results of strategies for promoting gender equality and greater involvement of people living with HIV and AIDS part of a new performance framework for managing AusAID grants to government and civil society partners.

Proposed actions

1. Building on the Minister Counsellor's initiative, set performance targets for gender sensitivity and equality activities to make all staff responsible for promoting gender equality in HIV activities.
2. Provide support to funded partners to conduct more in-depth gender analysis and to develop strategies that address the social-structural factors than increase men and women's vulnerability to STI and HIV infection.
3. Review and adapt stigma and discrimination monitoring tools to the PNG context to allow more effective monitoring of the impact of gender sensitivity and equality, and GIPA initiatives on partners and the communities they work with.
4. Work with partners to develop a set of indicators and targets for demonstrating how organisations are assuring greater involvement of people living with HIV and AIDS.
5. Ensure that gender equality and GIPA sensitive indicators are reported on by funded partners.

8.3 How well has AusAID nurtured sustainability and ownership?

With AusAID's support, PNG has put in place a number of structures and systems for addressing its HIV epidemic. Some of these are embedded in the legal fabric of the country, such as the HAMP Act and NAC. Other systems, such as the annual planning system facilitated by AusAID, are a useful model for future sustainable planning of the national response. However, the levels of dependency on Australian Government and other donor funding for all aspects of the HIV response mean that the PNG response is a long way off being sustainable. Despite some stakeholders indicating that the Government of PNG intends to reduce its dependency on donor funding for HIV and other development priorities, neither the Government nor AusAID have put in place plans for making this happen.

Moves towards sustainability are further hampered by the mixed degree of ownership of the HIV response. Just like the HIV epidemic itself, political and community commitment to reducing HIV rests in pockets. It is possible that AusAID is partly at fault as its programs have so dominated the HIV landscape for much of the last ten years. *By playing such a dominant role AusAID has not left much space for PNG actors to develop their own analysis and direction for the HIV response.* The question remains as to whether, had AusAID not pushed for much more attention to be given to HIV, PNG stakeholders would have created their own solutions and been as effective or more effective.

There is no doubt in any stakeholder's mind when interviewed that without AusAID support the HIV response would not be as extensive as it is today. However, there are questions as to whether this has been at the cost of allowing the time needed to build greater national and community consensus as to the shape of this response, and greater PNG leadership to determine how this response should have unfolded. *Now is the time to take stock and see how AusAID can be less of a driver and more of an enabler of the national HIV response.* This may mean working at a slower rate to allow PNG partners the time to identify and develop their own plans and initiatives. It also means taking a more integrated approach so that work on HIV addresses other pressing health

needs in PNG that are likely to be more prioritised in the minds of PNG stakeholders, especially maternal and reproductive health.

Recommendation 9: Enable greater Papua New Guinean ownership of the HIV response by clearly delineating Papua New Guinean and AusAID stakeholder roles and responsibilities in the response.

Proposed actions

1. Enable and support PNG driven initiatives in maternal, sexual and reproductive health that have integrated HIV components:
 - Identify and work with PNG stakeholders (such as provincial authorities, PNG Alliance of Civil Society Organisations Against HIV and AIDS, church organisations and so on) and international NGO partners (such as FHI, Save the Children) who can take on direct grant management and coordination responsibility for maternal, sexual, HIV and reproductive prevention, treatment and care programs.
 - Intensify support for PNG champions of the HIV response while reducing the currently high Australian profile. In other words, make space for Papua New Guineans (Ministers, Members of Parliament, NGO directors and so on) to lead together with other members of the NAC.
 - Negotiate with the Government of PNG to provide greater funding, training and support for the Special Parliamentary Committee for HIV/AIDS and other strategic level bodies that are developing and approving wider sexual and reproductive health policy and strategy.

Capacity development is an important area of contribution for assuring long-term sustainability of programs. *The HIV Program's support to raising the profile, capacity and effectiveness of NGO and civil society partners has been an effective intervention.* A solid HIV response needs the inputs of all sectors in society. Civil society is particularly important for ensuring that HIV services get to those who need them, that community prevention and care strategies are implemented, and for advocating for the rights of people infected and affected with HIV. This is especially true in a country like PNG where public sector services and capacity remain relatively weak. This evaluation agrees with findings of the ODE case study of the HIV program's work with civil society, which states:

It is important for AusAID (and other donors) to have a clear strategy and goals for working with civil society. Given that capacity building of civil society partners has been identified as critical to the achievement of the Program's goals, it may be helpful to develop a formal strategy for working with civil society with identification of capacity building timeframes and actions to address a range of issues. There may also be value of research into the nature of civil society organisations and their potential to contribute to the HIV response, and how further partnerships could be built.¹⁰¹

Capacity building objectives have been part of all phases of AusAID support for the PNG HIV response since 1996. AusAID support has been instrumental for:

- setting up the NAC, NACS and Provincial AIDS Committees
- facilitating greater leadership for HIV
- facilitating the development of a number of HIV strategic plans
- increasing the engagement of the non-state sector in the HIV response.

Despite the attention given to developing PNG capacity to respond to the HIV epidemic more effectively, these efforts have not been underpinned by any defining strategy. A strategy is

¹⁰¹ Kenyon and Rudland, 2010, Papua New Guinea-Australia HIV and AIDS Program: Civil Society Engagement Component. Case Study Report, Canberra, p. 45.

necessary to describe what the end result of all this activity should be and what the most effective interventions are that need support from AusAID to attain this result.

Recommendation 10: Change the strategic approach to how HIV services and interventions are supported and managed, through greater use of international non-governmental organisation contractors to manage grants and build capacity.

Proposed actions

1. Work at the strategic level with NDOH and NACS to assess what areas would be more efficient if contracted out to other organisations, building on lessons learned from contracting through the Church Medical Council and from other countries.
2. Change AusAID's capacity building approach to focus on public sector management of service delivery contracts as opposed to direct service delivery itself.
3. Increasingly focus coordination efforts at provincial level, working together with the Department of Provincial and Local Government and AusAID programs of support to decentralised levels, putting initial effort into following the energy exhibited by certain provincial administrations and NGO partners.

Furthermore, AusAID staff are not best placed to provide long term intensive capacity building interventions for partners, especially those working outside Port Moresby. By comparison, international NGOs have bases and staff working at provincial level and below. *In many countries international NGOs have been useful partners for delivering sustained, long term capacity development to both government and non-governmental staff* as most are engaged in some form of training already. This also is the case in PNG and, as such, much more concrete capacity development work could be done through NGO partners.

Recommendation 11: Invest capacity building efforts in strategies and approaches for civil society and public sector organisations that are shown to be most effective at leading to a sustained, integrated health response encompassing sexual and reproductive health, HIV and maternal health.

Proposed actions

1. Undertake a review of public sector and civil society capacity needs.
2. Develop joint workforce planning and capacity development strategies based on the results of this review so there are clear and mutually agreed targets, benchmarks and exit strategies for those doing capacity building.
3. Focus on those organisations that have demonstrated genuine interest in developing staff capacity (and not simply capacity substitution).
4. Develop linkages and integration between staff and leadership at all levels to integrate maternal and child health (including sexual and reproductive health for all ages and gender) and HIV services.
5. Where possible, encourage peer-to-peer capacity development (between organisations) such as through mentoring and funding international NGOs to build the capacity of local NGOs.

AusAID inputs into HIV mainstreaming have also been significant, especially in the current phase of its funding. HIV mainstreaming is an important component of ensuring the sustainability and ownership of the HIV response more generally. *The evaluation team found many areas of innovative and pro-active engagement within some of the sectors that AusAID supports. However much of this work is entirely dependent on the interests and energy of individual advisers.* The HIV Program is the natural driver for mainstreaming within AusAID in PNG. However, it has not been able to finalise a mainstreaming strategy for the organisation, has not developed its own HIV work place policies, and provides little coordination of those activities being done by individual advisers.

