# Strengthening HIV/AIDS Services *for* Key Populations in PNG

## QUARTERLY REPORT

*Quarter Two, FY 2018*
*January 1 - March 31, 2018*

PEPFAR

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THE SCIENCE OF IMPROVING LIVES

# ABBREVIATIONS/ACRONYMS

| | |
|---|---|
| **ACM** | Active Case Management |
| **AIP** | Annual Implementation Plan |
| **ART** | Antiretroviral Therapy |
| **ARVs** | Antiretroviral Drugs |
| **BMU** | Basic Management Unit |
| **CBO** | Community-Based Organization |
| **CDC** | U.S. Centers for Disease Control and Prevention |
| **CHS** | Christian Health Services |
| **CHWs** | Community Health Workers |
| **COP** | Country Operational Plan |
| **CPHL** | Central Public Health Laboratories |
| **CSO** | Civil Society Organization |
| **DFAT** | Australian Department of Foreign Affairs and Trade |
| **DQA** | Data Quality Audit |
| **DSD** | Direct Service Delivery |
| **DVIT** | Data Verification and Improvement Tool |
| **EAC** | Enhanced Adherence Counseling |
| **EOA** | Enhanced Outreach Approach |
| **EQA** | External Quality Assessment |
| **FSVAC** | Family Sexual Violence Action Committee |
| **FSO** | Field Support Officer |
| **FSW** | Female Sex Worker |
| **GBV** | Gender-Based Violence |
| **GFATM** | Global Fund to Fight AIDS, Tuberculosis, and Malaria |
| **GOPNG** | Government of Papua New Guinea |
| **HPDB** | HIV Patient Database |
| **HTC** | HIV Testing & Counseling |
| **HTS** | HIV Testing Service |
| **IBBS** | Integrated Bio-Behavioral Surveillance |
| **ICPT** | Index Client Partner Testing |
| **IEC** | Information-Education-Communication |
| **IMAI** | Integrated Management of Adolescent and Adult Illness |
| **INA** | Institute of National Affairs |
| **INGO** | International Non-governmental Organization |
| **IPs** | Implementing Partners |
| **IR** | Intermediate Result |
| **IRB** | Institutional Research Board |
| **KAP** | Knowledge, Attitudes, and Practices |
| **KP** | Key Populations |
| **KPMIS** | Key Population Management Information System |
| **LTFU** | Loss to Follow-Up |
| **M&E** | Monitoring & Evaluation |
| **MIS** | Management Information System |
| **MSF** | Médecins Sans Frontières |
| **MSM** | Men who have sex with men |
| **MTE** | Mid-Term Evaluation |
| **MTS** | Men in Transactional Sex |

| | |
|---|---|
| **mVCT** | Mobile Voluntary Counseling & Testing |
| **NACS** | National AIDS Council Secretariat |
| **NCDHS** | National Capital District Health Services |
| **NDOH** | National Department of Health |
| **NUIC** | National Unique Identifier Code |
| **NUPAS** | Non-U.S. Organization Pre-Award Survey |
| **OI** | Opportunistic Infections |
| **OSF** | Oil Search Foundation |
| **PEPFAR** | The U.S. President's Emergency Plan for AIDS Relief |
| **PEs** | Peer Educators |
| **PHCS** | Protection of Human Subjects Committee |
| **PICT** | Provider Initiated Counselling and Testing |
| **PLGHA** | Protecting Life in Global Health Assistance |
| **PLHIV** | People Living with HIV |
| **PMP** | Performance Management Plan |
| **PNG** | Papua New Guinea |
| **QA/QI** | Quality Assurance/Quality Improvement |
| **QIP** | Quality Improvement Plan |
| **RTK** | HIV Rapid Test Kits |
| **SBCC** | Strategic Behavior Change Communication |
| **SDI** | Service Delivery Improvement |
| **SI** | Strategic Information |
| **SIMS** | Site Improvement Through Monitoring System |
| **SOP** | Standard Operating Procedure |
| **STIs** | Sexually Transmitted Infections |
| **TA** | Technical Assistance |
| **TB** | Tuberculosis |
| **TB-ICF** | Intensified TB Case Finding |
| **TG** | Transgender People |
| **TSA** | The Salvation Army |
| **TWG** | Technical Working Group |
| **UIC** | Unique Identifier Code |
| **USAID** | United States Agency for International Development |
| **VCT** | Voluntary Counseling & Testing |
| **VL** | Viral Load |
| **VSO** | Volunteer Services Overseas |
| **WHO** | World Health Organization |
| **WTS** | Women in Transactional Sex |
| **WV** | World Vision |

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## EXECUTIVE SUMMARY

HIV prevalence among adults in Papua New Guinea (PNG) is currently estimated at 0.9% (UNAIDS 2016), but HIV infection rates remain higher (> 1%) in some geographical locations, such as the Highlands region and the National Capital District (NCD), and among key populations (KPs), including female sex workers (FSW), men who have sex with men (MSM), and transgender people (TG). Reaching KPs with critical HIV prevention services in PNG is hampered by criminalization of sex work, high stigma and discrimination, and lack of designated places (such as brothels and special night clubs) for KPs. Per the recent Integrated Bio-Behavioral Survey (IBBS) conducted in Port Moresby, NCD in 2017, HIV prevalence among FSW and MSM/TG is 14.9% and 8.5%, respectively. FHI 360 is implementing a six-year cooperative agreement with funding from the United States Agency for International Development (USAID), Philippines Mission to carry out the Project, "Strengthening HIV/AIDS Services for key populations in PNG". The goal of the Project is to reduce the incidence of HIV among KPs in PNG and mitigate its impact on KPs, their sexual partners, and their families. This year, Fiscal Year 2018 (FY 2018) is the sixth and last year of implementation of project activities. For this reason, the FY 2018 Annual Implementation Plan (AIP) focuses on: (1) strengthening technical assistance (TA) to the National District Health Services (NCDHS) and HIV clinics in NCD; (2) working with stakeholders to sustain essential components of the program; (3) documenting and disseminating lessons learned from implementing various strategies and approaches developed and/or implemented under the project; and (4) closing out sub-awards with implementing partners

