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MIDTERM EVALUATION OF THE STRENGTHENING OF HIV/AIDS SERVICES FOR KEY POPULATIONS PROJECT IN PAPUA NEW GUINEA

August 2016

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Midterm Evaluation of the Strengthening HIV/AIDS Services for Key Populations Project in Papua New Guinea

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
APRO	Asia Pacific Regional Office
ART	Antiretroviral therapy
BSS	Behavioral surveillance survey
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CCSP	Community care and support program
CDC	Centers for Disease Control and Prevention
CPHL	Central Public Health Laboratory
CMT	Case management teams
CoPCT	Continuum of prevention to care and treatment
DFAT	Australian Department of Foreign Affairs
DSD	Direct service delivery
EOA	Enhanced Outreach Approach
FBO	Faith-based organization
FGD	Focus group discussion
FHI 360	Family Health International
FSC	Foursquare Church
FSVAC	Family and Sexual Violence Action Committee
FY	Financial year
GBV	Gender-based violence
GoPNG	Government of Papua New Guinea
HIV	Human immunodeficiency virus
HRM	High-risk men (non-KP)
HRM/W	High-risk men/women (non-KP)
HRW	High-risk women (non-KP)
HTC	HIV testing and counseling
IA	Implementing agency
IBBS	Integrated bio-behavioral survey
IEC	Information, education and communication
IMAI	Integrated management of adolescent and adult illness
IPT	Isoniazid preventive therapy
KP	Key population
LRM	Low-risk men
LRW	Low-risk women
LTFU	Lost to follow-up
MARP	Most-at-risk populations
M&E	Monitoring and evaluation
MHTC	Mobile HIV testing and counseling
MSM	Men who have sex with men
MTS	Men engaging in transactional sex
NACS	National AIDS Council Secretariat

NCD	National Capital District
NDOH	National Department of Health
NGO	Non-governmental organization
PAC	Provincial AIDS Council
PE	Peer educator
PEO	Peer education outreach
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PHA	Provincial Health Authority
PHO	Provincial Health Office
PICT	Provider-initiated counseling and testing
PLHIV	People living with HIV
PMP	Performance monitoring plan
PNG	Papua New Guinea
Q1	Quarter 1 (October to December)
Q2	Quarter 2 (January to March)
Q3	Quarter 3 (April to June)
Q4	Quarter 4 (July to September)
SA	Salvation Army
SBC	Strategic behavior change
SOP	Standard operating procedure
STI	Sexually transmitted infection
TA	Technical assistance
TB	Tuberculosis
TG	Transgender persons
TPHA	Treponema pallidum hemagglutination assay
TWG	Technical working group
UIC	Unique identifier code
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
VSO	Voluntary Services Overseas
WHO	World Health Organization
WTS	Women engaging in transactional sex

GLOSSARY

Note: The definitions for key populations and high-risk populations draw on the FHI 360 Decision Tree, used by peer educators and clinical staff to classify clients according to behavioral criteria.

Term	Definition
90-90-90 targets	By 2020, 90 percent of all people living with HIV will know their HIV status; 90 percent of those diagnosed will be receiving antiretroviral therapy; and 90 percent of those on antiretroviral therapy will be virally suppressed.
Decision Tree	A behavioral risk assessment tool used by the project's peer educators and clinic staff (for non-referred walk-in clients) to identify people who have been engaged in high-risk behaviors for STIs and HIV
Defaulter	Clients who were once actively attending clinic for HIV/AIDS care and possibly medication and who have not returned for care within three months of their last appointment
High-risk men (HRM)	Men who have had more than one sexual partner in the last three months and who do not disclose risk behavior that would meet the criteria for classification as MSM, TG or MTS
High-risk populations (HRM and HRW)	Men and women who have had more than one sexual partner in the last three months and who do not disclose risk behavior that would meet the criteria for classification as one of the key populations (MSM, TG, MTS and WTS). In PNG, there is a high degree of fluidity between high-risk populations and the key populations of MTS and WTS, as many people engage in transactional sex on an as-needed basis. Similarly, some men who identify as heterosexual engage in homosexual sex.
High-risk women (HRW)	Women who have had more than one sexual partner in the last three months and who do not disclose risk behavior that would meet the criteria for classification as WTS or TG
Key populations (KPs)	Key populations are MSM, TG, MTS and WTS. See the definitions for each category of key population.
Lost to follow-up (LTFU)	Clients who were once receiving HIV/AIDS care and possibly medication who have not returned for care after three months from their last clinical appointment
Low-risk men (LRM) Low-risk women (LRW)	Persons who have not had more than one sexual partner in the last three months and who do not fit the definitions of MSM, TG, MTS or WTS
Men who have sex with men (MSM)	A behavioral term that refers to biological males who have sex with other biological males, regardless of their sexual orientation or gender identity. The Decision Tree includes only men who have had sex with another male in the past three months, including those with only one male sexual partner.
Men in transactional sex (MTS)	Men who have had sex with another partner (male or female) in the last three months in exchange for money, goods, services or favors. See definition of transactional sex. Many men engaged in transactional do not identify as sex workers.

Term	Definition
Performance evaluation	Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision-making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual. (USAID definition.)
Process evaluation	Process evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, and management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014.)
Quarter 1	October 1–December 31
Quarter 2	January 1–March 31
Quarter 3	April 1–June 30
Quarter 4	July 1–September 30
Women in transactional sex (WTS)	Women who have had sex with a partner in the last three months in exchange for money, goods, services or favors. See definition of transactional sex. Many women engaged in transactional do not identify as sex workers.
Transactional sex	Transactional sex is providing sexual services in exchange for money, goods, services or favors. This can be a frequent practice or on an occasional basis in response to a particular need. Those engaged in transactional sex usually do not self-identify as sex workers. ‘Clients’ may be met in a range of places, such as markets, transport hubs and other general population venues, although there is anecdotal evidence that selling sex is becoming more structured around guest houses and entertainment venues.
Transgender persons	Transgender persons are individuals whose gender identity and/or expression of their gender differs from social norms related to their sex of birth. The term describes a wide range of identities, roles and experiences, which can vary considerably from one culture to another. The Decision Tree includes only transgender persons who have had sex with another person in the past three months, including those with only one sexual partner.

EXECUTIVE SUMMARY

Evaluation purpose

This midterm evaluation of USAID's PEPFAR project, *Strengthening of HIV/AIDS Services for Key Populations in Papua New Guinea (PNG)*, was designed to serve five main purposes:

1. To assess the effectiveness, efficiency and quality of the project at the national, provincial, facility and community-based service levels; identify implementation gaps and challenges; and determine how well the project is achieving its goals, objectives and performance targets/results.
2. To propose recommendations for improvement and direction for the remaining activity period.
3. To document lessons learned and provide recommendations that will inform future programming directions for the project and the design of a follow-on activity.
4. To make specific proposals for a project sustainability/exit plan, given its current level of funding for the clinic staff.
5. To assist the USAID team in evaluating the cost versus benefits of the entire project.

Questions

The key evaluation questions were:

1. How effective is the project in achieving its goals, objectives and performance targets?
2. What are the project's strengths, weaknesses and gaps in planning, management, service delivery and sustainability?
3. What are the constraints to successful implementation of this project?
4. How well does the project align with PEPFAR global priorities and approaches?
5. How do the benefits to the clients compare with the cost of providing these services to them?

Design, methods and limitations

This performance evaluation primarily used qualitative data collection through a wide range of interviews with project implementers, key informants (national and provincial health authorities, community- and faith-based organizations, and development partners) and focus group discussions with key population (KP) project beneficiaries. This was supplemented by an extensive review of the project's performance indicator data, including secondary analysis, and document review. All data were triangulated at the analysis stage.

A primary limitation was the absence of population size estimates for KPs, which meant it was not possible to calculate coverage levels for the project's interventions. The evaluation used project performance data because it was not possible to collect quantitative data within the time and resources available. There were, however, no project data for some key areas, such as the HIV-related knowledge, attitudes and behavior of KPs.

Project background

Estimated prevalence of HIV among adults in PNG in 2015 was 0.8 percent.ⁱ HIV prevalence is mostly concentrated in the Highlands Region (1.07 percent) and the National Capital District (NCD) (1.3 percent). PNG has a mixed HIV epidemic, occurring mostly among two population groups: KPs and high-risk men and women (HRM/W). In PNG the KPs are men who have sex with men (MSM), transgender persons (TG), men engaging in transactional sex (MTS) and women engaging in transactional sex (WTS).

A total of 40,000 people were estimated to be living with HIV in 2015, with 52 percent on antiretroviral therapy (ART). The primary challenges for an effective national response to HIV in PNG are limited

human and organizational capacity and the poorly functioning health system. Gender-based violence (GBV) and homophobic violence, which increase victims' HIV risk and vulnerability, are believed to be widespread in PNG.

The goal of USAID's six-year, \$19.4 million project, *Strengthening HIV/AIDS Services for Key Populations in PNG*, is to reduce HIV incidence among KPs by (1) increasing demand for HIV/AIDS services by KPs, their sexual partners and families; (2) increasing the supply of quality HIV/AIDS services for KPs, their sexual partners and families; (3) increasing the use of facility- and community-based GBV interventions; and (4) strengthening health systems for HIV/AIDS service delivery.

The project uses a continuum of prevention to care and treatment (CoPCT) approach, which is implemented by FHI 360 and its local implementing agencies (IAs). Peer education outreach (PEO) targets KPs and HRM/W to promote HIV knowledge and behavior change and increase uptake of HIV and sexually transmitted infection (STI) clinical services at five project-supported clinics in NCD and Madang. The project supports direct service-delivery costs for PEO and clinics and provides extensive technical assistance (TA) to IAs. Gender and GBV programming are integrated into prevention and clinical services through screening and referral. The project supports two safe houses in NCD for GBV survivors.

Findings, conclusions and recommendations

The evaluation's key findings, conclusions and recommendations are set out below by project component, in relation to the evaluation questions in the areas of effectiveness, strengths, weaknesses, gaps and constraints.

Prevention component: effectiveness

The number of KPs and HRM/W reached by peer educators (PEs) with the minimum prevention package has increased each year, but mostly has been substantially below target. From FY 2013 to FY 2015, KP reach averaged 46 percent of the target, but it has increased significantly in FY 2016, which may be attributable to FHI 360's new PEO IA in NCD. Demand by KPs and HRM/W for HIV testing and counseling (HTC) and STI clinical services has increased significantly from FY 2013 to FY 2015, although demand for STI services is significantly below demand for HTC, particularly among KPs. The number of walk-in KP and HRM/W clients for HTC has significantly exceeded the number of successful referrals by PEs. The total number of condoms distributed from FY 2013 to FY 2015 was 834,492, which met or exceeded targets, except for the first year. The project has developed nine high-quality information, education and communication (IEC) materials in different media and languages for use by PEs and clinicians.

The prevention component is a linchpin within the CoPCT for increasing demand for clinical services, particularly HTC, as an entry point to HIV treatment. Given the significant increase in utilization of clinical services by target populations, the low levels of PEO reach do not appear to have had a significantly adverse effect on the level of demand for or access to HIV and STI clinical services.

The project's KP programming is aligned with global evidence and adapted to the PNG context. FHI 360's expertise in KP programming is nationally recognized and appreciated. USAID's long-standing focus on KP programming, coupled with a better understanding of the PNG HIV epidemic based on improved epidemiological data and the importance of addressing KPs, has resulted in much higher priority being accorded to KPs by all partners in PNG's national HIV response.

Prevention component: strengths, weaknesses, constraints and gaps

In 2014, FHI 360 developed and rolled out an Enhanced Outreach Approach (EOA) to address the low number of contacts by PEs and limited clinical referrals. Multiple challenges were encountered during its

implementation. Despite some improvement, progress has been slow, and PE reach continues to be well below target. Contributing factors appear to be: (1) PNG is a challenging environment for implementation of KP PEO program because of stigma and discrimination and the legal environment; (2) it takes time to adjust programming, including training and testing new approaches; (3) PEO targets may be unrealistically high, especially given the geographic overlap with other development partners conducting PEO; (4) many of the PEs have low literacy levels; (5) the original IAs lacked previous experience in HIV and PEO programming; (6) the original PEO IAs in NCD never developed sufficient capacity to effectively implement PEO/EOA, despite significant capacity-building support; (7) one IA had problems related to attitude toward KPs; and (8) it took time for FHI 360 to decide to find a new IA for the PEO (albeit recognizing that choices in PNG are limited). The history of development and refinement of the EOA demonstrates FHI 360's persistent commitment to quality improvement and capacity development, despite ongoing challenges and obstacles. Recent improvements in PEO reach and referrals may be the result of ongoing refinement to the EOA and more effective implementation by the new PEO IA.

Prevention programming is currently the least sustainable component of the CoPCT model, primarily because most prevention programming is funded and implemented by donor projects and the number of agencies with technical capacity is limited. Longer-term planning and capacitation of government to manage and fund prevention programming are needed.

Clinical services component: effectiveness

HIV testing uptake has increased among KPs and HRM/W over the life of the project, and annual testing targets at each of the clinics have been exceeded. A total of 13,280 people have been tested for HIV in the project's first 3.5 years. To further increase HTC uptake, the project has innovated with mobile HTC and plans to introduce community outreach testing by PEs. The project has exceeded targets for the number of HIV-infected adults and children newly enrolled on ART. FHI 360 reports that, cross-sectionally, about 30 percent of ART clients were lost to follow-up (LTFU) as of September 2015. However, many clinic staff reported that LTFU at clinics was closer to 40 percent. The true extent of LTFU across the entire HIV care cascade is not known because of data limitations.

To the end of FY 2015, the project mostly did not meet targets for the percentage of people living with HIV in clinical care who were screened for TB symptoms at their last clinical visit. Following quality improvement measures, the project will exceed targets in this area in FY 2016. The project has largely not met targets for the number of individuals who receive STI clinical services, although following prioritization of KPs and HRM/W for STI services, service utilization has increased, particularly in FY 2015 and FY 2016.

In 2015, the project conducted a friendliness assessment of the four NCD clinics, using KP mystery patients to measure staff attitudes, clinic facilities/setup, service availability, privacy and confidentiality. Three of the four clinics were assessed as satisfactory and one as below par. Results were reported back, and all clinics are reported to have made improvements.

FHI 360 is assisting with rolling out viral load testing in NCD. This is allied with the project's recent expansion of TA to five additional clinics in NCD, in support of PNG's commitment to the 90-90-90 targets.

Clinical services component: strengths, weaknesses, constraints and gaps

The USAID project has increased the availability of care and treatment services for KPs and HRM/W, and it provides quality HIV and AIDS services in the five project-supported clinics (four NCD; one Madang). Overall, clinical service delivery is functioning well and aligned to the National HIV Strategy and international best practice. Standard operating procedures have been developed for all key clinical areas, and staff receive continuous mentoring and supportive supervision, indicating a commitment to

continuous quality improvement. Periodic use of external experts to assess service quality and gaps has provided a robust and ongoing focus on quality improvement.

HIV pre- and post-test counseling is of high quality and consistent with international best practice. Mobile clinical services could be expanded to include STI and other services to improve KP reach. ART management was stronger in the Madang clinic than the NCD clinics, which have commenced ART work only recently. LTFU is the biggest concern and will affect the Government of Papua New Guinea's (GoPNG) ability to meet 90-90-90 targets. Strategies for retaining ART patients in care and minimizing LTFU are broadly consistent with international best practice, although enhanced implementation, tailored to the specific LTFU challenges of PNG and guided by operational research, is needed. Syndromic management of STIs, consistent with national policy, coupled with lack of laboratory facilities, means that asymptomatic STIs go largely undiagnosed and untreated. At project clinics, only clients with STI symptoms are referred to STI nurses. Contact tracing for the partners of STI patients is conducted infrequently, except by one clinic.

Despite the aim of providing an integrated “one-stop shop” model, most clinics are organized along vertical program lines. Although many staff have been trained in multiple clinical areas, they usually only provide service in their designated area of work (e.g., STI, voluntary counseling and testing (VCT), or ART). This rigid division of job functions necessitates internal clinical referrals, creates inconvenience for clients and barriers to accessing care, creates cost inefficiencies because some clinics could operate with fewer staff if jobs were multi-tasked, and necessitates refresher trainings because clinicians rarely use skills outside their own job function. In some clinics, there are not enough consulting rooms to accommodate all staff, creating inefficiencies through staff downtime.

The quality of FHI 360's trainings, on-site mentoring, supportive supervision and clinical standard operating procedures was reported by many key informants as excellent. Capacity building has been effectively tailored to needs by use of structured assessment tools. Adoption of a train-the-trainer model and TA on standardizing national training and mentoring standards would promote sustainability.

For clinic service delivery to be sustainable, FHI 360 needs to work with provinces to ensure that government can take on responsibility for payment of staff positions currently funded by USAID, with particular attention to addressing clinical staff cost inefficiencies and funding for positions, such as case managers, that do not currently exist in public sector staffing structures.

Gender component: effectiveness

Following the introduction of standardized routine GBV screening of all clients in project-supported clinics, the number of clients screened has increased steadily over recent quarters, but only a very small number of GBV survivors have been identified (3-4 percent). The number of identified survivors who have chosen to access the minimum package of GBV-related services through referral has been very low, although it had increased by mid-FY 2016. Similarly, use of the project-supported safe houses by survivors of GBV has been mostly low.

Gender component: strengths, weaknesses, constraints and gaps

The integration of routine GBV screening into project-supported clinics and development of a GBV-related service referral pathway has provided a highly relevant service and further promoted the “one-stop shop” concept of programming. FHI 360 has facilitated greatly improved networking between organizations providing GBV-related services. FHI 360 GBV trainings were reported by many informants to be of high quality.

Given the high prevalence of GBV in PNG, self-disclosure of GBV to clinic staff is remarkably low, as is the number of people receiving post-GBV care and accessing the safe houses. This appears to be related

to cultural prohibitions against self-disclosure of GBV and seeking external assistance, and a preference for managing GBV within extended families.

Some aspects of FHI 360's gender programming resemble broad mainstream gender programming with no specific relevance to health services, HIV or KPs. While there is a great need for mainstream gender programming in PNG, the issue is whether an HIV KP project is the appropriate mechanism for such programming or whether more specific, project-relevant GBV programming would be preferable. The project has not developed any programming related to homophobic violence or violence against women and men in transactional sex. There is scant emphasis on GBV prevention programming, with most programming targeted toward GBV survivor services. Additionally, there is weak integration of GBV into HIV prevention programming. Overall, the GBV component is the weakest component of the project. FHI 360 recognizes the need to strengthen this component. This should include an assessment of how to more effectively address GBV and homophobic violence in the context of PNG culture.

How well does the project align with PEPFAR global priorities and approaches?

The project has a high degree of alignment with PEPFAR's key agendas in the areas of impact, sustainability, partnership action and human rights. Examples are the project's focus on reducing HIV incidence, strengthening the sustainability of PNG's HIV response through comprehensive TA in prevention and care and treatment programming, and promotion of non-discriminatory health care services for KPs.

Exit planning

USAID's preference to transition from supporting the cost of direct service delivery to only supporting TA in any follow-on project should continue to be actively pursued. However, the possibility that the GoPNG will not pick up service delivery costs due to its fiscal crisis needs to be considered in transition planning. More detailed operational planning is needed to facilitate a smooth transition from donor funding to government funding.

Overall conclusions

The project's prevention component is well designed and has been progressively improved since inception. Progress with implementation has been disappointingly slow, but there are concrete signs of increased PE coverage, which is a dividend from ongoing quality-improvement efforts. While the demand for health services generated by PEs has been relatively low, the high levels of demand for HTC, the entry point to HIV treatment, has meant that the CoPCT model has continued to function. The project has increased the availability of care and treatment services for KPs and HRM/W, and provides good-quality HIV, AIDS and STI services at the clinics it supports. The project has demonstrated effective implementation of services tailored to KP needs and is largely meeting its objectives, although some targets are still not being met.

FHI 360 has done a good job in implementing the USAID HIV project in what is a difficult operating environment, particularly because of the high levels of stigma and discrimination against KPs and generally low capacity and weakness of the health system. These challenges were compounded by working with IAs that were mostly new to HIV programming and to working with KPs. The need to build the capacity of the new IAs has slowed project roll-out but has resulted in an expansion of services with HIV and KP-related capacity. FHI 360's work is characterized by a strong and persistent commitment to ongoing, step-by-step capacity building and quality improvement, coupled with a willingness to innovate.

Recommendations

A consolidated list of all recommendations is below. The recommendations in bold are regarded by the evaluation team as the highest priorities.

Peer education outreach

1. **To allow adequate time for quality interventions, USAID and FHI 360 should consider either reducing the target for PEs of 50 KP members reached per week, or increasing the number of PEs. The number of PEs needed should also be reviewed when KP size estimates become available.**
2. Following development of KP size estimates, USAID should consider developing PEO targets for specific KP sub-populations (e.g., for MSM, WTS, etc.) to replace the current overall target for all KPs. Performance monitoring plan data on PEO reach and utilization of clinical services by MSM/TG should be disaggregated because these are two separate populations.
3. FHI 360 should conduct an evaluation to assess the effectiveness of the EOA in terms of increasing reach to KPs and HRM/W and in improving their HIV/STI-related knowledge, attitudes, and risk and health-seeking behaviors. The evaluation should assess the need for a follow-up system for PE referrals to ensure that they have been completed.
4. The project needs to strengthen community-level gender interventions by PEs to challenge gender power dynamics that have an adverse impact on the power of women to negotiate condom use.
5. USAID should consider initiating discussions with other donors and the National AIDS Council and National Department of Health (NDOH) to assess the feasibility of addressing geographic overlap in PEO activities or address this issue in the planning for a possible follow-on HIV project.
6. FHI 360 should conduct new and refresher PE training separately; refresher training should focus on identified areas where the capacity of previously trained PEs needs strengthening.
7. USAID and FHI 360 should continue advocacy for maintenance of the current definition of risk behavior for HRM/W (more than one sexual partner over the last three months) so that prevention programming can continue to be targeted to those most at risk.
8. FHI 360 should make the peer education EOA package available to all relevant international and national partners working in PNG for their adaptation and use.
9. **USAID, in consultation with the GoPNG, should consider providing equal prioritization in prevention programming for KPs and HRM/W for the remainder of the project. This should be accompanied by employment of PEs who are HRM/W. Nonetheless, higher priority should continue to be accorded to PEO reaching KPs because they are more difficult to identify than HRM/W.**

Care and treatment services

10. FHI 360 should closely monitor the quality of PE outreach HTC in community settings to ensure adequacy of pre-test counseling, confidentiality, test kit quality, infection control, clinic linkage uptake and ability to manage clients' psychological reactions to an initial positive test.
11. FHI 360 should request IAs to remove all judgmental posters from patient areas in clinic settings and ensure that all job aids are accurate.
12. FHI 360 should augment mobile HTC with other sexual health service delivery, in collaboration with other groups conducting mobile outreach services.
13. **FHI 360 should accord high priority to rigorously analyzing project-supported clinical staffing profiles prior to the conclusion of the project, to identify cost inefficiencies and determine an appropriate number of staff positions. Information from this study should be used by USAID and FHI 360 in discussions with government on the level of staffing needed in a transition from donor to government funding.**

14. **FHI 360 should develop short- and long-term strategies and operational research to reduce LTFU and evaluate these strategies for cost-effectiveness and feasibility for scaling up by the GoPNG. FHI 360 should disseminate best practices nationally and advocate for the development of guidelines for retention. Strategies need to include strengthening the referral pathways between HIV and TB.**
15. FHI 360 should standardize a training package for case managers and work with the GoPNG to identify job descriptions and establish the position/job function of case manager in the public sector system.
16. **FHI 360 should give priority to constructing a general and KP-specific cohort cascade analysis to trace individuals from the point of testing through 12 months of treatment on a continuous basis (i.e., retention) to identify the number of dropouts at each point in the cascade and by specific populations (e.g., MSM, WTS, etc.).**
17. **FHI 360 should work with the management of project-supported clinics to integrate HIV and STI service delivery, ensuring that clinicians provide all services to clients rather than referring to other clinic staff for specific services.**
18. USAID and FHI 360 should advocate to the NDOH for policy change related to the current requirement of gender-specific staffing for VCT counselors and STI clinicians.
19. FHI 360 should provide clarification to IAs on who is responsible for the procurement of commodities and ensure that this is adequately reflected in budgets and clearly communicated to staff.
20. FHI 360 should train STI nurses in using anosopes to ensure thorough clinical examinations.
21. FHI 360 should work with clinical IAs in NCD to strengthen partner contact tracing for partners of persons screening positive for STIs.
22. FHI 360 should build the GoPNG's capacity to integrate quality service delivery for KPs by standardizing training, developing guidelines and tools for mentoring or supportive supervision, implementing a training-of-trainers model, and identifying mentors for a mentoring-of-mentors model.
23. FHI 360 should address the training gaps most commonly reported during interviews: couples counseling, advanced counseling skills, counseling for children, nutrition and GBV.

Gender-based violence

24. **USAID and FHI 360 should, in close consultation with PNG partners, undertake an assessment of the types of GBV programming that are most likely to be effective within the context of PNG's culture.**
25. **USAID and FHI 360 should broaden their GBV programming to include interventions that address homophobic violence against MSM and TG and also violence directed to WTS by their clients. This needs to be accompanied by a greater emphasis on community GBV prevention programming.**
26. FHI 360 should provide additional GBV training for peer educators on strategies KPs can use to avoid violence and deal with dangerous situations, and it should support legal services for the victims of violence. This should include training tailored to violence against WTS by their clients.
27. FHI 360 should facilitate training of staff at the project-supported GBV safe houses on counseling and support for children of victims of GBV.
28. FHI 360 should provide additional GBV training in the following areas: advanced counseling skills, trauma counseling and pediatric counseling for children who have witnessed violence, and it should increase mentoring to staff of the safe houses.

Monitoring and evaluation

29. FHI 360 should provide timely and more complete feedback to clinics on performance and key indicator data.
30. FHI 360 should work with clinical IAs to establish a system for tracking internal and external referrals consistently.
31. FHI 360 needs to work with the NDOH to determine the feasibility and acceptability of the government adopting CommCare as part of the sustainability plan.

Supply chain management

32. FHI 360 should provide TA to the NCD TA expansion sites, using the same systems for tracking stock of test kits and medications to minimize stock-outs. The systems should be aligned to national efforts, including any national software systems that are being implemented.
33. The Madang Provincial Health Office (PHO) project coordinator should develop staff capacity at the Id Inad clinic and others in the province to ensure adequate stock of test kits and medications.

Exit planning

- 34. FHI 360 needs to take the opportunity provided by the one-year extension of the USAID project to ensure that detailed operational planning occurs in NCD to facilitate transition from donor support. This needs to factor in the possible scenario of no alternative funding being secured and a plan to ensure that patients currently on ART are retained in care.**
35. FHI 360 should take the opportunity provided by the deferral of the Madang exit to assist the PHO and Modilon General Hospital with detailed operational planning to maximize transition of all aspects of its support, with the aim of achieving full sustainability. A focus of this planning should be on how to develop sustainable systems within the province's health system in areas such as supply chain management, which will be needed after short-term stop-gap support from FHI 360 is no longer available.

I. EVALUATION PURPOSE AND METHODOLOGY

I.1 PURPOSE

This midterm evaluation of USAID's PEPFAR project, *Strengthening of HIV/AIDS Services for Key Populations in Papua New Guinea* (PNG) serves five primary purposes:

1. To assess the effectiveness, efficiency and quality of the project at the national, provincial, facility and community-based service levels; identify implementation gaps and challenges; and determine how well the project is achieving its goals, objectives, and performance targets and results.
2. To propose recommendations for improvement and direction for the remaining activity period.
3. To document lessons learned and provide recommendations that will inform future programming directions for the project and the design of a follow-on activity.
4. To make specific proposals for a sustainability/exit plan for FHI 360, given its current level of funding for the clinic staff.
5. To assist the USAID team in evaluating the cost versus benefits of the entire program.

The scope of work for the evaluation is in Annex I. An overview of the project is in Section 2.

I.2 KEY QUESTIONS

The key evaluation questions were:

1. How effective is the project in achieving its goals, objectives and performance targets?
2. What are the project's strengths, weaknesses and gaps in planning, management, service delivery and sustainability?
3. What are the constraints to successful implementation of this program?
4. How well does the program align with PEPFAR global priorities and approaches?
5. How do the benefits to the clients compare with the cost of providing these services to them?

I.3 METHODOLOGY

The evaluation was designed to comply with USAID's Evaluation Policy (2011) and PEPFAR's Evaluation Standards of Practice (2014). It is consistent with the USAID definition of a performance evaluation and the PEPFAR definition of a process evaluation (See Glossary). A full description of the evaluation design and methodology are in Annex 2. The evaluation was conducted by a seven-member team, consisting of an HIV specialist, evaluation specialist, gender specialist, three local evaluators and a logistics assistant, between mid-April and July 2016, with field work from mid-May to mid-June 2016.

The major components of the methodology are outlined below.

Document review: The evaluators reviewed background documents provided by USAID and FHI 360. These included work plans, progress reports, strategic plans, technical reviews and information, education and communication (IEC) materials from the project, as well as PEPFAR's Country Operational Plan, progress reports, guidelines and strategies, and documents relating to PNG's response to HIV. These are listed in the bibliography (Annex 6).

Performance data: The evaluators reviewed data from FHI 360's project performance monitoring plan (PMP). The main focus was analysis of data that contributed to answering the evaluation questions. The evaluation team examined trends in output data and assessed performance against targets. They also conducted secondary analysis of PMP and other data provided by the project to determine whether targets were achieved (by percentage), disaggregated by gender and risk classification where possible.

Where data were missing or where disaggregation of data was preferred, the evaluation team requested specific data to be provided by the project where possible.

Key informant interviews: The evaluators conducted an extensive range of interviews to collect data relating to the evaluation questions. They interviewed USAID and U.S. Centers for Disease Control and Prevention (CDC) staff, FHI 360 project staff, implementing agency (IAs) staff, health authorities at national and provincial levels, international development partners (UNAIDS, WHO and Global Fund) and civil society (key population community-based organizations and church health services). Interview guides and are in Annex 3. A list of informants and organizations consulted is in Annex 4. All key informants provided informed consent prior to the interview.

Focus group discussions (FGDs): The evaluators held focus groups with the clients/beneficiaries of FHI 360's implementing partners and the project's peer educators. Separate FGDs were held in Port Moresby and Madang for (1) men who have sex with men (MSM), transgender people (TG) and men engaged in transactional sex (MTS); (2) women engaged in transactional sex (WTS); (3) people living with HIV (PLHIV); and (4) the project's peer educators (PEs). All participants provided informed consent prior to the FGD. Discussions were conducted in the participants' choice of language: English or Tok Pisin.

Cost efficiencies: After consultation with USAID, and given the absence of a health economist on the evaluation team, it was decided that the focus for this component of the evaluation would be on identifying strategies for how staffing cost efficiencies could be realized for project-funded clinical operations. This was done by analyzing clinic staffing structures (primarily vertical), observing clinic spaces to determine the maximum number of clients that could be seen at one time; inquiring about staff competencies in multiple areas to assess whether multitasking was possible; and assessing patient load against available staff. From these inquiries, themes emerged and the evaluators drew conclusions.

Analysis: The evaluators thematically reviewed qualitative data from interviews and FGDs, connecting the data to the evaluation questions and focusing on relationships, context, interpretation, nuances, and homogeneity and outliers in relation to key informant views on the evaluation questions. Qualitative data were used to substantiate quantitative findings derived from project reports, other assessments and gap analyses conducted by the project, and the PMP, to provide more insights and context than quantitative data could provide and answer questions where other data did not exist. At the conclusion of data collection, the evaluation team triangulated all sources of information from document review, the PMP and interviews to develop findings and conclusions.

Limitations: The primary limitations for this evaluation were:

- The absence of population size estimates for key populations (KPs) makes it impossible to calculate coverage levels for the project's interventions.
- Within the time and resources available, it was not possible to collect quantitative data other than that provided by the project. There were no project data for some important areas, such as improvement in the HIV-related knowledge, attitudes and behaviors of KPs.
- The only feasible strategy for recruitment of FGD participants to was to seek the assistance of IAs. There may have been some selection bias in recruitment by IAs. This was addressed by asking the agencies to recruit participants on a random basis, with oversight by FHI 360. Clear selection criteria were also identified, although it was apparent that IAs and FHI 360 had not followed these on all occasions.
- It was not possible to interview current or former clients of the safe houses for victims of gender-based violence (GBV).

2. PROJECT OUTLINE

2.1 OVERVIEW OF KEY CONTEXTUAL ISSUES

HIV epidemiology: The recently released HIV estimates for PNG indicate an HIV prevalence rate of 0.8 percent among adults in 2015.² HIV prevalence is mostly concentrated in the Highlands Region (1.07 percent), where it is estimated to be one percent or more in four of the seven provinces (1.75 percent in Enga, 1.51 percent in Jiwaka, 1.3 percent in Western Highlands and 1.0 percent in Eastern Highlands). Other parts of PNG with higher estimated HIV prevalence are National Capital District (NCD) (1.3 percent) and Western Province (1.0 percent). Estimated HIV prevalence in Madang Province, a current USAID project site, is 0.6 percent.³

Estimated HIV prevalence has increased by 0.1 percent in 2015 from the previous year, though some stabilization has occurred in some higher prevalence provinces (e.g., Enga, Western, Morobe and Jiwaka), with an upward trend in other areas (NCD and Eastern and Western Highlands). The reasons for the increase in estimated HIV prevalence are not clear, although it may reflect better quality data rather than a trend in the epidemic. For example, the 2015 estimates are based on much more complete HIV testing data than the previous year.

There were an estimated 2,700 new HIV infections for all age groups in 2015, an increase of 700 from the previous year. A total of 40,000 people were estimated to be living with HIV in 2015, and 52 percent are currently on antiretroviral therapy (ART). The estimated number of deaths from AIDS in 2015 was 887.

At the time the existing USAID HIV project was designed, the importance of addressing KPs was starting to get increased traction, although the priority accorded to them in the national response was still low. Over the last four to five years, there has been a significant shift in the perception of PNG's HIV epidemic by its government (GoPNG) and key national and international partners, with much higher prioritization of KPs. This has been driven in large part by the profile given to KPs by USAID HIV programming, and a reorientation of Australian Department of Foreign Affairs (DFAT) and Global Fund programming toward a focus on KPs.

Data to describe PNG's HIV epidemic by risk categorization or type of population are still limited. The relative contributions of KPs (MSM, TG, MTS and WTS) and general population high-risk men and women (HRM/W) is unknown. PNG's HIV epidemic is best described as "mixed": a concentrated epidemic among KPs and an epidemic among HRM/W, primarily occurring in areas of higher prevalence (primarily Highlands and NCD).

PNG's national response to HIV: PNG's *National HIV and AIDS Strategy 2011-2015* has been extended to 2017, but is in many respects out of date. The strategy does not reflect the current prioritization of KPs or changes in international HIV guidelines. Work to develop a new national strategy has recently commenced. The National AIDS Council Secretariat (NACS) is supposed to be the principal policy and coordinating agency for PNG's national HIV response. However, NACS has recently experienced significant budget and staff cuts, with all remaining positions being re-advertised, and therefore was essentially dysfunctional at the time of this evaluation. The National Department of Health (NDOH) develops national policies and guidelines on all health-related aspects of HIV, coordinates the health sector response, provides technical and financial support to Provincial Health Offices and Authorities (PHOs/PHAs) and is responsible for surveillance. PHOs and PHAs are responsible for management and supervision of health services in their provinces. The primary challenges to an effective national response to HIV/AIDS in PNG are limited human and organizational capacity and the poorly functioning health system.