Recommendation 12: Prioritise funding and support for HIV mainstreaming where it facilitates greater PNG ownership of HIV mainstreaming, by focusing resources where government departments and other partners have already demonstrated leadership.

Proposed actions

1. Enable greater strategic prioritisation and coordination of HIV mainstreaming support by finalising and implementing a PNG Program strategy for support to HIV mainstreaming in the PNG Government, private sector and civil society, supported by an action-learning approach.
2. Provide a model of internal mainstreaming by finalising and approving the AusAID HIV work place policy for PNG.

8.4 Was AusAID's contribution efficiently managed?

After a decade of managing the Australian contribution to the PNG HIV response through managing contractors between 1995 and 2006, AusAID made the decision to take direct management responsibility of the PNG HIV program to show it was a strategic priority.

At a strategic level, the risks related to the current model identified in the Program Implementation Framework appear to have been borne out. The Program Implementation Framework stated that care is needed to ensure that the HIV Program and its elements adopt a 'light footprint' in terms of how they position themselves both physically and in their interactions with PNG counterparts. The size and the level of resourcing of the HIV Program could dominate and overshadow the PNG leadership of the response. Relationships with key government entities, including with NAC, NACS and NDOH, will need to be defined and nurtured.¹⁰²

Reports and interviews indicate that the HIV Program has had anything but a 'light footprint.' *The HIV Program team have opted for taking on ever-greater roles (both visibly and behind the scenes) in planning, managing and coordinating the HIV response.* This has had the benefit of keeping things going, but there appear to have been no reflective moments for the HIV Program, and the AusAID mission, to step back and explore other, lighter touch options.

At an operational level, being part of AusAID appears to have reduced the rigour of the HIV Program's programmatic and financial reporting. Previous contractors have perhaps paid too much attention to reporting on activities to AusAID, but reporting for the current program has swung too far in the opposite direction. Program staff are unable to report accurately on how AusAID funding is being spent by partners according to the annual plans they have agreed. This is not an argument for insisting on isolating AusAID funding within each partner's portfolio. However, it would make sense to provide an accurate reflection of the scale of the AusAID contribution to partner activities compared to their other sources of funding so that some form of contribution analysis is possible.

¹⁰² Mooney et. al., 2006, Program Implementation Framework, p. 53.

Separating AusAID health and HIV advisory support also does not appear to have had the intended effect of creating greater energy or coordination for HIV mainstreaming within AusAID, nor for improving the greater integration of HIV evidence and international best practice into AusAID funded programs. What it has inadvertently done is create more structural barriers to better collaboration between AusAID's health and HIV programs, with advisers and staff on each side relatively ignorant of what their colleagues are doing. This problem is currently being redressed by the Minister Counsellor.

The strategic evaluation finds that having senior in-house HIV experts who can speak knowledgeably about and advocate for HIV-related issues, and who can engage strategically with the PNG Government and other partners, has had strong benefits. However *the evaluation team has not found evidence that having a very large and complex program (that is also managed in-house) brings added benefits.* This is especially the case when AusAID management systems are not very well set up to support such arrangements. Also, by having an in-house program that is so dominant in the sector, *the Australian Government has become, in many PNG stakeholders' view, responsible for the successes and failures of the HIV response more generally.* This is not appropriate, as the Government of PNG together with its non-governmental partners should be seen as the responsible body for delivering appropriate, quality services and a comprehensive response to the PNG population.

AusAID now needs to consider how it may carry on enabling the PNG response both strategically and operationally without being so closely tied to its overall management and coordination. The Minister Counsellor will need to consider what type of technical support is needed to carry on providing strategic inputs to PNG policy and strategy discussions, and at what level this support should be provided.

Recommendation 13: Move to a program management model that combines strategic technical HIV capacity within AusAID and implementation through a managing contractor (international non-governmental organisation, national organisation or private sector).

Proposed actions

1. AusAID should continue to have an in-house HIV technical expert, with a wider sexual and reproductive health role, to oversee and coordinate AusAID programs while also working as an advocate and mentor to senior levels of government.
2. Shift grants management responsibilities to one or more international non-governmental partners, to be selected and agreed together with the National AIDS Council.
3. One of the main functions of the grant management agency should be to continue capacity building and mentoring of local organisations, or to contract out this responsibility to other more appropriate (non-governmental) institutions.
4. Ensure appropriate endorsement of grant approval as part of the national response coordination structures.
5. With changes in program functions, reduce staff working within the HIV Program to the minimum required for effective strategic engagement to influence HIV policy and practice in PNG, including through liaison with grant managers.

ANNEX 1: AusAID management response

1. AusAID welcomes the findings of this evaluation of the PNG-Australia HIV and AIDS Program. As the HIV and AIDS Program has been integrated with the Health Program in 2012, it is now referred to as the Health and HIV Program. The Health and HIV Program operates in the context of a fragile health system and has evolved in response to performance feedback, policy and clinical research and evidence about effectiveness. This evaluation makes an important contribution to improving the effectiveness of this program.
2. AusAID agrees with, and is already implementing, the majority of recommendations of the evaluation. AusAID fully accepts ten of the thirteen recommendations and partially agrees with recommendations 3, 4 and 12.
3. AusAID management would like to highlight three key aspects of the evaluation findings for clarification:
 - a. AusAID agrees that **promoting country ownership and leadership** on HIV must be a priority. The Health and HIV Program was designed with the long term aim of building the commitment and institutions needed to lead and manage the response to the HIV epidemic, whilst supporting local civil society organisations to fill immediate gaps in service delivery. However, promoting country ownership and leadership has been a challenge, due to factors such as political instability, weak health systems and entrenched social drivers of the epidemic, such as gender inequity. The Health and HIV Program has responded to this fragile operating environment by balancing the immediate need for HIV services, with longer term institution building.
 - b. **Support to the National AIDS Council Secretariat (NACS):** In line with the findings of the evaluation, the Health and HIV Program has begun to reduce its support for governance within NACS. However, we believe that a complete withdrawal of engagement with NACS would be counterproductive. NACS is the mandated body for national HIV co-ordination, and is increasingly accepted by government bodies at provincial and local levels. The 2011–12 restructure of NACS is encouraging and we believe that the Health and HIV Program should continue to support NACS via targeted technical support to strengthen key functions, including leadership and advocacy on the highest priorities for action to address HIV, informed by evidence on the epidemic in PNG. The Health and HIV Program will also work closely with the PNG National Department of Health (NDoH) and provincial governments to appropriately integrate HIV services within broader sexual and reproductive health services.
 - c. **The Health and HIV Program’s measurable impact on HIV:** The evaluation found that a major challenge for the Health and HIV Program has been demonstrating a direct impact on the HIV epidemic. The lack of reliable time series country data for the HIV epidemic in PNG adds to this challenge.

The Health and HIV Program has achieved some clear results. These include “tremendous gains” to HIV prevention from testing and treatment, noted by the Independent Review Group (IRG)¹⁰³ in 2011. The Health and HIV Program has directly supported more than a third of the country’s 315 testing sites by 2011.¹⁰⁴ The Poro Sapot project reached 74 per cent of sex workers in Port Moresby with condoms, while the PNG Business Coalition on HIV/AIDS was funded to distribute 25 million condoms nation-wide. In addition, the Health and

103 A panel of HIV international specialists who review progress in PNG annually.

104 <http://www.ausaid.gov.au/country/png/hivaids.cfm>

HIV Program has contributed to the emergence of a strong civil society response to HIV; increased provincial government coordination; and leveraged a significant increase in the Government of PNG budget allocation to HIV measures, through high-level engagement between Australia and PNG. This has resulted in an additional 6 million kina in 2010, and 15 million allocated in the Government of PNG recurrent budget for anti-retroviral treatment in 2011, with the total government HIV budget a record 49 million kina in that year.

AusAID is addressing the broader challenge of obtaining reliable country data which covers all of PNG, in two ways: by making best use of available data and by improving surveillance and data collection. For instance, modelling based on existing data is used by the Kirby Institute, University of NSW, to show the deaths and infections that would have occurred had antiretroviral drugs not been introduced or condom usage not improved.