This report summarizes activities and achievements for the period January 1 to March 31, 2018 (Q2 FY 2018). In compliance with the USG 'Protecting of Life in Global Health Assistance (PLGHA) and Statutory Abortion Restrictions 2018' policy, FHI 360 conducted due diligence checks on implementing partners, amended their contracts to include relevance clauses regarding the policy, and sensitized program staff on the needs to routine compliance checks as part of onsite mentoring activities. Clay Epperson, the Deputy Mission Director, USAID Philippines Mission, visited the project during the quarter. Efforts to sustain essential components of the project continued to yield results as the management of Foursquare Church (FSC) reserved three full time clinical positions under its current funding from Christian Health Services (CHS) to absorb the ART prescriber and two case managers attached to Kaugere Clinic at the end of the project. Significant progress was made with the technical documentation of project results as three abstracts for submission at the 2018 International AIDS Conference were written, six concept notes for academic papers on key intervention were developed, and documentation of lessons learned in the implementation of KP friendliness assessment and mobile voluntary counselling and testing (mVCT) were completed.

The Project continued to: (1) conduct outreach services among KPs, their partners, and families to increase demand for services related to HIV and sexually-transmitted infections (STIs); and (2) link these populations to HIV prevention, care, and treatment services at health facilities. Other high risk individuals as well as those considered to be at low risk of acquiring HIV and STIs continued to benefit from services. Index client partner testing (ICPT)[1] was

[1] A voluntary process whereby an PLHIV received at the facility acts as a contact to reach out to other individuals within their network who do not know their HIV sero status, offer them HIV testing and consequently provide them HIV prevention and treatment services.

introduced as part of efforts to increase HIV testing yield, while activities to strengthen 'test and treat', viral load (VL) services, intensified TB case finding (TB-ICF), and Isoniazid preventive therapy (IPT) were given priority. The FY 2018 cumulative results for most of the key PEPFAR Monitoring, Evaluation and Reporting (MER) indicators reached and surpass the fifty percent mark expected at the end of the reporting period.

During the quarter, a total of **1,180** KPs (833 FSW; 308 MSM & 39 TG) were reached with preventive interventions. In addition, **773** other high risk individuals (415 men (including 238 men in transactional sex) and 358 females) were also reached with prevention services. A total of **546** individuals received STI services, while **6,709** individuals (including 831 KPs) received HIV Testing and Counselling (HTC) with an overall program HIV positivity rate of **4.3%**. A total of **288** people living with HIV (PLHIV) were identified during the quarter, **337** PLHIV were registered into care, and **321** were newly initiated on antiretroviral therapy (ART), and **3,726** were active on treatment at the end of March, 2018. A total of **199** survivors of GBV (including 65 KPs) received post-GBV care, representing **98%** of GBV survivors seen during the reporting period. Three TA clinics (Heduru, Tokarara and 9 Mile) reported GBV data for the first time as the project scaled up technical assistance (TA) on GBV integration to TA sites. Reporting rates for the national surveillance reports in NCD continued to improve as the proportion HIV clinics submitted all national reports timely (within the first week of a new month) increased from **85%** to **90**% within the quarter. District wide data quality audit (DQA) also commenced during the reporting period with the participation of the National Department of Health (NDoH), NCDHS and USAID.

Temporary suspension of TA activities at Gerehu Hospital, imminent stockout of ARVs and other medical commodities, and exit of some key personnel are the main challenges encountered during the reporting period. The project also experienced a major drop in the number of PLHIV currently receiving ART (TX_CURR) compared to Q1 as it transitioned from using the 'tracklog'[2] and 'Summary for period' report in HIV Patient database (HPDB)[3] to generate data for DSD and TA sites, respectively, to using 'PEPFAR MER' report in the HPDB to generate the data for all sites.

[2] An excel based tool developed by the FHI 360 and used as a form of electronic medical record (EMR) system for monitoring PLHIV in care and treatment.

[3] PNG government EMR system for monitoring PLHIV in care and treatment.

## QUARTER 2 ACHIEVEMENTS

(See annex 1 for summary of achievements on core indicators by site.)