Gender-based violence: GBV is believed to be widespread in PNG, although there are no large-scale prevalence studies describing its extent. A small study of women accessing health services in four provinces found that 58 percent suffered physical and emotional abuse in relationships, 44 percent sexual abuse, 38 percent social isolation and 47 percent financial abuse.⁴ GBV is known to increase both HIV transmission risk and vulnerability. Violence against KPs is also very common, with 57 percent of MSM and 66 percent of WTS in NCD reporting in a 2011 survey that they had been physically assaulted at least once in the previous year.⁵

2.2 OVERVIEW OF THE STRENGTHENING HIV/AIDS SERVICES FOR KPS PROJECT

USAID, through the President's Emergency Plan for AIDS Relief (PEPFAR), has been supporting the GoPNG's HIV/AIDS response since 2003. In 2012, USAID awarded FHI 360 a US\$14,900,000 cooperative agreement for a follow-on project to its previous USAID-supported work with KPs. The five-year award was to run from Oct. 1, 2012 to Sept. 30, 2017, but it has been extended to run through Sept. 30, 2018, with an increase in funding to \$19.4 million.

The project is overseen by USAID/Philippines and the Agreement Officer's Representative based in USAID's Pacific Islands Office in PNG. CDC also operates in PNG, providing technical assistance (TA) to the GoPNG since 2007, also under the auspices of PEPFAR.

The project, *Strengthening HIV/AIDS Services for Key Populations in Papua New Guinea*, builds on USAID's previous HIV/AIDS project, which introduced the continuum of prevention to care and treatment (CoPCT) approach that was subsequently adopted nationally by the NDOH. The goal of the current USAID project is to reduce HIV incidence among KPs and their sexual partners and families. The objectives are to:

1. Increase demand for HIV/AIDS services by KPs, their sexual partners and their families.
2. Increase the supply of quality HIV/AIDS services for KPs, their sexual partners and their families.
3. Increase the use of facility- and community-based gender and GBV interventions.
4. Strengthen health systems for HIV/AIDS services delivery.

Like the previous USAID project, the current project operates in NCD and Madang. FHI 360 provides prevention programming through peer education outreach (PEO) targeted toward KPs and HRM/W to promote HIV knowledge and behavior change and increase uptake of HIV and sexually transmitted infection (STI) clinical services. Clients reached through peer outreach are referred for services at five clinics. In NCD, the Salvation Army (SA) and Foursquare Church (FSC) have been contracted to implement the CoPCT framework for care and treatment for HIV and STIs; each operates two clinics (SA: Koki and Ela Beach; and FSC: Kaugere and Kila Kila). The four clinics are located in Moresby South, the area where PEO is conducted. FSC and SA implemented PEO activities in NCD until 2015, when PEO was transferred to Voluntary Service Overseas (VSO). In Madang, the project supports the Id Inad clinic at Modilon General Hospital for HIV and STI services. Until 2016, FHI 360 funded VSO to implement PEO in Madang, but PEO is now funded by the Global Fund.

FHI 360 provides TA to improve the quality of HIV and STI services for KPs at all of the clinical sites through ongoing training, mentoring and supportive supervision. A TA expansion model was implemented in Heduru, Begabari, Lawes Road, 9 Mile, and 6 Mile clinics in NCD in FY 2016, with no support for direct service delivery.

Gender and GBV programming is integrated into prevention and clinical services through screening and referral. FSC and SA operate two safe houses in NCD for GBV survivors. The Family and Sexual Violence Action Committee (FSVAC) focuses on improving coordination of the GBV response in NCD, working with mass media and in partnership with Child Fund, which is implementing a national

counseling hotline. In Madang, technical support is provided to the Family Support Center for GBV activities and the Madang PHO to facilitate HIV coordination in the province.

Table I describes how this project is aligned to PEPFAR 3.0.

Table I: USAID PNG project alignment to PEPFAR 3.0

PEPFAR 3.0 Priority Agendas	USAID’s PNG KP project alignment to PEPFAR 3.0
Impact Agenda	Targets KPs to increase access to core interventions that reduce HIV incidence and increase TB screening in HIV service delivery. Integrates gender issues across the four program objectives, focusing on decreasing GBV, discrimination and other barriers to HIV prevention, care and treatment.
Sustainability Action Agenda	Strengthens the monitoring and evaluation systems within PNG and integrates comprehensive training and mentoring for HIV prevention, care and treatment in support of health systems strengthening. Works closely with the GoPNG, multilateral institutions and civil society organizations to implement programming aligned to national HIV strategy. FHI 360 currently participates in more than 10 technical working groups and has been working with six IAs to strengthen internal systems for long-term viability.
Partnership Action Agenda	Works with the other donors, UNAIDS, WHO, community- and faith-based organizations and non-governmental organizations, in coordination with the GoPNG, to align programming for KPs toward meeting the 90-90-90 targets. Through the HIV and other technical working groups, organizational support to the GoPNG is leveraged for maximum impact.
Human Rights Agenda	Works to create non-stigmatizing/discriminatory health care environments for KPs accessing services in direct service delivery sites, and worked nationally to integrate provisions for KPs into the national response. Works with the NDOH to ensure that indicators for KPs are integrated into routine data collection, providing sensitization to working with KPs across IAs, partners and government, and promoting programming that increases awareness about GBV.

3. PREVENTION COMPONENT

3.1 PROJECT COMPONENT OVERVIEW

The primary intended results for the project's prevention component are to improve the HIV and STI-related knowledge, attitudes and behaviors of KPs and HRM/W and to improve the health-seeking behavior of these populations. This component plays a key role in increasing demand for HIV and STI clinical services by KPs and HRM/W, as part of the CoPCT, and linking these populations to those services. Outcomes from the project's Strategic Behavior Communication Strategy relevant to the prevention component are: (1) increasing consistent use of condoms and appropriate lubricants among target populations; (2) increasing uptake of a comprehensive package of sexual health services, including screening and treatment of STIs, HIV testing and counseling (HTC), and HIV/AIDS care and treatment services; and (3) increasing uptake of facility-based care and support services by survivors of GBV.

The prevention component is primarily delivered through PEO, designed around delivery of the minimum prevention package, based on PEPFAR guidelines. Essential elements of the package are: (1) peer outreach and empowerment, including behavioral risk assessment and classification of peers by PEs using the Decision Tree (see Glossary); (2) targeted IEC materials on HIV, STI, HTC, GBV and family planning to promote safe behaviors and increase demand for clinical services; (3) provision of male and female condoms and lubricant; and (4) referrals to HTC, STI, HIV/ART, TB and GBV services.

3.2 PROJECT EFFECTIVENESS

Knowledge, attitudes and behavior: The project does not collect data to assess its effectiveness in improving the HIV/STI knowledge, attitudes and risk behaviors of KPs or HRM/W, largely due to the expense of population surveys. No baseline data were collected, although the behavioral surveillance survey (BSS) conducted toward the end of the previous USAID project could be regarded as proxy baseline data. No further BSS survey is planned, although an Integrated Bio-Behavioral Survey (IBBS) in NCD is currently underway. Some comparison between the results of the 2011 BSS and 2016 IBBS may be possible.⁶

Reach of PEO: The number of KPs reached by PEs with the minimum prevention package has increased each year but mostly has been substantially below targets, which have increased annually (see Figure 1, below).⁷ From FY 2013 to FY 2015, KP reach averaged 46 percent (range 40-52 percent) of the target and for HRM/W averaged 75 percent (range 38-122 percent). KP reach has increased significantly in FY 2016. If this trend is maintained in the second half of the year, 64 percent of the KP target will be reached, the highest for any year, which may be attributable to FHI 360's new PEO IA in NCD. (The project's performance against targets for all PEPFAR indicators for FY 2013 to mid-FY 2016 is set out in Table 3 in Annex 5.)

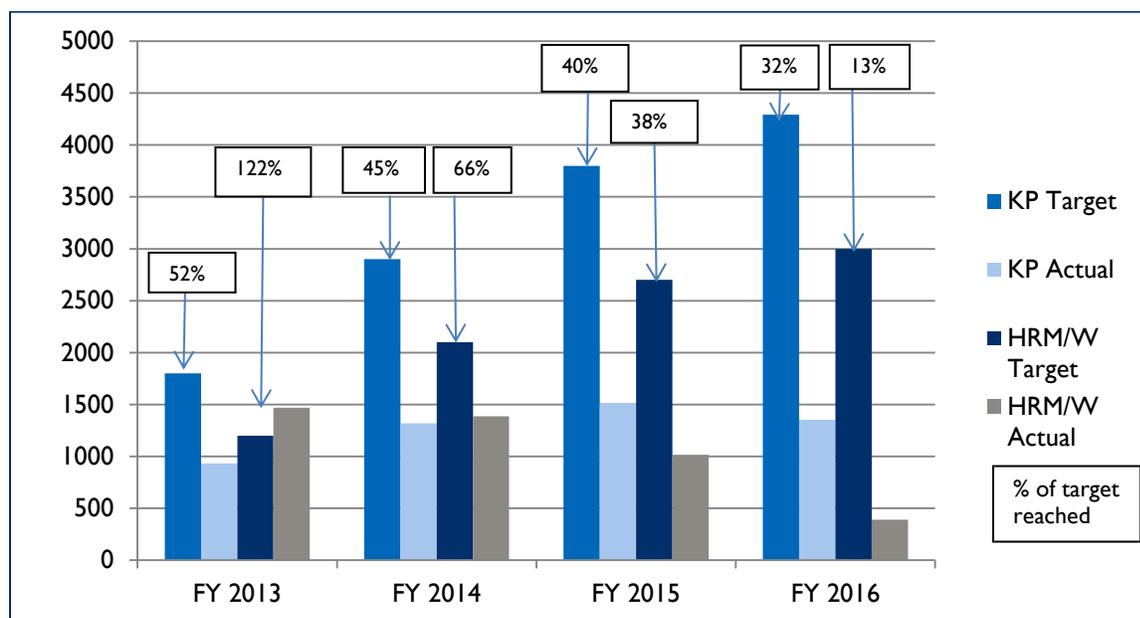
From FY 2013 to FY 2015, the number of MTS reached by PEO increased by 99 percent, while MSM/TG reach has been relatively stable, ranging from 249-289 each year. MTS and MSM/TG reach has increased significantly in the first half of FY 2016. From FY 2013 to FY 2015, the number of WTS reached increased by 84 percent, with further significant increase in the first half of FY 2016. (See Figure 5, Annex 5.) It is not possible to estimate KP coverage by PEO because KP size estimates do not exist.⁸

In contrast to trends in PEO reach for KPs, from FY 2013 to FY 2015, the number of HRW reached by PEO decreased by five percent and the number of HRM reached decreased by 51 percent, with further decreases in reach for HRM/W in the first half of FY 2016.

Of the total of 5,120 KPs reached by PEs from FY 2013 to mid-FY 2016, 57 percent of contacts were in Port Moresby and 43 percent in Madang.⁹ For HRM/W, of the total of 4,259 contacts from FY 2013 to

mid-FY 2016, 44 percent were in Port Moresby and 56 percent in Madang. Given the much larger population of Moresby South, project reach in Madang has a higher proportional coverage rate.

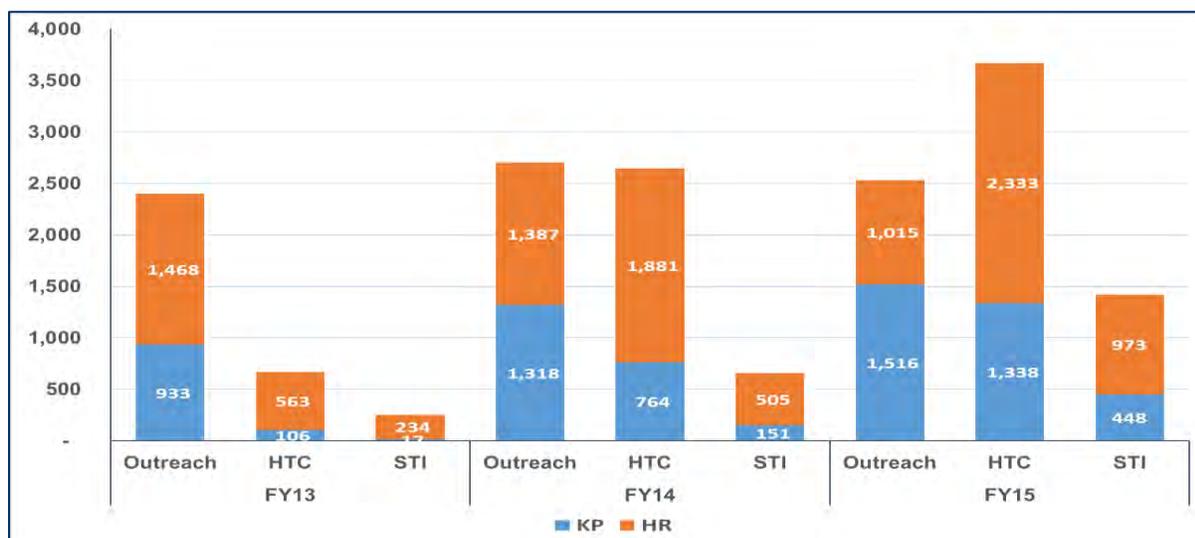
Figure 1: Reach of peer educator outreach: actual vs. target, FY 2013 to mid-FY 2016



Source: FHI 360 PMP data. Note: FY 2016 only includes data for the first half of the year.

Health-seeking behavior: Demand by KPs and HRM/W for HTC and STI clinical services has increased significantly from FY 2013 to FY 2015, although demand for STI services is significantly below demand for HTC, particularly among KPs (see Figure 2). In FY 2015, the success rate of PE referrals of KPs and HRM/W for HTC was 79 percent in NCD, but only 18 percent in Madang (see Figure 6, Annex 5). PEs and clinic staff in Madang reported that many of their clients, especially KP members, chose to have HTC at a privately located Catholic voluntary counseling and testing (VCT) clinic rather than the project-supported clinic, which is known as the HIV clinic.¹⁰ The number of walk-in KP and HRM/W clients for HTC has significantly exceeded the number of successful referrals by PEs. In FY 2015, of the 3,671 KP and HRM/W having HTC in a project-supported clinic, 32 percent were successful PE referrals and 68 percent were walk-in clients.

Figure 2: Peer educator reach and demand for HTC and STI services, FY 2013-2015



Source: FHI 360 PMP data

Condoms and lubricant: The total number of condoms distributed from FY 2013 to FY 2015 was 834,492, which met or exceeded annual targets except for the first year.¹¹ Male condoms account for 91 percent of all condom distribution. (See Figure 7, Annex 5.) PEs report female condoms are generally not popular among WTS and HRW. Lubricant distribution has totaled 501,721, 60 percent of the total for condom distribution. Male and female condoms and lubricant were readily available at all project sites visited, with no reports of stock-outs.

IEC: The project has developed nine different types of IEC materials in English, Tok Pisin and Motu, in different media (posters, booklets, leaflets, badges, radio jingles, and interactive HIV risk assessment cards) to be used by PEs and clinicians. Topics covered include condom promotion, HIV and STI prevention, HTC promotion, what to expect during an STI checkup, GBV and post-exposure prophylaxis, stigma and discrimination, transgender human rights, clinic promotion cards, and TB infection control.

Training: FHI 360 has trained more than 50 PEs and field support officers to implement PEO. With FHI 360 technical support, the project’s PE curriculum was used as the basis for development of the national PE curriculum.

3.3 STRENGTHS, WEAKNESSES, CONSTRAINTS AND GAPS

PEO challenges in NCD: The failure to meet PEO targets, particularly in NCD, reflects the significant challenges FHI 360 has faced in implementation of this project component. Implementing a KP PEO project in PNG is especially challenging because of the high level of HIV and KP-related stigma and discrimination and the legal prohibition of sodomy and sex work. Given this environment, KPs are more hidden in PNG than in many other countries. From FY 2013 to FY 2015, the PEO program in NCD was implemented by two faith-based organizations (FBOs), the FSC and SA, both of which were new IAs with no previous experience in HIV work, PE and working with KPs. These IAs were establishing new HIV clinical services at the same time as launching PEO programming, which represented a significant workload.

To address the low level of performance of PEO and limited number of clinical referrals, particularly for MSM and TG, FHI 360 decided in FY 2014 (Q2), to develop an Enhanced Outreach Approach (EOA),¹² which was rolled out in NCD in October 2014. The EOA introduced a unified form for use by PEs,

integrating a simplified Decision Tree risk assessment tool, and standardized delivery of the minimum prevention package messages, client registration and referral to clinical services, supported by an easy to follow handbook for PEs. The EOA placed a greater emphasis on STI management and included family planning and TB in the referral form. An incentive payment to PEs for successful clinic referrals was introduced, although there was no provision for follow-up to check that referrals had been successful.¹³ To supplement PE referrals to clinics, the EOA introduced a “pass it on” clinic referral card, which PEs give to peers for distribution to their social and sexual networks to achieve a snowballing effect through second- and third-wave referrals. FHI 360’s roll-out of the EOA involved a high level of field monitoring and support oriented toward quality improvement, and it was an innovative approach to a significant programming challenge.

The project encountered multiple challenges in rolling out the EOA, including incorrect completion of referral forms and confusion on roles in data collection and collation between PEs, field support officers, and monitoring and evaluation (M&E) officers.¹⁴ In the first quarter of FY 2015, FHI 360 conducted EOA reorientation training of the FSC and SA management and their PEs to address implementation problems. By the first quarter of FY 2015, the EOA was starting to show results, with a 61 percent increase in PE contacts with KPs and HRM/W, although still well below target, and a 196 percent increase in the number of clinic referrals, particularly for STI checkups, compared to the previous quarter.¹⁵ However, by the third quarter of that year, the number of KPs reached by PEs remained well below target, as PEs were reported by FHI 360 to be focusing on reaching peers likely to complete referrals to increase their incentive payments.¹⁶ Major issues identified in a further review of the EOA by FHI 360 were lack of commitment by some PEs, limited contact time with peers, poor supervision by field support officers and poor application of the EOA. Use of second- and third-wave “pass it on” referral slips was low, although this was outside the control of PEs. FHI 360 responded by refining the PE recruitment criteria¹⁷ and incentive system and developing a protocol for delivery of the minimum prevention package. This was accompanied by strengthened microplanning, a more structured approach to outreach, addressing logistical issues that were limiting PE time in the field, and strengthened field supervision.¹⁸ There was also renewed emphasis on the importance of PEs reaching as many KPs and HRM/W as possible with the minimum prevention package, rather than just concentrating on clinic referrals.

EOA implementation problems continued, and in the fourth quarter of FY 2015, FHI 360 decided to engage VSO to take over implementation of the prevention component in NCD from the FSC and SA. FHI 360 based this decision on VSO’s good performance in Madang, the need for an IA that could focus solely on the prevention component¹⁹ and concerns regarding the inadequacy of implementation by FSC and the SA. There were also concerns with FSC’s ability to work with KPs. A 2014 quality review conducted by FHI 360 international experts reported issues with FSC’s attitudes toward KPs, which affected service delivery. The review recommended “that a new community-based IA be identified; one that is willing to serve all project target populations without hesitation.”²⁰ FSC management informed the evaluators that they tried to minimize visibility of the project to church members because they were not supportive of working with KPs. “We keep it [the project] sort of low key. We don’t want our church to talk about it.” In contrast, SA management stated that working with KPs aligned to their broader mission. “They [KPs] are welcome. We are here to help. That’s the culture of the SA.”

During the transition period to VSO, outreach activities were significantly reduced.²¹ This was seen as a necessary cost to achieve improved results. Since the transition, VSO has substantially increased KP reach (see data for FY 2016 in Section 3.2 under “Reach of PEO”) and condom distribution by PEs in NCD. VSO’s management of PEO appears to be effective. It has recruited new PEs exclusively from KPs and primarily from within the areas where they are conducting PEO. Many of these PEs have previous PEO experience from other donor HIV projects and are reported by FHI 360 to have a higher level of

commitment. FHI 360 reports (with PEs verifying) that the support and supervision of PEs has increased and is more effective.

The history of the development and refinement of the EOA demonstrates FHI 360's persistent commitment to quality improvement and capacity development, despite ongoing challenges and obstacles. Progress in improving PEO has, however, been slow, and PE reach continues to be significantly below targets. Contributing factors appear to be:

- PNG is a challenging location for implementation of a KP PEO program, due to the lack of enabling environment.
- It took time to adjust programming, including training and testing new approaches.
- PEO targets may be unrealistically high, especially given the geographic overlap with other development partners conducting PEO.
- Many of the PEs have low literacy levels.
- The original IAs lacked previous experience in HIV and PEO programming.
- FSC and SA did not develop sufficient capacity to effectively implement PEO/EOA, despite significant capacity-building support by FHI 360.
- FSC had problems related to attitudes toward KPs.
- It took time for FHI 360 to decide to find a new IA for the PEO (albeit recognizing that choices in PNG are limited).
- Problems that should have been foreseen, such as the effects of incentive system on the way PEs prioritized their work, were not anticipated.

While some aspects of FHI 360's roll-out of PEO and the EOA could have been improved, especially switching IAs sooner, many of the above factors were largely beyond FHI 360's control.

The below-target reach by PEO may have limited the extent to which the project has improved the HIV and STI-related knowledge, attitudes and behavior of KPs and HRM/W, although this cannot be measured because the project does not collect data in these areas. Given the significant increase in use of clinical services by target populations, the low levels of PEO reach do not appear to have had a significantly adverse effect on demand for or access to HIV and STI clinical services.

While PEO reach to KPs remains significantly below target, data for the first two quarters of FY 2016 demonstrate its largest increase over the life of the project. This may be the result of the modified EOA and more effective implementation by VSO.

PEO in Madang: In the second quarter of FY 2014, FHI 360 terminated its contract for PEO implementation with the Madang community-based organization (CBO), People Living with Higher Aims, because of financial misappropriation.²² It was not until the fourth quarter of 2014 that FHI 360 contracted VSO to take over this work. Following recruitment and training of PEs, VSO began work in March 2015, using the EOA. During this time, FHI 360 reports that PEO activities in Madang were severely disrupted.²³ FHI 360's contract with VSO for PEO in Madang ended in February 2016, as part of USAID's planned exit from the province. VSO is now funded under a Global Fund grant to conduct PEO in Madang. The funding transition from USAID to Global Fund resulted in a cessation of PEO work from March to May 2016.

PEO reach for MSM, TG and MTS: The low level of reach to MSM, TG and MTS in NCD may partly be attributable to the long-standing DFAT-funded project, Poro Sapot, which targets these same populations and overlaps in geographic coverage with the USAID project. Multiple key informants reported that Poro Sapot has established good links with MSM, TG and MTS and has a dedicated clinic that includes MSM and TG staff. FHI 360's IAs have had difficulty in recruiting MSM and TG PEs, partly

because of competition with Poro Sapot. Four out of five MSM PE positions in NCD were vacant at the time of the evaluation, with further recruitment efforts underway.

PEO reach for HRM/W: According to FHI 360, the reduction in the number of HRM/W reached by PEO (see Figure 1) occurred because PEs became more skilled at identifying KP members who were previously misclassified as HRM/W. Another possible contributing factor is the project's prioritization of reaching KPs over HRM/W because KPs are the project's primary target group and are more difficult to reach. PEs may also prioritize outreach to KPs because their incentive payment for a successful KP clinic referral is higher than for a successful HRM/W referral.

Networking vs. hot spots for reaching KPs: FHI 360 has undertaken a number of hot-spot mapping exercises to guide the geographic targeting of PEO. Hot-spot mapping, while commonly used internationally to focus KP program targeting, has less applicability in PNG because many of the locations where KPs may be found in other countries (e.g., brothels, gay bars, cruising sites, etc.) do not exist there. While there are a limited number of hot spots (e.g., guest houses, general public nightclubs, markets and transport hubs used by WTS), many KPs (especially MSM, TG and MTS) make contact with their peers through informal social and sexual networks that are not tied to geographic hot spots. Because of this, it is especially important for PEs to link to these networks in broadening their reach, rather than overly relying on a hot-spot approach. This has the potential to link with the EOA "pass it on" referral system to provide a snowballing effect.

FHI 360 claims that a proxy indicator for the effectiveness of PEs in identifying high-risk individuals is a high HIV-positive rate among KPs and HRM/W who have received HTC at project clinics.²⁴ However, as the number of walk-in clients for HTC is well in excess of the number successfully referred by PEs and disaggregated data are not available, the extent to which this is the case is unknown.

PEO targets: PEs have been allocated a PEPFAR-driven target of 50 KP and HRM/W contacts per week, to be achieved within 20 hours of field work.²⁵ The target's high level may compromise the quality of outreach work and should be reviewed in light of the IBBS KP size estimates that will be available in late 2016, and to ensure sufficient time for quality interventions.

Condoms: The training curriculum for clinical staff in project-supported clinics includes sections on how to prevent HIV and STI transmission, male and female condom and lubricant demonstrations and condom negotiation. The training includes a specific section on how to teach WTS to negotiate condom use. It was not possible for the evaluation to realistically assess the extent to which clinical staff apply training in this area, although a female condom demonstration kit was observed in the Id Inad clinic. A likely mitigating factor is that many women lack the power in relationships to negotiate condom use, which points to the need to strengthen community-level interventions to challenge gender power dynamics.

Recommendations

1. USAID and FHI 360 should consider either reducing the PEs' target of reaching 50 KP members per week, to allow adequate time for quality interventions, or increasing the number of PEs. The number of PEs needed should also be reviewed when KP size estimates become available.
2. Following development of KP size estimates, USAID should consider developing PEO targets for specific KP sub-populations (e.g., for MSM, WTS, etc.) to replace the current overall target for all KPs. PMP data on PEO reach and utilization of clinical services by MSM/TG should be disaggregated because these are two separate populations.
3. FHI 360 should evaluate the effectiveness of the EOA in terms of increasing reach to KPs and HRM/W and improving their HIV/STI-related knowledge, attitudes, and risk and health-seeking behaviors. The evaluation should assess the need for a follow-up system for PE referrals to ensure that they have been completed.

4. The project needs to strengthen community-level gender interventions by PEs to challenge gender power dynamics that have an adverse impact on the power of women to negotiate condom use.

Health-seeking behavior: FGDs with PEs in NCD indicated that the biggest barriers to accessing clinical services were distance from clinics, the cost of transport and limited access to project vehicles for outreach use. The PEs also reported that KP clients will not return to clinics if they encounter “unfriendly” staff. PEs interviewed had mixed views on whether staff at the project clinics were “mostly friendly” to KPs or not. “Friendliness” assessments of clinics were conducted in 2014 and are described in section 4.3.1.

No data exist to explain why there is such a high number of walk-in clients for HTC. FHI 360 staff hypothesized that many of the walk-in clients may have been referred by project PEs but do not take the referral card to the clinic. This may be to avoid being identified as a member of a KP. Other possible reasons are that they were informally referred by PEs from other donor programs because of the overlap in geographic coverage, or that they heard about clinic services from other KPs, HRM/W or PEs but were never formally referred. These explanations are speculative. Operational research in this area would help to explain the health-seeking behavior of the target populations. It should be noted that referrals from other clinics, such as TB, antenatal care and family planning, are counted as walk-in clients because they are not referred by PEs.

Geographic overlap: USAID and other donors do not appear to have effectively addressed complementary geographic programming in program planning. In Moresby South, there is geographic overlap in KP PEO activities between the USAID HIV project, DFAT’s long-running Poro Sapot project, and the recent Global Fund sub-recipient award to Hope Worldwide. Meetings between FHI 360 and Save the Children, which implements the Poro Sapot project, did not result in the issue of overlap being effectively addressed. A broad range of stakeholders expressed the view that HIV programming was overly concentrated in NCD.

Recommendation

5. USAID should consider initiating discussions with other donors, the National AIDS Council and the NDOH to assess the feasibility of addressing geographic overlap in PEO activities and addressing this issue in the planning for a possible follow-on HIV project.

IEC and tool development: Materials reviewed by the evaluation team are considered to be of high quality. Strengths were the variety of issues covered, segmentation of messages by target populations, use of MSM and WTS imagery, which is not commonly found in PNG, explicitness regarding some taboo topics such as anal sex, and high production standards. More low-literacy IEC material and a greater variety of materials are needed. KP advocacy groups reported that they were usually consulted by FHI 360 in IEC development and reported satisfaction with this process. While FHI 360 has not formally evaluated IEC materials, materials were tested with target groups and modified during the process of development. FHI 360 has shared IEC materials with other partners.

The work of PEs has been supported by the development of good strategic behavior change (SBC) tools to facilitate promotion of condom use, HTC and STI treatment. Messages are focused on key barriers and facilitators, although a weakness is that these are common to all groups, with no segmentation by population.

Training: PEs reported that much of their refresher training is repetitive, based on the PE curriculum used in initial training. FHI 360 indicated that this is because refresher training often includes existing and new PEs. PEs in NCD identified training needs in human rights, TB, GBV, family planning and counseling. PEs in Madang requested leadership training to facilitate their community work.

Recommendation

6. FHI 360 should conduct new and refresher PE training separately; refresher training should focus on identified areas where the capacity of previously trained PEs needs strengthening.

Behavior-based programming: An important strength of the project's PEO programming is that targeting is based on an HIV-risk behavioral assessment, using the Decision Tree, rather than self-identifying with a KP. This approach is particularly applicable to PNG, given the hidden nature of KPs and the nature of sex work. For example, most MTS and WTS would not regard themselves as sex workers, and may only engage in transactional sex on an occasional basis. FHI 360 plans to validate the Decision Tree; the key issue that needs to be explored is the effectiveness of administration by PEs and clinic staff.

The NDOH has adopted the project's Decision Tree but is considering changing the definition of HIV risk to more than one sexual partner over the last 12 months, rather than the current definition of the last three months.

Recommendation

7. It is recommended that USAID and FHI 360 continue advocacy for maintenance of the current definition of risk behavior for high-risk men and women (more than one sexual partner over the last three months) so that prevention programming can continue to be targeted to those most at risk.

Key population programming: FHI 360's KP programming is aligned with global evidence and adapted to the PNG context. In particular, PEO programming is based on evidence from the 2011 BSS conducted during the previous USAID HIV project. Key informants from multiple organizations reported that FHI 360's expertise in KP programming is nationally recognized and appreciated. FHI 360 has briefed partners on the EOA.

Recommendation

8. FHI 360 should make the EOA package available to all relevant international and national partners working in PNG for their adaptation and use.

More broadly, USAID's long-standing focus on KP programming, coupled with a better understanding of the PNG HIV epidemic based on improved epidemiological data and the importance of addressing KPs, has resulted in much higher priority being accorded to KPs by all partners in PNG's national HIV response. The DFAT-funded Poro Sapot and Tingim Laip projects have also contributed to this shift in prioritization. Collectively, these have helped move PNG's national response from the idea that "everyone is at risk" to prevention programming targeted to those with actual behavioral risks. There is, however, insufficient epidemiological data to indicate the extent to which PNG's interlinked HIV and STI epidemics are being driven by KPs versus HRM/W. It may be that the USAID project's prioritization of KPs has meant that insufficient attention has been placed on HRM/W.

Recommendation

9. USAID, in consultation with the GoPNG, should consider providing equal prioritization of prevention programming for KPs and HRM/W for the remainder of the project. This should be accompanied by employment of PEs who are HRM/W. Nonetheless, higher priority should continue to be accorded to PEO reaching KPs because they are more difficult to identify than HRM/W.

3.4 SUSTAINABILITY

Prevention programming is currently the least sustainable component of the CoPCT model, primarily because most is funded and implemented by donor projects, while government-supported HIV service delivery is clinically focused. Additionally, positions such as PEs do not exist in the public sector human resources structure. Currently, the organizational and technical capacity of CBOs or national non-governmental organizations (NGOs) to conduct PEO is at a low level, and fiduciary risks have made most donors hesitant to support longer-term development of service-delivery capacity for this sector. Similarly, most PHOs/PHAs currently have very limited capacity for managing PEO. Longer-term planning and capacitation of government to fund and manage prevention programming is needed. FBO capacity is highly variable and can be influenced by negative attitudes toward KPs and HRM/W. International NGOs such as Save the Children and VSO have significantly higher capacity but may not be sustainable in the long term, unless the GoPNG elects to fund these organizations for this type of work.

4. CLINICAL SERVICES PROGRAM COMPONENT

4.1 PROJECT COMPONENT OVERVIEW

The project’s objective is to “increase the supply of quality HIV/AIDS services for KPs, their sexual partners and their families.” The sub-objectives are:

1. Increase program coverage to increase service uptake among KPs.
2. Increase quality of HIV/AIDS services provided.
3. Enhance local capacity of service delivery.

FHI 360’s clinical program component is based on the CoPCT framework, which is implemented in four clinics in NCD and one in Madang.

In partnership with three IAs, the project uses an integrated service delivery model to provide sexual health services that include HTC as the entry point for the CoPCT framework, referral for TB screening, STI services and in three of these clinics, HIV care and treatment (Table 2). Nationally, the project is working in partnership with others to increase access to viral load testing for PLHIV, which is central to meeting the 90-90-90 goals. GBV screening and referral occur at all sites. Staff at all sites are trained to provide comprehensive, culturally sensitive service delivery to KPs.

Table 2: Type of clinic services provided by implementing agency

Location	Implementing agency	Clinic	HTC	ART	CD4	TB ²⁶ screening	STI	GBV ²⁷ screening
National Capital District	Foursquare Church	Kila Kila	X	X	X	X	X	X
		Kaugere	X			X	X	X
	The Salvation Army	Koki	X	X	X	X	X	X
		Ela Beach	X			X	X	X
Madang	Modilon General Hospital	Id Inad	X	X	X	X	X	X

In 2016, FHI 360 will be expanding TA services to five other ART clinics in NCD: Heduru, Begabari, Lawes Road, 9 Mile and 6 Mile clinics, with no support for direct service delivery.

In addition to the evaluation team’s assessment of the clinics, two previous assessments done in FY 2014 were used to inform the evaluation’s findings and conclusions. Firstly, in May 2014, Dr. Laurent Ferradini of FHI 360 Cambodia conducted a quality assurance and gap analysis of all FHI 360-supported VCT, STI and ART facilities. The gap analysis evaluated the extent to which sites achieved FHI 360 standards and reported their performance levels using quality assurance tools for each activity.²⁸ Secondly, a program and technical quality assessment was conducted by external FHI 360 experts in June and July 2014 to “collaboratively explore and prioritize needs to strengthen the management and technical quality of the KPs project.”²⁹

All data related to indicators and targets in this section are from the project’s PMP, unless otherwise indicated.

4.2 EXPANDED COVERAGE TO INCREASE SERVICE UPTAKE AMONG KPS

4.2.1 Project effectiveness

Overall, the project has established effective, quality HTC services for clients that are aligned to national guidelines and is testing a high number of KPs and HRM/W.

Clinics use both VCT (for walk-in clients), and provider-initiated counseling and testing (PICT) (for clients who present symptomatically for TB or STIs, or who are accessing antenatal care). In October 2015, the project started mobile HIV testing (MHTC) events to increase community access to HIV testing and to raise awareness about its program activities. MHTC services offered include VCT, education and outreach, distribution of condoms and lubricant, demonstration of condom use, and risk assessment. To decrease HIV-related stigma and discrimination, MHTC also screens for blood pressure and body mass index.

Since the project's inception, HIV testing uptake has increased across KPs and HRM/W, and annual testing targets at each of the clinical sites have been exceeded, due to the high rate of acceptance for testing by both walk-in and referred clients. Of the 13,280 people tested from FY 2013 through the second quarter of FY 2016, 23 percent were KPs, 45 percent were HRM/W and 32 percent were LRM/W. From FY 2013-2015, women accounted for 59 percent of all HIV tests, compared to 41 percent of men.³⁰ The HIV positivity rate for KPs and HRM/W has declined from FY 2013-2015, but not for LRM/W (Figure 8 in Annex 5). WTS represented the highest overall HIV positivity rate in both Madang and NCD, at 11 percent and 8 percent respectively.