To improve surveillance and data quality, AusAID continues to support the Government of PNG to collect and analyse strategic information. Building the NDoH capacity in disease surveillance will be a key focus for the Health and HIV Program, and will continue to build the evidence base. Commencing in 2011 and continuing in 2012, AusAID has been funding a large scale Integrated Bio Behavioural Survey through the World Bank which will both survey and test 12,000 people across PNG. This will provide reliable information on HIV prevalence across the different regions of PNG. AusAID is also improving program monitoring and evaluation systems to better track its contribution and achievements.

4. Overall the Health and HIV Program is delivering real improvements for the people of PNG and will benefit from implementing the recommendations from this evaluation.
5. Detailed responses to each evaluation recommendation are outlined below.

Response to evaluation recommendations

Recommendation 1

Focus resources on increasing and improving the integration of HIV services into basic primary care, sexual, reproductive and maternal health services, especially in high prevalence areas of Papua New Guinea.

Management response to Recommendation 1

Agree

Integration of HIV into sexual and reproductive health and maternal and child health programs is assisted by integration of AusAID's Health and HIV Programs in 2012. This integrated program is reflected in the combined schedule for Health and HIV under the Partnership for Development (<http://www.ausaid.gov.au/country/partnership/png.cfm>).

AusAID's PNG Sexual Health Improvement Program, which started in 2007, has been a pioneer in testing innovative models for integrating HIV with STI diagnosis and treatment in PNG. For example, 9,441 people attended the Lopi Clinic in Goroka for HIV and/or sexually transmitted infection (STI) testing and treatment in 2011, up from 2,773 in 2008. This was delivered through a Department of Health and NGO partnership. The program will be reviewed again in 2012 and lessons captured.

AusAID will carefully monitor the effectiveness and impact of combining health and HIV assistance under the one program. This will ensure the benefits of integration are realised while the quality and quantity of HIV services are maintained, and to avoid an increasing burden on the health system.

Recommendation 2

Take a pro-active approach to mitigate the expected negative impact of large extractive and infrastructure projects, such as the Liquefied National Gas project, on sexually transmitted infections and HIV in affected provinces.

Management response to Recommendation 2

Agree

In 2012 the Health and HIV Program supported civil society partners to extend services to provinces and districts affected by the Liquefied National Gas project (LNG). The Health and HIV Program is also working closely with Oil Search Ltd to mitigate the risks for employees, surrounding communities and sex workers. It is equally important to improve the quality and reach of STI and HIV services in areas which are transit points for the LNG sites such as Mt Hagen, Lae and Port Moresby. Over one quarter of LNG workers pass through Mount Hagen, Lae and Port Moresby while taking leave and almost half of these visit sex workers during their stop over.¹⁰⁵

The National Catholic AIDS Office and the Clinton Health Access Initiative are both working in highlands provinces affected by the LNG project. The PNG Business Coalition Against HIV & AIDS (BAHA), also funded by AusAID, is working with business partners to mitigate the risks for their employees. AusAID-funded programs like *Tingim Laip* and *Poros Sapot* target sex workers in urban transit areas.

Recommendation 3

Invest resources in expanding community based, integrated sexual health prevention and promotion services, building on the more successful experiences of current projects in this area (for example, Family Health International, Poros Sapot, and Tingim Laip).

Management response to Recommendation 3

Partially agree

We agree that there is a strong role for community-based interventions in the HIV response in PNG. However, there are a number of models for integrated sexual health prevention and promotion services and the choice of model for future interventions should be guided by evidence on which approaches are most effective in the PNG context. Some community-based approaches such as *Tingim Laip* focus on a geographic community taking responsibility for the direction of services at local level. Others work through government health services and focus not on geographically-defined communities but most-at-risk populations such as men who have sex with men and sex workers. For example, Save the Children provides STI services at the Department of Health's Lopi Clinic, Eastern Highlands Province, and links with community organisations and *Poros Sapot* (also managed by Save the Children) to reach out to sex workers and men who have sex with men. Our experience is that geographic community-based prevention interventions have been resource intensive and less successful in reaching marginalised populations which are most at risk from HIV in PNG.

¹⁰⁵ National Research Institute, 2011, *Behavioural Surveillance Research in Rural Development Enclaves in Papua New Guinea: A Study with Oil Search Ltd.*

Recommendation 4

Suspend support to the National AIDS Council Secretariat until the planned institutional reform takes place and the Secretariat structure is made fit for purpose.

Management response to Recommendation 4

Partially Agree

We recognise that capacity and performance in NACS has been variable over its life. AusAID has reduced support to NACS governance in 2011 and current government budget allocations for NACS means that direct AusAID funding to support governance and management of the NACS is unlikely to be required in the near future. However, we believe that a complete withdrawal of engagement with NACS would be counterproductive. NACS is the mandated body for national HIV co-ordination, and is increasingly being accepted by government bodies at provincial and local level. The 2011-12 restructure of NACS is encouraging and we believe that the Health and HIV Program should continue to support NACS via targeted technical support to strengthen strategic functions. This support is subject to a continued mandate from the PNG Government and satisfactory performance by NACS.

Recommendation 5

Re-focus attention towards provincial and non-state coordination of service delivery, to ensure that the Papua New Guinean population has access to good quality and comprehensive sexual health, reproductive health, maternal health and health promotion services that integrate HIV.

Management response to Recommendation 5

Agree

In keeping with the streamlining of the Australia-PNG Partnership for Development in 2011, the Health and HIV Program has finalised its Provincial Engagement Strategy. This strategy sets out priority provinces where the Health and HIV Program will focus its attention and how it will support health services and provincial administrations to better target and coordinate services for HIV and STI. The Health and HIV Program will provide technical assistance to NACS and its Provincial AIDS Councils to deliver against the priorities set out in the strategy. The Health and HIV Program will work closely with health programs in Eastern and Western Highlands provinces towards better integration and delivery of HIV/STI services at the district level.

Recommendation 6

Move to performance-based funding mechanisms for all partners.

Management response to Recommendation 6

Agree

In 2011 the Health and HIV Program advised its civil society partners that their 2012 annual plans would need to be based on strategic fit and consistent with the Australia-PNG Partnership for Development. During 2012 civil society organisation (CSO) contracts will shift to an Implementing Service Provider (ISP). Implementation will be closely monitored by the ISP and performance-based funding will form the basis of the contracts between the ISP and CSOs.

Recommendation 7

Support initiatives that ensure that research partners and implementing partners come together to identify, review and use the latest local and international surveillance and research evidence for program planning.

Management response to Recommendation 7

Agree

The Health and HIV Program is taking this recommendation forward through funding and publication of commissioned research and systemic literature reviews, and regular forums to discuss research findings through the Research Coordination Unit in NACS. In mid-2011, the Health and HIV Program began a series of workshops with CSOs to look at how they could better use evidence in their work. Such workshops will be conducted annually with CSOs prior to the development of their annual plans.

The Integrated Bio-Behavioural Survey (IBBS) planned for 2012 and funded by AusAID and other donors will generate reliable information on HIV epidemiology, and assess demographics and behavioural risk factors to help design and monitor programs better. The survey will also determine coverage of existing services providing a stronger baseline for interventions over the next phase of the Health and HIV Program.

Recommendation 8

Make the results of strategies for promoting gender equality and greater involvement of people living with HIV and AIDS part of a new performance framework for managing AusAID grants to government and civil society partners.

Management response to Recommendation 8

Agree

Gender equality and involvement of people living with HIV has long been part of AusAID NGO quality assurance processes that are undertaken six monthly by all partners including faith-based NGOs. The Health and HIV Program will strengthen its monitoring and evaluation of this issue. Gender-based violence is also a focus for AusAID programming due to the links with HIV as a cause and consequence, and partners are increasingly linking HIV services to sexual assault services.