**Table 1: Summary of Capacity Building Activities**

| Training | Beneficiaries/ Participants | Goal/Objectives | Date | Collaborating partner(s) | Outcome | # of participants | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Male | Female | TG | Total |
| **Key Population (KP) Sensitization Training.** | Community leaders in Bundi settlement | To sensitize community leaders on sexual diversity, and the rights and special needs of KPs. | 18th Jan | | Participants were sensitized on sexual diversity KPs. Community leaders pledged their support for KP outreach activities. | 11 | 9 | 0 | **20** |
| **Training on Index Client Partner Testing (ICPT).** | Program Officers, Outreach Workers (Peer Educators (PEs), FSOs & consultant) and Clinicians. | To (i) introduce the concept of ICPT to service providers, (2) discuss strategy for integrating ICPT into outreach and clinical services. 3) introduce the forms to use when providing ICPT services. | 25th Jan | | Outreach team and clinicians from DSD clinics understand the concept of ICPT, the standard operating procedure (SOP) for integrating ICPT and the forms to use. They agree to support its implementation. Implementation of ICPT started in February and March for Koki and other clinics, respectively. | 8 | 16 | 0 | **24** |
| **Refresher Training on Sexual & Reproductive Health** | Outreach Workers (PEs and FSOs). | To refresh participants' knowledge on STIs and the relationship between other STIs and HIV. | 5th Feb | | All PEs who attended were given a refresher training on STIs as well as the male and female reproductive systems. | 2 | 9 | 1 | **12** |
| **Training on Couple Counselling for HTC** | Clinicians and other healthcare workers (HCWs) form DSD and TA Clinics, and lay counsellors (among PEs). | To (1) build capacity of participants on couple counselling for HTC, and how to support and guide clients through safe disclosure of HIV status, and (2) to strengthen partner referrals for HIV and STI management services. | 5th-9th Feb | NDoH and NCDHS | 18 participants were certified by NDoH to provide couple counselling services. | 3 | 14 | 1 | **18** |
| **Gender-based violence (GBV) Data Tools Training for technical assistance only (TA) Clinics** | Clinicians and other HCW in TA clinics. | To orientate participants on (1) GBV service flow and referral pathways, (2) reporting requirements, (3) indicators, and data capturing and reporting tools. | 12th-13th Feb | | Clinicians and other HCW from participating TA clinics became familiar the client flow, referral pathways, and reporting requirements for post-GBV services. | 4 | 7 | 0 | **11** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 3 TA clinics (Heduru, Tokarara and 9 Mile) started providing and reporting statistics on post-GBV care. | | | | |
| **In-house M&E Refresher Training.** | Outreach team (program officer, consultant and field support officers). | To re-orientate the outreach team on community prevention indicators, data flow and reporting requirements under the national KP Management Information System (KPMIS). | 16th Feb | | FHI 360 commence reporting outreach data into national KPMIS database. | 1 | 6 | 0 | **7** |
| **GBV Screening Protocol Training.** | Clinicians and other HCWs from TA clinics. | To train participants on (1) the application of the GBV screening protocol in the routine screening of individuals accessing HCT, STI and ART services, and (2) the provision of appropriate post-GBV services including referral linkages to other (non-health) services. | 26th-27th Feb | | Participants became familiar with the application of the GBV screening protocol, and provision of the minimal essential package including psychological first aid, medical care and referral.<br>3 TA clinics (Heduru, Tokarara and 9 Mile) started providing and reporting statistics on post-GBV care. | 3 | 11 | 0 | **14** |
| **Gender Norms Training.** | Members of Sabama Community. | To sensitize participants and develop their knowledge on gender, sexuality and GBV, and to increase awareness on availability of post-GBV services in NCD. | 27th-28th Feb | | Participants became more aware of GBV and its prevalence in their communities.<br>Some participants resolved to seek and support others to access relevant post-GBV services (including legal) when necessary. | 6 | 12 | 0 | **18** |
| | Members of Goi Settlement and Badihagua Communities. | | 8th March | | | 13 | 12 | 0 | **25** |
| | Leaders of Mahuru and Manu communities. | | 15th -16th March | | | 14 | 11 | 0 | **25** |
| **Refresher Training on National Unique Identifier Coding (NUIC) system** | Outreach Workers (FSO & PEs). | To re-orientate participants on how to correctly generate client NUIC and to fill out the NUIC form with emphasis on codes for district of birth and of residence. | 26th March | | Participants are now in a better position to generate client NUIC more accurately. This will help increase the effectiveness of the NUIC in minimizing double counting of KP accessing HIV services. | 1 | 13 | 2 | **16** |
| **Financial Literacy Training for shelters.** | GBV survivors and support group members under 'Meri Seif Haus'.. | To equip participants with basic finance management skills to help them effectively plan and manage their income. | 27th March | ANZ Financial Literacy Program. | Participants were enlightened on the principles of budgeting, understood the difference between 'wants' and 'needs,' and how to better manage their financial income to address critical needs and to plan. | 19 | 12 | 0 | **31** |
| | GBV survivors and support group members under 'House of Hope'. | | 28th March | | | 7 | 7 | 0 | **14** |

## CHALLENGES THIS QUARTER

**Lack of CHS funding for Salvation Army health programs in NCD**

The project encountered a setback in its effort to sustain project activities at Koki Clinic, as the management of Salvation Army (TSA) did not receive any financial allocation from Christian Health Service (CHS) to support its health programs in NCD for the current fiscal year. With this development, TSA's ability to sustain payment for the salaries of nine project staff that were transitioned to them at the beginning of FY 2018 has been weakened. The attention of NCDHS has been drawn to this challenge during a meeting with the Director of Public Health, Dr. Niko Wuatai, in March. Dr. Wuatai promised to meet with the leadership of CHS and TSA to find a way around the situation. FHI 360 will continue following up with NCDHS and TSA on this issues in the coming quarter.

**Temporary suspension of TA activities at Gerehu Hospital**

Although the management of Gerehu Hospital expressed readiness to sign the Memorandum of Understanding (MoU) with FHI 360 to continue technical assistance to hospital, FHI 360 temporarily suspended TA activities at the facility during the second half of the quarter following concerns raised by the Deputy Secretary of Health (Dr Dakulala) regarding co-location with Médecins Sans Frontières (MSF), another international non-government organization (INGO), which also provides TB services at the facility. The leadership of FHI 360 met with the Deputy Secretary to clarify the scope of FHI 360's TA to the hospital which focuses on strengthening the weak components of HIV services, integrating of GBV and HIV and improving data quality. FHI 360 also reassured the Deputy Secretary that it will limit its TA to HIV services, while MSF focuses on TB services. The MoU has now been signed and FHI 360 will work with NDoH to accredit the health facility and roll out ART services in the coming quarter. The gender team will also complete GBV readiness assessment in preparation for the integration of GBV and HIV services.