MHTC has significantly increased the number of people testing for HIV at both Koki and Kila Kila clinics. For example, at Koki from October 2015–March 2016, 151 clients were tested at facilities.³¹ During MHTC, an additional 149 clients were tested over a three-day period during that same time frame in Koki alone, of which 106 (71 percent) were classified as HRM/W, and another seven (5 percent) were classified as WTS. Project staff reported that targeting KPs during MHTC is a challenge and have modified their approach to better mobilize KPs specifically to MHTC events, with limited success.

To increase uptake of HIV testing for KPs and HRM/W who are not accessing clinics, the project is planning to introduce targeted outreach testing by PEs in community settings, using one-step finger prick testing. If the first test is reactive, PEs will offer clients an assisted referral or bus fare to a clinic for a confirmatory test. The training will commence in June 2016.

4.2.2 Strengths, weaknesses, constraints and gaps

Pre- and post-test counseling: Dr. Ferradini's quality assurance and gap analysis report indicated that, overall, all five VCT sites implemented good to excellent pre- and post-test counseling procedures. While the evaluation team did not observe pre- or post-testing sessions, staff descriptions of the areas covered were appropriate and consistent with international standards. Team members observed the VCT consultation rooms and found some questionable posters or job aids posted on the counselor's wall. For example, in one consultation room in a FSC clinic, in prominent view of clients seeking HTC, a poster said, "The wages of sin is death, but the gift of God is eternal life." In another consultation room in a SA clinic, FHI 360's risk cards were misclassified by risk; for example, kissing was listed under "high-risk."

MHTC: Currently, the project's MHTC offers limited services to communities, with referrals to clinics for HIV confirmatory testing, more comprehensive care, and follow-up. FHI 360 staff reported that they had previously tried to finalize a memorandum of understanding with Marie Stopes to offer more comprehensive mobile services and leverage other organizations to complement service delivery, but this is still pending. Mobile STI syndromic management has been found to be feasible, acceptable and cost-effective for service delivery, especially for higher-risk populations.³² WTS focus group participants

reported that mobile clinical outreach beyond just HTC is necessary to target hidden KPs who may not otherwise be willing to access clinic-based services. Services reported to be important include family planning, STI prevention, care and treatment, adherence support and TB diagnosis and treatment. Not providing more comprehensive mobile services is a missed opportunity, given the access it provides to a range of populations and the space and human resource constraints at most clinics.

Recommendations

10. FHI 360 should closely monitor the quality of PEs' outreach HTC in community settings to ensure adequacy of pre-test counseling, confidentiality, test kit quality, infection control, clinic linkage uptake and ability to manage clients' psychological reactions to an initial positive test.
11. FHI 360 should request IAs to remove all judgmental posters from patient areas in clinic settings and ensure that all job aids are accurate.
12. FHI 360 should augment MHTC with other sexual health service delivery, in collaboration with other groups conducting mobile outreach services.

4.3 QUALITY OF HIV/AIDS SERVICES

4.3.1 Project effectiveness

Overall, the project has well-functioning clinical service delivery, which is aligned to the National HIV Strategy. Standard operating procedures (SOPs) have been developed for all key clinical areas of service delivery, and staff receive continuous mentoring and supportive supervision to integrate existing and new SOPs into clinical practice. The screening tools that clinics use are comprehensive and incorporate STI, HIV, TB and GBV screening questions directly into the forms for ease of use. Many of Dr. Ferradini's identified gaps were rectified by the time this evaluation was conducted. Retention of clinical staff was reported to be a challenge.³³ Loss to follow-up (LTFU) was reported to be the biggest concern and will impact GoPNG ability to meet 90-90-90 targets.

HIV: In the second year of project activities, FHI 360 shifted its focus from establishing clinic spaces to standardizing operating procedures, improving quality of service through training and mentoring of clinical staff, and increasing staff sensitivity toward KPs. IA clinical staff were trained in practical opportunistic infection/ART care and treatment; some staff were also trained in PICT. The Koki and Kila Kila clinics completed the pre-assessments required for accreditation of ART services by the NDOH. The NDOH approved opportunistic infection prophylaxis and ART roll-out in the second quarter of FY 2014. Koki started HIV care and treatment services in FY 2014, the same year that USAID donated point-of-care PIMA CD4 machines to the Id Inad, Koki and Kila Kila clinics. Clinic staff begin the process of ART initiation with three sessions of adherence counseling prior to commencing medication, though clients may be "fast-tracked" to medication at a clinician's discretion (e.g., low CD4 count). Although some staff reported that the process of three counseling sessions was challenging for clients,³⁴ some indicated the counseling process is useful to ascertaining client readiness to start ART.

Id Inad clinic is the only project-supported clinic that offers comprehensive HIV care and management for both adults and children. Government and clinic staff reported that, as a result of FHI 360 capacity building, the clinic is now recognized as an integrated management of adolescent and adult illness (IMAI) practical site and has started training district health care workers, who are completing didactic IMAI sessions. FHI 360 recently sponsored a joint supportive supervision and mentoring visit to the clinic by the Momase regional STI/HIV medical officer. This was the first time in five years that the medical officer had been able to visit, and many key informants reported that it was extremely beneficial. Dr. Ferradini's gap analysis had indicated treatment failure detection and switching to second-line regimens was lacking at the Id Inad clinic. During the midterm evaluation, staff at Id Inad conveyed that they had developed a "Suspect Register for ART 1st Line Resistance," using blood results and repeat WHO staging to monitor

potential treatment failure and guide a switch to second line therapy. This process was reviewed and approved by the regional STI/HIV medical officer.

All clinics reported appointment systems for ART patients, with follow-up for defaulters, primarily by phone. Some clinics also reported sending case managers to communities to find patients who missed appointments, if transportation was available. Across clinics, periodic monitoring of the track log was reported to determine defaulters or those LTFU, though those terms were inconsistently defined between clinics. In FY 2014 and FY 2015, the project has exceeded targets for the number of HIV-infected adults and children newly enrolled on ART and the number of adults and children currently receiving ART, and it is well on track to exceed those targets for FY 2016. Id Inad clinic³⁵ has the majority of ART clients enrolled in all fiscal years, compared to Koki and Kaugere, though enrollment has increased across all sites each year.

The CoPCT model has been an important contributor to an increased focus on retention in care and reducing LTFU, using four primary activities as part of retention: (1) establishment and expansion of case management teams (CMTs), including case managers, to track treatment defaulters and clients LTFU; (2) implementation of support groups; (3) the planned establishment of the Community Care and Support Program (CCSP); and (4) referrals for internal and external linkages. These activities are described below:

- **CMTs:** Clinic staff reported that CMTs are important to supporting PLHIV and tracking clients, and are an integral part of service delivery.³⁶ Case managers at Id Inad clinic perform a broader scope of activities compared to other sites. As Dr. Ferradini recommended, active case management using CMTs was started at the end of FY 2015, and they seem to be effectively reducing LTFU by linking clients back to care. For example, in the fourth quarter of FY 2015, CMTs were able to track 11 of 14 (79 percent) Id Inad ART clients, two out of 10 (20 percent) Kila Kila ART clients, and two out of three (67 percent) Koki ART clients who were LTFU and bring them back to care.³⁷ The project also used Frontline SMS to send out adherence messages to ART clients in Madang, which was reported to have been appreciated by clients.³⁸
- **Support groups:** In FY 2013, the project supported the initiation of the first PLHIV support group, called “*Kirap Bung Wantaim*,” which was implemented by the IA People Living with Higher Aims³⁹ and the Modilon Hospital. That year, 32 Madang PLHIV participated in the group. Also in 2013, FSC and SA started WTS and MSM/TG support groups with the PEs.⁴⁰ Although support groups were reported by staff to be an important support mechanism for PLHIV, they have not been held regularly, and PLHIV participation has been low, particularly when compared to the number of clients enrolled in ART. Clinic staff in NCD reported current participation to be about 10-12 individuals per meeting, including PLHIV and their families, and groups are not currently operating in Madang.
- **CCSP:** A CCSP will be implemented in 2016 with the aim of increasing ART treatment success through the use of case managers who will provide follow-up in the community. It will initially reach PLHIV who are bedridden and unable to reach clinics to initiate treatment. Koki and Kila Kila clinics are each recruiting one additional case manager to implement the program. FHI 360 has contracted a consultant to help develop the CCSP and train case managers to implement it.
- **Referrals:** In FY 2015, the project started using referral cards for internal linkages. During the fourth quarter of FY 2015, 97 percent of all persons testing HIV-positive were enrolled in care and treatment.⁴¹ In some clinics, staff reported that clients presenting with referral cards are fast-tracked, which was identified both as a positive (e.g., an informant reported: “For WTS, time is money, so we don’t want them to wait too long...”) and as a negative because it can create stigma if KPs are perceived as getting special treatment.

Koki and Kila Kila clinics are not currently initiating children on ART. FHI 360 staff reported that pediatric ART is available at the Port Moresby General Hospital. After HIV-infected pregnant women deliver, Koki and Kila Kila clinics often transfer them to the hospital, so maternal and child ART can be managed at one location. FHI 360 staff also reported that there is no plan to start HIV care and treatment at Kaugere or Ela Beach clinics. Persons who test HIV-positive at either of those locations are given an assisted referral to either Koki or Kila Kila clinics.

Dr. Ferradini's 2014 gap analysis reported a gap in monitoring and testing sexual partners and young children born of HIV-infected mothers, and that staff were using expired test kits. TPHA test kits and STI drugs were also expired, but at the time of the midterm evaluation, FHI 360 staff reported that expired tests are no longer used for either HTC or STIs. Dr. Ferradini also found that STI clinical examination procedures were insufficient and that referrals for HTC from the STI setting were lacking. While examinations are still lacking (described below), referrals had improved at the time of the midterm evaluation. Koki and Kila Kila clinics had been initiating and managing ART for only 1.5 and 15 months respectively at the time of the assessment, and there was great disparity among the sites, with only Id Inad demonstrating strong management of its ART clinic, including excellent patient flow and service delivery.

TB-HIV integration, particularly related to infection control, was found to be lacking across all clinical sites during Dr. Ferradini's assessment, and, with the exception of FY 2013, the project has not met the targets for percentage of PLHIV in clinical care who were screened for TB symptoms at their last clinical visit (through the end of FY 2015) (Figure 11, Annex 5). Part of this was attributed to poor documentation of TB clinical screening, which FHI 360 addressed with a quality improvement plan, and, through the first two quarters of FY 2016, the project has already exceeded the target for this indicator. FHI 360 worked with NCD Health to improve the referral mechanism between TB and HIV at project clinic sites, and NCD Health agreed to provide isoniazid preventive therapy (IPT) for HIV-positive clients at Kila Kila and Koki in FY 2014.⁴² To strengthen this co-infection mitigation work, FHI 360 also joined the national TB technical working group (TWG) in FY 2015.⁴³ Referral pathways were built into revised tools for clinicians and piloted in NCD before roll-out, to ensure better TB screening across clinics, but referrals were still occurring externally to project service delivery.

In July and August 2015, the project implemented an innovative approach to assess "friendliness" of staff toward KPs at clinics; this included staff attitudes, clinic facilities and setup, service availability, privacy and confidentiality. Members from three KP civil society organizations, Kapul Champions, Friends of Frangipani, and Igat Hope,⁴⁴ served as "mystery patients." Each mystery patient completed a survey with an FHI 360 staff person after their encounter. Overall, patients accessing care at Ela Beach, Koki and Kaugere reported that they would refer their peers there. Kila Kila clinic was rated very low, and, because of this, FSC staff reported that a nurse was fired due to a negative attitude toward KPs. This approach of using mystery patients was described as an "eye opener" by one IA manager and was reported to be well liked by the civil society organizations that participated. Kila Kila clinic has actively worked to improve overall quality of care for KPs as a result of this process.

The Global Fund's senior fund portfolio manager for South and East Asia visited the Kila Kila clinic on Nov. 13, 2014 and was "very impressed with services and paid compliments to FHI 360."⁴⁵ FHI 360 also coordinated and supported the first PEPFAR Site Improvement Monitoring System assessment in December 2014 at Kila Kila clinic.

Clinic leads were established at each clinical site and oriented on Dec. 7, 2015. The leads are responsible for ensuring that services are provided in line with SOPs, drugs and other commodities are properly handled, and services provided are consistently documented.

Dried blood spot quality checks are conducted on every 20th test done at VCT sites. The Central Public Health Laboratory (CPHL) visits quarterly, and clinic staff reported that it provides good feedback.

In collaboration with CDC, WHO, the Clinton Health Access Initiative and the Global Fund, the project has made important contributions to establishing a viral load testing and management algorithm, as well as developing the national viral load training and pilot study through involvement on the sub-TWG.⁴⁶ PLHIV will have access to viral load monitoring services at Heduru, Begabari and Koki clinics in NCD, which are all PEPFAR-supported. The initial focus of this viral load scale-up will focus on helping partners establish reliable sample management and logistics systems for the timely movement of samples and results between clinics and the CPHL in Heduru clinic.

In FY 2016, the project, in partnership with CDC and WHO, developed and conducted baseline assessments of six clinics in NCD, which are the PEPFAR TA expansion sites. Clinic sites included Heduru, Begabari, 9 Mile, Lawes Road, and 6 Mile. St. Joseph's clinic declined PEPFAR TA. A proposed PEPFAR TA package was approved by all sites and includes assisting clinics to ensure effective linkages for newly diagnosed PLHIV to HIV care and treatment services, and promoting early initiation of KPs on ART through "test and treat."⁴⁷ A calendar has been developed for FY 2016, and TA has started. FHI 360 staff reported sufficient staffing to fulfill this expanded role.

STI: As Dr. Ferradini recommended, STI care and management was started in FY 2016 at Ela Beach clinic, based on its proximity to a known hot spot for transactional sex and concentration of KPs. This should help the project to meet the STI targets in FY 2016 and for the duration of the project.

The evaluation team observed that many of the recommendations outlined in the gap analysis had been addressed by FHI 360, with a few exceptions described in section 4.3.2.

The infrequency of partner contact tracing in most clinics was noted, with only one clinic reporting actively doing so for clients who test positive for an STI.

With the exception of FY 2013, the project has not met the targets for: (1) numbers of individuals who received STI management services or (2) percentage of individuals from priority populations who completed a standardized HIV prevention intervention (including the specified minimum components) during the reported period, through the end of FY 2015. Despite not meeting these targets as they relate to STI management services, the project prioritized KPs and HRM/W for STI management services, resulting in an increased number of individuals accessing services (Figures 9 and 10, Annex 5). Of those accessing STI management services from the project's inception through the first two quarters of FY 2016, 928 (20 percent) were classified as KPs, 2,257 (48 percent) were HRM/W, and 1,518 (32 percent) were LRM/W. Fifty-eight percent of individuals accessing STI services were women, compared to 42 percent men during the same time period.

4.3.2 Strengths, weaknesses, constraints and gaps

Overall: The USAID project has increased the availability of care and treatment services for KPs and HRM/W, and it provides quality HIV and AIDS services at the clinics it supports. While some gaps exist (described below), the project has demonstrated effective implementation of service delivery for KPs and is largely achieving its goals and objectives, although some targets are still not being met. Should the approaches the project is currently developing—starting with assessments at facilities in the six TA expansion sites and rolling out targeted TA to meet deficits found—prove to be effective toward effectively achieving 90-90-90, USAID and FHI 360 should advocate for the NDOH to scale up these approaches nationally.

Staffing inefficiencies: Despite FHI 360's goal of the "one-stop shop" integrated care model, most clinics run vertical programming. HIV nurses typically refer to the STI nurse for care and treatment, despite having been trained in STI care and management. Likewise, some STI nurses have been trained in IMAI, but only serve in this role if the ART prescriber is away. While many clinicians have been trained in PICT, many refer to the VCT counselor for testing rather than doing the test. TB is referred out to

either a different clinic or a different area of the clinic. The rigid division of clinical staff jobs creates inconvenience for clients and barriers to accessing care, creates cost inefficiencies in the clinic setting, and necessitates refresher trainings because clinicians rarely use skills external to their main job function. To streamline client encounters, staff should provide comprehensive services to clients without referring to other areas of the clinic for services. This would be one way to reduce the overall number of staff needed to implement the same set of services in clinics with low client volume.

Other cost inefficiencies were identified related to clinic staffing. In some clinics there are not enough consulting rooms to accommodate all staff. For example, in one clinic there was one counseling room and two counselors, so only one person could work at a time. While it was cited that the national guidelines/policies for staffing VCT and STI clinics require both male and female staff, most nurses interviewed stated that they can see clients of the opposite gender, which they do when they are the only ones working, and it is acceptable as long as they bring in a colleague of the opposite gender, like the counselor, to be present just for the genital exam. Staff working should match the number of consulting rooms. One clinic site had planned to offer a men's clinic. This approach should be evaluated for feasibility and acceptability. If the approach of offering gender-specific care is found to be effective, testing gender-specific clinic hours for service delivery might be an approach to ensure that staff working have consistent access to consulting rooms to see clients, while potentially minimizing the number of staff needed to implement the same set of services. For example, gender-specific days could be offered alternatively between different sites, necessitating only half of the current staff on those days to work at one site, while the other half worked at another site, which can switch during the week.

Additionally, two clinics' STI nurses reported that they were only working at half capacity because of low client volume. Given low volume in some clinics, having two clinicians offering the same services is not cost-effective. Clinic volume needs to be assessed to determine the number of staff needed at each facility. If staff are not at full capacity, it would be more cost-effective to provide them a travel allowance to assist at other sites that are over capacity or to reduce the staff number.

Finally, client volume in the afternoons was reported by clinic staff to be very low. Most clients accessed services in the morning. Some focus group participants recommended service delivery begin earlier (before the current 8 am start time), to enable them to access services prior to going to work and to provide some potential anonymity by avoiding the general population that is also accessing services. Clinics should assess whether offering alternative hours like early morning or evenings increases clinic volume, especially for KP target groups. If HIV and STI nurses were able to offer comprehensive services to each client rather than referring to other nurses, staffing times could potentially be changed so that there were two shifts of staff, one starting earlier in the morning and the other staying later in the evening. This could provide a creative solution to lack of consulting rooms for all staff, as well as increase number of clients served, but it would depend on safety of staff and feasibility for each site.

Staffing of the project's clinics needs to be assessed against government clinics. It was outside the scope of this evaluation to assess government, faith-based or NGO clinical settings to determine what is feasible for clinical programs similar to this project. In order to assess the sustainability of projects like this, government staffing structures need to be considered to determine what is feasible for offering the same basic services. The project will need to work with government to ensure that staff positions currently funded by USAID can be integrated into the public sector staffing structure to ensure continuity of the project's activities.

Recommendation

13. FHI 360 should accord high priority to conducting a rigorous analysis of project-supported clinical staffing profiles prior to the conclusion of the project, to identify cost inefficiencies and to determine an appropriate number of staff positions. Information from this study should be

used by USAID and FHI 360 in discussions with government on the level of staffing needed in a transition from donor to government funding.

HIV: The reconstruction of Kila Kila clinic, which started in May 2016, was reported to be a major challenge. Project activities are being maintained during construction with the use of temporary containers located in a temporary site around the clinic. The overall impact on service delivery is unclear and should be closely monitored, with contingency plans in the event that disruption is too significant to continue services in that location.

LTFU was the most commonly reported challenge in HIV service delivery and poses the greatest risk to the GoPNG's ability to meet the 90-90-90 targets. FHI 360 reports that, cross-sectionally, about 30 percent of ART clients were LTFU as of September 2015,⁴⁸ with a slightly higher rate in NCD. However, many clinic staff reported that LTFU at clinics was closer to 40 percent. The 2016 Annual Implementation Plan reports a 74 percent retention rate for ART, though it is not disaggregated by location or risk classification. The true extent of LTFU across the entire HIV care cascade is not known. There are also some unexplained data related to the care cascade. For example, in Madang, the number of persons enrolling in care is far more than PLHIV who test positive. This is likely from referrals from HTC sites not part of the project, but it needs to be investigated. Additionally, FHI 360 has no data that describe the HIV care cascade from testing through retention by risk classification, although it can track individual/cohort data from enrollment through retention at 12 months. LTFU for key populations is very common across the HIV care cascade and contributes to a significant and preventable burden of HIV morbidity and mortality. This is a major limitation of project activities for KP programming and should be the primary focus of any operational research conducted by the project. Some international strategies for reducing LTFU for consideration include using peer navigators to support PLHIV (a natural add-on function for PEs), incentivizing linkage for LTFU (also a PE add-on), and conducting more rigorous SMS follow-up (an add-on for Frontline SMS).

Key informants reported that, generally, tracking clients is difficult because they may give false or non-specific residential addresses or change mobile phone numbers frequently. Clients also stop taking treatment for reasons such as symptom improvement, use of herbs, or strongly held religious beliefs (e.g., "God has cured me."). Social unrest can also contribute to LTFU, limiting clients' ability to get to appointments or case managers' ability to track clients in the community. In some instances it forces clinic closures, e.g., Kila Kila for two weeks in the third quarter of FY 2014. The project is implementing a variety of strategies across each site to reduce LTFU, such as using Frontline SMS for medication reminders and establishing CMTs. However, there are limited data on the effectiveness of those individual strategies in reducing LTFU. Improved lifelong and adapted counseling to help support clients on ART was reported to be a gap by some clinic staff and a member of a civil society organization interviewed, but it is not currently used by case managers.

Pediatric initiation is an important component of providing clinical care to KP and their families, which reflects a gap in programming at NCD clinics. Additionally, ART is only offered at Koki and Kila Kila clinics in NCD, despite Ela Beach being a more accessible location for KPs. ART initiation and management should be expanded to Ela Beach (at a minimum) and Kaugere.

Despite the recommendation in Dr. Ferradini's report, HIV and TB integration was reported by clinic staff to be still weak at NCD sites, largely because of the referral pathways. TB service delivery occurs at sites external to the clinics, and there is potential for LTFU. Additionally, integration is limited. The project screens for TB, but it is unknown if TB referral sites do HTC.⁴⁹ Staff at Modilon and Id Inad reported an integrated approach: The hospital's TB clinic now does PICT onsite for all patients, and Id Inad has trained case managers to advise clients on how to collect a good sputum sample.

The CCSP is starting in FY 2016. This intervention should have started sooner. Additionally, the approach actually being implemented is significantly different than the one proposed in the original

concept note, with far fewer staff being hired to implement the activities.⁵⁰ As the project shifts toward exit planning and sustainability, it should assess government interest and ability to absorb the CCSP and determine how it might be integrated into the active case management activities in the TA expansion sites.

The project should analyze best practices across all case managers and refine recommendations for the terms of reference, in addition to training staff on any gap areas identified. Reliable transportation for case managers is of paramount importance in tracking clients and needs to be improved, especially at Id Inad clinic, where staff reported that the case manager's ability to do home visits was hampered by lack of transport. The project should consider donating the project vehicle to the Modilon Hospital at the time of exit, for use by the Id Inad clinic to support case managers tracking clients who default or are LTFU. Additionally, the case manager position does not exist in the public sector system, nor is training for case managers standardized, which has created challenges for the GoPNG to absorb such positions. Lessons learned from implementation of the "TB supporter" role may be relevant to creation of the case manager position in the public sector system. Further assessment of the overlap of roles may be beneficial.

Recommendations

14. FHI 360 should develop short- and long-term strategies and conduct operational research to reduce LTFU, and evaluate these strategies for cost-effectiveness and feasibility for scaling up by the GoPNG. It should disseminate best practices nationally and advocate for the development of guidelines for retention. Strategies need to include strengthening the referral pathways between HIV and TB.
15. FHI 360 should standardize a training package for case managers and work with the GoPNG to identify job descriptions and establishment of the position/job function of case manager in the public sector system.
16. FHI 360 should give priority to constructing a general and KP-specific cohort cascade analysis to trace individuals from the point of testing through 12 months of treatment on a continuous basis (i.e., retention), to identify the number of dropouts at each point in the cascade and by specific populations (e.g., MSM, WTS, etc.).
17. FHI 360 should work with the management of project-supported clinics to integrate HIV and STI service delivery, ensuring that clinicians provide all services to clients rather than referring to other clinic staff for specific services.
18. USAID and FHI 360 should advocate to the NDOH for policy change related to the current requirement of gender-specific staffing for VCT counselors and STI clinicians.

STIs: Multiple informants reported that STI care and treatment is lacking in PNG and that the STI epidemic among KP and HRM/W is significantly contributing to the HIV epidemic. Syndromic management does not account for asymptomatic STIs, and STI laboratory capacity is lacking, which means that asymptomatic STIs go largely undiagnosed and untreated. At project clinics, it was commonly reported that only clients with symptoms are referred to STI nurses. One major constraint reported is the delay in the revision of the current STI guidelines, which were last reviewed in 2008. Review of the guidelines by the NDOH has been delayed for some time. Having outdated STI guidelines is a major constraint for project activities, and STI training has been deferred until the guidelines are revised.

Dr. Ferradini's gap analysis indicated that proper STI clinical examination using a speculum/anoscope needed improvement at all STI sites. The midterm evaluation team observed that with the exception of Id Inad clinic, no anal or vaginal specula were available for use during physical exams. At Id Inad clinic, which does use them, anal specula were only used for MSM. Some clinics had been waiting for FHI 360 to order and deliver specula for several months or more. Further, two STI nurses reported that they

are not trained sufficiently to use an anoscope. Mentorship for STI nurses in using anoscopes should be prioritized to ensure that comprehensive clinical examinations occur.

Koki clinic has laboratory capacity to conduct gram stains and wet mounts, but since November 2015 it has been hampered by stock-outs of sterile swabs, which are necessary to conduct confirmatory testing for chlamydia, trichomonas and gonorrhoea and to look for white blood cells. Some project-supported clinics reported problems with commodity procurement. FHI 360 should work with the management of IA clinics to provide clarity on who is responsible for procurement and ensure that this is reflected in budgets and communicated clearly to clinic staff.

At the project's inception, one of the core services described was presumptive treatment and enhanced syndromic management of STIs. While clinics used syndromic management algorithms from the national guidelines, FHI 360 project staff reported that clinics do not currently offer presumptive treatment. That was not consistent with what the evaluation team observed during clinic visits: STI staff in two clinics reported giving presumptive STI treatment to KPs who tested HIV-positive or disclosed unprotected sex. Consistency is needed across sites.

Recommendations

19. FHI 360 should provide clarification to IAs on who is responsible for the procurement of commodities and ensure that this is adequately reflected in budgets and clearly communicated to staff.
20. FHI 360 should train STI nurses in using anoscopes to ensure that thorough clinical examinations occur.
21. FHI 360 should work with clinical IAs in NCD to strengthen partner contact tracing for partners of persons screening positive for STIs.

4.4 LOCAL CAPACITY FOR SERVICE DELIVERY

4.4.1 Project effectiveness

From the project's inception, FHI 360 has provided extensive mentoring and technical support to IA staff, including KP sensitization, clinical operating guidelines/SOPs, gender sensitization, PICT, HIV and STI care and treatment (including IMAI), HIV prevention for KPs, viral load algorithm and M&E. The quality of FHI 360 trainings and clinical operating guidelines/SOPs has been reported as excellent by many key informants interviewed. External support from FHI 360's Asia Pacific Regional Office (APRO) has been an ongoing benefit to project staff, with assessments and targeted training.

From project inception, FHI 360 has used structured assessment tools to target capacity building based on needs, starting with the adaptation of the Technical and Organizational Capacity Assessment Tool to the PNG context in the second quarter of FY 2013 and use of the Performance to Standards Tool in 2014. This approach has provided a high level of consistency across sites and was an effective way to scale up service delivery. FHI 360 has also had external experts conduct gap analyses to assess clinical service delivery and overall program and technical quality. Using structured assessment tools and conducting routine gap analyses has established robust attention to quality throughout the project. FHI 360 has actively integrated recommendations of the analyses and has targeted mentoring and training activities to address identified deficiencies.

Clinical trainings offered are: IMAI, opportunistic infections/ART, STI, PICT, GBV sensitization, KP sensitization, and basic and adherence counseling. Reducing stigma and discrimination has been cross-cutting for all IA and FHI 360 staff. Onsite mentoring for both prevention and clinical activities is ongoing, and staff reported satisfaction in the frequency and quality of mentoring provided by FHI 360 technical officers.

4.4.2 Strengths, weaknesses, constraints and gaps

Many key informants report that FHI 360's model of assessing needs and gaps and then providing training, mentoring and supportive supervision to address those gaps is excellent. This approach should be transitioned to a more cascade-type approach, focusing on building capacity of local organizations to implement a similar process. Standardizing national trainings, training trainers, and describing and setting national mentoring and supportive supervision guidelines (including assessment tools) would be very beneficial to building the GoPNG's capacity to implement similar programming, which was reported to be very important. Informants requested a capacity-building approach during the remainder of this project and in a possible follow-on project.

Clinic staff informants emphasized the importance of ongoing mentoring and supportive supervision to ensure that knowledge transfer occurs from didactic to clinical settings. Refresher trainings, especially sensitization to working with KPs, were reported by staff to be important and should be ongoing to help address stigmatizing attitudes of staff. Staff from several organizations interviewed as well as participants in the PE focus groups reported the need to change the structure of refresher trainings, making them more skills-based and different from the initial trainings.

Recommendations

22. FHI 360 should build the GoPNG's capacity to integrate quality service delivery for KPs by standardizing training, developing guidelines and tools for mentoring or supportive supervision, implementing a training-of-trainer model, and identifying mentors for a mentoring-of-mentors model.
23. FHI 360 should address the most commonly reported training gaps reported during interviews: couples counseling, advanced counseling skills, counseling for children, nutrition and GBV.

4.5 SUSTAINABILITY

For clinic service delivery to be sustainable, FHI 360 needs to work with both the NDOH and provinces to ensure that the government can take on responsibility for payment of staff positions currently funded by USAID. The case manager positions do not currently exist in public sector staffing structures; this will limit the government's ability to absorb staff. FHI 360 should work with the GoPNG to develop a transition plan for positions, including provisions for stop-gaps to continue funding to those positions while they are integrated into the public system, which can be a lengthy process. Key informants in Madang reported that case managers will be funded temporarily by the PHO, but that in the long term, the positions, along with the project coordinator position, will need to be under the hospital's purview to be sustainable. This process should have started much earlier and is critical to maintaining the integrity of the quality of KP programming as well as positive GoPNG relationships.

FHI 360 also needs to shift to an approach that builds technical capacity of the IAs, government and TA expansion sites to implement a package of services for KPs. The approach needs to include the training of trainers and mentors, so that FHI 360 is not directly responsible for training everyone, but rather training people to train others. Advocating nationally for KP indicators and revised data collection tools needs to be continued and included in sustainability planning with government. Using a training-of-trainers model for key training activities is essential, and standardizing national training and mentoring standards is needed.

5. FACILITY- AND COMMUNITY-BASED GENDER AND GBV PROGRAM COMPONENT

5.1 PROJECT COMPONENT OVERVIEW

Recognition of the widespread nature of GBV in PNG and the increase in HIV risk and vulnerability (see Section 2.1), resulted in inclusion of GBV programming in the design of the current USAID HIV project. The project has a specific objective to “increase the use of facility- and community-based gender and GBV interventions.” The project has developed a number of GBV-specific activities and also has undertaken work to integrate GBV into prevention and clinical programming.

The project has funded the FSVAC to undertake work focused on improving coordination of the GBV response in NCD. FSVAC’s work includes media monitoring of GBV reporting; training of journalists in responsible GBV reporting; development and use of GBV IEC materials; and raising community awareness through IEC materials and mass media, such as radio talk shows. The project has also provided funding to Child Fund for the national GBV hotline. The GBV work of FSVAC and Child Fund does not have a health, HIV or KP-specific focus; it is similar to mainstream GBV programming.

In addition to support for FSVAC and Child Fund, the project has integrated GBV into existing HIV interventions. PEs have had some training on GBV and are encouraged to raise community awareness, including of referral services, as part of their PEO work. The project has developed and is using a routine GBV screening protocol for all clients attending project-supported clinics. Survivors of GBV who are identified through GBV screening are offered counseling and referral to other services. This has been facilitated by case management and clinical pathway training for staff in project-supported clinics and development of GBV referral pathways.

The project has also provided funding for two Port Moresby safe houses for the survivors of GBV. These are operated by the FSC (Meri Saif Hous) and the SA (House of Hope). FHI 360 has developed SOPs for the safe houses.

5.2 PROJECT EFFECTIVENESS

Media monitoring and journalist training: FSVAC provided training for 22 journalists on GBV and gender sensitization. FSVAC staff report that, overall, the media messaging and coverage of GBV by the Post Courier, a national newspaper, has improved as a result of the training. During the midterm evaluation, the Post Courier carried a story on “Positive changes for gender equality,” which described a public forum in Mt. Hagen, sponsored by FHI 360 with DFAT support, to support gender equality in the province.⁵¹

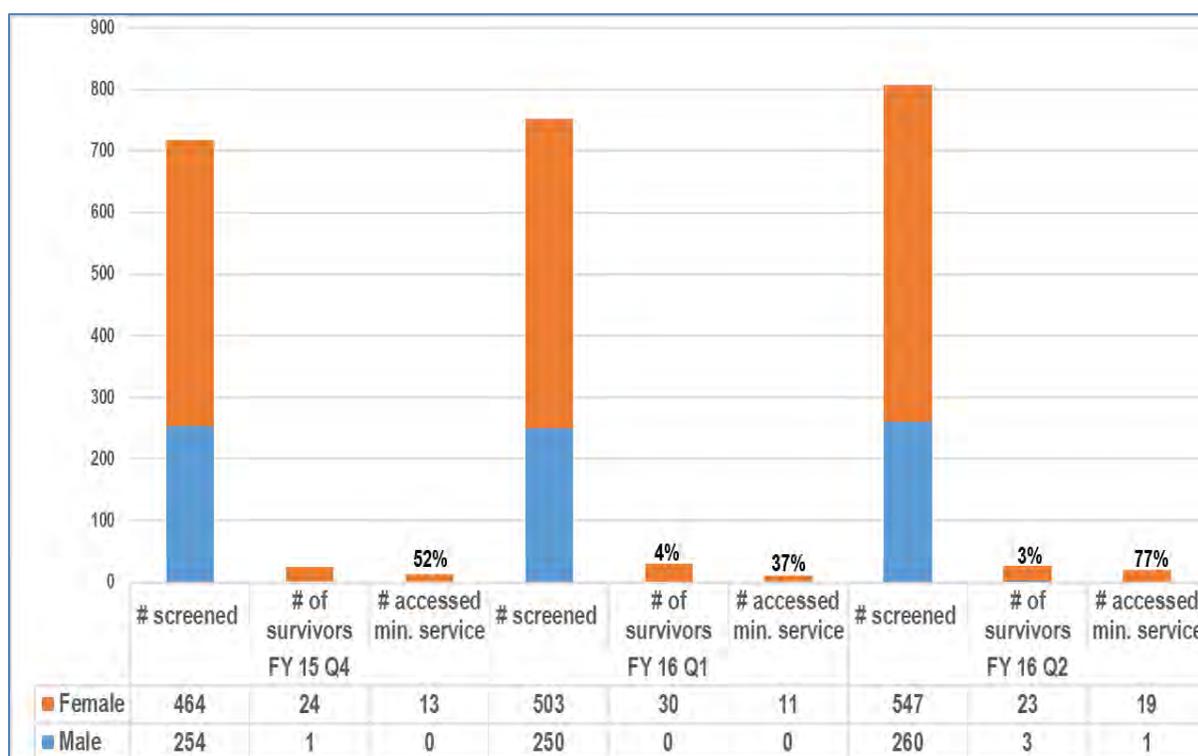
Hotline: The project funds two counselors to work on Child Fund’s GBV counseling hotline, which operates 7am–7pm seven days a week. The hotline has a referral pathway to facilitate callers’ access to other services. The hotline does not offer KP-specific counseling or collect KP-relevant data from callers, and it has no HIV-specific component of work. It is reported to have had an increase in callers, from a low base.

Clinical GBV services: In the second quarter of FY 2015, the project introduced a protocol for routine GBV screening of all clients in project-supported clinics. This was accompanied by the provision of psychological first aid and the development of referral pathways to other services for GBV survivors. The project trained 27 clinicians in use of the GBV screening protocol and the provision of five essential services to survivors, including basic and trauma counseling.