Strongim Pipol Strongim Nesen (SPSN) is a four year partnership between the Governments of Papua New Guinea and Australia that supports the engagement of civil society, the private sector and government in shared public decision-making to improve service delivery areas including health and HIV and gender. SPSN has developed a Gender Equality and Social Inclusion Action Plan to provide a framework for mainstreaming these cross-cutting issues across the SPSN program and its management. Under this framework, all grants to government and civil society partners under SPSN are required to develop strategies to promote social inclusion—which includes promoting gender equality and the inclusion of people living with HIV/AIDS—during activity design, implementation and review.

Recommendation 9

Enable greater Papua New Guinean ownership of the HIV response by clearly delineating respective Papua New Guinean and AusAID roles and responsibilities in the HIV response.

Management response to Recommendation 9

Agree

We fully support this recommendation. PNG Government and community leadership and ownership is essential for a successful and sustainable HIV response. The Health and HIV Program has attempted to fill a major gap in the national HIV response while promoting domestic leadership on HIV since 1995.

The Schedule for Partnership for Development for Health and HIV,¹⁰⁶ signed by PNG and Australia in 2011, clearly defines joint targets and will be used as a basis for reporting in the future. The Schedule reflects the National HIV Strategy 2011-2015 outline of the roles and responsibilities of the relevant government departments and statutory bodies in the HIV response.

The Health and HIV Program's performance monitoring and evaluation framework will also be strengthened to clarify AusAID's contribution towards PNG's national HIV objectives.

Recommendation 10

Change the strategic approach to how HIV services and interventions are supported and managed, through greater use of international non-governmental organisation contractors to manage grants and build capacity.

Management response to Recommendation 10

Agree

AusAID has contracted an international non-governmental organisation as part of a consortium arrangement for the Health and HIV Implementing Service Provider. This will enable more efficient management and capacity building for CSOs.

Recommendation 11

Invest capacity building efforts in strategies and approaches for civil society and public sector organisations that are shown to be most effective at leading to a sustained, integrated health response encompassing sexual and reproductive health, HIV and maternal health.

Management response to Recommendation 11

Agree

The Health and HIV Program started a process in mid-2011 to map capacity development needs with CSO partners. A strategy will be completed early 2012 and will set out a range of capacity building approaches that will be used by CSOs and guide the Health and HIV Program in providing technical assistance to partners. It is expected that all CSO partners will develop a capacity development plan and this will be reviewed along with their annual plans each year.

¹⁰⁶ <http://www.ausaid.gov.au/country/partnership/png.cfm>

Recommendation 12

Prioritise funding and support for HIV mainstreaming where it facilitates greater Papua New Guinea ownership of HIV mainstreaming, by focusing resources where government departments and other partners have already demonstrated leadership.

Management response to Recommendation 12

Partially Agree

While we agree that an effective HIV response encompasses more than the health sector; international research shows that different levels of multi-sector responses are required for different levels of prevalence. The evaluation supports mainstreaming without investigating the likely effectiveness in the context of an epidemic with just 0.9 per cent national prevalence. The Health and HIV Program maintains that wholesale mainstreaming across all sectors may dissipate efforts rather than strengthen responses. Ensuring a supportive enabling environment for the HIV response is important, but must be well-targeted and clearly linked to improved HIV outcomes.

Support for mainstreaming has been refocused around key sectors—health, education and law and justice. These sectors have the most relevance and capacity for an effective response in the PNG context. The role of the Health and HIV Program will be to work within AusAID and with NACS to ensure coherence of HIV responses in these sectors. The Health and HIV Program will also work with NACS to assist the PNG Government to take a lead on improving coordination and coherence of multi-sector government programs in responding to HIV, in line with National HIV Strategy priorities.

Recommendation 13

Move to a program management model that combines strategic technical HIV capacity within AusAID and implementation through a managing contractor (international non-governmental organisation, national organisation or private sector).

Management response to Recommendation 13

Agree

AusAID will continue to manage and provide strategic oversight of the Health and HIV Program. AusAID will continue to engage with PNG government and CSO partners on policy and technical direction. An Implementing Service Provider has been contracted to take over responsibility for the day to day management and implementation of grants, research and technical assistance procurement as of April 2012.

ANNEX 2: Independent progress review rating

Table A2.1: Independent Progress Review rating

Evaluation Criteria	Rating (1-6)	Explanation
Relevance	4	The current program's approach was based on: data that indicated the seriousness of a growing HIV epidemic in PNG from 2004 onwards; the principle of a 'programmatic' approach to development assistance; and the view that the HIV Program needed maximum flexibility to be responsive to need in PNG. All were relevant assumptions at program design and to some degree fit with the Australian Government's overall HIV strategy 'Intensifying the Response' (2009). The HIV Program has retained a degree of relevance through the flexibility in its funding of implementing partners. However, there are a number of areas where interventions and approaches funded (vertical HIV services, poor evidence-based prevention) reduce the overall relevance ranking of the HIV Program.
Effectiveness	3	Program effectiveness remains mixed, but tends to the 'less than satisfactory' side of the scale. Rating effectiveness is hampered by the poor M&E framework and weak program-generated evidence of effectiveness. The evaluation found that while the HIV Program has effectively contributed to the rapid scale up of voluntary counselling and testing services, support for people and communities affected by HIV, and expansion of HIV-related research, the quality of the services is not consistent. Other areas of HIV Program contribution remain mostly ineffective, in particular support to the dissemination and use of evidence-based prevention interventions and capacity building.
Efficiency	3	Program financial management and monitoring systems are not detailed enough to judge adequately whether the HIV Program has managed to get value for money from AusAID inputs of funds, staff and other resources, and to continually manage risks. Audits of implementing partners indicate that, for the most part, AusAID funding is being used for the purposes intended, but a 2010 financial risk analysis concluded that the HIV Program has been incurring substantial risk because of the poor systems in place. The program management model does not appear to have added any benefit as far as greater efficiency of AusAID's contribution.

Evaluation Criteria	Rating (1-6)	Explanation
Sustainability	2	HIV Program interventions are not sustainable without continued AusAID support. The PNG HIV response is heavily dependent on Australian Government funding and advisory support, and HIV coordination institutions remain very weak. There are few strategies in place with the GoPNG and other partners that outline how this dependence can be reduced in the medium term, and there is no exit strategy to operationalise the GoPNG desire to increase its proportion of financing for HIV and health services relative to external aid received. Greater sustainability will only be achieved as and when the GoPNG assumes more ownership and leadership of its national HIV response.
Gender Equality	3	Despite efforts by some advisers, and short term technical assistance, interventions to tackle gender inequalities are poorly integrated into overall planning and implementation, and remain largely ineffective. To date, too much emphasis has been put on increasing women's participation, with little to no work with men on addressing the causes of gender-based violence and mostly negative attitudes to women more generally.
Monitoring & Evaluation	2	Efforts have been made to improve program M&E in the last year, but these improvements remain limited. The M&E framework that is in place is not a helpful tool for monitoring program progress, and includes indicators that are difficult to report on, while data is not consistently gathered to report on other indicators. The introduction of Quality at Implementation (QAI) reporting for funded partners is a good start, but these reports still fall short of describing what the Australian aid contribution is to partners' programs, and how effective that contribution is.
Analysis & Learning	3	The HIV Program has supported annual reviews of the PNG HIV response and has been instrumental in helping to develop and then support implementation of a national HIV research agenda. Unfortunately it has not capitalised on having an abundance of information available, and has not made sufficient efforts to use both PNG-based and international evidence to inform intervention strategies. It is also not apparent how well the HIV Program team have addressed recommendations arising from its program and financial reviews, nor the reviews done of implementing partners. On balance this means 'analysis and learning' needs to be rated on the 'less than satisfactory' side.