**Eminent national-wide stock-out of ARVs**

There were indications that the national HIV program was heading for a nation-wide stock out of ARVs, HIV rapid test kits (RTKs) and other medical commodities, as NDoH had not received the required funds for the procurement of these commodities. By the end of the reporting period, first lines ARVs were out of stock at the central and area medical stores and only limited stocks were available at the various ART clinics. To mitigate the impact of this development on PEPFAR supported clinics, FHI 360's care and treatment team took inventory of the current stock levels of the various ART regimens in the PEPFAR supported ART clinics and provided guidance to ART prescribers in those clinics on how to manage available stocks to cover treatment for PLHIVs for as long as possible, and to give priority to registered PLHIV who were already on treatment. The information on stock levels of ARV regimens was also shared with NDoH, including the Regional Medical Officer (in charge of the Southern Region) and logistics for their information and necessary action.

Stock-out of STI reagents was a cross cutting issue in all sites. There was a nation-wide stock-out of rapid test kits used for point of care syphilis testing and reagents for gram staining during the reporting period. This constituted a hindrance to the smooth implementation of STI services in clinics across NCD. The issue was discussed with NDoH and at the HIV TWG and NDoH promised to take urgent steps to address it.

**Exit of senior level personnel**

With the uncertainty surrounding the possibility or otherwise of a follow-on to the current project, the project has started experiencing exit of some of its project staff including senior level personnel. During the quarter, two key personnel; the Associate Director and program lead (Margie Nobertus) and Gender Advisor (Mirriam Dogimab) voluntarily disengaged from the services of FHI 360. With only six months to the project end date, replacing these personnel is a major challenge. FHI 360 has therefore taken steps to reassign the role of both officers to other staff while looking for suitable individuals to fill their positions. There are indications that some program and support staff may also voluntarily disengage in the coming quarter.

**Inconsistencies in TX_CURR data in the HIV Patient Database (HPDB)**

The project observed major drop (41%) in TX_CURR results in Q2 from Q1 results, as it transitioned from using the 'tracklog' and 'Summary for period' report in HPDB to generate data for DSD and TA sites, respectively, to using the 'PEPFAR MER' report that was recently set up in HPDB to generate data for all sites. To understand the reason behind the drop, FHI 360 carried out a data audit following which two main factors were identified;

i. *Change in data source for measuring the indicator:*

For TA sites, the transition in data source from the 'Summary for period' report to the 'PEPFAR MER' report resulted in a significant drop in TX_CURR compared with Q1 report. The 'Summary for period' was generating much higher, but less accurate values for the indicator because it was programmed to generate 'number of PLHIV active on ART' from 'number ever received ART' by deducting only cumulative 'number of deaths' from inception of ART services in each clinic. The 'PEPFAR MER' report generates less, but more accurate values because it was programmed to take into consideration all relevant parameters (including deaths, LTFU, transfers, treatment stop/restarts) in generating TX_CURR from 'number ever received ART'. For the DSD sites, the transition from using the 'tracklog' report to using the 'PEPFAR MER' report on the HPDB resulted in marginal decline compared with Q1. The 'tracklog' was generating slightly higher values because it considers defaulting clients who were not yet LTFU (defaulted for up to 3 months from the date of last scheduled appointment) as part of TX_CURR, whereas the 'PEPFAR MER' report excludes this set of patients from TX_CURR and therefore generates less values.

ii. *Delays in updating of patient clinic visits and statuses in HPDB*

This has been a major challenge with the TA sites, especially 6 Mile and 9 Mile. When patient clinic visits and ART statuses are not updated on time, defaulting patients who are not yet LTFU are not counted as part of TX_CURR based on how the 'PEPFAR MER' report was programed on HPDB.

Although the 'PEPFAR MER' report generates slightly less values than expected, FHI 360 has decided to use that as the data source for generating TX_CURR going forward while working with NDoH and CDC to review the definitions and queries for generating all government and PEPFAR indicators on the HPDB. The drop in Q2 result will impact on the projects ability to meet its FY 2018 targets, especially for TA sites.

A detailed audit report is submitted as part of this report and observations with the HPDB have already been escalated to the Strategic Information Technical Working Group (SI-TWG).

**Table 2: Summary of achievements for the quarter, by intermediate results (IRs)**

| Planned Activities | Achievements during the reporting period |
|---|---|
| **Objective 1. (IR 2.1): To increase demand for HIV/AIDS services by key populations (KPs), their sexual partners, and their families** | |
| **Task 1.1. Improve risk-reduction and healthcare-seeking behaviors through strategic behavior change communication (SBCC)** | |
| **Activity 1.1.1. Carry out Hotspot review and mapping.** | • Implemented in the Q1. |
| **Activity 1.1.2. Explore other options to reach KPs through social media.** | • 8 clients (7 key populations (KPs) and 1 priority population (PP)) were reached with prevention services and referred for HTC and STI services through Facebook during the period. Five out of those reached and referred successfully accessed services.<br>• The number of clients reached through social media dropped significantly compared with Q1 results because the focal person for this component of the program disengaged from the project in January. Therefore, no outreach activities were conducted through social media in February and March. The project is currently sourcing for a replacement. |
| **Activity 1.1.3. Distribute SBCC materials.** | • Various Information, Education and Communication (IEC) materials were distributed to end-users by outreach workers and through clinics supported by the project.<br>• As many as 3,477 units of IEC materials including; 1) various posters/brochures on HIV, STI, GBV, family planning, condoms, human rights, stigma & discrimination; 2) risk assessment and self-care cards; and 3) clinic service information cards including GBV service information cards, were distributed during the quarter.<br>• These materials include those developed by the project and others sourced from other programs/partners.<br>• Other SBCC materials distributed include male dildos and branded T-shirts. |
| **Activity 1.1.4. Provide KP focused outreach services.** | • The project continued to offer community outreach services using the peer driven Enhanced Outreach Approach (EOA) to reach KPs with a minimum prevention intervention package which includes risk assessment; HIV, STI, TB & HIV empowerment; condom demonstration and distribution; and referral for health facility based services, especially STI screening and HIV testing. Previously registered PLHIV, presumptive TB cases, GBV survivors among KPs and PPs are also referred for ART, TB diagnostic services and post-GBV care as indicated.<br>• The project also focused on developing the capacity of peer educators (PEs) and Field Support officers (FSOs) to provide GBV related information and referral services for their peers by providing mentoring support on the application of the standard operating procedures (SOP) for GBV services and the GBV safety planning tool kit.<br>• Night interventions became more regular with twenty-seven events held during the quarter. A total 276 clients (233 KPs & 43 PPs) were reached, and 215 (185 KPs & 30 PPs) accepted referrals for HTC/STI services. |