Introduction of case management and the clinic pathway for GBV survivors enables cases to be managed based on the type of GBV experienced. The project staff assist women who wish to pursue their cases in court. A small number of survivors have reported cases to police and proceeded with legal action.

As indicated in Figure 3, the number of clients who received routine GBV screening has steadily increased from the fourth quarter of FY 2015 to the second quarter of FY 2016, although only a very small number of survivors of GBV have been identified through use of the screening tool (3-4 percent). Given the high prevalence of GBV in PNG, self-disclosure of GBV to clinic staff is remarkably low. In the fourth quarter of FY 2015, only 52 percent of identified survivors chose to access the minimum package of services through referral; in the first quarter of FY 2016, this declined to 32 percent. However, this increased to 77 percent in the second quarter of FY 2016. The number of people receiving post-GBV care is very low compared to targets: 13 people (3 percent) received post-GBV care out of a target of 400 in FY 2015, and only 34 (6 percent) out of 500 for the first two quarters of 2016.

Figure 3: Screening for GBV and service uptake by identified survivors, Q4 FY 2015–Q2 FY 2016



Source: FHI 360 presentation to the evaluation team

GBV safe houses: On average, the FSC Meri Seif Place only has three to four clients per month, while the SA Ela Beach safe house has 10-12 clients per month. Clients can stay up to 21 days in both places.

Following an assessment of clinics and safe houses, the project developed comprehensive SOPs for safe house operations and trained and mentored clinicians in the procedures. As a result of an FHI 360 gender gap analysis report,⁵² project staff have increased TA for implementation of the SOPs, but some clinic staff reported that additional mentoring support is needed to help operationalize them. Staff at the two safe houses reported that they had not been given copies of the SOPs.

Community education: Targets for the number of people completing an intervention pertaining to gender norms that meets the minimal criteria were exceeded after the first two quarters of FY 2016 (50

people compared to a target of 30), which is an improvement from FY 2015 (39 people compared to a target of 70).

National clinical guidelines: The project made significant contributions to the development of the NDOH's national guidelines on GBV: *Medical and Psychosocial Care for Survivors of Sexual and Gender Based Violence: National Clinical Practice Guidelines*, released in 2015. The project has also provided TA to the NDOH on the development of a National GBV Strategy and a national GBV data management system.

5.3 STRENGTHS, WEAKNESSES, CONSTRAINTS AND GAPS

Clinical GBV services: The integration of routine GBV screening into the project-supported clinics has provided a highly relevant service and further promoted the “one-stop shop” concept of programming. However, a number of clinic staff interviewed reported that the screening tool was too long and time-consuming. Staff appeared to be resistant to taking on an extended job role in GBV screening. Some clinic staff reported that there is a lot of paperwork involved in GBV screening and that staff often leave the forms incomplete.

Project staff report that ongoing dialogue with other partners has greatly improved networking between organizations providing GBV-related services, which assists in the referral process.

FHI 360 staff and clinicians reported that the low number of clinic clients self-disclosing a history of surviving GBV through the screening tool appears to be related to cultural prohibitions against self-disclosure of GBV and seeking external assistance, and a preference for managing GBV within extended families. Another factor may be fear that disclosure, even in a confidential clinical setting, may result in further violence. These factors may also contribute to the low uptake of referrals by those who disclose a history of GBV.

An overall constraint relating to referral services is that there are no longer-term support services for survivors who seek a permanent solution to family violence that involves separating from the perpetrator.

In addition to the development of the referral pathways for IA clinics, FHI 360 has taken a broader approach by providing TA to FSVAC to develop a referral SOP and national referral pathway.

Prevention: The project does not collect data on the number of KPs referred by PEs for GBV services. This should be included in the project's reporting system. The lack of data in this area has prevented the evaluation from coming to any conclusions on the effectiveness of the work of PEs in relation to GBV.

GBV safe houses: While the availability of emergency shelter for GBV survivors is an important service, the underutilization of these services stands out, particularly in light of the limited number of safe houses in Port Moresby and the high prevalence of GBV. In PNG, where culturally, family support plays a key role in providing comfort and support to the survivor, people may not feel comfortable seeking external assistance and self-disclosing what may be seen as a private family matter. Fear of further violence from perpetrators was also reported by informants to be a factor in the low use of the safe houses.

A factor reported by the safe houses that may hinder their use is their proximity to FSC and SA clinics. This is a security concern for survivors who fear further violence from perpetrators. The location of the safe houses appears to be well known, and it would be easy for the perpetrators of GBV to blend in with people accessing clinical services and engage in further violence.

Women who access the safe houses often bring their children to the house. These children can be traumatized, especially if they have witnessed the violence. Staff are currently not able to assist them because they have not been trained in how to manage children in these circumstances.

Data collected at the safe houses are not comprehensive because some clients will not disclose information out of fear of the perpetrator. This makes it difficult to analyze services to inform future planning.

It was also reported by some informants that no follow-up visits are made with GBV survivors after discharge from a safe house because this would not be safe for staff or clients.

The safe houses only cater for female victims of GBV. MSM, TG and MTS victims of violence cannot access the houses. Rooms are shared, since there is not enough space to separate clients into single rooms, and it would be inappropriate for the female victims of GBV to share rooms with males.

Training: Many key informants reported that FHI 360 GBV training was of high quality. Shelter staff interviewed reported a high degree of satisfaction with the training. Staff requested additional training, including advanced training in trauma counseling to boost the quality of counseling services provided to GBV survivors and pediatric counseling for children witnessing or experiencing violence. Staff also requested an increase in mentoring and supportive supervision to further increase knowledge and skills to improve the quality of GBV and counseling services. Counseling seemed to be largely aligned toward family reunification. The appropriateness of this approach needs to be further investigated, taking into account PNG culture.

Limited scope of programming: Initial programming in areas such as media monitoring, the hotline and support for FSVAC resembles broad mainstream gender programming with no specific relevance to health services, HIV or KPs. FSVAC staff reported that they would like additional assistance from FHI 360 on how to integrate KP issues more directly into their activities. While there is a great need for mainstream gender programming in PNG, the issue is whether an HIV KP project is the appropriate mechanism for such programming or whether more specific, project-relevant GBV programming would be preferable. Over time, more project-relevant programming was introduced, with routine GBV client screening being integrated into the work of PEOs and clinics.

More broadly, it is apparent from consultations that the meaning of GBV in PNG is confined to violence perpetrated by a man against his wife or partner and does not include homophobic violence. The current project has not developed any programming related to homophobic violence or to violence against women and men in transactional sex. There is a strong case for reorienting programming to make it more directly relevant to the lives of KPs and HRM/W. This could involve more community-level programming.

The evaluation saw little evidence of GBV prevention programming, with most programming targeted toward GBV survivor services. Additionally, there is weak integration of GBV into HIV prevention programming.

Overall, the GBV component is the weakest component of the project. FHI 360 recognizes the need for strengthening this component. FHI 360 (DC office) conducted a gender gap analysis of FHI 360 activities in October 2014⁵³ and reported many deficiencies in existing gender programming. FHI 360 has been actively working to rectify some of those deficiencies but has had mixed success. This is, in part, due to underlying questions about whether current programming is relevant to the context of PNG.

5.4 SUSTAINABILITY

A mobile phone company has donated the safe houses to the FSC and SA. The FSC Meri Safe House will be funded by the NCD government from 2017. Child Fund reported that it is not reliant on USAID

funding to ensure the continuation of hotline services. The larger question is how to make safe houses and gender programming more culturally appropriate to increase service uptake. Poor utilization of the safe houses may indicate a lack of awareness and appreciation of the services, or it may be that this type of intervention may not be best suited to the PNG context. The project needs to adjust activities and strategies to ensure they meet needs in PNG. FHI 360 and implementing partners need to work with churches and through the existing community programs and youth and women's groups to understand how to address GBV more effectively.

Recommendations

24. In close consultation with PNG partners, USAID and FHI 360 should undertake an assessment of the types of GBV programming that are most likely to be effective within the context of PNG's culture.
25. USAID and FHI 360 should broaden their GBV programming to include interventions that address homophobic violence against MSM and TG and also violence directed to WTS by their clients. These need to be accompanied by a greater emphasis on community GBV prevention programming.
26. FHI 360 should provide additional GBV training to PEs on strategies KPs can use to avoid violence and deal with dangerous situations, and it should support legal services for the victims of violence. This should include training tailored to violence against WTS by their clients.
27. At the project-supported GBV safe houses, FHI 360 should facilitate staff training on counseling and support for children of GBV victims.
28. FHI 360 should provide additional GBV training in advanced counseling skills, trauma counseling and pediatric counseling for children who have witnessed violence, and it should increase mentoring of safe house staff.

6. HEALTH SYSTEMS STRENGTHENING PROGRAM COMPONENT

6.1 PROJECT COMPONENT OVERVIEW

The health systems strengthening project component builds on the CoPCT model, which is designed to integrate a health systems approach to ensure effective coordination and governance, increase data use for decision making, improve access to high-quality services, ensure functioning supply chains and coordinate case management at the clinic level. The goal of this project component is to work closely with the NDOH to strengthen GoPNG capacity to ensure appropriate service coverage, quality, efficiency and HIV commodities. This objective includes two sub-objectives: (1) Strengthen data management and information among partners and GoPNG counterparts through standardizing procedures and indicators; and (2) improve supply chain management.

6.2 MONITORING AND EVALUATION

6.2.1 Project effectiveness

FHI 360 staff reported that strengthening M&E and strategic information has been a major priority for the GoPNG. Overall, the project has done a good job supporting the national system to provide a foundation for M&E across the country to collect KP indicator data, and has adapted government tools at the clinic level that align both government and PEPFAR indicators.

Development of FHI 360's data collection and reporting systems has been an iterative process. This has largely been based on lessons learned as the project scaled up, but also has been a result of ongoing gap analyses and assessments conducted by internal and external FHI 360 staff. As new recommendations have occurred throughout the life of the project, data collection and reporting tools have changed to reflect those recommendations. Training and mentoring to implement revised tools and systems have been conducted over the life of the project. For example, in the third quarter of FY 2014, FHI 360 revised the electronic ART tracking system at ART sites to trigger alerts to the HIV CMT about clients who have defaulted or are LTFU. CMTs can then try to re-link clients through home visits, text messaging or phone calls.

FHI 360 has proactively modified M&E systems to align to government monitoring, evaluation and reporting requirements as well as the related PEPFAR indicators. For example, in the fourth quarter of FY 2014, the project conducted a review of national M&E tools to assess whether they meet the new PEPFAR monitoring, evaluation and reporting requirements. Results from this assessment were reported to the NDOH and other development partners to encourage the NDOH to revise national M&E tools.⁵⁴ The project has developed new data collection tools, aligned to both government and PEPFAR monitoring, evaluation and reporting indicators, and started working with NDOH surveillance teams in the first quarter of FY 2015 to ensure that parallel data collection systems are not developed.

WHO is currently leading the development of a framework that will merge the HIV patient database and the HIVQUAL indicators into one system. FHI 360 reviewed content and set indicators for the national HIV patient database as part of this effort. The project has also taken government tools used at the clinic level, such as clinic forms, registers and log books, and assessed them for gaps. Based on those gaps, the project has revised the government reporting and program tools to support monitoring, evaluation and reporting indicators and provide required disaggregation by KPs,⁵⁵ piloted them at project clinics and is working with the government on potentially rolling them out nationally.

The project has worked with the Madang PHO to strengthen linkages and referrals between different service providers.⁵⁶ The Madang PHO reported that the project introduced the HIV reporting and recording tools to the province.

In 2014, FHI 360 participated in the NDOH STI and HIV/AIDS Surveillance Unit's data analysis lockdown workshop to enable staff to analyze national HIV/AIDS surveillance and program monitoring data from 2012.⁵⁷

In FY 2016, the project is seconding an active case management/M&E coordinator to NCD Health to maintain databases for all PLHIV newly identified by testing sites, actively follow LTFU clients, coordinate CMTs in project-supported NCD clinics and strengthen the reporting of national surveillance forms by all HIV clinics.⁵⁸ NCD government staff reported that they committed to absorbing this position into their system at the end of the project.

FHI 360 has conducted extensive M&E training both for IA staff to complete necessary reporting requirements and also for government. Training has included data interpretation, which was identified by key informants as a critical need in PNG. Data quality audits are conducted quarterly or biannually and verify indicators; ensure data integrity, accuracy and reliability; and promote feedback toward a strong M&E system. Refresher trainings and mentoring have been provided to all IAs whenever changes are made to existing data collection tools.

6.2.2 Strengths, weaknesses, constraints and gaps

While FHI 360 has developed and implemented referral cards to facilitate linkages, referrals are not tracked internally or externally. Within project-supported clinics, cards are not collected, but rather put into client files. This makes it challenging to enumerate the actual linkage of clients to care. This is further complicated by the fact that sometimes clients do not present their referral cards at clinics. Clients that are referred to other facilities, for example TB services, are not tracked in any consistent way to ensure that they were linked to care at those facilities. Some clinic staff reported trying to conduct assisted referrals to TB services if they are in close proximity, or called to see if clients made it to care, but no standard procedures are applied across all sites. A system is needed for tracking referrals consistently to establish linkage. CommCare, a mobile data application system, was developed in 2015 to help track services accessed by KP during outreach and successful referrals, but it has not yet been implemented in full. A significant amount of time went into the development of CommCare, but it is being introduced very late in project activities. FHI 360 needs to work with the government to determine the feasibility and acceptability of adopting this technology as part of the sustainability plan; otherwise, introducing it this late in project activities may be problematic.

Quarterly project performance review meetings were introduced in 2015 with the NDOH, NACs and civil society organizations working with KPs; these have been a way to disseminate project goals more broadly. In Id Inad, Koki, and Kila Kila clinics, staff reported that FHI 360 does not adequately provide feedback on findings from data collected. Access to findings was reported to be important to staff to address gaps, and FHI 360 should try to report data back to clinics more frequently.

During interviews, one gap identified by informants at several organizations was that FHI 360 has not contributed to a broader understanding of the KP epidemic and that most data generated is routine program reporting. The lack of impact data on service delivery was also reported to be a gap for project activities.

Recommendations

29. FHI 360 should provide timely and more complete feedback to clinics on performance and key indicator data.

30. FHI 360 should work with clinical IAs to establish a system for tracking internal and external referrals consistently.
31. FHI 360 needs to work with the NDOH to determine the feasibility and acceptability of the government adopting CommCare as part of the sustainability plan.

6.3 SUPPLY CHAIN MANAGEMENT

6.3.1 Project effectiveness

In the third quarter of FY 2013, FHI 360 conducted an initial assessment and gap analysis of drug registration, forecasting systems and drug inventory management at the Id Inad clinic. Based on the assessment, FHI 360 provided mentoring to establish an early warning system for antiretroviral drug stock-outs. This tracking system was replicated to new ART sites in NCD in 2014. FHI 360 has worked with IAs to develop systems for tracking stock of test kits and medications and ensured that clinic leads are present for any NDOH supply chain management training starting in FY 2015.

In Madang, government informants reported that FHI 360's project coordinator/HIV technical officer has an essential role in ensuring a constant supply of HIV test kits and medications for the Id Inad clinic.

6.3.2 Strengths, weaknesses, constraints and gaps

In Madang, the PHO project coordinator/HIV technical officer needs another six months to train Id Inad clinic staff on the supply chain management functions that he has been doing. The current project coordinator position was reported to be important to government informants interviewed, but it does not exist in the public service staffing structure. For the position to be absorbed into the PHO's staffing structure, it needs to be created in the public health system.

NDOH supplies for specific clinical necessities remain a challenge. At one NCD clinic, the dried blood spot quality assurance forms provided by the NDOH have been out of stock for the past 12 months, and the CPHL ran out of quality assurance samples, which compromises quality of testing activities. Other commodity challenges are described in previous sections.

Recommendations

32. To minimize stock-outs, FHI 360 should provide TA to the NCD TA expansion sites, using the same systems for tracking stock of test kits and medications. The systems should be aligned to national efforts, including any national software systems that are being implemented.
33. The Madang PHO project coordinator should develop staff capacity at the Id Inad clinic and others in the province to ensure adequate stock of test kits and medications.

7. FHI 360 PROJECT MANAGEMENT

7.1 RELATIONSHIPS

7.1.1 External relations

FHI 360 has invested in the development of positive relationships with many external organizations. Country Director Daniel Tesfaye and Deputy Director Ignatius Mogaba are very highly regarded by key informants and recognized for the quality of their leadership. In particular, Dr. Mogaba has helped develop a good technical relationship with the NDOH.

Key informants reported that TWGs are essential coordinating mechanisms. FHI 360's membership in TWGs and the Global Fund Country Coordinating Mechanism (CCM) has been important for establishing and maintaining relationships across government, donors and implementing partners and in sharing FHI 360's technical expertise in the development of policies, guidelines and training curricula. FHI 360 provides ongoing TA to the GoPNG through participation in more than 10 TWGs and committees: strategic information, HIV, KPs, prevention of parent-to-child transmission, STI, gender, M&E and surveillance, violence against children, and sexual health TWGs, and the M&E oversight and activity grants committees. It is also the elected international NGO member to the CCM for the Global Fund. FHI 360 is also contributing with the strategic information TWG to develop a unique identifier code (UIC) system for PNG. The system, which is designed to monitor service delivery and access by KPs, is being led by VSO.⁵⁹ FHI 360 has participated in the revision of the care and treatment guidelines and will be essential to the STI guideline revision process in FY 2016.

7.1.2 Internal relations

FHI 360 has an overall positive relationship with its IAs, with some challenges. In general, IA staff highly appreciated the significant level of technical support provided through training and mentoring. Some staff expressed the view that FHI 360 was too controlling or that the frequency of TA was too high. As FHI 360 has been primarily working with partners new to HIV programming, a high level of ongoing capacity building has been needed. For some staff, the extent of accountability required by FHI 360 may have been uncommon, given that ongoing supervision and close monitoring of clinics is not usually the case in PNG.

Some IA staff reported that they had little involvement in budgeting or developing work plans, and are not being consulted about transition and sustainability plans, which is challenging. FHI 360 has very rigid budget and accounting requirements, which have helped increase IA capacity to manage their sub-agreements, but it was reported to also “grind work to a halt, even for something as small as finding a \$1.50 receipt.”

7.2 EXIT PLANNING

By the end of the current project, USAID and PEPFAR have a strong preference to transition support from a direct service delivery (DSD) model, where USAID pays for most service delivery costs, (e.g., PE and clinic staff salaries and some operational costs), to a TA model, in which, preferably, government (or other donors) would take over all DSD costs and USAID would support only TA costs in a follow-on project.

The GoPNG is currently experiencing a major fiscal crisis due to a collapse in royalty payments associated with globally depressed prices for natural resources and the level of government spending and external borrowing. Key informants reported that this has already led to a significant reduction in government health expenditure. While the objective of a transition from DSD to TA support should

continue to be actively pursued, the possibility that the GoPNG will not pick up DSD costs needs to be considered in transition planning and the design of the follow-on project.

NCD: FHI 360 reports that it has made significant efforts to build a working relationship with NCD Health since the commencement of the project.⁶⁰ NCD Health and the NDOH are aware that USAID plans to cease DSD funding of the FSC and SA clinics and PEO at the end of the project. NCD Health has started planning to take over funding of staffing and operational costs at these clinics. Funding has not yet been secured. The director of public health for NCD Health has indicated that he does not believe it will be in a position to take over responsibility for funding and management of PEO for up to five years. If NCD Health took over clinical service delivery costs but not prevention programming costs, with no other source of ongoing or replacement funding for PEO, this would mean that the CoPCT model would transition into simply a continuum of care and treatment model, adversely affecting the achievement of the 90-90-90 targets.

USAID will need to assess the likelihood of NCD Health taking over DSD costs. Given the economic climate in the country, it is possible that the GoPNG will not be in a position to absorb even clinical costs. In this circumstance, USAID will need make a decision on whether to continue with DSD funding, and for how long, with the option of an agreement with NCD Health to transition to a TA model at a set time in the follow-on project. Alternatively, interim funding support for these clinics may be available from the Global Fund. However, it should be noted that the CCM is not aware that USAID DSD for these clinics may stop at the end of the USAID project.⁶¹

Exit planning for NCD to date has been focused on securing government funding for DSD costs. There has been no detailed operational planning to facilitate a smooth transition from donor support. This type of planning is essential to avoid the pitfalls experienced in the close-out of the previous USAID project and to minimize reputational risk to USAID and FHI 360. A weakness of FHI 360's current exit planning in NCD is that it has not involved the management of the FSC and the SA in discussions it has been holding with NCD Health. This should be rectified.

Recommendation

34. FHI 360 needs to take the opportunity provided by the one-year extension of the USAID project to ensure that detailed operational planning in NCD occurs to facilitate the transition from donor support. This needs to factor in the possible scenario of no alternative funding being secured and a plan to ensure that patients currently on ART are retained in care.

Madang: The other dimension of exit planning is that USAID made a decision to exit from DSD support in Madang in May 2016. The purpose was to free up funds to concentrate on NCD, in support of reaching the 90-90-90 objectives. This was justified by NCD's significantly higher HIV prevalence. This pivot involved the provision of TA support to five additional clinics in NCD, without support for DSD costs.

The decision to exit from Madang was made in May 2015.⁶² The Madang PHO was not informed of the exit until July 2015. FHI 360 did not hold its first exit planning meeting with the Madang PHO and Modilon General Hospital until November 2015. This was originally scheduled for September. It was not until late January 2016 that FHI 360 held detailed discussions with the PHO on the estimated budget needed to fully sustain project activities. FHI 360 estimated total annual costs would be 419,000 Kina (US\$135,000). The PHO set aside a budget of 100,000 Kina (\$32,000), with the aim of increasing this allocation in subsequent years. Approval for the initial allocation by the provincial administration has not yet been given. While the 100,000 Kina allocation covered salary costs, it is unlikely that activities such as PEO outreach could have been sustained because there was no allocation for management, supervision and operational costs.⁶³

FHI 360's contract with VSO for PEO in Madang ended in March 2016 and was not renewed, given USAID's planned exit. The Global Fund subsequently made VSO a sub-recipient for delivery of PEO in Madang to fill the gap left by USAID's exit. There was a three-month gap between the end of USAID funding and the re-commencement of VSO PEO with Global Fund support.⁶⁴

FHI 360 has suggested that delays in exit planning in Madang may in part have been because USAID was reconsidering the timing of its exit.

Exit planning for Madang has appropriately focused on securing government funding. It has, however, not extended to detailed operational planning to facilitate a smooth transition from donor support. For example, case managers based at the Id Inad clinic are currently reliant on the FHI 360 vehicle to track treatment defaulters. Operational planning needs to cover whether the vehicle will be donated to the hospital at the project's end and, if so, ensure that the hospital will be able to provide a driver and petrol. While this may seem a minor issue, LTFU rates could increase significantly unless this is addressed.

Given that USAID has provided more than seven years of support for Madang and that services, particularly at the Id Inad clinic, have reached a good level of technical competence, the decision to exit was justified. It would have been preferable to provide more notice of the intention to exit, to allow the PHO more time to secure provincial funds.⁶⁵ Areas of concern in FHI 360's handling of the exit are the long delay in initiating detailed exit planning discussions with the Madang PHO and in providing budget estimates of funds needed to ensure full sustainability, plus the lack of detailed operational planning. USAID has now decided to defer the Madang exit until September 2017.

Recommendation

35. FHI 360 should take the opportunity provided by the deferral of the Madang exit to assist the PHO and Modilon General Hospital with detailed operational planning to maximize transition of all aspects of its support, with the aim of achieving full sustainability. A focus of this planning should be on how to develop sustainable systems within the province's health system in areas such as supply chain management, which will be needed after short-term stop-gap support from FHI 360 is no longer available.

8. OVERALL CONCLUSIONS

This section discusses the contributions of the project's components to achieving the overall project goal, within the context of the CoPCT framework. The goal of the project is to reduce HIV incidence among KPs and to mitigate the impact of HIV on KPs, their sexual partners and families.

The underlying logic of how the project's components are intended to synergistically contribute to the goal is described in Figure 4 below and is as follows:

Prevention component:

- Improved KP HIV-related knowledge, attitudes and behaviors will reduce the risk of HIV transmission among KPs.
- Improved health-seeking behavior by KPs will increase demand for HIV testing, which will be an entry point to life-saving ART, which in turn will mitigate the impact of HIV and reduce onward transmission through viral suppression.
- Increased demand for comprehensive, combination HIV/AIDS-related services, such as STI and TB screening and treatment, will reduce the STI-related risk of HIV transmission and mitigate other adverse HIV-related health impacts.

Care and treatment component:

- Coverage of HIV care and treatment services will be improved by demand-generation activities of the prevention component and the project's support for service delivery by its IAs.
- Enhanced local capacity for integrated service delivery will result in improved quality of HIV services.
- Adherence and retention of PLHIV in care and support will result in ongoing viral suppression and reduce morbidity and mortality.
- The combined effect of the above three results will be an increase in the number of PLHIV enrolled and retained in life-saving treatment.

Gender component:

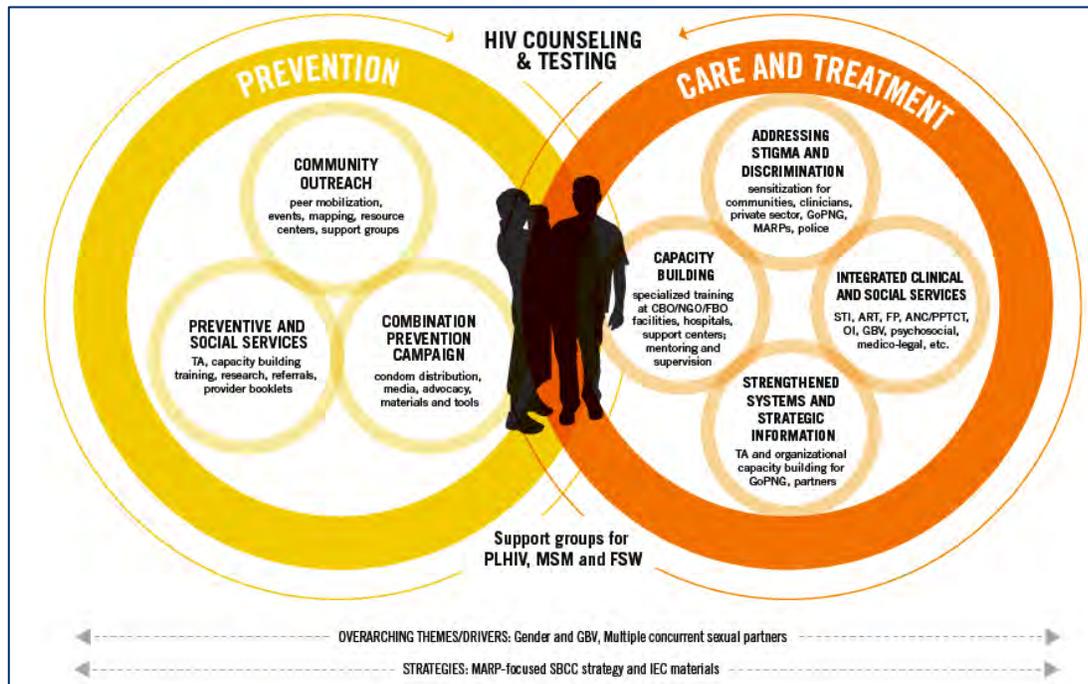
- Increased use of facility- and community-based gender and GBV interventions will reduce the GBV-related vulnerability of KPs to HIV, thereby contributing to reduced HIV incidence.

Health systems strengthening:

- Improved health systems will strengthen the CoPCT model and contribute to mitigation of the impact of HIV.
- Capacity building for institutional stability will result in long-term sustainability of programming.

It is, however, important to note that reducing HIV incidence among KPs is a longer-term goal that is beyond the life of the project. It was beyond the scope of this performance evaluation to measure the impact of project activities on reducing HIV incidence, although observations on the contribution of project components to achieving this goal were possible.

Figure 4: Continuum of prevention to care and treatment (CoPCT) model



Prevention programming: The contributions of the prevention component to the goal are mixed. No conclusions can be drawn on effectiveness of the project in improving HIV/STI knowledge, attitudes and risk behaviors because the project does not collect data in these areas, due to the expense of population surveys. The potential of the project to achieve these outcomes has been inhibited by the below-target reach of PEO work. While the number of KPs reached with the minimum prevention package has increased each year, reach is still substantially below target. Access to condoms appears to be good, with the project mostly meeting or exceeding targets for condom distribution. The absence of behavioral data means, however, that there is no evidence on the extent of consistent condom use.

The project’s prevention component is well designed and has been progressively improved since inception to respond to considerable implementation challenges, most of which have been specific to PNG context. While progress with implementation has been disappointingly slow, the increased PEO coverage is likely to be a dividend from ongoing quality-improvement efforts.

The prevention component is a linchpin within the CoPCT for increasing demand for clinical services, particularly HIV testing, as an entry point to treatment. Demand by KPs for HIV testing has increased significantly each year, with annual targets being exceeded. However, the number of walk-in KP and HRM/W clients for HTC has significantly exceeded the number of successful referrals by PEs. The contribution of PEO to increased demand for HIV testing is unclear. Possible explanations for the high number of walk-in clients are they were referred by PEs but did not take the referral card to clinic; they were referred by PEs from other projects; or they heard about the services informally. While the demand generated by PEs for health services appears to be relatively low, the high levels of demand for HTC has meant that this key aspect of the CoPCT model has not been compromised.

Although demand for STI services has increased significantly, there have been far fewer STI clients than HTC clients, particularly among KPs. As a result, the potential to reduce the risk of HIV transmission through effective STI control has not been fully realized. A constraining factor is the limitation of the PNG Government’s syndromic management approach.

Care and treatment programming: The project has increased the availability of care and treatment services for KPs and HRM/W, and effective TA has resulted in good-quality HIV, AIDS and STI services at the clinics it supports. Linked to the high level of HIV testing, the project has exceeded targets for the number of HIV-infected adults and children newly enrolled on ART. This directly contributes to the goal of mitigating the impact of HIV.

The true extent of LTFU across the HIV treatment cascade is not known due to data limitations, but it would appear to be between 30-40 percent. Strategies for retaining ART patients in care and minimizing LTFU are broadly consistent with international best practice, although enhanced implementation, tailored to the specific LTFU challenges of PNG and guided by operational research, is needed.

While TB screening of HIV patients has been below target, following quality improvement measures, the project will exceed its target in this area in FY 2016. The roll-out of viral load testing in NCD, allied to the PEPFAR pivot of greater support for NCD, will help to improve the HIV treatment continuum.

Gender: There is scant emphasis on GBV prevention programming, with most programming focused on GBV survivor services. Additionally, there is weak integration of GBV into HIV prevention programming. Despite its KP focus, the project has not developed any programming related to homophobic violence or violence against women and men in transactional sex. Overall, the GBV component is the weakest component of the project.

Measuring the impact of gender programming on reducing HIV vulnerability would be challenging and is beyond the capacity of a performance evaluation. Given problems with the design and implementation of this component, it is unlikely that such a higher-level outcome has been achieved.

Health system strengthening: The project's HSS work has been focused on two quite small sub-components of work in M&E and supply chain management. More broadly, across all project components, HSS activities to strengthen the CoPCT model have included improved service coverage, quality and efficiency; improved access to services; coordinated case management at the clinic level; and increased data use for decision-making.

Key conclusions: Of the two major project components, prevention programming has struggled to meet its key targets, while care and treatment targets have generally been exceeded. Key observations are that:

- Due to data limitations, it is not possible to conclude whether prevention programming has resulted in improved HIV/STI knowledge, attitudes and risk behaviors, which may contribute to the project goal of reduced HIV incidence.
- A key element of the CoPCT model, which is high rates of HIV testing among at-risk populations and enrollment in care and treatment, has been successful. However, the high number of walk-in clients for HIV testing means that the extent to which the project has been successful in creating demand for HIV testing is unclear.
- While improved health-seeking behavior has resulted in a significant increase in the demand for comprehensive HIV services, the extent to which this is a result of project demand-creation activities is unclear.
- The objective of increased supply of HIV services has clearly been met, accompanied by quality and coverage improvements.
- The significant increase in PLHIV newly enrolled in ART would have had a significant effect in mitigating the impact of HIV on KPs, but the benefits have been partly eroded by the number of PLHIV on ART who have been LTFU.

Overall, FHI 360 has done a good job in implementing the USAID HIV project in what is a difficult operating environment, particularly because of the high levels of stigma and discrimination against KPs and generally low capacity and weakness of the health system. These challenges were compounded by working with IAs that were mostly new to HIV programming and to working with KPs. The need to build the capacity of the new IAs has slowed project roll-out but has resulted in an expansion of services with HIV and KP-related capacity. FHI 360's work is characterized by a strong and persistent commitment to ongoing, step-by-step capacity building and quality improvement, coupled with a willingness to innovate. Effective exit planning to ensure that activities are sustainable is essential to maintain the CoPCT framework.

ANNEX I: SCOPE OF WORK

Purpose of the evaluation

The main purposes of this project evaluation are to:

1. Assess the effectiveness, efficiency and quality of the FHI 360 project at the national, provincial, facility and community-based service levels; identify implementation gaps/challenges; and determine how well the project is achieving its goals, objectives and performance targets/results.
2. Propose key recommendations for improvement and direction for the remaining activity period.
3. Document lessons learned and provide recommendations that will inform future programming directions for USAID’s PNG PEPFAR project and the design of a follow-on activity.
4. Make specific proposals for a Sustainability Plan/Exit Plan for FHI 360, given their current level of funding for the clinic staff.
5. Assist the team in evaluating the cost vs. benefits of the entire program.

Audience

The primary audiences for this evaluation report are the USAID PNG Health Office and the FHI 360 Strengthening HIV/AIDS Services for Most at Risk Populations in PNG Project staff.

Application and use

Findings and recommendations from this project evaluation will be used for further improvement and direction for the remaining activity period and to inform the design of follow-on activities. Conclusions from this evaluation will assist USAID in deciding whether or not there should be a follow-on project, and if so, how it will be designed.

Evaluation questions and areas for recommendations

	Evaluation Question	Evaluation Methods	Application or Data Use
1	How effective is the project in achieving its goals, objectives and performance targets?	<ul style="list-style-type: none"> • Document and data review • Key informant interviews • Focus group discussions • Secondary data analysis 	<ul style="list-style-type: none"> • Feedback for course correction • Recommendations for future project(s)
2	What are the project’s strengths, weaknesses and gaps in planning, management, service delivery and sustainability?	<ul style="list-style-type: none"> • Document and data review • Key informant interviews • Focus group discussions • Secondary data analysis 	<ul style="list-style-type: none"> • Feedback for course correction • Recommendations for future project(s)
3	What are the constraints to successful implementation of this program?	<ul style="list-style-type: none"> • Document and data review • Key informant interviews • Focus group discussions • Secondary data analysis 	<ul style="list-style-type: none"> • Feedback for course correction • Recommendations for future project(s)
4	How well does the project align with PEPFAR global priorities and approaches?	<ul style="list-style-type: none"> • Document and data review • Key informant interviews 	<ul style="list-style-type: none"> • Feedback for course correction • Recommendations for future project(s)
5	How do the benefits to the clients compare with the cost of providing these services to them?	<ul style="list-style-type: none"> • Document and data review • Key informant interviews • Focus group discussions • Secondary data analysis 	<ul style="list-style-type: none"> • Feedback for course correction • Recommendations for future project(s)

Recommendations

At the conclusion of the evaluation, it is expected that the following recommendations will be provided to USAID/Philippines:

- 1) Recommendations to build on strengths, correct weaknesses and improve implementation to enable USAID and implementing agency staff to develop a course of action for the remainder of the activity.
- 2) Recommendations that can be used to inform the design of a follow-on activity focusing on sustainability and eventual Government of Papua New Guinea ownership.
- 3) An analysis of the cost vs. benefits of the model used in this project.
- 4) USAID is aware that the current practice of paying multiple staff salaries is counter to project sustainability. It is hoped that the evaluation team can come up with creative recommendations for a lower cost model of clinic and community outreach that provides the same basic services.