Table A2.2: Rating scale

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

ANNEX 3: Evaluation principles and methods

Evaluation principles

The evaluation was conducted based on the principles of ‘realistic evaluation’.¹⁰⁷ Realistic (or realist) evaluation holds that programs arise from the human imagination and that they are based on a number of assumptions and theories that lie in the minds of designers and implementers. As programs begin to be implemented, various approaches and interventions are likely to change as the theoretical constructs and assumptions of program design meet the reality of how things actually work. Realistic evaluations therefore examine ‘what works, for whom, in what circumstances, how and why.’ Through this evaluation the team attempted to analyse whether the basic design, and then subsequent implementation plans, have been valid and appropriate for what they set out to achieve given the available evidence and context the HIV Program is working within.

Evaluation methods

Theory of Change exercise: As part of the inception phase of this evaluation, two facilitated workshops were conducted with PNG country office staff and some of their key partners to identify their understanding of the logic of the aid program’s contribution to the national HIV response in 2010. Through this process, the participants developed a model of how the aid program’s activities collectively support the PNG national response, and how this contribution is thought to help the GoPNG achieve its goals. This ‘Theory of Change’ model is documented in a diagram and narrative form (see Annex 10). The model formed a thinking tool for the evaluation, and helped the evaluation team to understand the scope and scale of the aid program’s involvement in the HIV response, and AusAID staff’s understanding of the links between their activities and higher-level goals. It was used to inform the identification of priority focus areas for the evaluation.

Document review: The document review, along with the analytical work, was an important part of the evaluation. A large amount of information is available on HIV in PNG, and on the AusAID contribution. Each team member had specific responsibility for each of these priority areas to ensure they are covered in our analysis of the HIV Program. The team analysed programmatic priority areas and the management model used by the HIV Program, as well as support for HIV mainstreaming through the sector programs, in order to advise AusAID on the appropriateness and efficiency of their way of working. Besides the programmatic priority areas the team also analysed the management model used by the HIV Program in order to advise AusAID on the appropriateness and efficiency of this particular way of working as well as support for mainstreaming through the AusAID sector programs.

Questionnaires: The team provided two different questionnaires for stakeholders in PNG. One explored stakeholder views of national ownership of the HIV response, more details of which can be found in Annex 14. The other questionnaire asked AusAID staff and contractors about the

¹⁰⁷ See, for example, Pawson & Tilley, 1997, *Realistic Evaluation*, Sage Publications, London.

effectiveness of HIV mainstreaming efforts within AusAID-funded programs, details of which can be found in Annex 15.

Synthesis and analysis of information: The team synthesised and analysed existing information and conducted additional analytical work, structured around the main questions to be addressed by the evaluation.

Key informant interviews: The team used a semi-structured approach to key informant interviews. A topics guide was developed prior to interviews to help ensure systematic coverage of questions and issues (see Annex 7). Key informant interviews took place in Canberra and in PNG over the course of the evaluation period. These interviews were used to provide qualitative information in order to explain why certain approaches, strategies or decisions were taken, and what their effect was. These interviews also allowed the team to explore questions raised by the analytical work, as well as to explore the counterfactual (what would have happened if AusAID did not have a presence in PNG). Several interviews and a stakeholder workshop were undertaken during the inception phase of this evaluation in May, all of which helped to identify the main evaluation priorities and questions. Quotes used from these interviews are provided where they illustrate views expressed to the evaluation team on three or more occasions.

Provincial visits: The team visited three provinces (Western Highlands, Madang and Sandaun) in Papua New Guinea. The visits provided an opportunity to meet provincial authorities and organisations that are implementing AusAID activities in order to gain a better perspective of how AusAID support is being translated into interventions at decentralised and community levels. The provinces were selected on the following basis (see the Evaluation Inception Report for further details):

- Western Highlands Province—HIV priority province, high reported prevalence
- Sandaun Province—HIV priority province, low reported prevalence (but HIV risk-border with Indonesia)
- Madang Province—not HIV priority province, low reported prevalence

Workshops with PNG stakeholders: During the visit to PNG the team held workshops to explore the evaluation themes around mainstreaming and national ownership. For the mainstreaming workshop AusAID staff and contractors were invited to discuss their experience with mainstreaming. For the national ownership workshops, two were held at provincial level (Sandaun and Madang Provinces) and one at national level. These different workshops were preceded by targeted questionnaires to elicit information from key stakeholders on both themes. The answers of these questionnaires were then used to inform workshop discussions.

Australian aid program's contribution to the national HIV response: theoretical framework

In general, program logic is built around five key factors: inputs, processes, outputs, outcomes and impact. A Theory of Change exercise was undertaken through a facilitated participatory process with AusAID stakeholders and key partners in the PNG HIV response between September 2009 and May 2010. The Theory of Change indicated that the focus of AusAID's contribution, as signified by its intermediate outcomes, has been on inputs, processes and outputs. The Theory of Change outputs and details can be found in the Theory of Change model in Annex 10 of the Reference annexes.

It is useful here to compare the headlines of HIV Program Outcomes, as described in the Program Implementation Framework and the ‘intermediate outcomes’ as described in the Theory of Change workshops. Table A3:1 provides an overview of different constructions of program outcomes.

Table A3.1: Comparison of program outcomes in 2006 and 2010

Program Implementation Framework (2006)	Theory of Change Analysis (2010)
<p>Outcome 1: Support for activities within agreed priority focus areas contributing to the achievement of the PNG NSP</p> <p>Focus on: Prevention Acceleration of universal treatment access Responsive to other priorities as they arise Annual planning and prioritisation process</p>	<p>Multi-sectoral response activities (3rd level)</p> <p>Focus on: Prevention activities HIV testing, counselling, treatment and care services Activities to build leadership and action</p>
<p>Outcome 2: Enhanced individual, institutional and sector Papua New Guinean capacity to lead and manage a national response to HIV and AIDS</p> <p>Focus on: NAC, NACS and NDOH Provincial capacities</p>	<p>AusAID Program Intermediate Outcomes</p> <p>Focus on: Strengthened civil society organisations as partners in the HIV response Integrated (civil society, people living with AIDS and HIV, Gender sensitive) approach to HIV response Evidence informed approach—research, good practice, mainstreaming, surveillance Strengthened enabling environment—legal frameworks and political commitment Integrated multi-sectoral planning, including increased funding and implementation capacity at central and provincial levels.</p>
<p>Outcome 3: AusAID’s PNG Country HIV/AIDS response managed effectively</p>	

The Theory of Change outputs appear to demonstrate an evolution, or refinement, in AusAID’s contribution to the national response since the Program Implementation Framework was developed in 2006. It was relevant for this evaluation to map these changes, to understand why changes in prioritisation were made and to analyse whether they were reasonable changes to make in the given circumstances.

It is, however, important to note that any program logic must be explicit about what is under the direct control and responsibility of the organisation or program being evaluated (and therefore what it can held accountable for), versus what is being contributed to or influenced. For example, the Theory of Change model has an intermediate outcome on ‘strengthening enabling environment.’ In this case the AusAID program may only advocate for and try to influence such areas as legal frameworks, GoPNG political commitment or indeed institutionalisation of ‘enablement.’ The GoPNG itself is the responsible body for making these happen. It is not clear in the Theory of Change narrative found in the Reference annexes how stakeholders understood this difference. In evaluating the AusAID program the team therefore also considered how each phase of Australian support to the HIV response contributed to, supported, or indeed drove the process of strengthening a more enabling environment for the HIV response.

ANNEX 4: Chronology of HIV related events in PNG

Table A4.1: Chronology of HIV related events in PNG

Year	Significant events of the PNG national HIV response	Australian aid program's contribution
1987	First two confirmed HIV antibody positive cases reported.	
	NDOH Circular recommends commencement of AIDS awareness in the provinces. National Executive Council Policy Submission No. 116/87 for formulation of HIV strategy and amendment of Public Health Act to make AIDS a notifiable disease.	
	Routine screening of blood donations commenced.	Australian Government funding for blood screening kits and equipment.
1988	National AIDS Surveillance Committee of NDOH Disease Control Unit develops one year Short Term Plan and National AIDS Control Policy (NACP).	
1989	National AIDS Surveillance Committee develops National Medium-Term Programme for the Prevention and Control of AIDS 1989-1995.	
1990	National workshop on AIDS in the workplace held.	
1991	IMR commences nationwide qualitative study on sexual and reproductive knowledge and behaviour.	
1992	National seminar on social and economic impact of AIDS held, including launch of PNG Defence Force AIDS Education Program with own <i>Gumi</i> brand of condoms.	
1993	High-level national conference on social and economic impact of HIV held.	Australian Government co-sponsor.
1994	Results of IMR study published in monograph titled <i>National Study of Sexual and Reproductive Knowledge and Behaviour in Papua New Guinea</i> (National Sex and Reproduction Research Team and Jenkins 1994).	
1995		Sexual Health and HIV/AIDS Prevention and Care Project commences (Foundation Project).