| Planned Activities | Achievements during the reporting period |
|---|---|
| | • A design has also been developed to pilot the peer mobilizer model[4] which is being implemented by FHI 360 in other countries under the linkages project. The peer mobilizer model is proposed as more effective in reaching KPs and is currently being considered for implementation as part of the respondent driven approach (RDA) in PNG under the Global Fund grant. |
| **Activity 1.1.5. Carry out condom promotion and distribution services.** | • A total of 120,512 condoms (110,903 male & 9,609 female condoms) and 3,664 lubricants were distributed during the quarter. This was done through multiple channels including outreach activities, clinics, and other non-USAID supported implementing partners.<br>• Condom distribution through 'one-on-one' contact by PEs includes condoms demonstration to promote correct and consistent use. |
| **Activity 1.1.6: Document lessons learnt from outreach services.** | • At the request of USAID, a three-page EOA flow chart summarizing the three referral waves in the EOA, incentive structure and the challenge with each referral wave, which was used to engage with stakeholders in discussions around the implementation of the peer mobilizer model and RDA as the main strategy for KP outreach under the current GF grant. The flow chart was presented in different forums including; a stockholders' meeting organized by GF in March to discuss implementation of the new strategy, the PEPFAR update meeting with NCDHS in March, and an informal meeting with Scott Berry (GF consultant) to better understand the similarities and difference between the current EOA structure and the proposed Enhanced Outreach Prevention Approach. Subsequently, FHI 360 decided to run a mini pilot on the peer mobilizer model.<br>• The concept note for provision of NCD-wide community outreach services for KPs was placed on hold till January 2019 when GF support for NCD would have ended.<br>• An abstract on the EOA has been developed for the 2018 International AIDS Conference (IAC) in July, and is currently undergoing in-house review and vetting for submission.<br>• A concept note for a scientific paper on the implementation of EOA was developed and will be subjected to a non-research determination by FHI 360's Protection of Human Subjects Committee (PHSC). |
| **Task 1.2. Mobilize and train peers and volunteers to increase use of HIV prevention services** | |

[4] Under this model, Peer Mobilizers (KPs) are recruited on a non-permanent/full time basis to approach peers within their networks, and persuade them to accept and access HTC services. The peer mobilizers do not earn a regular payment, but only receive a non-cash incentive for every peer they successfully get to access HTC. The peer mobilizer only remains in the system until his/her network is exhausted.

| Planned Activities | Achievements during the reporting period |
|---|---|
| **Activity 1.2.1. Conduct Refresher trainings for peer educators on the minimum prevention intervention package.** | • FHI 360 conducted a series of refresher trainings for PEs and FSOs during the quarter. The trainings include;<br>  ○ Two trainings in January to re-orientate PEs on the EOA, minimum prevention intervention package, and basic HIV/AIDS. A total of 19 participants (13 females, 4 males & 2 TGs) benefitted from the training.<br>  ○ Trainings on Sexual and Reproductive Health (focusing on STIs) and on TB (focusing on the links between TB and HIV) in February.<br>  ○ Re-orientation on the National Unique Identification Code (NUIC) system in March<br>• In addition, PEs involved in the lay counsellor assisted testing also participated in the couple counselling and testing training and orientation on Index Client Partner Testing (ICPT) conducted in February for both clinicians and outreach workers.<br>• See table on capacity building for details. |
| **Activity 1.2.2. Train peer educators and field support officers on GBV SOP and safety planning tools.** | • This activity was implemented in Q1.<br>• PEs are now equipped with the knowledge and skills to apply the GBV SOP. Relevant questions have also been incorporated in the EOA form. One PE successfully referred a for GBV survivor in February. |
| **Activity 1.2.3. Provide life skill trainings for the peer educators.** | • The activity was primary design to motivate high performing PEs while preparing them for life after close of project. However, most of the high performing PEs have already undertaken the skill acquisition course with Ginigoada, a local NGO whom FHI 360 partners to training PEs on basic life skills.<br>• Due to the above reason, the activity is further delayed pending identification of PEs and may be implemented in Q3. |
| **Activity 1.2.4. Support revision of national PE training manual to incorporate GBV interventions.** | • Progress on this activity was hindered by the absence of Prevention Steering Committee under NACS. However, with the reconstitution of NAC and appointment of a new Director, FHI 360 will follow up with the prevention lead at NACS to initiate the process beginning with the reconstitution of the Prevention Steering Committee. |
| **Task 1.3. Strengthen linkages and referral mechanisms between community and clinical services** | |
| **Activity 1.3.1. Enhance the implementation of '4-3-2' strategy.** | • The project is now implementing the '5-4-3'[5] strategy to increase coverage and meet FY 2018 targets within the nine-month period of implementation for the fiscal year. The prevention team continues to monitor the productivity of PEs and replace poor performing PEs. The "Certificate of Best Performance" remains a huge source of motivation for PEs to increase their performance. |