Methods

This evaluation will collect information about the success of FHI 360 implementation in providing quality and comprehensive HIV/AIDS prevention, care and treatment services; establishing linkages and referrals between provincial, facility and community services; technical assistance to local and national partners; and challenges. This program evaluation will assess the contribution of FHI 360's Continuum of Prevention to Care to Treatment (CoPCT) model to improving the quality of HIV/AIDS prevention, care/support and treatment services, alongside the clinical cascade, at the health center and community levels and capacity building at the national and provincial levels. Whenever possible, the evaluation should mention gaps in programming, as well as innovations and successes, both of which will inform the design of the follow-on project.

The primary methods to be used by the evaluation are document and data review, key informant interviews with stakeholders, and focus group discussions with project beneficiaries.

Cost analysis: Data on the cost of services and/or intervention activities will be used to estimate the cost of the services per MARP that can then be used to compare the benefits by their estimated costs.

Secondary analysis of existing data: A thorough review of existing data and descriptive statistical analysis (including the construction of the clinical cascade from FHI 360 program data), with the possibility for more advanced statistical analysis of existing quantitative data, will also be conducted. Possible datasets for re-analysis are listed below.

Data Source (<i>existing dataset</i>)	Description of data	Recommended analysis
PNG KP project monitoring data routinely collected by FHI 360	Data routinely collected as part of the project, primarily for indicator reporting and management purposes	<ul style="list-style-type: none"> • Confirm findings as reported in quarterly and annual reports. • Trends over time since the beginning of the project • Cross-tabulations of key indicators by key demographics (e.g., location, sex, age)
HIV, STI and behavioral surveillance survey (BSS) data	In 2010, FHI 360 conducted a BSS among MSM and women in Port Moresby to better understand how HIV is transmitted. Respondent-driven sampling (RDS) was used to survey 585 participants.	Comparison of project sites to non-project locations, if feasible
PNG KP Project formative research and evaluation datasets		

Analytical plan

The evaluation will:

1. Review information related to the relevant HIV/AIDS and health issues being addressed and determine the extent of current initiatives of FHI 360 in addressing these health concerns. To the extent possible within the resources available to the evaluation, an assessment will be made of the contribution of the government (national and local), private/business, other non-government sectors and other donor agencies in addressing these health concerns.
2. Analyze data within the context of PEPFAR initiatives, focusing on the provision of technical assistance, capacity building and advocacy.
3. Assess the various current and potential areas for intervention, such as the CoPCT model for HIV/AIDS, building capacity of local implementing agencies and government counterparts and gender-based violence activities.
4. Recommend the logical framework for planning and implementation processes of the future HIV/AIDS support program/assistance.
5. Suggest high-level key indicators appropriate to measure the efficiency and effectiveness of the proposed HIV/AIDS support program/assistance.
6. Provide recommendations for a follow-on activity design to USAID/Philippines.

All analyses will be geared to answer the evaluation questions, and each evaluation question will be answered using the same analytical methodology. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets. Quarterly and annual implementation plans will be reviewed for further context and understanding of the performance measures reported annually and cross-tabulated against data collected from interviews.

Quantitative data provided by the project will be analyzed primarily using descriptive statistics, specifically calculating percentages of targets met over the course of the project. Data will be stratified by demographic characteristics, such as sex, age and location, whenever feasible, using data provided by the project. Performance data will be analyzed to determine whether targets were achieved annually by the program or not and to determine what percentage of persons reached with the intervention were from the target audience. All data sources will be provided by the project and will include quarterly reports, monitoring and evaluation plans, annual implementation plans and PMP data.

Qualitative data collected through semi-structured interviews with key informants will be analyzed to determine themes that emerge for connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances, and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data behavior surveillance survey data, etc.), will allow the team to triangulate findings to produce more robust evaluation results.

ANNEX 2: EVALUATION DESIGN AND METHODOLOGY

The key components of the evaluation methodology were as follows:

A. Data review and collection

1. Document review

Evaluation team members reviewed key background documents provided by USAID in the following categories:

- **PEPFAR documents:** relating to PEPFAR strategic directions (PEPFAR 3.0), PEPFAR technical guidance, the PNG Country Operational Plan and PEPFAR progress reports
- **USAID documents:** the request for applications for the project and the cooperative agreement between USAID/Philippines and FHI 360 for the project, including modifications
- **Project documents:** including annual implementation plans, quarterly progress reports, the Performance Monitoring Plan and related performance data, expenditure analysis, research and technical papers
- **PNG response documents:** the PNG National HIV and AIDS Strategy, the midterm review of the strategy and the PNG Concept Note submitted to the Global Fund
- **Bilateral and multilateral partners:** documents relating to other HIV programs (e.g., Global Fund), reports such as Global AIDS Response Progress Reports for PNG and technical guidance documents

2. Review of performance-related data

The evaluation team analyzed project PMP data to identify achievement of key outputs and outcomes. The main focus of this review was an analysis of data that contributed to answering the evaluation questions. The team examined trends in output data and compared performance indicator data to targets. They explored how PMP targets were set, assessed the appropriateness of these targets and conducted a secondary analysis of the PMP data to identify trends over time for key indicators.

3. Key informant interviews and focus groups:

The evaluators interviewed a broad range of key informants to address the evaluation questions in the scope of work. The following categories of key informants were interviewed:

- USAID Pacific Islands Health Office
- FHI 360 project management and staff
- FHI 360 implementing partners (including site visits to clinical and other services)
- PNG National Department of Health staff
- PHO staff for the National Capital District and Madang Province
- National AIDS Council Secretariat staff
- The PNG Global Fund Country Coordinating Mechanism and Principal Recipient
- PNG civil society, non-government and faith-based organizations' representatives
- International development partners such as U.S. CDC, UNAIDS, WHO, DFAT, and their implementing partners

Interviews with FHI 360 implementing partners were supplemented by a semi-structured observation checklist, related to the evaluation questions, that was completed during site visits.

In addition, the evaluators held FGDs with the clients/beneficiaries of FHI 360's implementing partners. The following FGDs were conducted in both Port Moresby and Madang:

1. MSM, TG and MTS
2. WTS
3. PLHIV

FGDs were also held with project PEOs in Port Moresby and Madang. Each focus group consisted of 8-19 participants. These were held at off-clinic sites to ensure confidentiality.

FGDs with MSM/TG, MTS and WTS covered both the project's prevention outreach activities and clinical services. VSO recruited FGD participants for groups 1 and 2 listed above. Eligibility criteria to participate these FGDs was a past history of contact with the project's outreach workers and/or use of project-funded clinical services. Use of VSO for recruitment guarded against selection bias from the project's clinical service providers.

Participants for the PLHIV focus group in Port Moresby were jointly recruited by the SA and FSC clinics. Clinic recruitment was on a random selection basis, supervised by FHI 360.

Participants for the PLHIV focus group in Madang were jointly recruited by the Id Inad clinic. Clinic recruitment was undertaken on random selection basis, supervised by FHI 360.

The eligibility criterion to participate in the Port Moresby and Madang PLHIV FGD was a past history of use of project-funded clinical services.

It was not appropriate to hold focus groups with GBV survivors because of strong cultural norms against sharing what is seen to be private family information with others. It was also not possible to hold one-on-one interviews with GBV survivors.

Interviews and FGDs were semi-structured, using guides developed for each category of key informant and focus group. The guides were a checklist of the key areas that need to be covered, based on the evaluation questions, thus ensuring a consistent approach.

The purpose of the evaluation was explained at the commencement of all interviews and FGDs. The evaluators explained that they would not be using information collected in a way that would disclose the source, and that responses would be aggregated when reported. All interview and focus group participants were informed that they had the right to decline to answer any questions and to end their participation in evaluation activities at any point, without adverse consequence. Oral consent for participation was sought prior to the commencement of all interviews and FGDs.

4. Cost efficiency

After consultation with USAID on expectations for this area of work, it was agreed that the team would try to identify strategies for how cost efficiencies could be realized for project-funded clinical operations, including establishing the number of staff needed to implement health services, focusing on the minimum package for key populations.

B. Analysis

This evaluation predominantly collected qualitative data through key informant interviews and FGDs. A thematic review of qualitative data was performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances, and homogeneity and outliers to better explain what was happening and the perception of those involved. Qualitative data were used to substantiate quantitative findings derived from project reports, other assessments and gap analyses conducted by the project, and the PMP, to provide more insights and context than quantitative data can provide, and to answer questions where other data did not exist.

In order to manage the significant amount of qualitative data collected in interviews and focus groups, the team developed a data analysis grid to group data into themes. This categorization by theme assisted the team when analyzing data to develop key findings and conclusions.

The evaluators conducted secondary analysis of PMP and other project-provided data to determine whether targets were achieved (by percentage), disaggregated by gender and risk classification where possible. Where data were missing or where disaggregation of data was preferred, the evaluation team requested specific data to be provided by the project where possible. For example, the team requested mobile HTC numbers be extracted from the overall HTC indicator by location and risk classification and used them to compare testing yield for mobile versus facility-based HTC. Additionally, the team requested a cohort analysis for the HIV care cascade by location, which was provided by the project. Figures and graphs were created using data from the secondary analysis of project data to better understand trends over time visually. PMP data were the essential benchmark of project performance and were cross tabulated against the quarterly and annual implementation plans, and key informant interviews for context. All quantitative data sources used in the secondary analysis were provided by the project. This approach was used for all evaluation questions.

The evaluation team was involved in ongoing analysis of all data through formal and informal team meetings. This iterative process allowed for emerging issues to be explored and potential findings to be tested as the evaluation progressed.

Following the completion of interviews and FGDs, the evaluation team met to conduct a thorough analysis of all data and developed preliminary findings, conclusions and recommendations related to the evaluation questions. This analysis included triangulation of information from document review, PMP data and qualitative data collected in interviews and focus groups. This analysis formed the basis upon which the evaluation report was written.

C. Debriefings

At the conclusion of the field work and following data analysis, the evaluation team conducted three debriefing meetings with:

1. USAID/Philippines and the USAID Pacific Islands Office
2. FHI 360 PNG management and staff
3. Stakeholders who took part in interviews and focus group discussions.

The purpose of these meetings was to share the evaluation team's preliminary key findings, conclusions and recommendations and to receive feedback, validation and further input. Feedback from the meetings was considered by the team when drafting the evaluation report.

Limitations

The key limitations for this evaluation were:

- The absence of population size estimates for key populations makes it impossible to calculate coverage levels for the project's interventions.
- Within the time and resources available it was not possible for the evaluation to collect quantitative data other than that provided by the project. There were no project data for some key areas, such as improvement in the HIV-related knowledge, attitudes and behaviors of key populations.
- The only feasible strategy for recruitment of FGD participants was to seek the assistance of implementing agencies. There may have been some selection bias in recruitment by the agencies. This was addressed by asking implementing agencies to recruit participants on a random basis,

with oversight by FHI 360. Clear selection criteria were also identified, although it was apparent that implementing agencies and FHI 360 had not followed these on all occasions.

- It was not possible to interview current or former clients of the safe houses for GBV victims.

ANNEX 3: DATA COLLECTION INSTRUMENTS

This annex contains the oral informed consent statements for key informant interviews and focus group discussions and the interview guides that were used for different categories of key informants.

Introduction and informed consent for all key informant interviews

We are independent consultants working with the United States Agency for International Development (USAID) to conduct an evaluation of the Strengthening HIV/AIDS Services for Key Populations project in Papua New Guinea. This program is being implemented by FHI 360 and local implementing partners.

The purpose of the evaluation is:

1. To understand how effective FHI 360 and its local implementing partners have been in achieving the goals of the program. This includes examining efficiency and quality and implementation gaps and challenges.
2. To identify the costs and benefits of the program.
3. To identify lessons learned.
4. To make recommendations for a sustainability plan and exit plan for FHI 360 given the current level of funding for clinic staff.
5. Make recommendations for how the program could be improved, including recommendations for the design of any possible follow-on project.

You have the right to decline to answer any question and to end the interview/your participation in the focus group at any time without consequence.

The information we collect from you today will be used by the evaluation team in developing our key findings and conclusions. However, the evaluation report will not name individuals as the source of information. The report will describe the sources of information in more general ways, which will protect your confidentiality. Each member of the evaluation team has signed a confidentiality agreement and will not be disclosing information you have provided to others in a way that would identify you.

Do you have any questions about the purpose of the evaluation or this interview/focus group?

Is it OK to proceed with the interview?

FHI QUESTIONS

General

1. How did you go about selecting the IPs? Did you have any concerns about possible negative attitudes by some of the IPs towards the KPs, and if so, how did you address this? Has this been an issue in implementation?
2. Can you outline FHI's working relationship with NCD PHO? (Probes: Explore challenges. Do you think NCD Health has an understanding of what it takes to sustain HIV and STI programming for KPs?)
3. What is FHI's working relationship with NDOH? Apart from FHI's involvement in TWGs, do you think there is scope for a closer relationship with NDOH? If so, would there be priority areas, and what would you be trying to achieve from a closer relationship?
4. Have you been satisfied with the quality, frequency and range/breadth of technical support from FHI APRO? Any gaps to date or priority areas of TA needed over the remainder of the project?
5. What variations in implementation, if any, occur by site? Why are variations occurring? How have they effected program outcomes?

Prevention programming

Outreach/PEs/SBC

6. Can you describe how the client UIC is used? When was it introduced? Is the UIC just used within FHI and its IPs, or is it a UIC used in other services? Is the UIC used in generating PMP data for indicators that measure the “number of individuals”?
7. Can you describe CommCare? When will it be introduced?
8. Numbers of KPs and HRM/W reached with prevention interventions is well below targets for all years, and the enhanced outreach approach was developed in FY 2014 to address this. The EOA has been modified multiple times and VSO brought in as the IP. Can you take us through, in some detail, (1) what the problems were that led to the development of the EOA and (2) the problems that were encountered with the roll-out of the EOA and how it was modified over time to deal with challenges?
9. At this point in time, do you have sufficient evidence to demonstrate that the current EOA approach is effective? What are the key elements of that evidence?
10. Has the latest version of the EOA resulted in an increased number of referrals made and increased referred clients attending clinics?
11. How do second- and third-wave referrals work under the EOA? Was this approach tested before it was rolled out?
12. Who are the PE outreach workers? Peers? What were the key strengths and weaknesses of the PEs employed by the clinical IPs? How are the current newly recruited (?) PEs different from the previous PEs?
13. What systems do FHI and VSO have in place for assessing the quality of the PEs’ work and addressing any issues? What is your current assessment of the quality of their work? Strengths/weaknesses?
14. How do the quality and effectiveness of the PEs in this project compare to those of the PEs in the previous project (that finished in 2012)? Any lessons to be learned from the previous project? How have these been applied?
15. How do PEs go about identifying and reaching KPs and HRM/W? What are the different ways in which they do this, and how has this changed over the life of the project? What have been the key difficulties in targeting KPs and HRW/M? Innovations? Results? Strengths and weaknesses? Lessons learned?
16. In regard to KPs and HRM/W, are you able to characterize or describe who is being reached by peer educators and who is not being reached? (e.g., sub-populations)? Any data, anecdotal information or hunches?
17. In particular, how do you reach hard-to-reach populations, such as women engaged in transactional sex? What difficulties have been encountered in reaching MSM/TG/MTS?
18. What is the project’s approach to frequency of contact with KPs and HRM/W? Are there any targets for how often you want to reach individual members of these populations through PEs? Do you have data on how frequently individuals have been reached? Range?
19. What has been your approach to dealing with SBCC messaging becoming stale and KP fatigue from over-exposure to PEs and their messages?
20. How many hours a week do peer educators work, and how much of that is devoted to outreach? What reach targets do the PEs have? (Prevention target of 245 client contacts per year is around one per day. Can this be regarded as a high target as is claimed in the FY 2016 Q1 report?)
21. How does your project work with non-USAID IPs conducting outreach to KPs and HRM/W in NCD to avoid overlap and duplication and sharing lessons learned, etc.? What were the problems

with Save regarding overlap of geographic areas? Has this been resolved? Have there been any issues, either positive or negative, relating to collaboration with Global Fund program implementing agencies?

22. Has PREP been considered for high-risk segments of the KPs? Suitability for PNG?
23. From SBC, “Redesign of existing Risk Cards (communications tool) and Risk Message Cards (IEC material); re-targeting of the community discussion flipchart to target KPs as well as the key behaviors and messages under this strategy; appropriate informational materials on sexually transmitted infections; and clinical/GBV service promotion.” Get copies. How were they tested? How were they used?
24. From SBC, “Staff will conduct refresher trainings on key HIV/AIDS/STI information” and “quarterly half-day to one-day trainings on additional key information including alcohol use, HIV and GBV...” How many did they have? Number of people trained?
25. How is the field-based monitoring and mentoring using the standardized QA/QI tool implemented?
26. From SBC, “Peer-to-peer outreach in hot spots and community sites where MARPS meet their sexual partners. Also, group level “edutainment” activities to be conducted on a limited schedule at hot spots.”
 - a. How often where hot spots and community sites assessed to see if there were new venues or areas to visit?
 - b. How were contacts with peer-to-peers documented?
 - c. How many edutainment activities were held?
 - d. How many people participated? Results/outcomes?
 - e. Were activities expanded to the Gold Club at Lamana Hotel?
23. In Madang, how have they implemented the CDC’s Social Networks Testing peer-driven approach to recruit via networks and social and sexual contacts?
24. External Opp: From SBC, “the growing uptake of internet enabled smartphone technology in PNG potentially opens up entire new platforms for reaching hidden MARPS.” How has FHI 360 leveraged this in its programming? What activities were implemented in 2015 and beyond as indicated?
25. FHI 360 states that it is a “victim of its own success” and that many other organizations have started implementing KP-focused activities. What makes FHI 360 better? What is its niche? How is it linking and leveraging those relationships?

Referrals by peer educators

26. Do you have data on the number of clinic referrals made by peer educators and the number of people that attended clinical services following the referral, by type of service? (This is an issue because the number of people attending clinical services is significantly greater than the number of people reached by peer educators. It would be good to know the percentage of clients who accessed services based on a referral by a peer educator, as this is key information in terms of evaluating the success of the EOA.)
27. How effective is the peer educator referral system? If you look at the FY 2014 Q2 data, despite the huge drop-off in outreach for the quarter, there was an increase in STI and HCT patients at the clinics. The same observation can be made in FY 2014 Q4, with reduced number of KPs reached by outreach but increased KP HCT and increased use of other clinical services. This suggests that referrals were not a significant source of clinic attendance. Has this changed?

Mapping and size estimation

28. At what point was hot spot mapping undertaken? Reference to mapping in latest quarterly report. Was there earlier mapping?
29. We understand that KP size estimates will be derived from the IBBS. Is that correct? The work plan for your first year included developing size estimates for KPs. Why was this not done?

Condoms and lube

30. Is lube always distributed with condoms? (Data show more condoms than lube distributed. Why?)
31. Why was condom distribution so far below target in the early years of the project? Why was there such a rapid increase in condom distribution in the last year or so?
32. How has FHI 360 implemented and maintained community-based condom outlets?
33. The quarterly reports say that condom outlets in NCD are likely saturated. Do you have evidence to support this claim?
34. FHI 360 indicated in the SBC Strategy document that it has access to a large and currently under-utilized supply of female condoms. It states: "Specific advantages of the FC should be promoted, and one key message may be that FCs are a choice the woman (or receptive male) can make for themselves, thus giving them the power to control their own health. Further investigation is necessary, but for MSM clients in particular it may be desirable to promote a different name (e.g. "the bottom condom") to avoid the misconception that FC use is somehow contrary to masculinity."
 - a. Did it access the supply?
 - b. Did it change attitudes and norms about FCs?
 - c. What was the distribution and uptake?
 - d. How has messaging about oil-based lube with FC impacted uptake?

Care and treatment

HTC

35. For KPs and HRW/M, what approach do you take in terms of frequency of HIV testing and STI management? Do you have any data on the actual frequency of HIV testing and STI management for these clients?
36. What advice is the project giving to KPs about how frequently they should have an HIV test and STI consultation? How frequently are people actually being tested for HIV?
37. What strategies or approaches have you used to increase HIV testing among KPs? Effectiveness? Lessons learned?
38. Quite high HIV-positive diagnosis rates among LRM and LRW: Is the risk categorization correct or is there some other reason?
39. Low HIV-positive yields from mobile HIV testing: Is mobile testing worth the effort/cost at these levels? Are there viable alternative sites for mobile testing that are likely to return a higher yield?
40. The number of HIV tests is significantly greater compared to number of people reached with prevention interventions, e.g., FY 2015: 1,516 individuals reached with prevention interventions and 4,882 HIV tests. In other countries' KP programs it is the other way around. Why?
41. Do you have data on the number of KPs and HRM/W reached by PEs who have had an HIV test through one the IP clinics?
42. MSM access of HCT and other clinical services is low: Why?

43. Do you have data on the number of people reached by PE in Madang who are having HTC through the Catholic Clinic (relates to low uptake for HTC in Madang)?
44. How has loss to follow-up decreased with the implementation of HCT rapid screening and confirmation protocol at FHI 360-supported sites?

Clinical services

45. Which are your strongest and weakest IPs in terms of clinical service provision? Why? Strengths? Weaknesses? What are you doing to address the weaknesses? Kila Kila clinic appears to be problematic regarding GBV screening and client friendliness. Explore.
46. The client friendliness assessments conducted in 2015 indicated some problems with the Foursquare clinics, particularly Kila Kila. How did you address this? Have there been improvements?
47. How have you responded to the challenge of retention of staff in clinics (identified in quarterly reports as a challenge)?
48. What are the actual operating hours for each of the clinics (the hours they actually see patients)? How many staff show up for work on a typical day? Is this something that is monitored by IP management and FHI? Has this been a problem, and how have you addressed it?
49. For health checkups, how do you track what services were accessed by clients? How do you follow up with people and at what frequency?

TA to clinics

50. Can you give us a reasonably detailed overview of the approach you have taken to developing the capacity of the clinical services? What are the components of your capacity-building approach (e.g., training, types of on-site TA, QA support and supervision you provide to the clinics) and the emphasis you place on each? Is there a set frequency for in-clinic TA activities (e.g., mentoring visits: frequency per clinic by area of mentoring and length; describe how mentoring visits are structured)? What have been the key challenges? What modifications have you made to this during the course of the project? Lessons learned? What are your current key clinical TA priorities?

PLHIV care and treatment

51. For PLHIV both on treatment and not, what is the frequency of clinical monitoring and what assessments/tests are routinely conducted?
52. Why are Kaugere and Ela Beach clinics not providing ART? What do they do for HIV-positive clients at these services: transfer them to another clinic? If Ela Beach is the most comfortable site for KPs to visit for services (why is this?) why is it not providing HIV care and treatment services?
53. Do you have data on the total number of clients who are HIV-positive who are regularly receiving follow-up care (non-ART and ART patients)? (Trying to get at retention of people in clinical care prior to going on ART. For example, the indicator “number of HIV-positive adults and children who received at least one of the following: clinical assessment (WHO staging), CD4 count or viral load during the reporting period” is of limited use unless we know the size of the population group.)
54. Do you have data on the percentage of clients eligible for ART who are on treatment?
55. Do you have data on the HIV cascade for the cohort of clients by clinic?
56. How do you track clients who are lost to follow-up? Why three pre-ART counselling sessions prior to ART initiation? Can you fast-track this for clients who are in need of more rapid initiation of treatment (for example, pregnant women and persons with low CD4 count or based on WHO staging)?

57. Significantly more men on ART than women? Does this reflect HIV testing positive rates by sex or male health-seeking behavior?
58. Kila Kila: The number of new PLHIV enrolled into care and number initiated on ART (especially ART) is less than the number of new HIV diagnoses, whereas for Koki and Id Inad the achievements for these indicators are significantly better. Why is Kila Kila performing worse on a number of indicators? Action taken to address? Results?
59. What strategies/approaches are used to encourage ART uptake and retention? Effectiveness? What are the most significant challenges? Lessons learned?
60. Id Inad: Why is the retention rate for males on ART lower than females? What has been the response and result?
61. What approach have you taken to increasing TB screening of PLHIV?
62. To what extent have the recommendations by Dr. Laurent Ferradini for clinical improvement been addressed?
63. Have you considered revising the PMP ART treatment targets, given that you are well in excess of the targets?
64. Any plans to introduce Frontline SMS service for ART clients in NCD?

Clinical referrals

65. What systems have you established for referrals from one clinic to another clinic? What tracking systems are in place and how do you know if the patient actually goes to the other clinic? What follow-up do you do if the patient does not go to the other clinic? When were these systems introduced?

STIs

66. HIV testing and STI management: PMP data shows that number of people receiving HTC is significantly higher than number of people who received STI management services. Why?
67. FY 2015 Q2: “need to improve uptake of STI services amongst clients accessing HTC services, most clinic teams decided to tweak the service flow within clinics such that clients now go through STI screening/management before accessing HTC services.” Results? Why did this take so long? The issue was apparent from early on in project implementation.
68. Do clinics have capacity for diagnosis of STIs beyond syndromic approach?
69. NDOH review of national STI guidelines in 2015: FHI planned to facilitate a national workshop to review the guidelines. The 2015 midterm review of the National Strategy recommended that NDOH should complement its focus on syndromic management with a more public health approach focused on detecting and managing STIs, especially improved detection and management, an increased focus on screening and case finding of asymptomatic STIs in high-priority locations and populations. What is FHI’s view of this recommendation? Did FHI advocate along these lines? Result?
70. Clinician level of comfort and actual use of speculums for STI management, including anal speculum use for female KPs and HRW?
71. Are your targets for STI management appropriate, considering the high levels of STI prevalence and the need for regular STI management? (Background: HTC annual target 4,500 and STI target 2,000 (in FY 2015).
72. Promotion of health checkups, especially related to STI screening, care and treatment and emphasis on treatment literacy was highlighted (SBC).
 - a. Was there an uptake in services at FHI 360-supported clinical sites?

- b. Their goal is for people to have health checkups every three months, even if they have no symptoms. Checkups include presumptive treatment for bacterial STIs, screening and syndromic management of asymptomatic conditions and HCT. How do they track this? How do they follow up with people who have not been in for an appointment?
- c. Does FHI 360 work with any other partners to minimize the indirect costs of accessing health checkups (like travel)?
- d. The FHI 360 strategy “should be to promote project clinics as entirely free, one-stop shopping which saves clients both money and time.” How has this been marketed and promoted?

Service delivery

- 73. Clinics were supposed to be physically reorganized to ensure adequate privacy. Did this happen? (site level)
- 74. Service providers should all sign confidentiality forms to be kept on file. Did this happen? (site-level)
- 75. Patients who feel their rights or confidentiality have been violated should know who to contact. (site level)
- 76. Peers are supposed to actively query their peers on the quality of services received at FHI 360-supported centers and report back complaints or issues identified. How often do peer educators query people? How do they record their queries? What happens?
- 77. Are monthly meetings held between outreach staff and healthcare providers?
- 78. GBV: Standard operating procedures in place for KPs to ensure that they are screened for GBV and health care staff have been trained to identify signs that a patient is potentially a GBV survivor, counseled and referred.
- 79. GBV: Were quarterly meetings with the Family Support Center stakeholder meeting in NCD held and were Port Moresby General Hospital and Gerehu District Hospitals FSCs included in project trainings?
- 80. GBV: Did clinics maintain one male health provider, training in responding to GBV and providing trauma counseling to work with male GBV survivors?

GBV

- 81. The gender component of the program appears to have undergone significant changes over the life of the program. Can you outline how the program’s gender work has evolved and why?
- 82. Decision to appoint a Gender Officer at FHI 360 in FY 2015: Why?
- 83. What KP-specific GBV activities have been undertaken? E.g., has the project tried to equip KPs (WTS) with skills to deal with threats/how to avoid GBV? (FY 2015 Q2 identified the need for a clear strategy for providing gender and GBV services to KPs. Progress since?)
- 84. Training in FY 2015 Q2 on integrating GBV screening into HIV service delivery points: What have been the key challenges and obstacles to addressing GBV in clinical settings? How can GBV be more effectively addressed in clinic settings? Progress?
- 85. GBV screening is currently conducted at two clinics (check). Are there plans to introduce GBV screening at the other clinics?
- 86. What progress/plans have been made in addressing the findings of the quality assessment of the two GBV shelters? Have GBV products been expanded?
- 87. What happened to the GBV media monitoring and media training work? Quarterly reports stop reporting on this. What is the rationale for this work in a KPs program?

88. Is the GBV media intervention appropriate? Is that the sort of thing a project like this should be doing? Rationale?
89. For FY 2016, why are a number of post-GBV care indicators currently so far off the targets? What is being done to address this?
90. From SBC, “project staff under this strategy will work through the platform of an existing coordination meeting to maintain and strengthen relationships with other Family Support Center services in the catchment areas in order to provide a wider range of referral options to GBV survivors. This activity will include inviting staff of those centers to participate in trainings, and to provide copies of any promotional materials or tools developed under the project for those FSCs.” What happened? Did they do this? How many staff were trained?

PEPFAR pivot

91. Basis on which areas for TA support for NCD clinics was decided? (Why were increasing STI management/treatment and HIV/TB not included, as these seem to be priority areas in PNG?)
92. What progress has been made with involving NCD PHO in your expanded work in NCD?
93. What progress has been made with attribution of results for the TA you are giving to additional clinics in NCD?
94. What progress has been made with roll-out of TA to additional sites in POM? Achievements to date? Challenges and how have you responded?
95. How many clinicians does FHI have on staff in your PNG office? What areas of clinical practice are represented (check numbers for each category)? Does FHI APRO provide clinical TA to your IPs in PNG? If so, which types of clinical TA have been provided and how often? Do you think you have sufficient staff and clinical TA from APRO to cope with the expanded clinical TA workload that will result from the TA support you will be giving to additional clinics in NCD?

M&E

96. What happened regarding alignment between NDOH indicators and PEPFAR MER indicators?
97. How do you set targets across all program activities?
98. What happens to data collected from the quarterly C&T assessment tool? How are targets set for individual facilities and gaps addressed?
99. How do you measure reach of key messaging in communities?
100. How are program indicator summaries and reporting consistently reported and at what intervals to the government?
101. How are trained health care workers tracked? Is this reported as part of national human resource plans/national training plans for health?

IP organizational and financial capacity development

102. What have been the challenges in IP capacity development in this area? What is the current status of the KPMG work?

Civil society

103. What has the program done to build civil society involvement in the HIV response? Key activities? Results? Challenges and responses?

Madang exit

104. When was the decision made to exit Madang and by whom? When was the Madang exit plan developed? When were Madang partners notified? (First planning meeting with Madang partners in November 2015 for March 2016 exit?)

105. What impact on services will Madang withdrawal have? Will PE activities with paid PEs be continued? To what extent will PHO take over funding? What are the priority areas for ongoing TA? Who will provide this?

Sustainability

106. What are the lessons learned regarding sustainability and transition regarding HWW and the previous USAID project? Do you have any recommendations for the future? (HWW was the IP for the previous USAID HIV project.)
107. Is the level of staff in the IP clinics much the same as you would find in comparable clinics run by other FBOs and in government clinics?
108. What does FHI pay for in the clinics, and what is paid for by others—NDOH, PHOs, the FBOs and other sources (including no-cost supply of things like ART drugs)?
109. By the end of the project, where do you expect the IPs to be at in terms of sustainability, both in terms of technical competence, organizational and financial capacity, need for ongoing TA and need for funding support?
110. What has FHI/USAID done in regard to transition planning, possible exit planning and identifying sustainable funding sources for the ongoing operation of services by current IPs? Results? What are the sources of funding? How does the difficulty of engaging with NCD Health affect sustainability planning?
111. Replication: what is FHI doing to encourage replication of the COPCT model and adoption and actual roll out by government and FBOs? In practice, what does COPCT endorsement by NDOH and NACS mean? Where is it being implemented?
112. How have you addressed competition for resources and coverage areas because of all of the interventions and organizations working with KPs? How do you ensure that you are linking with and leveraging those relationships?

Follow-on project

113. What are the key elements you would like to see in a follow-on USAID HIV program in PNG?
Probe:
- a. Any role for ongoing direct support delivery or transition to a TA-only model?
 - b. Working in which geographic areas? (Transition out of NCD? Working in new provinces either instead of NCD or in addition?)
 - c. Programmatic priority areas: same as current or any new areas or changes of emphasis, approach or priority accorded to existing program components?

IMPLEMENTING PARTNER MANAGEMENT (Foursquare Church and Salvation Army)

Clinic services (core questions)

1. What have been your key achievements in this project in regard to the clinical area of work?
2. What difficulties and challenges have you encountered when providing HIV and STI services at your clinics?
 - a. How have you managed those challenges?
 - b. How has FHI 360 assisted you with managing those challenges? (Probe for assistance specific to serving key populations)
3. What have been the key lessons learned in implementation of the clinical component of this project?

4. How satisfied or dissatisfied are you with FHI 360's technical assistance to improve the capacity of your clinics?
 - a. What are the strengths of FHI 360's TA to your clinics? (Effectiveness?)
 - b. What are the weaknesses of FHI 360's TA to your clinics?
 - c. Are there any key gaps in FHI 360's TA to your clinics?
5. What are the actual operating hours for each of your clinics (the hours they actually see patients)? How many staff show up for work on a typical day? Is this something that you monitor? Has this been a problem, and how have you addressed it?
6. How do you make your clinics a place where key populations feel comfortable coming for care?
7. How are GBV services integrated into clinical service delivery (probe for GBV screening?)
8. Do you have a system for addressing patient complaints for services provided at your clinics and safe houses? Please describe the system and how effective you think it is. (Probe: number of complaints received and effective resolution.)
 - a. How has this prevented stock-outs or improved quality assurance if at all?
9. In what ways could you reduce costs in the clinical aspect of this project without having a negative effect on the quality and accessibility of services?

Clinic services (supplementary questions if sufficient time)

10. What systems have you established for referrals from one clinic to another?
 - a. How do you confirm whether that referral made it to the other clinic?
11. Describe your approach to TB and HIV integration. Probe for:
 - a. TB screening protocols for clients
 - b. Standardization of screening questions
 - c. IPT and CPT prophylaxis as per national treatment guidelines
 - d. Tracking referrals from and to TB services for ART assessment and initiation
 - e. Infection control practices
12. Describe how you address loss to follow-up with clients. (Probe for PLHIV.)
13. How does FHI 360 provide technical assistance for supply chain management and labs at your facility?

Gender

14. What have been your key achievements in this project in regard to the gender component?
15. What difficulties and challenges have you encountered with the gender component of the project?
 - a. How have you managed those challenges?
 - b. How has FHI 360 assisted you with managing those challenges? (Probe for assistance specific to serving key populations)
16. What have been the key lessons learned in implementation of the gender component of this project?
17. How satisfied or dissatisfied are you with FHI 360's technical assistance to improve the capacity of your GBV work?
 - a. What are the strengths of FHI 360's TA on GBV? (Effectiveness?)
 - b. What are the weaknesses of FHI 360's TA on GBV?
 - c. Are there any key gaps in FHI 360's TA on GBV?

Prevention programming

18. What have been your key achievements in regard to the peer outreach component of the project?
19. What difficulties and challenges have you encountered with the peer outreach component of the project? Probe for difficulties in implementing the EOA.
 - a. How have you managed those challenges?
 - b. How has FHI 360 assisted you with managing those challenges? (Probe for assistance specific to serving key populations.)
20. What have been the key lessons learned in implementation of the peer outreach component of this project?
21. How satisfied or dissatisfied are you with FHI 360's technical assistance to improve the capacity of your peer outreach work? Probe for EOA
 - a. What are the strengths of FHI 360's TA on peer outreach? (Effectiveness?)
 - b. What are the weaknesses of FHI 360's TA on peer outreach?
 - c. Are there any key gaps in FHI 360's TA on peer outreach?
22. What is your view on FHI 360's decision to transfer the peer education outreach work to VSO? What impact has had this had on your remaining work?