Year	Significant events of the PNG national HIV response	Australian aid program's contribution
1996	<i>National Health Plan 1996–2000</i> includes policy framework for the health sector on STI control and HIV prevention.	
	Demographic and Health Survey includes section on HIV knowledge and sexual behaviour.	AusAID technical input and support.
	Catholic provincial dioceses commence HIV awareness training of missionary and healthcare personnel.	
	IMR commences behavioural research intervention project, Transex Project, for people involved in transport industry, sex work, and police constabulary.	Integrated into Foundation Project as Component 8: Management Support for Transex Project.
1997	Work commences on developing the MTP, the first multi-sectoral strategy for responding to the epidemic.	Foundation Project provides technical advice and support for the process.
	First National Seminar on HIV to lay groundwork for development of MTP.	Foundation Project organises and provides technical advice and support.
	NAC Act passed by Parliament.	
	Adventist Relief Agency (ADRA) launches PNG HIV and AIDS program.	
1998	National Catholic HIV/AIDS Board established under the Catholic Bishops Conference (CBC).	
1999	AIDS reported as leading cause of death at Port Moresby General Hospital.	
2000	First Consensus Workshop held in Port Moresby to discuss HIV epidemiology and response to date.	Supported by Foundation Project Component 5: Surveillance and Monitoring for strengthening data collection capacity and procedures.
	Anglicare StopAIDS commences.	
2001	Launch of three-staged national HIV media campaign.	NHASP team commences.
	Social Mapping conducted in all provinces.	NHASP technical input and support.
2002	NAC develops VCT and HBC training manual.	NHASP technical input and support.
	Development of NSP 2004–2010 commences.	NHASP helps facilitate NSP development process and has representation on NSP Technical Working Group Committee.
	PNG classified by UNAIDS as having 'generalised' HIV epidemic.	

Year	Significant events of the PNG national HIV response	Australian aid program's contribution
2003	HAMP Act passed by Parliament in June and gazetted in September.	NHASP Legal Adviser drafts legislation.
	PNG medium term expenditure framework prioritises HIV and STIs as top health priorities.	
	Collaboration for Health in PNG develops training manuals on HIV diagnosis and comprehensive care and treatment for health care teams and supports home-based care programs.	
	Igat Hope declared national association of people living with HIV.	UNAIDS leads the establishment of Igat Hope (with support from NHASP).
	PNG becomes member of Asian Pacific Leadership Forum	
	IMR commences nationwide 3-year mixed-methods study of HIV, AIDS, STDs and sexual health and behaviour.	AusAID support.
	Poro Sapot commences, building on networks established through Transex Project.	NHASP support.
	First introduction of ART services.	
2004	PNG Medical Symposium on HIV and sexual health.	NHASP support.
	Stakeholder Mapping conducted.	High Risk Settings Strategy commences with NHASP technical input and support.
	HIV provincial and district planning commences.	AusAID support.
	Establishment of first VCT testing facilities and ART trials.	NHASP technical input and support.
		NHASP technical input and support.
	Second Consensus Workshop held in Port Moresby.	
	Special Parliamentary Committee on HIV/AIDS formed; begins nationwide tour to elicit community perspectives on state of HIV, stigma, and sexual violence.	NHASP technical input and support.
	Dr Peter Piot, Director of UNAIDS, formally launches Igat Hope.	Igat Hope receives grant funding from NHASP.
Global Fund supports rollout of ART.		

Year	Significant events of the PNG national HIV response	Australian aid program's contribution
2005	Diocese of Mendi opens comprehensive HIV and AIDS care centre, including VCT, Preventing Parent to Child Transmission, post-exposure prophylaxis and couples counselling services.	NHASP sponsors Faith Community Leaders Covenant and Red Ribbon Churches initiative.
	Leadership Development Forum.	
	NACS relocated to Prime Minister's Office and Minister responsible for HIV/AIDS appointed to assist Prime Minister.	
	National Surveillance Management Group established (NACS, NDOH, Central Public Health Library, IMR).	Facilitated by NHASP.
	Department of Education develops and launches HIV/AIDS Policy for the National Education System.	AusAID support.
	First National HIV Prevention Summit, Port Moresby.	AusAID co-sponsors National HIV Prevention Summit.
2006	Leadership initiatives expanded.	AusAID-funded LSI (joint initiative with UNAIDS, NACS, and British High Commission) commences, involving Members of Parliament, heads of government departments and agencies, provincial administrators, and PAC chairs.
	Establishment of HIV/AIDS Donor Partners Forum.	AusAID supports establishment of HIV/AIDS Donor Partners Forum as active member.
	National Catholic AIDS Office established and network of Diocesan HIV/AIDS Secretariats, five-year plan (2005-2010) developed.	AusAID funds Caritas through Church Partnership Program (CPP).
	Business Coalition Against HIV/AIDS founded.	AusAID support.
	PNG Alliance of Civil Society Organisations against HIV and AIDS formed.	UNAIDS with NHASP support.
	Government budget allocation of K4.1 million for NAC.	
	NSP 2006-2010 launched (timeframe adjusted due to slow development).	NHASP technical input and support.
	National Gender Policy and Plan on HIV/AIDS 2006-2010.	NHASP technical input and support.
	Department of Education commences HIV curriculum development.	NHASP technical input and support.
	NSP steering committee formed by NACS to guide development of implementation plan.	AusAID support (transition).
	HIV Epidemiological Modelling and Impact Study.	AusAID funded.
	2007 Estimation Report on the HIV Epidemic in PNG published.	PNG-Australia HIV and AIDS Support Program 2007-2010 commences.

Year	Significant events of the PNG national HIV response	Australian aid program's contribution
2007	IRG established to provide an independent and transparent mechanism for the review of the national response to HIV and AIDS; conducts first mission.	HIV Program support with other donors.
	Rural Enclaves Project commences.	AusAID support with other donors.
	National HIV/AIDS Training Unit established.	HIV Program support.
	Establishment of UNGASS Core Group to develop UNGASS Country Progress Report 2008.	HIV Program technical input and support.
	NSP M&E Framework developed; Provincial Monitoring, Evaluation and Surveillance Team and Country Response Information Systems established in all provinces.	HIV Program technical input and support.
	Submission of 2008 UNGASS Country Progress Report. NAC resumes under new Chair and membership.	HIV Program technical input and support.
2008	Special Parliamentary Committee on HIV/AIDS resumes.	
	First National People Living with HIV Conference, Port Moresby.	AusAID sponsors conference and is represented by 10 Program advisers.
	National Research Agenda launched.	HIV Program technical input and support.
	National Research Institute HIV Seminar Series commences.	
	IRG conducts interim review (April) and third review (August-September).	HIV Program support.
	National HIV Prevention Strategy (NHPS) developed.	HIV Program technical input and support.
2009	IRG conducts fourth review (April-May).	HIV Program support.
	Midterm NSP stock take workshop convened to supplement IRG recommendations.	HIV Program support.
	Development of NHS 2011-15 commences.	HIV Program technical input and support.
	PNG Alliance of Civil Society Organisations Against HIV/AIDS develops 5-year strategic plan as a basis for consolidation and building capacity to scale up its role within the national HIV response.	HIV Program technical input and support.