[5] The strategy ensures that each PE reaches at least five KPs every week, refer at least four KPs, and ensures that at least three KPs out of the three successfully access clinical services by offering accompanied referral to a testing site. It is a flexible principle and can amended based on the desired target for the project.

| Planned Activities | Achievements during the reporting period |
|---|---|
| **Activity 1.3.2. Conduct monthly focus group discussion with KP groups.** | • The focus group discussions (FGD) with peers provides opportunity for PEs to reiterate preventions messages to their peers, but more importantly, to interact with them with a view to understanding the barriers to service uptake and possible to address the impact of the barriers. A series of FGDs were held separately with male and female target populations participation ranging from 8 – 12 KPs. |
| **Task 1.4. Promote an enabling environment** | |
| **Activity 1.4.1. Conduct sensitization trainings/ meetings for community leaders.** | • Two sensitization meetings targeting Bundi and Goi communities in Port Moresby, were conducted during the reporting period. See table on capacity building for details. |
| **Activity 1.4.2. Participate in the annual 20- day activism campaign.** | • This activity was implemented in Q1. |
| **Activity 1.4.3. Support the establishment of Community Based Organizations (CBO) with the capacity to implement community prevention services.** | • The project is in the process of acquiring a post office box as part of requirement for registration with Investment Promotion Authority (IPA). |
| **Objective 2. (IR 2.2): To increase the supply of HIV/AIDS services for key populations, their sexual partners, and their families** | |
| **Task 2.1. Expand program coverage to increase service uptake among KPs** | |
| **Activity 2.1.1. Strengthen implementation of community HCT services to increase yield.** | • Microplanning and targeting of clients for community HTC services continue to improve as a total of 11 Lay Counsellor Assisted Testing Sessions at community level were held during the quarter. Five of these events were held at Burns Peak in Hohola, Mahuru, Sabama, Kaugere and Erima communities, while the rest took place at the outreach VCT site.<br>• Test yield also improved significantly compared to previous quarters as 14 clients out the total 259 clients (186-KPs; 71-other high risk individuals; & 2-low risk individuals) tested were reactive. Ten clients were subsequently confirmed HIV positive and enrolled into HIV care and treatment.<br>• Index Client Partner Testing (ICPT) was also rolled out during the reporting period as part of efforts to increase testing yield. |
| **Activity 2.1.2. Sustain technical assistance to TA only HIV clinics in NCD.** | • The project sustained its technical assistance to the 7 TA sites in NCD with a focus on implementing rapid initiation of PLHIV on ART and improving documentation using the KP version of the national surveillance tools. A review of clinic records for 6 Mile showed that majority of clients are commenced on ART within a week of enrolment and the clinic is now using the KP version of tools for documentation and therefore is now able to report disaggregated HTC data by risk group. Being a new ART site, Clinicians at Tokarara received onsite mentoring to build their skills in managing PLHIV on care and treatment, and |

| Planned Activities | Achievements during the reporting period |
|---|---|
| | documentation of services provided using standard clinic forms and log books. The clinic has 20 clients ever started on treatment and 19 were active on ART at the end of March.<br>• FHI 360 in collaboration with NCDHS facilitated site specific planning meetings with each of the seven TA clinics in March. The objectives of the meetings were to review progress made at each site, share experience, discuss challenges and way forward, and identify priority/key focus areas for the rest of the FY. Discussions were based on HIV testing data, care and treatment cascade, and overall progress in comparison to base line results. The meetings were led by the Coordinator for Disease Control and HIV Program Officer, both from NCDHS. A major outcome of this exercise is that NCDHS now has more information regarding the status of HIV services, the challenges and support needed from the leadership of NCDHS to ensure sustainability of project activities after September 2018.<br>• FHI 360 also supported NCDHS in planning for decentralization of pediatric HIV services. Two planning meetings were held with NCDHS management and another with health facility managers, to identify activities required and agreed on the health facilities that will be involved in the first phase of decentralization. Koki, 6 Mile, and Tokarara were selected for the first phase. |
| **Task 2.2. Improve quality of HIV/AIDS services** | |
| **Activity 2.2.1. Support the scale up of viral load (VL) services in NCD.** | • FHI 360, CDC and NDoH Regional Medical Officer conducted a joint mentoring visit to the 3 sites providing viral load (VL) testing services. The visit focused on proper use of VL testing algorithm, improving management of clients with high VL and handling specimens. Findings showed that Health workers in the 3 sites now have a better understanding of VL algorithm and collection of the follow-up VL sample for clients with high VL. This was a general problem in previous visits. Clinicians in the 3 clinics have also improved in terms providing Enhance Adherence Counselling (EAC) sessions. The team worked with sites to address factors contributing to low VL testing rates. The sample collection days for Begabari clinic were increased from 1 to 2 and aligned with the ART clinic days.<br>• FHI 360 also worked with Begabari and Koki to improve triage of clients to identify those due for VL test, to fast track access to EAC, and mentor clinicians on how to manage clients with high VL. Clinicians in both clinics also received mentoring to reinforce early identification of treatment failure using VL monitoring and management of clients with high VL.<br>• A follow up form was developed and is currently in use in DSD sites for clinical and immunological monitoring of clients on treatment. The tool will be rolled out in the TA sites in the coming quarter. |
| **Activity 2.2.2. Support GoPNG to strengthen guidelines and procedures for test and treat' and** | • In Feb 2018, FHI 360 conducted supportive supervision on rapid initiation of PLHIV on ART, as a follow up to the in-house training conducted in Q1. There were indications that clinics have improved in timeliness of ART initiation with most of them now initiating PLHIV on ART within one week of diagnosis or referral for enrolment in care. However, there are still |