Working with key populations

23. How do you involve key populations into your program activities?
24. Working with key populations can be in conflict with organizational and personal value systems. Has it been challenging for your organization as a faith-based organization and/or staff in clinics or in management to implement a program for key populations?
 - a. How have you addressed those challenges?
25. What barriers if any do key populations have in accessing care in your clinics?
 - a. How are you addressing those barriers?

Monitoring and evaluation

26. Describe the technical assistance and support for monitoring and reporting that FHI 360 has offered your organization, including your clinics.
 - a. What has been most beneficial?
 - b. What additional technical assistance is needed?
27. Describe the technical assistance that FHI 360 has provided on roll-out, scale-up and use of national data management systems at your facility. Probe for:
 - a. National HIV Patient Database
 - b. National UIC System
 - c. National Surveillance Forms
28. How are your clinic's data reported to NCD Health/Madang PHO and/or NDOH?
29. How do you use clinic data to adjust programming?

Financial and organizational capacity

30. What is the current status of the KPMG work?
31. How satisfied or dissatisfied are you with FHI 360's management of this project and its technical assistance to improve your organizational and financial capacity?
 - a. What are the strengths of FHI 360's management and its TA to improve your organizational and financial capacity?

- b. What are the weaknesses of FHI 360's management and its TA to improve your organizational and financial capacity?
- c. Are there any key gaps in FHI 360's TA to improve your organizational and financial capacity?

Sustainability

32. What does FHI pay for in your organization and clinics and what is paid for by others? What costs are paid by others?
33. By the end of the project, do you think your organizational and financial capacity will have developed sufficiently to effectively manage the program if there was no more support in this area from FHI 360? What would be the priority areas for any ongoing TA?
34. By the end of the project, do you think the capacity of your clinics and safe houses will have developed sufficiently to continue to effectively provide services if there was no more technical assistance in this area from FHI 360? What would be the priority areas for any ongoing TA?
35. Can you tell us about any discussions you have had with FHI 360 about what will happen at the end of the program (e.g., continuing to be an implementing agency for FHI 360 in any follow-on project or the possibility of not receiving any additional funding and TA from USAID/FHI)?
 - a. What planning has taken place for what might happen then?
 - b. What would be the consequences on service delivery if there was no more funding from FHI 360, and how would you respond (e.g., look for other funding, reduce services, etc.)?
36. USAID has asked us to make recommendations on the key elements of the design of a follow-on HIV project that it may fund after the current project ends. Based on your experience of managing the clinical components of the program and any lessons learned, do you have recommendations on any changes you would like to see in a follow-on program? (Priority populations, geographic scope, priority interventions, etc.)?

MADANG PHO

1. Can you tell us how FHI 360 has been working with your PHO? How satisfied are you with FHI's work in Madang?
 - a. Can you outline the work of the HIV Coordinator in the PHO (funded by FHI 360)?
 - b. What challenges do you face in providing HIV and STI services in Madang Province? How has FHI 360 helped you address these challenges?
 - c. What are FHI 360's key strengths and weaknesses?
 - d. What ways can FHI 360 improve how it works with your PHO?
2. What are the key achievements of the USAID program here in Madang since late 2012?
 - a. What are the key strengths and weaknesses of the USAID program?
 - i. How could the strengths be built upon and the weaknesses addressed?
 - b. Are there any key programmatic gaps in the USAID program that need to be addressed?
4. When was the PHO informed of the decision for USAID to exit from Madang? Was this sufficient notice?
 - a. Can you tell us how your PHO has been preparing for the exit of USAID support from Madang? Has FHI 360 assisted in planning for the exit?
 - b. What is the current status of USAID's exit from Madang? (Check for type of services that may the PHO may not be able to fund.)
 - c. What impact on services will USAID's exit from Madang have?

5. After USAID funding for Madang ceases, would you like your HIV and STI services to continue to receive technical assistance from FHI?
6. Are there plans for a Provincial Health Authority to be established in Madang? When? What technical support (not necessarily disease-specific) would be helpful in establishing a PHA in Madang?

The evaluation team has been asked to make recommendations to USAID to inform the design of a possible follow-on project, after the existing project ends, focusing on sustainability and eventual Government of PNG ownership. We would like to ask you some questions about that focusing on how USAID could best support the PNG Government in HIV and STI programming.

7. In your opinion, what are the priority areas of programming that are needed for PNG to meet the 90-90-90 targets?
 - a. What types of interventions are needed?
 - b. What are the priority populations that programming should target?
 - c. What changes would you like to see in the new program?
8. What areas of the health system are most in need of strengthening to improve the response to HIV, TB and STIs in PNG?

CLINICAL SERVICE PROVIDERS: FOURSQUARE, SALVATION ARMY AND ID INAD CLINIC

All providers

1. What are the key achievements your clinic has made in providing care to KPs?
2. What difficulties and challenges have you encountered when providing HIV and STI services to KPs at this clinic?
 - a. How have you managed those challenges?
 - b. How has FHI 360 assisted you with managing those challenges?
3. What training has been provided to you by FHI 360?
 - a. What is your level of satisfaction with the training?
 - b. How confident do you feel in putting into practice here in the clinic what you learn at training?
 - c. What additional training or other capacity building support would you like?
4. What mentoring and supportive supervision does FHI 360 provide to you?
 - a. What is your level of satisfaction with FHI 360's mentoring and supportive supervision? (Probe for quality and frequency.)
 - b. What are the strengths and weaknesses of FHI 360's mentoring and supportive supervision?
 - c. How has FHI 360's mentoring and supportive supervision affected quality of service delivery at your clinic?
 - d. Are there any gaps in FHI 360's mentoring and supportive supervision to your clinic?
5. How has FHI 360's support to your clinic improved the quality and availability of care and treatment services you are providing?
6. How do you make your key population clients feel comfortable coming to for care (Probe for specifics related to MSM, WTS, TG, and others)?
7. How does your clinic meet the needs of KPs?
8. What are barriers that key populations have in accessing care at this facility?

9. Working with key populations can be in conflict with organizational and personal value systems. Has it been challenging for your organization, as a faith-based organization, and/or staff in clinics or in management to implement a program for key populations?
 - a. How have you addressed those challenges?
10. What strategies do you use for improving retention in care and adherence for PLHIV (Probe for case managers, trained PLHIV, IEC materials)?
 - a. How do you track PLHIV clients who are lost to follow-up at your clinic?
11. In your job, how many clients can you reasonably see in one day?
12. What has the benefit of the peer educators been to your facility?
13. What FHI 360 communication materials do you regularly use in your work (Probe for Risk Cards, Risk Message Cards, community discussion flipchart, and other informational key behaviors and messages materials)?
14. What FHI 360 tools and IEC materials do you use to support adherence to treatment?
 - a. What is your level of satisfaction with the IEC materials you have for working with key populations?
 - b. What additional IEC materials would benefit your clinic?
15. How do you integrate GBV services into service delivery (Probe for GBV screening, HIV, STI and TB services)?
 - a. What has worked well?
 - b. What challenges have you had integrating GBV into clinical services?
 - c. What technical assistance is still needed to effectively integrate GBV into clinic service delivery?
16. Describe the technical assistance and support for monitoring and reporting that FHI 360 has offered you. Probe for:
 - a. Mentoring support to clinicians (type, duration, frequency)
 - b. Monthly data verification and data quality assessment on reported data
 - c. Monthly data reviews
17. What technical assistance for monitoring and evaluation has been most helpful to you?
18. What existing challenges do you have with monitoring and reporting program activities?
 - a. How could FHI 360 assist with those challenges?
19. USAID has asked us to make recommendations on the key elements of the design of a follow-on HIV project that it may fund after the current project ends. Based on your experience of managing the clinical components of the program and any lessons learned, do you have recommendations on any changes you would like to see in a follow-on program (priority populations, geographic scope, priority interventions, etc.)?

STI service providers

1. Tell me a little about what your job is at this clinic.
2. What is the package of services you offer for health checkups to key populations at this facility? (Probe for comprehensive HIV services like VCT, ART, prevention of parent-to-child transmission, TB, STI prevention and treatment, condoms, etc.)
 - a. How do you feel that this service delivery model meets needs of key populations in your community?
 - b. What are the gaps in service provision?
 - c. Are STI services provided each day?

3. How effective do you think STI syndromic management is for the community you work with?
4. For STI services offered:
 - a. Do STI clients get physical examinations?
 - b. What is your comfort level using speculums for both anal and vaginal examinations among most men and women?
 - i. How often are you using speculums as part of routine physical examinations?
 - c. What diagnostic STI tests do you offer patients?
5. How are HIV services integrated into STI care?
6. How are your STI services integrated into other care? (Probe for specifics related to HIV and TB services.)
7. Describe your TB and HIV integration activities. (Probe for infection control practices, INH provision, screening for TB for all PLHIV at every visit.)
8. How do you use the decision tree for identifying people who are at highest risk for HIV? (Probe for frequency.)
9. (If interviewing Kaugere or Ela Beach):
 - a. Where do persons testing HIV-positive primarily go for HIV care and treatment?
 - b. How are clients who are referred for ART services followed to ensure they turn up at the clinic to which they are referred?
 - c. Are there any plans to start ART service provision at this site? GBV service provision?
10. (If interviewing Kila Kila, and Id Inad):
 - a. Please describe what happens when a patient tests HIV-positive. How does that patient get enrolled in HIV care and treatment? What steps occur in the clinic for this patient? Describe the steps in service delivery for HIV testing through treatment, including monitoring, at your clinic.
 - a. What strategies do you implement for improving adherence and retention in care for PLHIV? (Probe for case managers, trained PLHIV, IEC materials.)
 - b. Describe your system for tracking defaulters and missing patients.
 - c. How many patients are lost to follow-up at your clinic from testing HIV-positive to care and treatment? (Probe for pre-ART and ART differences.)
 - d. How do you track loss to follow-up at each point?
11. (If interviewing Koki):
 - a. Please describe what happens when a patient tests HIV-positive. How does that patient get enrolled in HIV care and treatment? What steps occur in the clinic for this patient? Describe the steps in service delivery for HIV testing through treatment, including monitoring, at your clinic.
 - b. What strategies do you implement for improving adherence and retention in care for PLHIV? (Probe for case managers, trained PLHIV, IEC materials.)
 - c. Describe your system for tracking defaulters and missing patients.
 - d. How many patients are lost to follow-up at your clinic from testing HIV-positive to care and treatment? (Probe for pre-ART and ART differences.)
 - e. How do you track loss to follow-up at each point?
 - f. How are you preparing for roll-out of POC viral load testing? How will the addition of viral load monitoring change clinical service delivery at your facility?
12. What are the greatest accomplishments you have achieved in your role as STI nurse?

13. What are the biggest challenges you have in your role as STI nurse?

VCT service providers

1. Tell me a little about what your job is at this clinic. On average, how long does it take to provide pre-test counselling? Post-test counseling?
2. If a patient comes for VCT do you refer them to the STI nurse?
 - a. If a patient tests HIV-positive, do you refer them for TB screening? To what extent do patients accept these referrals? What difficulties do you face in making referrals?
3. How do you use the decision tree to identify those at highest risk for HIV? (Probe for frequency.)
4. What happens when someone tests positive for HIV? How does that patient get enrolled in HIV care and treatment? What steps occur in the clinic for this patient? Describe the steps in service delivery for HIV testing through treatment, including monitoring, at your clinic.
5. What are the messages/counseling given to newly diagnosed HIV-positive clients? (Probe for partner tracing, testing and treatment messaging, risk reduction, etc.)
6. What HIV quality assurance measures do you use for finger prick testing?
7. Describe the mobile HTC activities.
 - a. With what frequency are they offered?
 - b. How do you decide where to go?
 - c. How do you advertise those events?
 - d. How many clients will you see during one day of mobile HTC?
 - e. How do you integrate HIV prevention with general health services?
 - f. What screenings do you do as part of the mobile HTC?
8. What has worked well for mobile HTC?
 - a. What are the greatest challenges in implementing mobile HTC?
 - b. How could mobile HTC be restructured to reach more people, particularly key populations?
9. How will the new finger pricking procedures affect your role as VCT counselor?
10. What are the greatest accomplishments you have achieved in your role as VCT counselor?
11. What are the biggest challenges you have in your role as VCT counselor?

ART providers

1. Tell me a little about what your job is at this clinic.
2. What is the package of services you offer to key populations at this clinic? (Probe for comprehensive HIV services like VCT, ART, prevention of parent-to-child transmission, TB, STI prevention and treatment, condoms, etc.)
 - a. How do you feel that this service delivery model meets needs of key populations in your community?
 - b. What are the gaps in service provision?
 - c. Are all services provided each day, for example, in clinics providing ART, is it offered daily?
3. How are HIV services integrated into STI care?
4. How are your STI services integrated into other care? (Probe for specifics related HIV and TB services.)
5. Describe your TB and HIV integration activities. (Probe for infection control practices, INH provision, screening for TB for all PLHIV at every visit.)

6. What happens when someone tests positive for HIV? How does that patient get enrolled in HIV care and treatment? What steps occur in the clinic for this patient? Describe the steps in service delivery for HIV testing through treatment, including monitoring, at your clinic.
7. What types of counseling do you do? (Probe for ART and adherence, frequency.)
 - a. In what instances do you fast-track ART adherence?
8. What strategies do you implement for improving adherence and retention in care for PLHIV? (Probe for case managers, trained PLHIV, IEC materials)
9. How do you monitor adherence at your clinic?
10. How do you monitor for treatment failure?
11. Describe your system for tracking defaulters and missing patients.
12. How many patients are lost to follow-up at your clinic from testing HIV-positive to care and treatment? (Probe for pre-ART and ART differences.)
 - g. How do you track loss to follow-up at each point?
13. If at Koki clinic, how are you preparing for roll-out of POC viral load testing?
 - a. How will the addition of viral load monitoring change clinical service delivery at your facility?
14. How do you work with the case manager?
15. What are the greatest accomplishments you have achieved in your role as ART provider?
16. What are the biggest challenges you have in your role as ART provider?

Case managers

1. Tell me a little about what your job is at this clinic.
2. How do you work with the ART prescriber?
3. What are challenges your key population clients encounter in accessing services at your clinic?
4. What types of counseling do you do? (Probe for ART and adherence, frequency.)
5. What strategies do you implement for improving adherence and retention in care for PLHIV at your clinic?
6. What are the greatest accomplishments you have achieved in your role as case manager?
7. What are the biggest challenges you have in your role as case manager?

VSO MANAGEMENT

1. Please give us an overview of how VSO goes about its work in the FHI 360 program in both Madang and NCD. Please cover the management and operational structure in your office and how you go about supervising PEs?
2. What are the key achievements of VSO in Madang and NCD?
3. The Enhanced Outreach Approach has been through a number of changes over the last couple of years, with the aim of increasing the number of KPs and HRM/W reached and increasing referrals to clinics.
 - a. How successfully is the EOA being implemented by VSO, particularly in NCD?
 - b. To what extent has VSO been able to successfully overcome the problems being previously encountered with the EOA when it was being implemented in NCD by SA and FSC (lack of commitment by some PEs; limited contact time by PEs with peers; poor supervision by field support officers; distortions in the priorities for PEs created by the incentive structure)?
4. What do you do to prevent PEs from gaming the incentive system through referring people who are not from KPs or high-risk groups or referring people whom they know to be HIV-positive? To what extent has this been a problem?

5. Has the transfer of the PE outreach program to VSO created any problems in your relationship with the SA and FSC clinics or between the PEs and these clinics?
6. How do you recruit PEs?
 - a. What are the key attributes you are looking for in PEs?
 - b. How many of your PEs are from each of the following groups: MSM/TG/MTS, WTS, HRM/W?
 - c. What are your levels of turnover for PEs?
 - d. How do you determine the number of PEs you need?
7. Training of PEs: Who does this and what is the length or training?
 - a. Can you outline the key elements of the training?
 - b. How adequately does the training equip PEs to do their job?
 - c. Is there refresher training?
 - d. How do you provide ongoing supervision and mentoring to increase the skills of the PEs?
8. What are the most difficult things peer educators face in their job? How does VSO help them address these challenges and difficulties?
9. What are the key strengths of your PEs? What are their weaknesses or areas where their work needs to be strengthened?
10. How do you go about ensuring and checking on the quality of work done by PEs? If you think there are problems with the quality of work by a particular peer educator, how do you address this?
11. How do PEs go about identifying and reaching KPs and HRM/W? What are the different ways in which they do this?
 - a. What have been the key difficulties in targeting KPs and HRW/M?
 - b. Innovations? Results? Lessons learned?
12. In regard to KPs and HRM/W, are you able to characterize or describe who is being reached by peer educators and who isn't being reached (e.g., sub-populations)? Any data or anecdotal information?
13. In particular, how do you reach hard-to-reach populations, such as women engaged in transactional sex? What difficulties have been encountered in reaching MSM/TG/MTS?
14. Do peer educators have targets on the number of people they need to reach? What are those targets?
 - a. Are the targets broken down by different populations (e.g., MSM, WTS, etc.) or just a total target? What is current level of performance against the targets?
15. What is the project's approach to frequency of contact with KPs and HRM/W?
 - a. Are there any targets on how often you want to reach individual members of these populations through PEs?
 - b. Do you have data on how frequently individuals have been reached? Range?
16. How many hours a week do peer educators work, and how much of that is devoted to outreach?
17. In Madang, how have you implemented the CDC's Social Networks Testing peer-driven approach to recruit via networks and social and sexual contacts?
18. Are there clearly defined boundaries for the work of VSO peer educators and the work of PEs working for other programs that are targeting the same populations?
 - a. Are these boundaries respected by VSO PEs and by the PEs working for other programs?
 - b. When problems of overlap or duplication occur, how do you address this?

- c. Are there areas where more duplication is suspected? Which ones? How are you addressing this?
- 19. What technical support does FHI 360 provide to VSO? Who at FHI 360 provides this?
 - a. Are you satisfied with the quality and frequency of the technical support you receive from FHI 360?
 - b. What are the strengths and weaknesses of this support? Are there any areas for improvement?
- 20. How satisfied (or dissatisfied) are you with FHI 360's management of the subcontract with VSO? Are there any areas for improvement?
- 21. Can you outline how the PEs go about addressing GBV, particularly for the KPs? How effective is this work? What are the key challenges?
- 22. Are the PEs educating KP clients on ways in which they might go about minimizing the risk of violence, e.g., FSWs on how to handle potentially violent clients?
- 23. What have been the key lessons learned by VSO in the course of implementing the PE outreach program?
- 24. Describe the technical assistance and support for monitoring and reporting that FHI 360 has offered your facility. Probe for:
 - a. Mentoring support to outreach workers (type, duration, frequency)
 - b. Monthly data verification and data quality assessment on reported data
 - c. Monthly data reviews
 - d. Quarterly program performance review meetings
- 25. What FHI 360 technical assistance for monitoring and evaluation has been most helpful to VSO?
- 26. What existing challenges do you have with monitoring and reporting program activities?
 - a. How could FHI 360 assist with those challenges?
- 27. We understand that the FHI 360 contract with VSO in Madang has ended and that VSO has become a sub-recipient under the Global Fund grant to continue the peer educator outreach work in Madang. Is that correct?
 - a. Is the level of funding from the Global Fund for your Madang work the same as it was under FHI 360?
 - b. Is your scope of work for the Global Fund grant the same as it was under the FHI 360 contract or broader or narrower?
 - c. Will FHI 360 or any other organization be providing management and technical support to VSO in Madang? Do you think you need this type of support?
- 28. Sustainability: By the end of the project, do you think VSO will have a need for ongoing technical and management support to help you run the peer outreach program, or will you have reached a level where you no longer need this?
- 29. If USAID/FHI 360 was no longer funding VSO for peer outreach work at the end of the project, what alternative sources of funding might be available?
 - a. Have you explored alternative funding sources, and if so, what is your assessment? Has there been any discussion on this with FHI 360 or USAID?
- 30. Does government in PNG (either national or provincial levels) provide grants to PNG NGOs or CBOs or to international NGOs to undertake community-level work similar to the work being undertaken by VSO peer educators? Are there established government systems for the allocation and management of grants to civil society?

31. USAID has asked us to make recommendations on the key elements of the design of a follow-on project that it may fund after the current project ends. Based on your experience of managing the PE outreach component of the program and any lessons learned, do you have recommendations on how a PE outreach program in a follow-on program should be designed?

VSO PEER EDUCATORS FOCUS GROUP DISCUSSION

1. How long have you been a peer educator?
2. Are you a member of one of the key populations?
3. Can you tell us what you do as a peer educator? (Probe for additional things if the outline appears to have missed key things.)
4. What are the key messages you are giving to people? (Probe for types of messages, target population fatigue at over exposure to PEs or the same messages.)
5. How do the messages you give clients change over time? Do you give the same prevention and clinical messages when you see people for a second and third time (for reinforcement), or are you giving new messages?
6. What do you most like about being a peer educator?
7. What do you most dislike about being a peer educator?
8. What has been most difficult for you in your job as a peer educator?
9. How do you go about finding key population members? (How do you find new people?) What strategies have been most effective in finding key population members?
10. Which key population members are most difficult to find? (Probe for difficulties in finding MSM/MTS or other categories of KPs or segments of KPs.)
11. Who do you usually see during your outreach? Are they the same people or are you also seeing new people? In an average week how many new contacts would you make?
12. At what time do you start and finish your outreach activities? What are the best hours for finding KP members?
13. How willing are KP members to go to clinics? What challenges have you faced in getting KPs to go to a clinic? What strategies have worked well to get KPs to go to clinics? What type of services do your clients most want from clinics? (Probe for differences between HIV and STI services.)
14. What are some reasons that your clients do not want to go to clinics? Are some of your clients more reluctant to go than others? What strategies do you use to encourage them to go?
15. Where else can people get condoms and lube apart from PEs?
16. How effective was the training that you received before you started working as a PE in preparing you for your job? Did you feel confident with knowledge and skills to undertake the job? How satisfied are you with the training? Were there any gaps in the training?
17. How does VSO support you to do your job as a PE? (Probe: If you are having problems, does anyone support you, and in what ways? What types of support have been provided to help overcome problems? How helpful has this support been?)
18. What additional training or support do you receive (e.g., mentoring) to develop your skills as a PE since your initial training? In what areas? How satisfied were you with the additional training or other support? What other support would be beneficial in your role as PE?
19. Were you a PE working for the Salvation Army or Foursquare Church? How does VSO's management and support of PEs compare with Salvation Army and Foursquare Church?
20. Are there any changes that could be made to improve the peer education outreach program/EOA that you would recommend?

FAMILY SEXUAL VIOLENCE AND ACTION COMMITTEE

1. Please give us an overview of what FSVAC does as part of the FHI 360 program.
2. What have been the key achievements of FSVAC?
3. What difficulties or challenges have you encountered in providing services and programming?
4. How does FSVAC coordinate activities related to GBV?
 - a. What have been the successes in FSVAC's coordination activities?
 - b. What challenges have you experienced coordinating GBV?
 - c. What strategies could improve coordination?
5. How do FSVAC and FHI 360 partner with the Child Fund? How satisfied are you with that collaboration? Are there ways that this collaboration could be improved?
6. What are the goals of the GBV hotline?
7. What have been the lessons learned in implementation of FSVAC's work as it relates to this program?
8. What training has FHI 360 provided to your organization?
 - a. Can you tell us about the level of satisfaction you have with FHI 360's training provided to your organization? (Probe for quality, including practical components, and frequency.)
 - b. What are the strengths and weaknesses of FHI 360's training?
 - c. What, if any, areas of additional training or refresher training do staff need?
9. Describe how FHI 360 provides onsite mentoring and supportive supervision for your organization.
 - a. What is your level of satisfaction with mentoring support?
 - b. What additional mentoring support would you like for your staff?
 - c. What other technical assistance does FHI 360 provide to FSVAC? (Probe for levels of satisfaction)
 - d. What additional technical assistance is needed?

Key populations

10. How does the GBV hotline include programming for key populations?
11. How do you involve key populations in your program activities?
12. What constraints or difficulties does your organization experience that limit your ability to implement successful program activities for key populations in the community?
 - a. How have you managed those challenges?
 - b. How has FHI 360 assisted you with managing those challenges?
13. For an HIV program targeting key populations, what types of services and interventions do you think would be most effective to effectively respond to GBV?
 - a. Are there specific interventions that have been more effective at addressing GBV, particularly for key populations? What are they? How has their success been measured?

Monitoring and evaluation

14. Describe the technical assistance and support for monitoring and reporting that FHI 360 has offered your facility.
 - a. What technical assistance has been most helpful to FSVAC?
15. What existing challenges do you have with monitoring and reporting program activities?

Financial and organizational capacity

16. What is the current status of the KPMG work?
17. How satisfied or dissatisfied are you with FHI 360's management of this project and its technical assistance to improve your organizational and financial capacity?
 - a. What are the strengths of FHI 360's management and its TA to improve your organizational and financial capacity?
 - b. What are the weaknesses of FHI 360's management and its TA to improve your organizational and financial capacity?
 - c. Are there any key gaps in FHI 360's TA to improve your organizational and financial capacity?
18. How satisfied (or dissatisfied) are you with FHI 360's management of the subcontract with FSVAC? Are there any areas for improvement?

Sustainability

19. By the end of the project, do you think FSVAC will have a need for ongoing technical and management support to help you run the GBV programming, or will you have reached a level where you no longer need this?
20. If USAID/FHI 360 was no longer funding FSVAC for GBV programming, what alternative sources of funding might be available?
21. Can you tell us about any discussions you have had with FHI 360 about what will happen at the end of the program (e.g., continuing to be an implementing agency for FHI 360 in any follow-on project, or the possibility of not receiving any additional funding and TA from USAID/FHI 360)?
 - a. What planning has taken place for what might happen then?
22. USAID has asked us to make recommendations on the key elements of the design of a follow-on project that it may fund after the current project ends. Based on your experience of managing the coordination of the GBV components of the program and any lessons learned, do you have recommendations on how a GBV program in a follow-on program should be designed?

GBV SAFE HOUSE STAFF

1. Can you please give us an overview of the services you provide to women coming to your shelter?
 - a. What types of counseling do women receive while at the shelter?
2. What have been your shelter's key accomplishments in providing services to women who come here?
3. What constraints or difficulties does your shelter experience that limit your ability to implement successful program activities for key populations in your community?
 - a. How have you managed those challenges?
 - b. How has FHI 360 assisted you with managing those challenges?
4. How are women referred to your shelter?
 - a. What number of women come to your shelter because of referrals from health facilities each month?
 - b. What are the other sources of referral? (PEs?)
5. What is your system of referral for women to clinics or other community resources?
 - a. Are there any problems with making referrals (e.g., a limited number of available services to refer to)?
6. What are the eligibility requirements for women to use shelter services?

- a. Are transgendered women able to access services here?
 - b. Are women eligible for readmission to the shelter if they accessed services before?
7. What trainings has FHI 360 provided to you and your staff? (Probe for sensitization to working with key populations.)
 - a. How satisfied (or dissatisfied) are you with the training provided by FHI 360?
 - b. What, if any, areas of additional training or refresher training do staff at this shelter need?
8. Describe how FHI 360 provides onsite mentoring and supportive supervision to you and your staff. (Probe for mentoring support on the use of standard operating procedures for shelter services and safety planning, child protection and support).
 - a. What is your level of satisfaction with mentoring support?
 - b. How frequently does FHI 360 visit?
 - c. What additional mentoring support would you like for you or your staff?
9. How have the new standard operating procedures rolled out by FHI 360 changed the way you operate?
10. What materials have been provided to you from FHI 360 for use in your work? (Probe for social and behavioral change communication.)
11. How do you record information about women accessing services here? Probe for:
 - a. Number of women access services here each month
 - b. Of the women accessing services here each month, how many are women engaged in transactional sex?
 - i. How many are women at high risk for HIV (high-risk women)?
 - ii. How many would be general population women?
 - c. How has FHI 360 provided technical assistance in monitoring and reporting?
12. How does this shelter meet the needs of women engaged in transactional sex, high-risk women or transgendered women?
 - a. How do you make your women engaged in transactional sex or high-risk women feel comfortable coming here for services?
 - b. What other technical assistance could FHI 360 offer your shelter to better meet the needs of women engaged in transactional sex, high-risk women or transgendered women in your community?
 - c. How do you involve women engaged in transactional sex, high-risk women or transgendered women in program activities, if at all?
13. How long do women typically stay here?
14. What follow-up services do you do for women once they leave the shelter? Probe for:
 - a. Phone or in-person follow-up and frequency
 - b. Referrals to support groups or other community services
15. USAID has asked us to make recommendations on the key elements of the design of a follow-on HIV project that it may fund after the current project ends. Based on your experience of managing the shelter and any lessons learned, do you have recommendations on any changes you would like to see in a follow-on program? (Priority populations, geographic scope, priority interventions, etc.)

GBV SAFE HOUSE BENEFICIARIES

1. Describe how you were you referred to this shelter? (Probe for clinic or walk-in.)
2. Tell me about the services you know this shelter provides.

3. What services have you received while you have been at this shelter? (Probe for safety planning, support groups, basic needs and support, child protection and support, counseling, etc.)
 - a. Of the services you have received, which have been most helpful to you at this shelter?
 - b. If you have children with you, what services have your children received while here?
 - i. What has been most beneficial?
4. What types of counseling have you received from staff? (Probe for trauma counseling, family reunification, etc.)
 - a. How helpful has the counseling been for you?
5. Has the shelter referred you to any other services? Which ones? (Probe for clinic and community services.)
6. How have you been treated by staff while you have been at this shelter? (Probe for courteous, respectful, poorly, looked down upon, etc.)
7. How knowledgeable is shelter staff about different services and community resources to help people in your situation?
 - a. Was staff able to clearly present this information to you?
8. Overall, how effective have shelter staff and services been at meeting your needs?
9. What additional services do you think this shelter should offer women?
10. What have you heard from other people in the community about this shelter?
11. If a friend told you she was thinking of coming here for help, what would you recommend to your friend?
12. How many days or weeks have you been at this shelter?
13. Have you ever been to this shelter before? (Yes/No) If yes, how many days did you stay?
14. How long do you plan to stay at this shelter?

HOPE WORLDWIDE

1. Who is currently funding the HIV, STI and other areas of clinical work in your clinics (including any government funding)?
2. Over the last 3-4 years and currently, what types of HIV and STI technical assistance has been provided to Lawes Rd. and 9 Mile clinics from external sources? Who has been providing this TA?
3. By the end of the previous USAID HIV project in PNG, which ended in 2012, to what extent was there a need for ongoing HIV and STI technical assistance at Lawes Rd. and 9 Mile clinics and in which areas?
4. We understand that HWW declined to be an implementing agency for FHI 360 under the current USAID project. Can you please tell us why that decision was taken?
5. Prior to the end of the previous USAID project, was there any exit or transition planning conducted by FHI and/or HWW to prepare for no longer being in receipt of USAID funding and FHI 360 TA?
 - a. If so, what were the key components of this planning?
 - b. Was the plan effectively developed and implemented?
6. Can you outline the transition arrangements that were put in place by FHI 360 to assist the HWW clinics in the first year of the current USAID HIV project (2012-2013)?
 - a. How effective was this assistance in transitioning the HWW clinics from USAID funding and technical support?

7. What are the key lessons learned in terms of effective exit/transition planning and for sustainability from HWWs transition out of USAID funding and FHI 360 TA?

We want to ask you some questions about the technical assistance that HWW-managed clinics (Lawes Rd. and 9 Mile) will be receiving from FHI 360 between now and the end of the current USAID project in October 2017.

8. Can you tell us about your level of satisfaction with the assessment of the technical assistance needs of your clinics that was carried out by FHI 360? To what extent did it correctly identify the priority HIV and STI priority needs as you see them?
9. What added value do you anticipate the FHI 360 TA will bring to your clinics? How well will the FHI 360 TA complement existing TA from non-FHI 360 sources? (Probe for duplication.)
10. How will FHI 360 coordinate with other organizations providing TA to your clinics?
11. We understand that FHI has commenced training for staff in your clinics, but technical assistance at the clinic level (e.g., mentoring) is yet to commence. How satisfied are you with the training provided by FHI 360? Strengths/weaknesses?
12. What discussions have you have had with FHI 360 on the monitoring systems that will be used to measure the effectiveness of FHI 360 TA to your clinics?
 - a. To what extent will you be able to integrate monitoring of the outputs and outcomes of FHI 360 TA within your existing M&E systems, or will they be on top of or in parallel to your existing systems?
 - b. Will it be possible to distinguish between outputs and outcomes that flow from FHI 360's TA and outputs and outcomes that flow from inputs from others (i.e., attribution of results)?
13. If you have sufficient knowledge of the current USAID HIV project being implemented by FHI 360 to make an assessment, what do you think are the projects key achievements, strengths and weaknesses?
14. In your opinion, what are the priority areas of programming that are needed for PNG to meet the 90-90-90 targets?
 - a. What types of interventions are needed?
 - b. What are the priority populations that programming should target?
 - c. What are the priority geographic areas?
15. For an HIV program targeting key populations, what types of services and interventions do you think would be most effective to effectively respond to GBV?
 - a. Are there specific interventions that have been more effective at addressing GBV, particularly for key populations? What are they? How has their success been measured?
16. What are the key constraints when working with key populations in PNG? PLHIV?
 - a. What are some effective strategies that your program or others have used to mitigate those challenges?
17. What areas of the health system are most in need of strengthening to improve the response to HIV, TB and STIs in PNG?
18. How can collaboration be improved across the different organizations working on HIV in PNG?
19. How could implementing partners and donor organizations better support the PNG Government in its HIV, STI and TB response with the aim of strengthening sustainability?

NDOH

- I. Can you tell us how FHI 360 works with NDOH? How satisfied with FHI 360's work in PNG are you?

- a. What are FHI 360's key strengths and weaknesses?
 - b. How satisfied are you with FHI 360's contributions to TWGs? What have been its major contributions? How could FHI 360 improve its contributions to TWGs?
 - c. Can you tell up about the extent of NDOH's involvement with the USAID Strengthening HIV/AIDS Services for Key Populations in PNG Project in NCD and Madang? (Check for consultation with NDOH on Pivot in NCD.)
 - d. What ways can FHI 360 improve how it works with NDOH and PHOs?
2. What are the key achievements of the USAID program?
 - a. What are the key strengths and weaknesses of the USAID program?
 - i. How could the strengths be built upon and the weaknesses addressed?
 - b. Are there any key programmatic gaps in the USAID program that need to be addressed?
 3. To what extent are the health services that are being provided through FHI 360-supported clinics in NCD and Madang fully aligned with NDOH policies and guidelines?
 4. What is the future of NACS? What implications does this have for leadership and coordination of the HIV response in PNG and NDOH's role?
 5. Can you tell us about what mechanisms exist for the Government of PNG to coordinate donors' HIV work at the national level and in NCD and provincial levels, particularly for the health sector?
 - a. How effectively are those mechanisms working?
 - b. Are there ways that coordination of donor work needs to be strengthened? How would this best be done?
 6. Currently none of the FHI 360-supported clinics in NCD have medical practitioners on staff, giving rise to the need for medical support from doctors based at national hospitals. We understand that some of the clinics have had difficulty in access to national hospital doctors with HIV expertise. Is there a system in place for doctors with HIV expertise in national hospitals to support clinics providing HIV services?
 7. What are the goals for task shifting and/or decentralization for HIV care and treatment in PNG with the scale up of Treat All?
 8. The evaluation team has been asked to make recommendations to USAID to inform the design of a possible follow-on project, after the existing project ends, focusing on sustainability and eventual Government of PNG ownership. We would like to ask you some questions about that, focusing on how USAID could best support the PNG Government in HIV and STI programming.
 9. Can you tell us about any discussions between NDOH and USAID or FHI on plans for a follow-on project?
 - a. Have these discussions involved whether USAID is likely to continue funding of direct service delivery and plans for provision of TA?
 - b. Is the level of staffing for the FHI 360-supported clinics sustainable by government?
 10. How should implementing partners and international donors be working with government on transition planning and sustainability?
 11. In your opinion, what are the priority areas of programming that are needed for PNG to meet the 90-90-90 targets?
 - a. What types of interventions are needed?
 - b. What are the priority populations that programming should target?
 - c. What are the priority geographic areas?
 12. What areas of the health system are most in need of strengthening to improve the response to HIV, TB and STIs in PNG?