Year	Significant events of the PNG national HIV response	Australian aid program's contribution
2010	NHPS launched by Prime Minister along with Commission on AIDS in the Pacific Report.	HIV Program technical input and support.
	PNG Christian Leaders Alliance on HIV and AIDS launched.	
	Development of National HIV Strategy 2011-2015 commences.	HIV Program technical input and support.
	Appointment of NACS Director confirmed.	
	Third National Consensus Workshop.	HIV Program technical input and support.
	UNGASS Report 2010.	HIV Program technical input and support.
	IRG conducts fifth review (April-May).	HIV Program support.

ANNEX 5: Lessons from other countries

During the strategic evaluation the team were asked on a number of occasions to provide some analysis of lessons learned from experiences in other countries. The main areas that stakeholders were interested in were:

- Providing aid for service delivery in countries with low political willingness and weak capacity.
- Effective institutional arrangements for National AIDS Coordinating Authorities.
- Creating synergies between improving maternal health services and HIV services.

This annex sets out some of the main themes that have been drawn out by various studies into these different issues, but is not meant to be exhaustive. It should also be noted that each of these issues has not yet been fully examined in the international arena, though there is substantial interest among a number of global stakeholders in developing a much more robust body of evidence around what is working and why. This annex is also provided in acknowledgement that PNG, as with any country, has unique and complex history, culture, political environment, socio-economic environment and relationships with external donors. Ultimately the solutions that need to be found will have to be found within PNG itself.

Providing aid for service delivery in countries with low political willingness and weak capacity

The following is taken from work done for the discussion of key issues related to development assistance effectiveness for National AIDS Responses that makes up part of this strategic evaluation (Annex 15). It is replicated here to highlight the main challenges and strategies for ensuring service delivery continues in contexts where the public sector in particular has weak capacity and/or weak political will to provide services itself.

Christensen et. al.¹⁰⁸ suggest that where there is no government leadership on policy making, then donor harmonisation becomes more critical for creating an enabling environment for when the country situation becomes more stable.¹⁰⁹ They also find that where government policies do exist, but political commitment to their implementation is weak, then donors are seen to bypass the state to work with non-state actors, often setting up parallel accountability systems that undermine further government legitimacy and that are difficult to integrate into government systems down the road. Poor implementation is also due to poor capacity. Donors should analyse how they can best build the capacity of governments to develop and implement policies. They should do so in ways that do not spread existing capacity too thinly due to meeting donor demands. For this the authors urge donors to prioritise and to sequence interventions to ensure national capacity is well prepared for moving from phase to phase of each intervention.

108 Christensen, Coyle & Lockhart, 2005, 'Senior Level Forum on Development Effectiveness in Fragile States' *Harmonisation and Alignment in Fragile States*, Overseas Development Institute, London.

109 Christensen, Coyle & Lockhart, 2005, 'Senior Level Forum on Development Effectiveness in Fragile States' *Harmonisation and Alignment in Fragile States*.

The recommendations on making progress through ‘manageable steps’ and investing heavily in institutional capacity building and governance in fragile states is echoed by both the UK Department for International Development¹¹⁰ and World Bank¹¹¹ analysis of aid effectiveness lessons for working in more difficult countries. The authors put particular emphasis on allowing sufficient time for institution building, with time being a commodity that many development partners do not feel they have.

A 2005 study that looked specifically at lessons learned in delivering health and education services in post-conflict or poor governance environments also found that donors need to tread carefully but can still play an important role in maintaining and improving essential basic services. A case study done on the Democratic Republic of Congo (DRC) (Box A5:1)¹¹² has certain resonance for PNG. As can be seen from the case study, the DRC has experienced decades of poor investment in health services from government. Donors and NGOs have been essential in keeping health services running, especially outside of the capital, Kinshasa. However, many of the key donors in DRC have also felt strongly that the health service delivery system that is supported through external assistance has to lay the foundations for eventual government funding and stewardship. For this reason external assistance has been organised in such a way that national and regional work first in partnership with external agencies while management and technical capacity are re-established, and then gradually take over control.

Box A5:1 Health service delivery in the Democratic Republic of Congo

The DRC is emerging after several decades of upheaval, first created by the kleptocracy of Mobuto and then civil war. Health service delivery has a long history of international involvement, beginning in the 1970s when international organisations such as Oxfam provided technical assistance to the Ministry of Health and decentralised management structures were set up, creating regional medical inspectorates and *zones de santé*.

Different donors and implementing partners took responsibility for providing health services to different parts of the country, using the state structure as its basis. Over the years providers have taken on clinics and delivered health services themselves, bypassing local systems entirely (mission clinics and private clinics); or they have worked to support national government health staff. The government (of then Zaire) provided no funding to the health system, despite the vast natural resource wealth of the state, and large funds transiting national accounts. All donor funding went directly to NGO partners providing the management and services.

The European Commission has been supporting similar work in the DRC since 1994, with a policy of ‘no enlargement and no regression.’ In other words, the objective of the program supporting health services is to try and maintain the existing structure and keep health staff in place, so that no further deterioration occurs. A change from previous renditions of the same type of support in the health sector, has been involving the government increasingly, at national and regional levels, in taking on standard-setting and regulating health services. In the latest phase of European Commission-funded programmes, Memorandums of Understanding have been set up so that a more formal contractual relationship has been developed between the government and the NGO providers. As the European Commission program only covers a certain number of regions, it is unclear what arrangements other donors have put in place to support similar structures.

110 Carlson et. al., 2005, *Service Delivery in Difficult Environments*, Department of International Development, Health Resource Centre, London, 2005.

111 World Bank, 2007, *Six Lessons for Greater Effectiveness in Fragile States*, World Bank, Washington DC.

112 Taken from Carlson et al (2005) *Service Delivery in Difficult Environments*.

Lessons learned in this work have included:

- The need to bring state actors into the equation, at some level, whether national, regional or local, in order to develop government capacity to provide policy and regulatory frameworks.
- The provision of support, both in terms of technical assistance and training as well as material and equipment resources has allowed public health services to ‘hold the line’ of where they were prior to the EC funding beginning.
- Differences in contracted providers has led to very unequal results in service provision. A number of people now suggest that it is important to separate projects supporting institutions from clinical service delivery, as they require different competencies.
- Sustainability of the current system remains problematic. Zaire/DRC was one of the first countries to introduce cost recovery through a Bamako Initiative type programme, in the 1980s. At the time many NGOs involved in service delivery considered this an ill-advised approach to cost-recovery, as the country was experiencing hyperinflation, resulting in an utter inability to keep up with the cost of drug purchases. There was also a feeling that with some of the fees raised through cost recovery returning into a government system that provided no support to health services, that this was merely another form of revenue generation that would never benefit the people. Cost recovery remains a principle within health programming in the DRC, although no assessment of how this affects poor people’s access has been undertaken.

The main lessons coming from the 2005 case studies were that: there needs to be overarching policy and strategy to drive service delivery, whether services are provided by the state or non-state sector; that management skills for delivering effective services need to be fostered; that sustainable systems need to be developed and nurtured within government and outside and; that funding needs to be consistent and continuous to allow time for skills to embed and political situations to stabilise.¹¹³

Effective institutional arrangements for NACS

While the National AIDS Council Secretariat (NACS) in PNG was not the subject of this strategic evaluation, it is one of Australia’s most important partners in the PNG HIV response, and much of the original HIV Program strategy was built around the assumption of a strong functioning NACS to work with. The Australian Government is also represented on the NAC, which is the governance body for the NACS. The Australian Government therefore is interested in how well the NACS functions, what the alternative models are for NACS, and how best to channel support to NACS in future.

The discussion of key issues related to development assistance effectiveness for National AIDS Responses, in Annex 14, gives an overview of experience of the National AIDS Coordinating Authority (NACA), and their secretariats, based on a number of studies, mostly from sub-Saharan Africa. These studies have tended to provide useful comparative analysis and give some sense of what the elements of a ‘successful’ HIV coordination body might be, but do not evaluate the effectiveness of different models. This may be due to the fact that different country circumstances dictate different needs.