| Planned Activities | Achievements during the reporting period |
|---|---|
| **VL services with emphasis on inclusion of KPs.** | circumstances where ART initiation is delayed especially when the PLHIV is not ready due to personal or medical reasons. There is need for a patient centred approach in the implementation of "Test and treat" was also emphasized. |
| **Activity 2.2.3. Strengthen diagnosis and management of HIV/TB co-infections and linkage to TB care.** | • With the roll-out of the new HIV registration and follow-up forms (which better captures data on initiation and monitoring of PLHIV on Isoniazid Preventive Therapy (IPT)) in FY 2017, FHI 360's care and treatment team is working with clinics to improve uptake and monitoring of IPT through completion for eligible PLHIV. During the quarter, the team focused its mentoring activities on documentation and reporting on IPT. IPT is currently a quality improvement intervention for the HIV care and treatment clinics.<br>• To strengthen collaboration between the TB and HIV programs, FHI 360 HIV program and TB program met in February to strategize on how to improve intensified TB case finding (TB-ICF) among PLHIV. The primary focus was on strengthening referral pathways between HIV and TB clinics and improving data management, especially in HIV clinics.<br>• FHI 360 HIV and TB program teams in collaboration with NCDHS and WHO conducted TB/HIV meetings with DSD sites and TB Basic Management Units (BMUs) to discuss ways of improving TB-ICF, IPT uptake and completion rates, HIV testing for confirmed TB cases, and uptake of TB treatment in co-infected patients. The main outcomes of the meetings were the development of a simple patient flow chart for TB/HIV services for Kaugere and for Koki and Badili. IPT registers were also provided to Kaugere and Koki to improve documentation and monitor IPT completions rates. |
| **Activity 2.2.4. Participate in the quarterly SIMS exercises.** | • In February, FHI 360 participated in the feedback session to Heduru Clinic on the Site Improvement through Monitoring System (SIMS) exercise conducted in Q1. While the clinic team expressed their appreciation with the exercise and feedback, the clinic management voiced their concern with the lack of financial support from the project to help address gaps flagged from the exercise.<br>• FHI 360 will continue providing the required TA to address the gaps identified. |
| **Task 2.3. Improve retention in care & treatment** | |
| **Activity 2.3.1. Implement and scale up strategies to improve retention on ART.** | • The project continues to strengthen the implementation of Active Case Management (ACM) as the core strategy for improving retention of PLHIV on ART. The pilot sites received mentoring support to improve their capacity to implement the 'three-tray' system, use of appointment registers, identify defaulters, and document and report tracking outcomes using the revised ACM reporting form.<br>• Overall tracking activities were minimal during the first part of the quarter because of human resource constraints as some clinic staff were on leave. Lack of funds for tracking and failure to maintain updated data entry in HPDB still hinder smooth implementation of ACM in the TA sites. Despite these challenges, Koki Clinic continues to do well in implementing the 'three-tray' system and on phone tracking. The clinic is now regarded as a center of excellence for implementation of the model. |

| Planned Activities | Achievements during the reporting period |
|---|---|
| | • Following a series of meetings with the management of Heduru Clinic, Global Fund (represented by oil Search at the time) and Igat Hope, Global Fund through Igat hope recruited five Adherence Counsellors and trackers in March to support ACM activities.<br>• Monthly Active Case Management (ACM) coordination meetings were held in February and March to review progress, share experience, and discuss challenges with the implementation of the model. |
| **Activity 2.3.2. Implement effective tracking systems to reduce lost to follow-up (LTFU).** | • Following reports of high LTFU observed in Ela Beach (a satellite ART sites to Koki) especially among FSW, a meeting was held with health workers at the clinic and the Medical Officer at Koki Clinic to develop strategies for reversing the trend. A quality improvement plan was put in place, while the case manager responsible for tracking was placed on a performance improvement plan due poor performance lack of interest carrying out tracking activities. The clinic is also discussing with the outreach team on the possibility working with FSW peer educators to assist in tracking the over 20 FSW LTFU at the clinic.<br>• Simple data collection forms were developed for Koki and Kaugere clinics to help clinicians plan and document outcomes of physical tracking activities.<br>• To improve networking and cooperation between sites in the tracking of clients LTFU, the ACM coordinator developed time lines for participating clinics to send names of eligible clients for interfacility tracking and for site visits. These timelines were dully communicated to all pilot sites. An immediate outcome from this innovation was the successful tracking of 5 clients declared LTFU at Koki during the quarter. The 5 clients were found to have self-transferred to Begabari and Heduru clinics. |
| **Task 2.4. Build capacity of service providers to implement 'test and treat'** | |
| **Activity 2.4.1. Strengthen the capacity of service providers to implement 'test and treat'.** | • All TA-SDI ART sites are now implementing 'test and treat' for all populations with mentoring support from FHI 360.<br>• The 'Test & Treat' brochure was presented to the national HIV TWG in March. The TWG approved the with a few suggest edits. These edits have already been made and the document is now ready for printing. |
| **Activity 2.4. 2. Conduct onsite mentoring support to service providers on sexually transmitted infections (STIs) management.** | • FHI 360 conducted site visits to support health workers on proper filling on the revised STI forms introduced in Q4 FY 2017.<br>• During supervision, the team supported the sites to address other challenges and ensured that STI algorithms and the necessary job aides are in place.<br>• Stock out of STI reagents was a hindrance to the smooth implementation of STI services during the quarter. Weak coordination of STI services at the level of NDoH is also impacting negatively on services at the clinic level. NDoH promised to address the challenges in procurement process. |
| **Activity 2.4.3. Train HCT providers on Couple Counselling.** | • Counselors and clinicians from both DSD and TA clinics participated in the training on couples counselling training conducted in February, as part of preparations for the roll out of ICPT. See table on capacity building for details |