13. Is there any current or planned work by NDOH or donors to support strengthening the institutional, organizational and technical capacity of Provincial Health Authorities or PHOs in order for them to play their role of supporting clinics and hospitals in the areas of supportive supervision, programmatic technical assistance and accountability? Is this seen as a priority area by NDOH?

NATIONAL AIDS COUNCIL SECRETARIAT

1. Can you tell us how FHI 360 works with NACS and your level of satisfaction with FHI 360's work in PNG?
 - a. What are FHI 360's key strengths and weaknesses?
 - b. How satisfied are you with FHI 360's contributions to TWGs? What have been its major contributions?
 - c. Can you tell us about the extent of NACS involvement with the USAID Strengthening HIV/AIDS Services for Key Populations in PNG Project in NCD and Madang?
 - d. Are there any ways in which FHI 360 could improve how it works with NACS?
2. What are the key achievements of the USAID program?
 - a. What are the key strengths and weaknesses of the USAID program?
 - i. How could the strengths be built upon and the weaknesses addressed?
 - b. Are there any key programmatic gaps in the USAID program that need to be addressed?
 - c. How could USAID better support NACS in HIV/AIDS programming?
3. To what extent are the prevention work of FHI 360 and the health services that are being provided through FHI 360-supported clinics in NCD and Madang fully aligned with the PNG National HIV and AIDS Strategy and NACS policies?
4. What is the future of NACS? What implications does this have for leadership and coordination of the HIV response in PNG? Does this have implications for NDOH's role?
5. Can you tell us about what mechanisms exist for the Government of PNG to coordinate donors' HIV work at the national level and in NCD and provincial levels?
 - a. How effectively are those mechanisms working?
 - b. Are there ways that coordination of donor work needs to be strengthened? How would this best be done?
6. The evaluation team has been asked to make recommendations to USAID to inform the design of a possible follow-on project, after the existing project ends, focusing on sustainability and eventual Government of PNG ownership. We would like to ask you some questions about that, focusing on how USAID could best support the PNG Government in HIV and STI programming.
7. Can you tell us about any discussions between NACS and USAID or FHI 360 on plans for a follow-on project?
 - a. Have these discussions involved whether USAID is likely to continue funding of direct service delivery and plans for provision of TA?
 - b. Is the level of staffing for the FHI 360-supported clinics sustainable by government?
 - c. How could prevention programming supported by FHI 360 be supported by others in future?
8. In your opinion, what are the priority areas of programming that are needed for PNG to meet the 90-90-90 targets?
 - a. What types of interventions are needed?
 - b. What are the priority populations that programming should target?

- c. What are the priority geographic areas?
9. What areas of the health system are most in need of strengthening to improve the response to HIV, TB and STIs in PNG?

NCD HEALTH

1. Can you tell us about the work of NCD Health in HIV in relation to curative and public health? (Probe the resourcing and capacity to provide leadership, TA and supervision.)
 - a. What challenges do you face in providing HIV and STI services in NCD? How has FHI360 helped you address these challenges?
2. Are there plans for a Provincial Health Authority to be established in NCD? When? What technical support (not necessarily disease-specific) would be helpful in establishing a PHA in NCD?
3. Can you tell us how FHI 360 has been working with your NCD Health since late 2012? How satisfied are you with FHI 360's work in NCD?
 - a. What are FHI 360's key strengths and weaknesses?
 - b. What ways can FHI 360 improve how it works with NCD Health?
4. FHI 360 has recently started to provide TA to a number of additional clinics in NCD. What discussions were held between FHI 360 and NCD Health prior to this work commencing? Does NCD Health have any ongoing involvement in this area?
 - a. To what extent are the areas where FHI 360 is providing TA in NCD in accord with your priorities?
5. What are the key achievements of the USAID program in NCD since late 2012?
 - a. What are the key strengths and weaknesses of the USAID program?
 - i. How could the strengths be built upon and the weaknesses addressed?
 - b. Are there any key programmatic gaps in the USAID program that need to be addressed?
6. Can you tell us about any discussions between NCD Health and USAID and/or FHI 360 on planning for the end of the current USAID project?
 - a. Have these discussions involved whether USAID will continue funding of direct service delivery through VSO for peer education and the FSC and SA for clinical services?
 - b. If USAID stops funding direct service delivery in NCD in September 2018, would NCD Health be able to take over funding of all clinical positions (FSC and SA) currently paid for by FHI 360? Is the level of staffing for the FHI 360-supported clinics sustainable by government?
 - c. Would NCD Health be able to take over funding of KP Peer Educators and Field Support Officers and manage this component of the work?
 - d. Has there been any detailed planning to deal with USAID's possible withdrawal of funding of service delivery in NCD?
7. After USAID funding for clinics in NCD ceases, would you like your HIV and STI services to continue to receive technical assistance from FHI 360?
8. The evaluation team has been asked to make recommendations to USAID to inform the design of a possible follow-on project, after the existing project ends, focusing on sustainability and eventual government of PNG ownership. We would like to ask you some questions about that, focusing on how USAID could best support the PNG Government in HIV and STI programming.
9. In your opinion, what are the priority areas of programming that are needed for PNG to meet the 90-90-90 targets?
 - a. What types of interventions are needed?

- b. What are the priority populations that programming should target?
 - c. What changes would you like to see in the new program?
10. What areas of the health system are most in need of strengthening to improve the response to HIV, TB and STIs in PNG?

KEY POPULATION CBOs: Friends Frangipani, Kapul Champions and Igat Hope

1. Can you tell us what the key activities of your organization are?
2. Can you tell me about any consultation by FHI 360 or USAID with your organization to find out how to best meet the HIV and STI needs of key populations and PLHIV? What has been the subject matter about which you have been consulted? Frequency?
3. Can you tell me about any joint work between your organization and FHI 360? How satisfied are you with any work or collaboration with FHI 360?
4. In what other ways could FHI 360 or its implementing partners could work with or collaborate with your organization?
5. What do you think of the HIV IEC and behavior change materials developed by FHI 360? Was your organization consulted by FHI 360 in the development and testing of these materials, and if so, how?
6. What is your assessment of the quality and effectiveness of the outreach work undertaken by the Peer Educators who work for FHI 360's implementing agencies (FSC, SA and VSO)?
7. How readily available are condoms and lubricant in Port Moresby and Madang? What do KPs think of the quality of the condoms distributed FHI (flavored/scented)?
8. The FHI 360 project provides services through four clinics in Port Moresby: Ela Beach, Koki, Kaugere and Kila Kila. Can you tell us what you think about the quality of the services for key populations and PLHIV at these clinics? What is your assessment based on—e.g., your own experience or what you hear from others?
9. Are there any differences in the quality of services provided by these clinics?
10. Are some of the clinics more popular with KPs and PLHIV? Which ones and why?
11. To what extent do these clinics provide friendly and non-judgmental services to KPs and PLHIV? The clinics are run by the Salvation Army and the Foursquare Church. Do you think that some KPs and PLHIV might be reluctant to go to these clinics because they are run by churches?
12. Are there any ways in which the clinics could improve the services they are providing?
13. How do the four clinics that are a part of the FHI 360 project compare to other HIV and STI clinics in Port Moresby? (Same/worse/better? In what ways?)
14. The number of men, including MSM, using the clinics is a lot less than the number of women using the clinics. Do you have any insights why this is the case? What could be done to fix this problem?

EXTERNAL STAKEHOLDERS

CDC, WHO, UNAIDS, PNG Sexual Health Society, Global Fund PR, Global Fund CCM, Catholic Health, Anglicare, DFAT, Abt/JTA

1. We would like to ask you about the extent of your involvement with the USAID Strengthening HIV/AIDS Services for KPs in PNG Project being implemented by FHI 360 and its implementing partners.
 - a. In what ways has USAID or FHI 360 consulted with or worked with your organization, specifically in relation to the USAID HIV program or more broadly?

2. How effective are the mechanisms for collaboration between different partners (government, NGOs/CBOs, international development partners) working in the HIV response in PNG? How could they be improved? (Probe for donor coordination.)
 - a. In relation to the USAID HIV program and how it might relate or intersect with the work of your organization, how satisfied are you with USAID's and/or FHI 360's level of collaboration with your organization? Are there areas for improvement?
3. What are the key achievements of the USAID program?
 - a. What are the key strengths and weaknesses of the USAID program?
 - i. How could the strengths be built upon and the weaknesses addressed?
 - b. Are there any key programmatic gaps in the USAID program that need to be addressed?
4. In your opinion, what are the priority areas of programming that are needed for PNG to meet the 90-90-90 targets?
 - a. What types of interventions are needed?
 - b. What are the priority populations that programming should target?
 - c. What are the priority geographic areas?
5. For an HIV program targeting key populations, what types of services and interventions do you think would be most effective to effectively respond to GBV?
 - a. Are there specific interventions that have been more effective at addressing GBV, particularly for key populations? What are they? How has their success been measured?
6. What are the key constraints when working with key populations in PNG? PLHIV? *(Optional depending on time)*
 - a. What are some effective strategies that your program or others have used to mitigate those challenges?
7. What areas of the health system are most in need of strengthening to improve the response to HIV, TB and STIs in PNG?
8. How could implementing partners and donor organizations better support the PNG Government in its HIV, STI and TB response with the aim of strengthening sustainability?
9. Does government in PNG (either national or provincial levels) provide grants to PNG NGOs or CBOs or to international NGOs to undertake community-level work such as outreach? *(Optional depending on time)*
 - a. Are there established government systems for the allocation and management of grants to civil society?

Global Fund PR (Oil Search)

1. We understand that the FHI 360 contract with VSO in Madang has ended and that VSO has become a sub-recipient under the Global Fund grant to continue the peer educator outreach work in Madang.
 - a. How has FHI 360 worked with the Global Fund to transition the peer education outreach program in Madang?
 - i. What worked well?
 - ii. What are any lessons learned in relation to donor exit or transition planning from the Madang peer education project?
2. Global Fund is working on reducing the prevalence of TB and the number of TB deaths. How is HIV integrated into TB activities? What are the interventions that Global Fund is using to do this? What has been most effective? What are your lessons learned?

3. What are Global Fund's health system strengthening initiatives?
 - a. What is the role of the Community Health Worker?

CCM

1. We understand that FHI 360 is a member of the CCM, representing international NGOs. What contributions has FHI 360 made to the CCM? How effective has it been in representing its constituency on the CCM?

CDC

1. How does CDC's work intersect and complement with USAID's in PNG?
2. What are CDC planned contributions to achieving 90-90-90 in PNG?
3. Does CDC have any new programming planned that directly relates to key populations and/or HIV in PNG?
4. Are there ways that USAID's current programming could more directly integrate with CDC's HIV surveillance activities, specifically related to key populations?
5. How could a follow-on project for key populations funded by USAID complement the work that CDC is doing in PNG?
 - a. What interventions should it include?
 - b. What are the essential strategies to ensuring sustainability in programs funded by the U.S. Government?
6. How effective is the collaboration with USAID/Philippines and USAID/Pacific Island's staff working? What could be improved?
7. What is the expansion plan for NCD? Is USAID/FHI 360 partnering with CDC? What has been the progress? Results? Effectiveness regarding clearly delineated roles and responsibilities?

UNAIDS

1. What are UNAIDS' planned contributions to achieving 90-90-90 in PNG?
2. Does UNAIDS have any existing or planned activities or programming that directly relate to key populations in PNG?
3. How could a follow-on project for key populations funded by USAID complement the work that UNAIDS is doing in PNG?
 - a. What interventions should it include?

WHO

1. What are WHO's planned contribution to achieving 90-90-90 in PNG?
2. Does WHO have any existing or planned activities or programming that directly relate to key populations in PNG?
3. WHO is working with CDC on the key populations management information system and case-based surveillance. Are there plans to involve USAID or FHI 360's current project in that effort?
4. The WHO recently released the updated consolidated guidelines for HIV testing, care and treatment, hepatitis, working with key populations, and strategic information. Will PNG be implementing any of the revised guidelines? How will WHO support NDOH with any of the changes?
4. How could a follow-on project for key populations funded by USAID complement the work that WHO is doing in PNG?
 - a. What interventions should it include?

PNG Sexual Health Society

1. How effective do you think STI syndromic management is in PNG?
2. What other STI diagnostic approaches would be beneficial in PNG for asymptomatic STIs?
3. What are the capacity building needs for health care workers in PNG related to sexual health? What about sexual health training needs for HCWs in relation to key populations?
4. FHI was to provide support in 2015 to NDOH and PNG Sexual Health Society to conduct a three-day refresher training for ART prescribers. What support did FHI 360 give? Was this beneficial?
5. How could a follow-on project for key populations funded by USAID complement the work that PNG Sexual Health is doing in PNG?
 - a. What interventions should it include?

Anglicare

1. How does FHI 360 provide technical support in the implementation of KP prevention activities?
2. How does FHI 360's work intersect and complement with Anglicare?
3. In your experience, what have been most successful activities for implementing community-based interventions to reduce stigma and discrimination among the families of KPs? (Probe for key achievements.)
4. What has worked well for Anglicare in terms of integrating GBV services into VCT?
5. How is Anglicare preparing for the roll-out of viral load testing?
6. How could a follow-on project for key populations funded by USAID complement the work that Anglicare is doing in PNG?
 - a. What interventions should it include?

Catholic Hope

1. Why did the St. Joseph's clinic decide they did not want FHI 360's technical assistance as part of the pivot in POM?
2. How could a follow-on project for key populations funded by USAID complement the work that CHASI is doing in PNG?
 - a. What interventions should it include?

CHILD FUND

1. What are the goals of the GBV hotline?
2. How does the GBV hotline include programming for key populations?
3. Can you tell me about any joint work between your organization and FHI 360? How does that partnership include the Family and Sexual Violence Action Committee? How satisfied are you with that collaboration? Are there ways that this collaboration could be improved?
4. In what ways has FHI 360 contributed to GBV hotline? Probe for:
 - a. Economic/funding
 - b. Counseling protocols that are used by counselors staffing the hotline
 - c. Training
5. What referrals does the GBV hotline make for callers? (Probe for clinics.)
6. How many callers use the GBV hotline each week or month?

7. What data, if any, is collected from the caller? (Probe for classification of key population, gender, etc.)

DFAT

1. USAID's decision to expand the scope of its work in NCD by providing TA to additional clinics: How does this impact on DFAT's program? What collaboration has there been between DFAT and USAID/FHI 360 on this? Satisfaction with the process and strategic direction and how it is being implemented?
2. DFAT is funding Save the Children to work with KPs in NCD. How do you work with USAID and FHI 360 and its IPs to ensure there is collaboration (e.g., sharing of lessons learned, etc.) and to avoid duplication? Has this worked effectively? (Issue of overlap in PE work between Save and FHI 360)

INTRODUCTION AND INFORMED CONSENT FOR FOCUS GROUP DISCUSSIONS

We are independent consultants working with the United States Agency for International Development (USAID) to conduct an evaluation of the Strengthening HIV/AIDS Services for Key Populations project in Papua New Guinea. This program is being implemented by FHI 360 and local implementing partners. [Give the name of the local implementing partner(s) if the participants are affiliated/clients of the partner.]

The purpose of the evaluation is to understand how effective FHI 360 and its partners have been in achieving the goals of the program, learn more about the program's strengths, identify ways in which the program can be improved, and whether there are gaps in the program that can be addressed.

You are being asked to take part in this evaluation because you have used program services or are part of the target group for the program. If you agree to participate, I would like to ask you some questions about your experience in the program, including what you liked about it, what you disliked, whether it has helped you, and what is missing from the program overall.

We will have one to two people who will take notes during our discussion, but no names or identifying information will be recorded. The notes will not be shared with anyone outside the evaluation team. When we write the evaluation report, no one will be able to identify who said what or know who participated in the discussion. All members of the evaluation team have signed secrecy agreements. They will not be telling anyone else what you said in a way that would identify you.

The discussion should take between one and two hours. Participation in this meeting is voluntary and includes only people who choose to take part. You can decide to stop participation at any time or decide to not to answer some questions with no adverse consequence.

We ask all of you to keep everything we talk about today private and not to reveal what anyone else said to other people.

Do you have any questions about this evaluation or our meeting? Is it OK to proceed with the meeting?

FOCUS GROUP DISCUSSIONS WITH MSM, TG, MTS, WTS and PLHIV

Prevention programming

To start, we are going ask you some questions about HIV-related information and messages in your community.

1. Tell me about your experience with the FHI 360 KPs project outreach teams.
 - a. Where did you meet them?

- b. How often do the project's peer educators see you?
 - c. What do they do? What services do they provide?
2. What messages do you hear from the FHI 360 KPs project peer educators/outreach staff about HIV and STI prevention and treatment? (Probe against the following checklist)
 - a. Condom use, condom negotiation skills, requesting condom use with sexual partners
 - b. Using condoms for both anal and vaginal sex
 - c. Use of female condoms
 - d. HIV treatment
 - e. STI treatment
 - f. Family planning
 - g. Fewer partners
 - h. Other messages?
 3. Is this information or are these messages changing people's risky sexual behavior? (Probe for why they think that: e.g., evidence of increased condom use, more people going to clinics for HIV testing and/or STIs, etc.)
 4. How do you or people in your community feel about the HIV prevention messages you hear from the FHI 360 KPs project peer educators?
 - a. Probe for message fatigue (hearing the same message too often?)
 - b. Do you think the peer educators are doing a good job? How could they improve?
 - c. Are the peer educators seeing you too frequently, not frequently enough or about the right number of times?
 5. In the past three years, have you ever met peer educators or other outreach staff from other projects? (i.e., not from the FHI 360 KP project)
 - a. Did you meet these other peer educators in the same places that the FHI 360 KPs project peer educators go, or a different place?
 6. How could HIV prevention messages provided by the FHI 360 KPs project Peer Educators to you and your community be improved?
 - a. Ways to increase condom use?
 - b. Ways to encourage more people to go clinics?
 - c. Ways to make the messages suitable for PNG cultural practices and beliefs?
 7. Do you ever get given condoms and lube by peer educators from the FHI 360 KPs project?
 - a. How many and how often?
 - b. What types? (female/male)
 - c. Did the peer educators demonstrate how to use condoms?
 8. Do the peer educators always have condoms and lube or do they run out sometimes?
 9. What do you think about the quality of the condoms that the peer educators give you?
 10. Can you tell me about condom use in this community?
 - a. How do people decide about using condoms? Is it for different types of partners?

Care and treatment services

(Get people to name the clinic or clinics they are talking about in their answers to the following questions.)

11. Have you ever been to one of these clinics?

- a. Which clinics have you been to, and how many times or how often do you go to the clinic? (e.g., once every three months, etc.)
 - a. What type of services have you received from these clinics? (Probe for HIV counseling and testing, STI checkup, HIV treatment and care including antiretroviral treatment, HIV, opportunistic infections, TB screening and treatment, family planning services, maternity services and EMTCT, malaria treatment).
12. When you first went to one of these clinics, were you referred by one of the Peer Educators, or did you go to the clinic on your own initiative without a referral?
- a. If you went on their own initiative, how did you know about the clinic?
 - b. Who told you?
 - c. Why did you go to the clinic?
13. Do you know other people in your community like yourself who might benefit from the health services at these clinics but who do not go to clinics?
- a. Why is it that they don't go to clinics?
 - b. Are there any barriers or problems that stop them going?
14. Thinking about your care you have received at one of the four clinics (Kaugere, Ela Beach, Kila Kila or Koki), how often do the clinic staff offer you:
- a. An HIV test?
 - b. Screening for sexually transmitted infections?
 - c. Screening for tuberculosis?
 - d. Family planning options?
 - e. Other services? (Get them to specify which clinic they are talking about in their answer.)
15. What difficulties or challenges exist for persons on antiretroviral therapy for HIV?
- a. How do the clinics address these difficulties or challenges? Is this helpful?
 - b. How else could people taking HIV treatment for HIV be supported?
16. How satisfied or dissatisfied are you with the health services you receive from these clinics?
- a. What do you like most about these clinics?
 - b. What do you like least about these clinics?
 - c. In what ways could the clinics improve their services?
 - d. What hours is the clinic open?
 - e. Do these hours suit you? Why or why not?
17. These clinics are run by the Salvation Army and the Foursquare Church. How do you feel about receiving health services from these churches?
- a. Have you experienced any stigma or discrimination accessing care at this clinic? Tell me about it.
 - b. What is the attitude towards you at the clinic? (Probe: friendly, looked down on, judgmental/non-judgmental.)
 - c. How do staff at these clinics treat different types of people? (MSM, TG, MTS, WTS, PLHIV, HRM/W)? Are they friendly to everyone or not?
18. In the last few years have you ever been to another clinic for HIV and/or STI services (other than the four clinics we are talking about)?
- a. What was the clinic and what type of service did you get (e.g., HIV test, STI checkup, etc.)

- b. How did the quality and friendliness of services at the other clinic compare to the services at the FHI 360-supported clinics?
19. Do people living with HIV have a role in providing services or being engaged in other activities at any of the four clinics? How? (e.g., patient support, etc.)

GBV services

20. What messages exist in your community related to GBV?
- a. Where do you hear them?
 - b. Did you hear any messages on GBV from the FHI 360 KPs project peer educators? If so, what were the messages?
 - c. What do people think about those messages?
21. What programs do you think are needed to help change attitudes and cultural norms related to GBV?
22. What messages and health education materials do you receive at any of the four clinics related to GBV?
- a. Probe for posters, other health materials
23. Thinking about your care here at any one of the four clinics, have the staff asked about violence against you by a partner or partners?
- a. How did you feel about being asked about this?
 - b. What services are available at the clinic for person who experienced violence by a partner or partners?
 - c. Did the clinic staff refer you to another service?

PLHIV questions

1. What type of follow-up do peer educators offer for HIV services?
2. What are the challenges you have with staying in care?
3. If you accessed HIV services at Kila Kila, Koki, or Id Inad clinics, how was the quality of care?
- a. Were you treated with dignity?
 - b. When did they tell you to return for follow-up?
 - c. Did they screen you for TB?
 - d. Did they screen you for STIs?
 - e. Did they talk to you about family planning?
 - f. What other services did they offer?
4. How could they improve the quality of care that they offer you?
5. How do you know when you need to return for care?
6. What other services would be beneficial to you?

ANNEX 4: STAKEHOLDERS INTERVIEWED

This annex lists the names, positions and organizational affiliations of stakeholders who participated in individual and small group interviews conducted as part of the evaluation.

The evaluation also conducted a number of FGDs with project beneficiaries. As participation in these FGD did not require participants to disclose their names (in the interest of confidentiality), names of FGD participants are not listed. A list of FGDs held is provided in Section I of this report.

Name and position	Organization
USAID Regional Pacific Islands Office and U.S. CDC PNG	
Joan Atkinson, PNG Health Advisor	USAID Regional Pacific Islands Office
Julie Hulama, Development Assistance Specialist	USAID Regional Pacific Islands Office
Jorge Velasco, Short-term Advisor	USAID Regional Pacific Islands Office
Steven Terrell-Perica, Country Director	CDC
Abel Yamba, SI Advisor	CDC
Percy Pokeya, HIV Advisor	CDC
Kevin Soli, Lab Advisor	CDC
Shane Araga, M&E Specialist	CDC
FHI 360 management and staff	
Daniel Tesfaye, Country Director	FHI 360 PNG
Ignatius Mogaba, Deputy Country Director	FHI 360 PNG
Miriam Dogimab, Project Director	FHI 360 PNG
Roselyn Nopa, Gender Officer	FHI 360 PNG
Nancy Aboga, Program Officer	FHI 360 PNG
Margie Norbertus, Associate Director	FHI 360 PNG
Vanessa Kapus, Senior Program Officer	FHI 360 PNG
Francil Kaemala, Program Officer	FHI 360 PNG
Elizabeth Tama, Program Officer	FHI 360 PNG
Bolalava Vaia, SBC Officer	FHI 360 PNG
Matilna Gendua, Capacity Building Officer	FHI 360 PNG
William Yeka, M&E and Research Officer	FHI 360 PNG
Emelyn Valaun, M&E Officer	FHI 360 PNG
Andrew Tabel, Senior Project Officer	FHI 360 PNG Madang Office
Samuel Nombo, Finance and Administration Officer	FHI 360 PNG Madang Office
Tony Angu, Driver	FHI 360 PNG Madang Office
FHI 360 implementing partners: Port Moresby	
Dawn Hoyle, Country Director	VSO
Waqas Sheikh, Health Program Manager	VSO
Peter Kambka, Field Coordinator	VSO
Daera Lahui, Field Support Officer	VSO
Paul Vandy, Field Support Officer	VSO
Alois Koloku, Field Support Officer	VSO
Geoffrey Orone, Acting Program Manager (VSO volunteer)	VSO
Peer educators for NCD (11 people)	VSO

Name and position	Organization
Rodney Tomuseri, Senior Pastor and Health Director	Foursquare Church management
Josephine Mamis, Project Manager	Foursquare Church management
Norah Mugga, M&E Officer	Foursquare Church management
Loretta, STI Nurse	Foursquare Church/Kaugere clinic
Pastor Mary, Program Manager	Foursquare Church Meri Seif Place (GBV Safe House)/Kaugere
Rose Marai, VCT Counselor	Foursquare Church/Kaugere clinic
Clinic Team Lead	Foursquare Church/Kila Kila clinic
Rose, ART Prescriber	Foursquare Church/Kila Kila clinic
Linda Wilson, STI Nurse	Foursquare Church/Kila Kila clinic
Case managers	Foursquare Church/Kila Kila clinic
Augustin Mayu, VCT Counselor	Foursquare Church/Kila Kila clinic
Rita Moumta, VCT Counselor	Foursquare Church/Kila Kila clinic
Vinoria Safihao, Receptionist	Foursquare Church/Kila Kila clinic
Kelvin Alley, Chief Secretary	Salvation Army management
Kevin, Program Secretary	Salvation Army management
David Embia, Project Coordinator/M&E Lead	Salvation Army management
James Mauwe, VCT Counselor	Salvation Army/Ela Beach clinic
Elizabeth Gelamp, VCT Counselor	Salvation Army/Ela Beach clinic
Male and female STI nurses	Salvation Army/Ela Beach clinic
Major Ridia Nenewa, Program Manager	Salvation Army House of Hope (GBV Safe House)/Ela Beach
Guanah Kih, Coordinator	Salvation Army House of Hope (GBV Safe House)/Ela Beach
Sarah, Team Lead/STI Nurse	Salvation Army/Koki clinic
Walter Sawarita, ART Prescriber	Salvation Army/Koki clinic
Peter, Laboratory Technician	Salvation Army/Koki clinic
Daniel Kinina, Case Manager	Salvation Army/Koki clinic
Paul Barker, Director	Institute of National Affairs
Emmanuel Peni, Corporate Manager	Institute of National Affairs
Ume Wainetti, Program Manager	FSVAC
Isi Oru, Senior Project Officer	FSVAC
Nester Horiva, FHI Project Administrative and Finance Officer/Manager	FSVAC
Cathy, Senior Finance Officer	FSVAC
<i>FHI 360 implementing partners: Madang</i>	
Christine Gawi, Hospital CEO	Modilon General Hospital
Sister Daing, ART Prescriber/Clinic Lead/STI Nurse	Id Inad clinic
Susan Kima, Medical Officer	Id Inad clinic
Nimrod Barn and Case Management Team	Id Inad Clinic
Goyo Bal, STI Nurse	Id Inad Clinic
Jennifer Rengo, STI CHW	Id Inad Clinic
Herman Ban, STI CHW	Id Inad Clinic
Darusila Diphen, Nurse	Id Inad Clinic

Name and position	Organization
VCT counselors	Id Inad Clinic
Peer educators (9 people)	VSO
Nola Quininga, Sister in Charge/Nurse Specialist	Family Support Center, Modilon General Hospital
Robin Borausk, Social Worker	Family Support Center, Modilon General Hospital
Government of PNG–national level	
Nick Dala, Program Manager, HIV/AIDS and STI	National Department of Health
Penial Boas, Program Manager, HIV/AIDS and STI	National Department of Health
Peter Bire, Director	National AIDS Council Secretariat
Valentine Kambori, KP Coordinator	National AIDS Council Secretariat
Tony Lupiwa, Research Manager	National AIDS Council Secretariat
National Capital District Provincial Health Office	
Nick Wuatai, Director, Public Health	NCD Health
Manasseh Kelly, HIV/AIDS Program Officer	NCD Health
Jerry Tanumei, Director, Curative Health	NCD Health
Madang Provincial Health Office	
Marcus Kachau, Director	Madang PHO
Arthur Walgung, Deputy Director, Technical Health Programs	Madang PHO
Paul Mabong, Deputy Director, Policy and Administration	Madang PHO
Boku Wanai, District Control Officer	Madang PHO
Darryl Raka, Project Coordinator and HIV Technical Officer	Madang PHO (USAID-funded position)
PNG Global Fund Program	
Martin Timothy, Manager	Global Fund Country Coordinating Mechanism
Kevin Miles, Head of Grants	Oil Search (Global Fund grant Principal Recipient)
George Raubi, Key Populations Capacity Development Officer	Oil Search (Global Fund grant Principal Recipient)
Stephan Stojanovik, Senior Fund Manager, South and East Asia Team	Global Fund
Bianca Auping-Kamps, Senior Manager, Portfolio Management Development	Global Fund
PNG non-governmental and faith-based organizations	
Tarcisia Hunoff, Director	CHASI
Justine McMahon, Program Manager	CHASI
John Millan	PNG Sexual Health Society
Rose Kunjip, Project Coordinator	Igat Hope
Alfred Mark, Program Manager	Igat Hope
Heni Meki, National Director	Anglicare
Manish Joshi, Country Director	Child Fund
Avdelfe Salvadora, Program Manager	Child Fund
Cathy Ketepa, Manager	Friends Frangipani
Joan Timothy, Country Director	Hope World Wide
Mactil Bais, Program Manager	Kapul Champions
Nick Evera, Senior Project Officer	Kapul Champions

Name and position	Organization
<i>International development partners</i>	
Meredith Tutumang, Senior Program Manager (Health and HIV)	DFAT
Anna Naemon, Program Manager (Health and HIV)	DFAT
Jyotie Mehrha, HIV Prevention Advisor	Abt JTA (implementation support the DFAT Health and HIV project)
Anup Gurung, Team Leader HIV, STI and Hepatitis	WHO
Shinsuke Miyano, Technical Officer for HIV Care and Treatment	WHO
Margaret Herman, HIV Qual Coordinator	WHO
Nola N'Drewei, EQAS Lab Services	WHO
Stuart Watson, Country Representative	UNAIDS
Malhoob Rahman, SI Advisor	UNAIDS

ANNEX 5: DATA TABLES AND FIGURES

This annex contains additional data that have been cross-referenced to this annex in the main body of the report.

RESULTS VS. TARGETS FOR PEPFAR INDICATORS

Table 3: Project results against targets for PEPFAR indicators, FY 2013–mid-FY 2016

Indicator	Indicator code	FY 2013		FY 2014		FY 2015		FY 2016*		
		Met (%)	Not met (%)	Met (%)	Not met (%)	Met (%)	Not met (%)	Met (%)	On target (%)	Not on target (%)
Number of individuals who received HIV testing and counseling services for HIV and received their test results	HTC TST-DSD	X 599%		X 200%		X 110%		X 107%		
	HTC_TST: TA-SDI	-	-	X 175%		X 103%				X 32%
Number of HIV-positive adults and children newly enrolled in clinical care during the reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	CARE_NEW: DSD	-	-	X**	-	X 122%			X 72%	
	CARE_NEW: TA-SDI	-	-	-	-	-	-			No data
Number of adults and children newly enrolled on ART	TX_NEW: DSD		X 50%	X 493%		X 157%			X 97%	
	TX_NEW: TA-SDI	-	-	-	-	-	-			No data
Percentage of key populations reached with individual-and/or small group-level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	KP_PREV: DSD		X 52%		X 45%		X 40%			X 32%
Percentage of individuals from priority populations who completed a standardized HIV prevention intervention, including the specified minimum components, during the reporting period	PP_PREV: DSD	X 122%			X 66%		X 38%			X 13%
Number of HIV-positive adults and children who received at least one of the following during the reporting period:	CARE_CUR: DSD	-	-	X**	-	X 180%		X 107%		

Indicator	Indicator code	FY 2013		FY 2014		FY 2015		FY 2016*		
		Met (%)	Not met (%)	Met (%)	Not met (%)	Met (%)	Not met (%)	Met (%)	On target (%)	Not on target (%)
clinical assessment (WHO staging) OR CD4 count OR viral load	CARE_CURR: TA-SDI	-	-	-	-	-	-			No data
Number of HIV-positive adults and children receiving care and support services outside the health facility	CARE_CO M: DSD	-	-	-	-	-	-			No data
Number of adults and children currently receiving ART	TX_CURR: DSD	X 141%		X 115%		X 128%			X 99%	
	TX_CURR: TA-SDI	-	-	-	-	-	-			No data
Percentage of PLHIV in clinical care who were screened for TB symptoms at the last clinic visit	TB_SCREEN :DSD	X 130%			X 79%		X 98%	X 121%		
	TB_SCREEN : TA-SDI	-	-	-	-	-	-			No data
Percentage of ART patients with a viral load result documented in the medical records within the past 12 months	TX_VIRAL: DSD	-	-	-	-	-	-			No data
	TX_VIRAL: TA-SDI	-	-	-	-	-	-			No data
Proportion of viral load tests with an undetectable viral load (<1000 copies/ml)	TX_UNDETECT: DSD	-	-	-	-	-	-			No data
	TX_UNDETECT: TA-SDI	-	-	-	-	-	-			No data
Percentage of adults and children known to be alive and on treatment 12 months after initiation of ART	TX_RET: DSD	-	-	X 115%			X 87%			No data
	TX_RET: TA-SDI	-	-	-	-	-	-		X	No data
Number of people completing an intervention pertaining to gender norms that meets minimum criteria	GEND_NO RM: DSD	-	-	-	-		X 56%	X 167%		
Number of people receiving post-GBV care	GEND_GB V	-	-	-	-		X 3%			X 6%

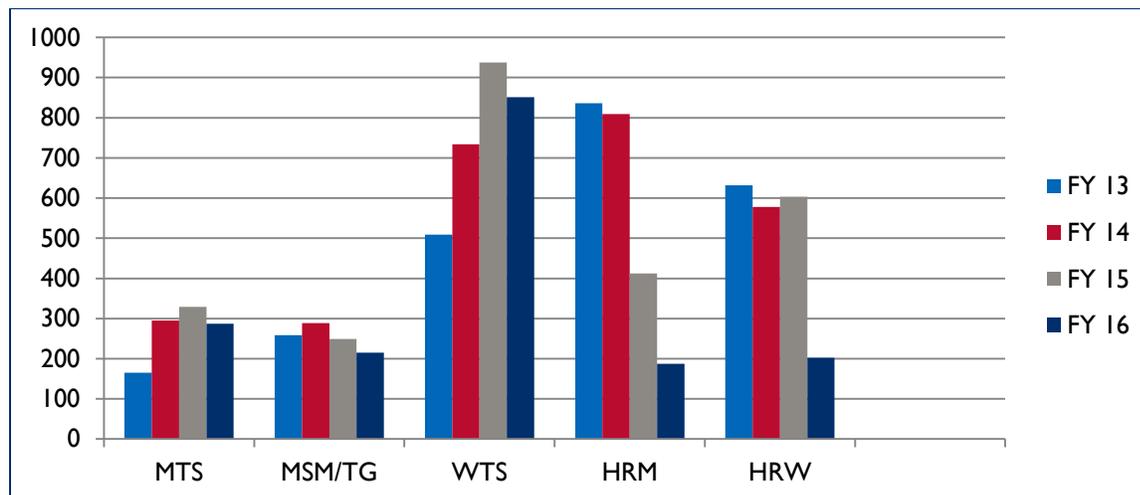
*FY 2016 data are only for the first half of the year. Targets for three indicators have already been met. For other indicators for FY 2016, where more than 50 percent of the target has been achieved in the first half of the year, the indicator is rated as “on target.” Where less than 50 percent of the target has been achieved in the first half of the year, the indicator is rated as “not on target.”