¹¹³ See: http://www.dfidhealthrc.org/publications/health_service_delivery/SDDE%20summary_revised%2021feb.pdf and http://www.dfidhealthrc.org/publications/health_service_delivery/DRC.pdf for further information.

Two broad models of NACAs have emerged over the last twenty years. These are either a stand-alone institution independent of any government ministry or a unit within a given ministry (usually the Ministry of Health).

Where stand-alone institutions have been set up, these are often governed by a Board of Commissioners or equivalent, and sited under the Office of the President or equivalent in any particular country. A 2008 synthesis of the experiences of sub-Saharan NACAs found that the sixteen countries reviewed had similar institutional arrangements in many respects, but also some key differences.¹¹⁴ In all cases the NACA had been set up by an Act of Parliament, Presidential Decree or Cabinet decision, and therefore had legitimacy from the highest executive authority in the country. Thirteen out of the 16 had separate Boards of Commissioners. Of these thirteen, three had the secretariat based within the Ministry or National Department of Health rather than having a separate body. Interestingly, in two of the three countries (Zambia and Zimbabwe) where the secretariat was based within a government department, staff salaries were set independently of the civil service salary scale.

Thirteen of the sixteen countries also operated some sort of grant management mechanism for funding the HIV activities of partners in countries. In five of these countries, the grant management function was contracted out to a third party, though in two cases (Malawi and Namibia) this function has since been absorbed by an internal grant management unit.

The Dickinson et. al. synthesis draws out what lessons were being learned in terms of effective institutional arrangements.¹¹⁵ They found that experience to date indicated the following features were important for a national coordinating body to function effectively:

- Senior level commitment and drive within the Secretariat, complemented by high level political connections of the Chair of the Board, as well as the relationships between the senior level management of the NACS and the President's office.
- Having governance arrangements that include a representative Board type body (representative here means including government, civil society, people living with HIV and AIDS and, where appropriate, donor representatives). Good governance arrangements include a clear separation of responsibility between the Board and the Secretariat. The lessons learned from the countries were that Board members may find themselves in positions that require a steep learning curve, both in terms of technical know-how (understanding their AIDS epidemic) and in terms of resource governance. In some cases Board members have also had to juggle potential conflicts of interest, such as where the NAC Board Chair is also the Executive Director of the NACS.
- Having a legal framework that clearly defines the authority and mandate of the NAC is critical. Where this is absent in other countries, the Secretariat's ability to manage and coordinate the response is severely hampered.
- The capacity to plan, manage and coordinate the AIDS response at decentralised levels remains fundamental, but is also a weak point in many countries, where people with the necessary skills are often absent or over-stretched.

A number of countries have opted for smaller, streamlined secretariats whose main role is to pull together reporting from all stakeholders involved in the national response. This has meant relying on public sector departments, decentralised levels and NGOs to all report regularly to the secretariat, which might be made up of seven to ten individuals at most. Where an NACS operate with a very few staff members, there tends to be more resources put towards leadership and coordination at decentralised levels, and very strong relationships between the secretariat and national level departments that are central to HIV service delivery and mainstreaming efforts. This

¹¹⁴ Serlemitsos with Mundy, Dickinson and Whitelaw-Jones, 2008, *A synthesis of institutional arrangements of twelve National AIDS Councils in Sub-Saharan Africa*, HLSP, London.

¹¹⁵ Serlemitsos et. al., *A synthesis of institutional arrangements of twelve National AIDS Councils in Sub-Saharan Africa*.

model can be seen in large, relatively decentralised countries such as Mali and South Africa. The main emphasis is then on the operational wings of government and non-government agencies getting on and delivering interventions. Meanwhile, the secretariat is focused primarily on strategy development, improving monitoring systems and ensuring regular reviews of national strategy implementation.

Given the difficulties experienced by the NACS in PNG it would make sense to explore what are, in fact, the essential areas that a secretariat needs to cover and to minimise the number of staff needed to do this work. After, albeit brief, interactions with NACS staff and advisers while the evaluation team was in PNG, and review of various reports, the strategic evaluation team would recommend a reassessment of the secretariat function needed by NAC. Key responsibilities and activities could then include: accountability for the delivery of the new HIV strategic plan as far as advocating for proper attention to be given to HIV as part of national development planning; monitoring what different stakeholders are doing; influencing stakeholders that are not yet engaged or not aligned with national priorities to get more in line; and facilitating regular reviews of progress. All other activities, such as capacity development, grant management and research coordination, could be moved to other institutions with better capacity to take on these functions.

Creating synergies between maternal health and HIV services

As noted early on in this report, PNG is faced with numerous health challenges besides the HIV epidemic. One of its major health problems is unacceptably high maternal morbidity and mortality. The new national health plan has identified improving maternal health as one of its top priorities for the next five to ten years, and AusAID in PNG is keen to support helping the government achieve its objectives. This could potentially come at the cost of support to other critical public health problems, including HIV.

Studies that have been done that look at the inter-relation between HIV and maternal health report that pregnancy, childbirth and childhood illness are the main times that women come into contact with health services.¹¹⁶ They also indicate that the risk of maternal mortality increases in women living with AIDS, through a combination of impact on direct obstetric death and on the impact malaria and tuberculosis has on complications in pregnancy and childbirth.

One of the main routes to reducing pregnancy and childbirth complications caused by HIV and AIDS is through early diagnosis of women (so that they know their HIV status) and then improving 'preventing mother to child transmission' services (preventing mother to child transmission [PMTCT]—known as preventing parent to child transmission in PNG). PMTCT has been, and will continue to be, the main route to reducing the impact HIV status has on maternal and child survival. This has been understood for some time, as indicated by the fact that the 2001 UNGASS Declaration of Commitment on HIV/AIDS, acknowledged that the achievement of prevention targets was linked to the delivery of an integrated set of interventions, including antenatal care, HIV testing and counselling, HIV-related care, treatment and support services, and appropriate sexual and reproductive health services across the wider health sector.¹¹⁷

There are numerous structural barriers to improving the integration of maternal health, HIV and wider sexual and reproductive health services, not least because of the way programs are funded, implemented and reported on (for example vertical programming with separate

¹¹⁶ Druce and Nolan, 2007, 'Seizing the Big Missed Opportunity: Linking HIV and Maternity Care Services in Sub-Saharan Africa,' *Reproductive Health Matters*, no. 15, vol. 30.

¹¹⁷ UN General Assembly Special Session on HIV/AIDS (UNGASS), Declaration of Commitment on HIV/AIDS, United Nations, New York, <www.unaids.org/en/Goals/UNGASS/default.asp>.

staff and facilities). Despite these challenges there are emerging success stories from low- and middle-income countries. Some of the factors contributing to these successes include support to decentralised responses, where provinces and districts are provided with the resources and training to scale up improved maternal health services that include PMTCT and access to HIV testing, counselling and testing. Strong national leadership that targets reducing maternal mortality and improving PMTCT services by ensuring that the health sector devotes sufficient staff and resources to doing so also helps. One country, Zambia, has required all donors that are funding PMTCT services to put funding into a complete package of antenatal care services, while in Kenya PMTCT is one pillar of the country's safe motherhood strategy. This has meant that PMTCT is then integrated into all levels of the health system, and is supervised as part of the routine maternal and reproductive health services.¹¹⁸

PNG has the potential to adapt these practices to its own health services. What is needed is the creation of a 'virtuous' cycle of reducing maternal mortality, whereby an increasing number of women attend antenatal care services and receive skilled assistance at birth. These services would also be able to offer women and their partners the opportunity for HIV testing and counselling. Susu Mamas already provides an integrated service, and can provide lessons for developing and strengthening such services. Care would need to be taken in how such initiatives are communicated so that women are not 'blamed' for bringing HIV infection into the family.

118 Druce and Nolan, 'Seizing the Big Missed Opportunity: Linking HIV and Maternity Care Services in Sub-Saharan Africa,' *Reproductive Health Matters*, p. 190–201.