** For FY 2014, there was no target for these indicators. As the level of achievement was relatively high in relation to the targets that were subsequently set for FY 2015, the results are classified as meeting the targets.

Note: A number of the PEPFAR indicators are being used for the first time in FY 2016, and some of these indicators apply to the new TA sites that have recently started receiving project assistance. For new indicators, there may be delays in sites reporting data. In addition, for the new TA sites there may be time lag between commencing TA in these sites and achieving results and in sites reporting against indicators.

PREVENTION COMPONENT

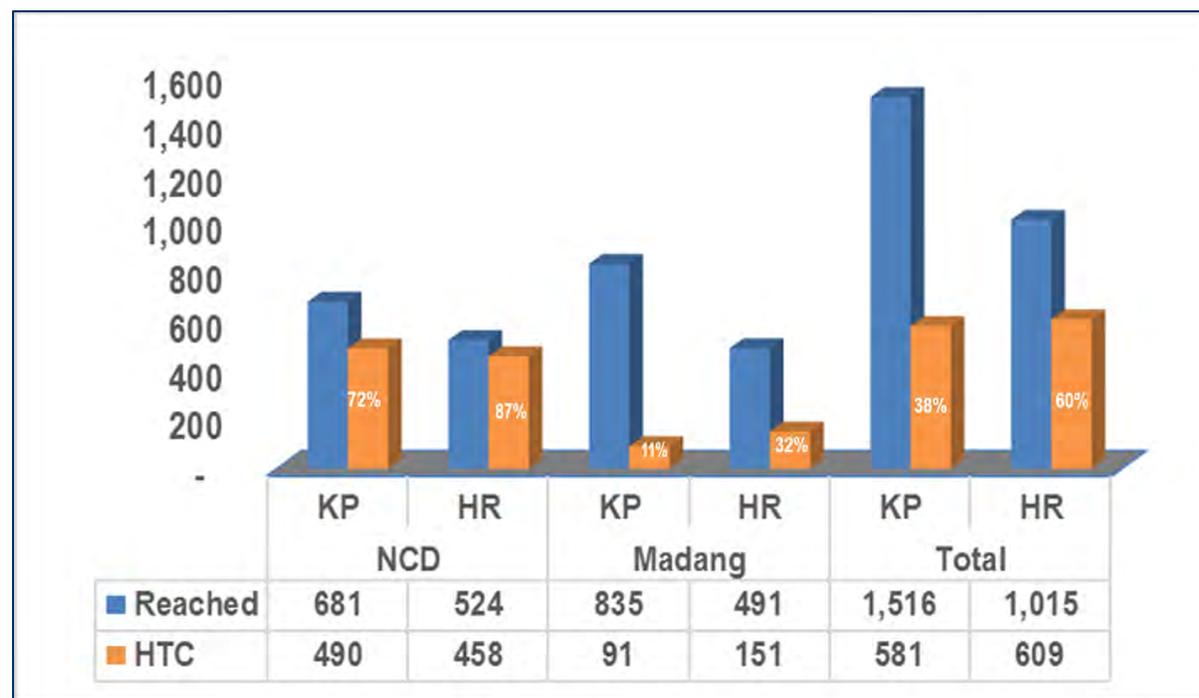
Figure 5: Reach by peer education outreach for key and priority populations, FY 2013–FY 2016



Note: FY 2016 data cover only the first two quarters of the year.

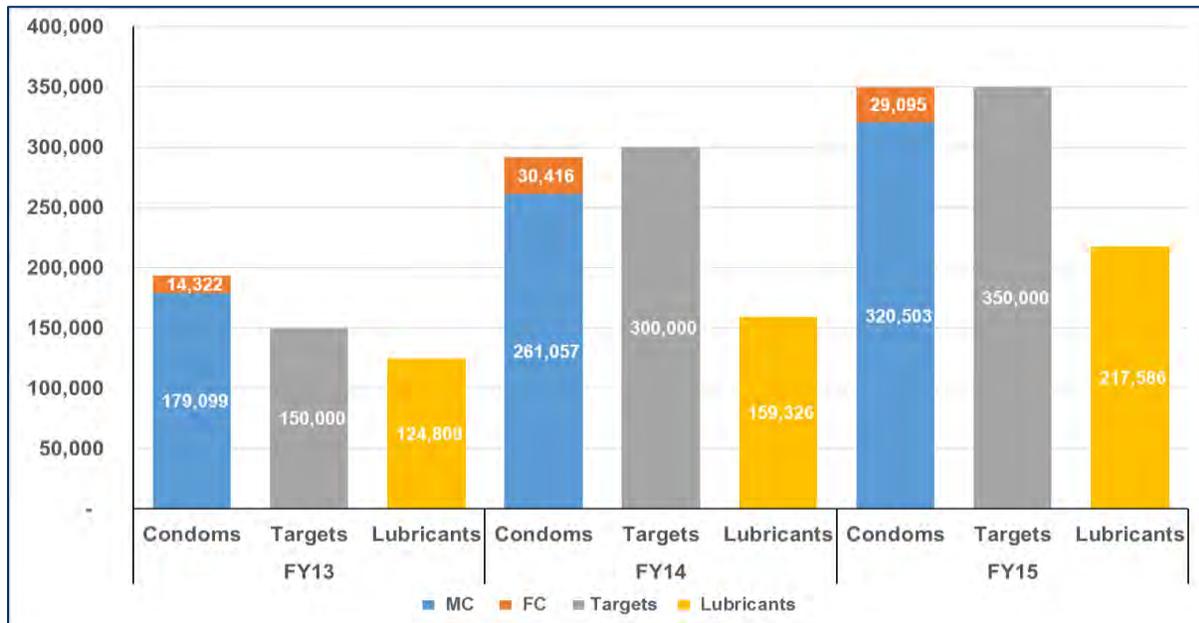
Source: FHI 360 PMP data

Figure 6: Number of KPs and HRM/W reached by PEs vs. completing HTC referral in FY 2015



Source: FHI 360 presentation to the evaluation team

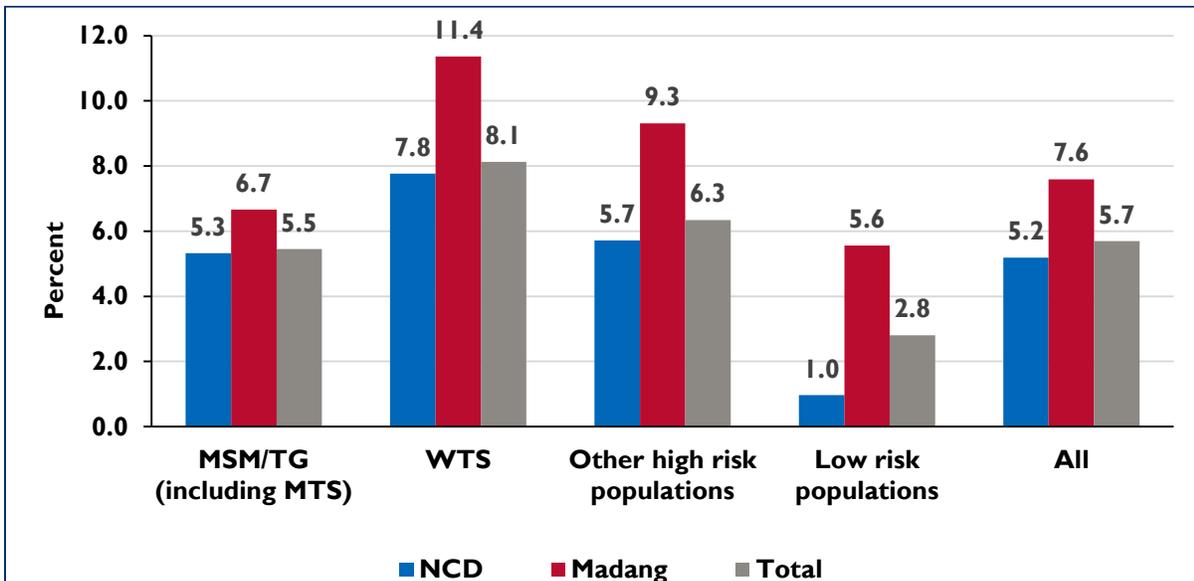
Figure 7: Condom and lubricant distribution: Number distributed vs. target, FY 2013–FY 2015



Source: FHI 360 presentation to the evaluation team

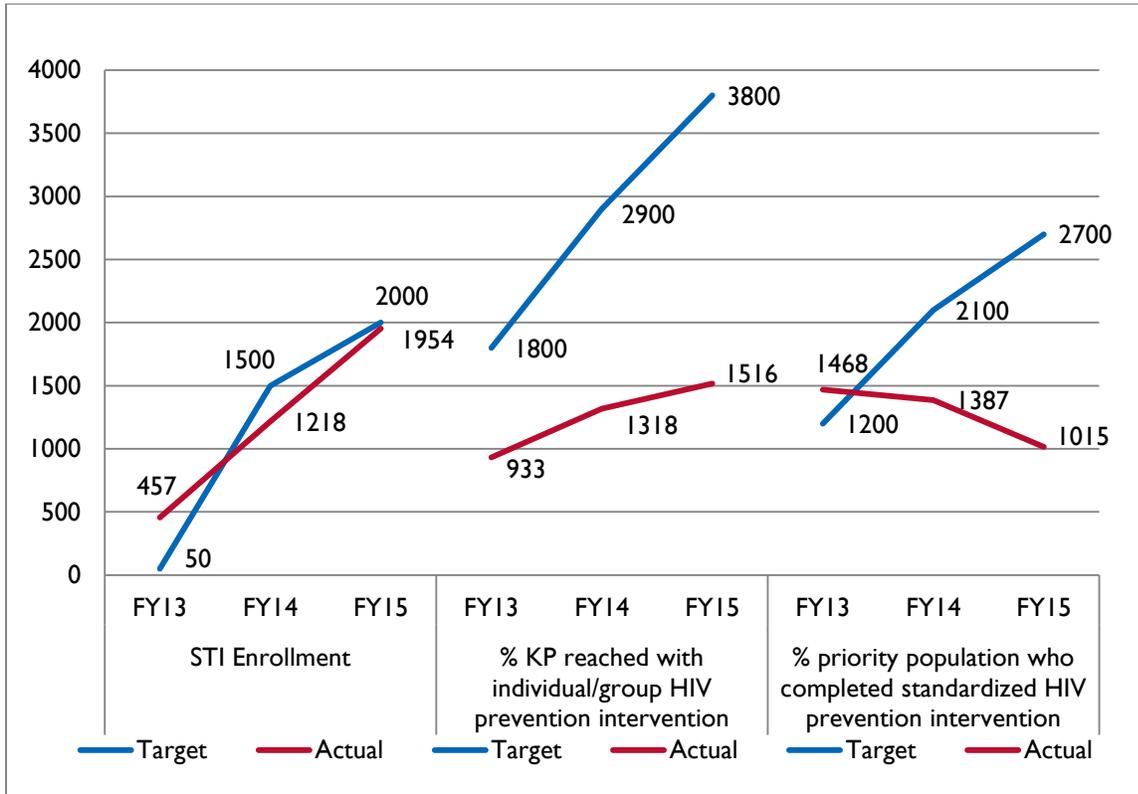
CLINICAL SERVICES COMPONENT

Figure 8: HIV positivity rate by population group in FHI 360-supported clinics, FY 2013–FY 2015



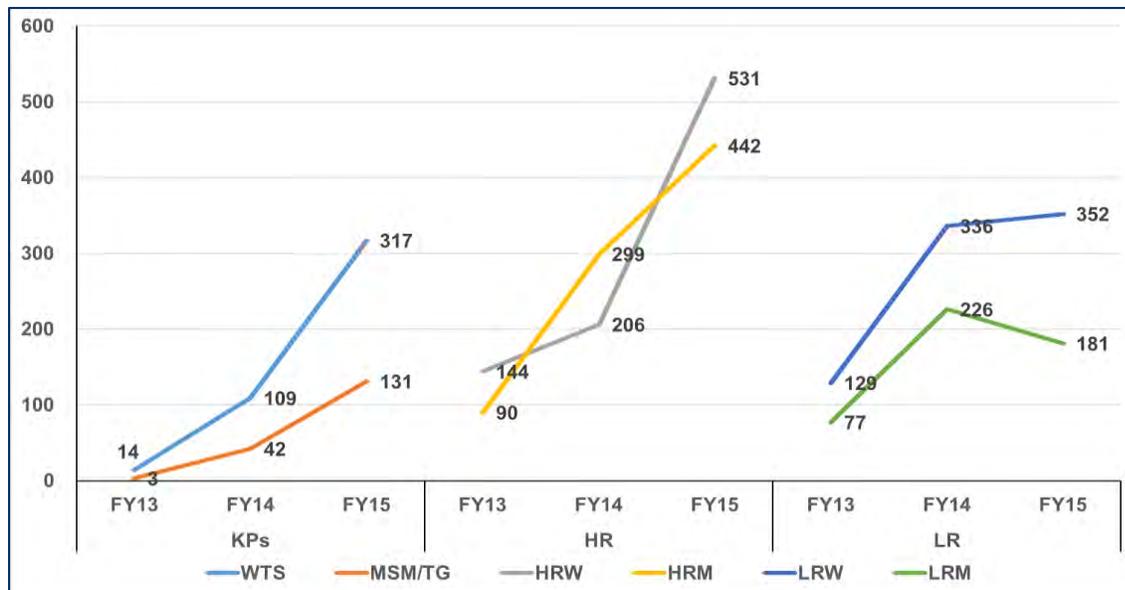
Source: FHI 360 presentation to the evaluation team

Figure 9: Trends in STI enrollment, and KPs reached and completing prevention interventions for all USAID project sites, FY 2013–FY 2015



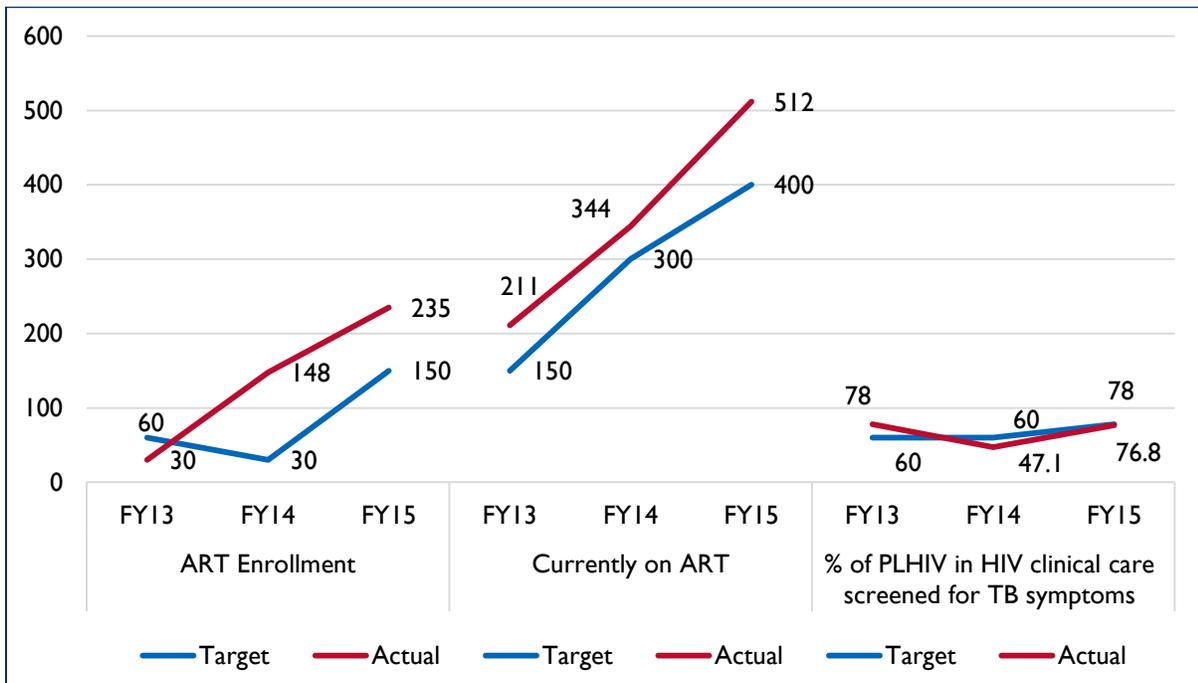
Source: FHI 360 PMP

Figure 10: Number of individuals accessing STI management services by risk classification for all USAID project sites, FY 2013–FY 2015



Source: FHI 360 presentation to the evaluation team

Figure 11: ART and PLHIV/TB service utilization for all USAID project sites, FY 2013–FY 2015



Source: FHI 360 PMP

ANNEX 6: BIBLIOGRAPHY

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ANNEX 7: EVALUATION TEAM

This evaluation was conducted by a team of three specialists, supported by three local evaluators and a logistics and evaluation assistant. The team leader was David Lowe, who also served as the team's HIV specialist. Team membership was made up of Jennifer Gilvydis, evaluation specialist; Maryanne Kehalie, gender specialist; Ware Aulakua, local evaluator; Mark Gilbert, local evaluator; Albertine Kabura, local evaluator; and Elias Passingan, logistics and evaluation assistant.

Short bios of each team member follow:

David Lowe has an extensive background in public health and HIV program design, monitoring and evaluation, management, strategy and policy development, gained through more than seven years in senior positions in the Australian public health system, followed by 20 years as an independent consultant in Australia and the Asia Pacific region. David has worked in partnership with a wide range of Asia Pacific governments and bilateral and multilateral development partners to build and consolidate national and regional responses to HIV and to address health and community systems strengthening. In addition to his HIV experience, David has undertaken a significant amount of work in a range of other public health areas.

Jennifer Gilvydis has more than 11 years of international public health experience in prevention science, operational research, and measurement and evaluation working with the University of Washington. Four years of her University of Washington tenure were based in South Africa, directing HIV, AIDS, STI and TB programming in partnership with the National and Provincial Departments of Health. This included health system strengthening, implementation of a large community-based combination HIV prevention program, and providing ongoing technical assistance to government. Prior to that, Jennifer worked with ministries of health in sub-Saharan Africa and India to strengthen the HIV and AIDS response. Jennifer has expertise in designing and implementing HIV, AIDS, STI and TB programs and in utilization of combined qualitative and quantitative data to inform prevention programming.

Maryanne Kehalie has a background in nursing, public health and community development, having held senior positions with a hospital run by the Catholic Church, then as the deputy executive officer of the Churches Medical Council of PNG, before taking up an advisory position with the AusAID-funded Women and Children's Health Project. Maryanne spent five years as the public health program coordinator with an NGO serving the Oil Search impacted communities and was later the public health program manager with PNG Sustainable Development. Maryanne worked with Caritas Australia for six years as the program coordinator and quality assurance officer supporting the Catholic Church of PNG. She has undertaken several evaluations in PNG and co-evaluated programs funded by Caritas Australia in West Timor and Zambia. Maryanne currently works with the Church Partnership Program as the executive officer of its Coordination Office.

Ware Aulakua has more than six years' experience in senior M&E positions in joint government and international donor-funded programs in PNG. From 2008–2011, Ware worked as the senior program officer with the AusAID-funded Law and Justice Sector Program and the PNG-Australia Law & Justice Partnership and from 2012–2014 as senior project officer with the PNG National Department of Agriculture and Livestock, with the Productive Partnership in Agriculture Project, a soft-concessional World Bank IDA and IFAD loan-funded project. Ware has also participated in various short-term trainings and data collection for evaluation and impact assessments since 2005. Ware has extensive working knowledge of development challenges in PNG and the national and international responses to these challenges in the areas of gender, HIV/AIDS, law and justice, politics, unemployment, and youth and how these challenges are linked to PNG cultural norms and values.

Mark Gilbert has worked with both the private and public sector since 2004. He has experience in general statistical support, data analysis, M&E and data management. For the past four years, he has worked as a consultant for the PNG government department that regulates the oil and gas industry, managing the project landowner beneficiary data. Mark also worked with the NDOH Disease Control Branch as a biostatistician for three years, collecting and analyzing HIV data for reporting, program interventions and responses for the Global Fund project on HIV/STI/TB. He also assisted NDOH in conducting the 2010 sentinel serosurveillance in the highlands region.

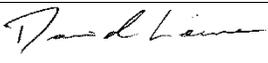
Elias Passingan has a background in logistics and supply chain, having worked in the freight forwarding industry and serving in supervisory positions and management levels. He has knowledge in handling dangerous goods, handling domestic and international freight, temperature- and time-sensitive shipments for domestic and international clients and managing freight deliveries and freight delivery services. Elias also has worked in the areas of transportation and procurement.

Albertine Kabaru has a Bachelor of Arts in Language and Communication from the University of Papua New Guinea. She is passionate about M&E and has five years of experience in this area. She believes it is important to learn from experience to improve practices and activities for stronger and more sustainable outcomes. Albertine has more than 10 years of work experience in human resources and special projects. Her long-term goal is to be an evaluation specialist in various development categories.

ANNEX 8: CONFLICT OF INTEREST DISCLOSURE STATEMENTS

Name	David Lowe
Evaluation Position	Team Leader and HIV Specialist
Evaluation Award Number	Global Health Program Cycle Improvement Project -- GH Pro Contract No. AID-OAA-C-14-00067
USAID Project Evaluated	Project Name: Strengthening HIV/AIDS Services for KPs in Papua New Guinea Implementer: Family Health International (FHI) 360 Cooperative Agreement No: AID-492-A-12-00011
I declare that I have no real or potential conflicts of interest to disclose.	
<p><i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> <i>1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.</i> <i>2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.</i> <i>3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.</i> <i>4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.</i> <i>5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.</i> <i>6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.</i> 	

I certify that I have completed this disclosure form fully and to the best of my ability and that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	 <hr/>
Date	May 1, 2016

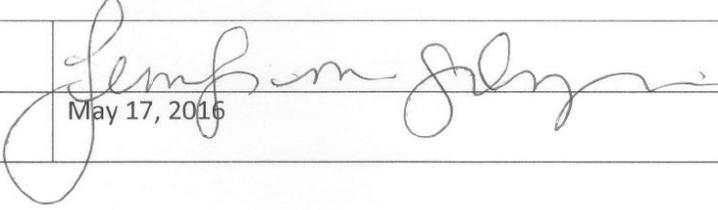
Name	Jennifer Mas Gilvydis
Evaluation Position	Evaluation Specialist
Evaluation Award Number	Global Health Program Cycle Improvement Project -- GH Pro Contract No. AID-OAA-C-14-00067
USAID Project Evaluated	Project Name: Strengthening HIV/AIDS Services for MARPs in Papua New Guinea Implementer: Family Health International (FHI) 360 Cooperative Agreement No: AID-492-A-12-00011

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Signature	
Date	May 17, 2016

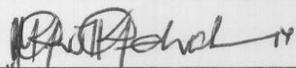
Name	Maryanne Kehalie
Evaluation Position	Gender/MARPs Specialist
Evaluation Award Number	Global Health Program Cycle Improvement Project -- GH Pro Contract No. AID-OAA-C-14-00067
USAID Project Evaluated	Project Name: Strengthening HIV/AIDS Services for MARPs in Papua New Guinea Implementer: Family Health International (FHI) 360 Cooperative Agreement No: AID-492-A-12-00011

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Date	May 17, 2016

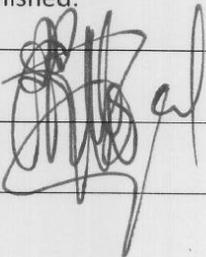
Name	Ware Aulakua
Evaluation Position	Local Evaluator
Evaluation Award Number	Global Health Program Cycle Improvement Project -- GH Pro Contract No. AID-OAA-C-14-00067
USAID Project Evaluated	Project Name: Strengthening HIV/AIDS Services for MARPs in Papua New Guinea Implementer: Family Health International (FHI) 360 Cooperative Agreement No: AID-492-A-12-00011

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Date	May 17, 2016

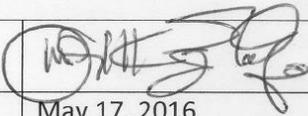
Name	Mark Gilbert
Evaluation Position	Local Evaluator
Evaluation Award Number	Global Health Program Cycle Improvement Project -- GH Pro Contract No. AID-OAA-C-14-00067
USAID Project Evaluated	Project Name: Strengthening HIV/AIDS Services for MARPs in Papua New Guinea Implementer: Family Health International (FHI) 360 Cooperative Agreement No: AID-492-A-12-00011

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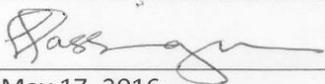
Name	Elias Passingan
Evaluation Position	Logistical and Evaluation Assistant
Evaluation Award Number	Global Health Program Cycle Improvement Project -- GH Pro Contract No. AID-OAA-C-14-00067
USAID Project Evaluated	Project Name: Strengthening HIV/AIDS Services for MARPs in Papua New Guinea Implementer: Family Health International (FHI) 360 Cooperative Agreement No: AID-492-A-12-00011

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Signature	
Date	May 17, 2016

Name	Albertine Kabura
Evaluation Position	Local Evaluator
Evaluation Award Number	Global Health Program Cycle Improvement Project -- GH Pro Contract No. AID-OAA-C-14-00067
USAID Project Evaluated	Project Name: Strengthening HIV/AIDS Services for MARPs in Papua New Guinea Implementer: Family Health International (FHI) 360 Cooperative Agreement No: AID-492-A-12-00011

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Signature	
Date	May 17, 2016

ANNEX 9: EVALUATION COSTS

To be inserted by GH Pro

ENDNOTES

¹ Unpublished data provided to the evaluation team by the UNAIDS Country Office.

² Unpublished data provided to the evaluation team by the UNAIDS Country Office. All epidemiological data in this section are from the 2015 HIV estimates.

³ The USAID project operates in Madang town, the capital of Madang Province. HIV prevalence is likely to be higher in Madang town than in other districts of the province.

⁴ Lewis I., Maruia B. and Walker S. 2008. Violence against women in Papua New Guinea. *Journal of Family Studies*, 14(2-3): 193-197.

⁵ FHI 360. 2011. Behaviors Knowledge Exposure to HIV Interventions. Report from a Behavioral Surveillance Survey, Port Moresby, Papua New Guinea. p. 12.

⁶ Differences in methodologies for KP recruitment and in the questions asked may limit comparisons that can be made between the 2011 BSS and the 2016 IBBS. For the project to effectively monitor changes in knowledge, attitudes and HIV/STI-related risk behaviors, a baseline survey among KPs and HRM/W would need to have been conducted at project inception, followed by a repeat survey toward the end of the project. The significant cost of these surveys is a consideration. The results may not have been fully attributable to the USAID project because changes in KAB can occur due to multiple influences, including other donor projects.

⁷ The source of all data in this section is the FHI 360 project performance monitoring plan (PMP).

⁸ Key population size estimates for Port Moresby will be derived from the IBBS to be conducted this year (2016). While these estimates will be for all of Port Moresby, it may be possible to derive estimates for Moresby South, the area where the USAID project is conducting PEO.

⁹ The total number of KPs and HRM/W reached include repeat contact with one person.

¹⁰ No data are available on the number of KP and HRM/W attending the Catholic VCT clinic in Madang, following contact/referral by a FHI 360 project peer educator.

¹¹ FHI 360 distributes condoms and lubricant through the USAID project's PEs and directly to some other agencies not involved in the USAID HIV project (Anglicare, Baptist Union and Poro Sapot).

¹² FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report. January 1–March 31, 2014. p. 5.

¹³ PEs receive a base salary of 200 PNG Kina (US\$64) per fortnight, and an incentive payment of 25 PNG Kina (US\$8) for each completed KP clinic referral and 15 PNG Kina (US\$4.80) for each completed HRM/W referral.

¹⁴ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report. July 1–September 30, 2014. p. 4.

¹⁵ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report. October 1–December 31, 2014. p. 26.

¹⁶ FHI 360 stated that following the introduction of incentive payments, some PEs stopped recording data for contacts with KPs and HRM/W who did not accept a clinic referral and that this artificially depressed the number of PE contacts recorded in the project's PMP data. The project educated PEs on the need to capture all contacts who had received the minimum prevention package in monitoring data and reinforced the need for effective supervision by the FSC and SA.

¹⁷ Prior to this, not all PEs were recruited from among KPs (so not all were peers) and they commonly did not live in the areas where they working, which limited their hours of working due to security concerns. The recruitment criteria were changed to require all PEs to be recruited from KPs and to live in the area where they would be working.

¹⁸ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report. April 1–June 30, 2015. p. 25.

¹⁹ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report. July 1–September 30, 2015. p. 29.

²⁰ FHI 360. 2014. Papua New Guinea 2014 Program and Technical Quality Assessment. Final Report. p. 18.

²¹ During the transition period from FSC and SA management of PEO activities to VSO, FHI 360 provided direct management of PEO in NCD involving 10 PEs, which was approximately one-third of the number of PEs employed by FSC and SA.

²² FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report. January 1–March 31, 2014. p. 5.

²³ VSO is an international NGO that has a long presence in PNG. This was the first time that VSO has undertaken HIV peer education outreach in PNG. The delay in recommencement of PEO activities in Madang was due to time

taken to find a replacement IA, contract negotiations, which were delayed by VSO's lengthy decision-making processes, and the need to recruit and train PEs.

²⁴ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report. Quarter 3, April 1–June 30, 2015. p. 26.

²⁵ This allows for an average of 24 minutes per contact and includes time taken to find KP members, who are often hidden, administering the minimum package of prevention interventions, and accompanying some clients to clinics. While PEs do not get paid overtime, PE FGD participants in NCD reported regularly working additional hours. The incentive payment for successful clinical referrals may encourage this.

²⁶ Clients are referred for clinical services.

²⁷ Clients are referred for clinical services.

²⁸ Ferradini L. 2014. PNG/Strengthening HIV/AIDS Services for MARPs. Care and Treatment Gap Analysis and Technical Support. Final Report. FHI 360.

²⁹ Van Dam J, Charoenying S, Merrigan M, Weissman A, Averill M. 2014. FHI 360 Papua New Guinea 2014 Program & Technical Quality Assessment: Final Report. Durham, NC: FHI 360.

³⁰ Testing performance data is based on the number of tests conducted with clients and includes repeat contacts.

³¹ Data provided by FHI 360 and Koki clinic.

³² Campos PE, Buffardi AL, Carcamo CP, Garcia PJ, Buendia C, Chiappe M, Garnett GP, Xet-Mull AM, Holmes KK. Reaching the unreachable: providing STI control services for female sex workers via mobile team outreach. *PLoS One*. Nov. 25, 2013; 8(11): e81041.

³³ Multiple quarterly reports (FY 14, Q1)

³⁴ FHI 360. 2016. Implementing Mechanism Level Narrative for FY16, Quarter 1. p.3.

³⁵ Id Inad clinic has been providing HIV the longest among all of the clinics.

³⁶ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. FY14 Annual Implementation Plan. October 1, 2013 to September 30, 2014. p. 7. (AIP FY2014 PNG 28 Oct 13)

³⁷ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report, Quarter 4. July 1, 2015 to September 30, 2015. p.14.

³⁸ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report, Quarter 1. October 1, 2015 to December 31, 2015. p.29.

³⁹ In FY14, FHI 360 suspended activities of People Living with Higher Aims due to financial misappropriation, which has led to challenges in mobilizing PLHIV to support groups. The same year, a CMT at Id Inad was added to the Modilon Hospital sub-agreement to ensure continuity of services and provide support services for PLHIV.

⁴⁰ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report, Quarter 3. April 1, 2013 to June 30, 2013. pp. 5-6.

⁴¹ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report, Quarter 4. July 1, 2015 to September 30, 2015. p.12.

⁴² FHI 360. Strengthening HIV/AIDS Services for KPs in PNG. Quarterly Report, Quarter 1. October 1, 2015 to December 31, 2015. p.33.

⁴³ FHI 360. Strengthening HIV/AIDS Services for KPs in PNG. Quarterly Report, Quarter 2. January 1, 2015 to March 31, 2015. p.20.

⁴⁴ These are membership-based national KP advocacy organizations. Kapul Champions is the MSM and TG organization. Friends of Frangiapani is the sex worker/transactional sex organization, and Igat Hope is the PLHIV organization.

⁴⁵ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report, Quarter 1. October 1, 2014 to December 31, 2014. p.5.

⁴⁶ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report, Quarter 1. October 1, 2015 to December 31, 2015. p.7.

⁴⁷ FHI 360. 2016. Implementing Mechanism Level Narrative for FY16, Quarter 1. p.4.

⁴⁸ FHI 360 staff presentation. "Strengthening HIV/AIDS Services for Most at Risk Populations in PNG Project: Implementation Progress." May 17, 2016.

⁴⁹ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report, Quarter 2. January 1, 2015 to March 31, 2015. p.12.

⁵⁰ FHI 360. 2016. Active Case Management for HIV Project Concept Note.

⁵¹ "Positive changes for gender equality." Post Courier, Papua New Guinea. Week of May 23, 2016.

⁵² Trip Report for Maryce Ramsey, Senior Gender Advisor. Report date: November 25, 2014.

⁵³ Trip Report for Maryce Ramsey, Senior Gender Advisor. Report date: November 25, 2014.

⁵⁴ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report, Quarter 4. July 1, 2013 to September 30, 2013. p. 36.

⁵⁵ FHI 360. FY 2016 Annual Implementation Plan for October 1, 2015–September 30, 2016.

⁵⁶ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. Quarterly Report, Quarter 4. July 1, 2013 to September 30, 2013. p. 14.

⁵⁷ FHI 360. Strengthening HIV/AIDS Services for MARPs in PNG. FY14 Annual Implementation Plan. October 1, 2013 to September 30, 2014. p. 7.

⁵⁸ Terms of reference for active case management/M&E coordinator. FHI 360. 2016.

⁵⁹ FHI 360. Strengthening HIV/AIDS Services for KPs in PNG. Quarterly Report, Quarter 2. January 1, 2014 to March 31, 2014. p.39.

⁶⁰ NCD Health is NCD's equivalent of a PHO.

⁶¹ Source: Daniel Tesfaye, FHI 360 Country Director, PNG.

⁶² Information on the project exit from Madang is derived from documents provided by FHI 360 and interviews with FHI 360 and the Madang PHO.

⁶³ Funds for the cost of clinic staff salaries at the Id Inad clinic did not need to be found because these were already paid for by government. The budget of 100,000 was for payment of salaries for the six case managers at the Id Inad clinic, 10 PEs employed by VSO, and the PHO HIV Coordinator. The budget did not include costs for VSO to manage the PEO program, ongoing training and capacity building for PEs, or funding for ongoing activities related to outreach, such as sensitization workshops, monthly meetings between clinicians and the outreach team, KP meetings and hot spot mapping.

⁶⁴ After the decision to delay USAID's exit till 2017, VSO was offered an extension of USAID funding. However, by this time, Global Fund support had already been secured. While the Madang PHO did propose to take over the salaries of the PEs, other aspects of PEO funding were not covered (see the endnote immediately above). It is unlikely PEO programming would have been sustainable with the limited resources made available by the PHO. In addition, the PHO budget allocation has as yet not been approved by the provincial government.

⁶⁵ The government budget process starts in March for the following financial year, which runs from January to December. The PHO was not informed till July 2015 that funding would cease in May 2016.

For more information, please visit
<http://www.ghtechproject.com/resources>

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