| Planned Activities | Achievements during the reporting period |
|---|---|
| **Activity 2.4.4. Conduct mentoring and supportive supervision on HIV testing and Counselling.** | • FHI 360 provided TA to HTC sites to implement recommendations from supportive supervisory visit conducted by the Central Public Health Laboratory (CPHL) in Q1. Follow-up action actions implemented during the quarters and successes recorded include;<br>○ Procured stopwatches for clinics that had no functional stopwatches, to ensure adequate timing of testing procedures<br>○ Distributed laminated HIV testing algorithms/job aides in all testing rooms (pinned in strategic areas where they can be read).<br>○ Provided mentoring support to ensure implementation and proper documentation of regular internal quality control (IQC) checks on RTKs. FHI 360 liaised with CPHL to obtain positive and negative control serum for IQC for health facilities that had none (Lawes road, 9 Mile, Ela Beach) and mentored them on the process to follow for replenishment. Health facilities have started conducting and recording IQC results in their HTC log book. Health facilities were also reminded to alternate staff who participate in national external quality assurance survey (NEQAS) and to record NEQAS results in the HCT log book.<br>○ Procurement of fridge thermometers and temperature log charts to all sites.<br>○ The outreach HIV testing site has been enlisted for NEQAS and will be eligible to participate in the next survey will be conducted in May 2018<br>○ An HTC counsellor was recruited for Lawes Road Clinic with funding support from the DFAT supported NCD Community Based TB Treatment project. This paved the way for normal HTC services to resume at the clinic.<br>• Follow up actions taken to improve quality assurance for CD$ testing using PIMA include<br>○ Training of health workers at 9 Mile and 6 Mile on how to conduct CD4 testing using the PIMA.<br>○ Addressed repeated error readings noted at Koki Clinic. |
| **Task 2.5. Documentation of lessons learnt** | |
| **Activity 2.5.1. Document and share lessons learned from implementation of various strategies.** | • Documentation of lessons learned from implementing KP friendliness assessment and implementation of mVCT was finalized with support from FHI 360 HQ.<br>• An abstract on TB-ICF was also developed and undergoing internal review before submission for the 2018 IAC in July.<br>• Concept notes have also been developed on scientific writing focusing various topic including the use of the 'decision tree tool' for categorizing clients, spectrum of engagement of PLHIV in care and treatment, and ACM. When finalized, the concept notes will be shared with FHI 360's PHSC for non-research determination. |
| **Objective 3. (IR 2.3): To increase use of facility and community based gender and GBV interventions** | |

| Planned Activities | Achievements during the reporting period |
|---|---|
| **Task 3.1. Strengthen clinical responses for GBV** | |
| **Activity 3.1.1. Scale up GBV services to four additional TA clinics in NCD.** | • Preliminary meetings were held with clinic leads of 5 site clinics (Heduru, Tokarara, 6 Mile, 9 Mile and Gerehu) in January, to sensitize them on GBV integration into HIV services, and to agree on possible dates for GBV readiness assessments. Subsequently, GBV readiness assessments were conducted in Heduru Clinic to assess the current system and capacity to offer post-GBV care to survivors, and make recommendations as per findings from assessment in terms of space and equipment, essential drugs for post-GBV care, and training requirements. Similar assessments were done for Tokarara Clinic in January and 9 Mile Clinic in February.<br>• FHI 360 supported two trainings in February (on the GBV screening protocol and GBV data collection tools) for TA clinics as part of preparations for the roll out of GBV services. see summary table on capacity building for details.<br>• In March the gender Officer provided onsite support to 9 Mile, Begabari, 9 Mile, Heduru, Gerehu and Tokarara to help each clinic develop their implementation plan for integrating GBV services into HIV services in Q3 and Q4.<br>• Facility GBV readiness assessments for 9 Mile and Tokarara were completed in March.<br>• A major outcome of the above interventions, 3 TA sites (Heduru, 9 Mile and Tokarara) commenced reporting GBV service statistics at the end of the quarter. |
| **Activity 3.1.2. Provide mentoring support to GBV service providers in supported clinics** | • In January, the gender team provided mentoring support to staff of Ela Beach Clinic and 'House of Hope' shelter, focusing on improving case management, accurate documentation and ensuring compliance with the US government "Protecting Life in Global Health Assistance (PLGHA) and Statutory Abortion Restrictions 2018" policy, especially as it applies to the management of GBV survivors. Similar mentoring was provided to staff of 'Meri Seif Haus' in Kaugere, focusing on case management, documentation and reporting, and application of standard operating procedures (SOP)/guidelines for shelter services.<br>• Two financial literacy trainings were also organized for GBV survivors and GBV support group members attached to 'House of Hope' and 'Meri Safe Haus' shelters in February and March, respectively in partnership with ANZ Bank's "MoneyMinded" Program team (see summary table on capacity building for details). The trainings were organized as part of economic empowerment activities to improve financial planning and management abilities of beneficiaries.<br>• FHI 360 also assisted to Anglicare PNG to mobilized technical assistance for its Economic Empowerment Program by linking them to ANZ Bank's "MoneyMinded" Program team who agreed to facilitate a financial literacy training for Anglicare staff and other beneficiaries of Anglicare programs. |
| **Task 3.2. Improve access to quality shelter services** | |

| Planned Activities | Achievements during the reporting period |
|---|---|
| **Activity 3.2.1. Develop a two-day training curriculum on trauma counselling.** | • This activity was pending availability of FHI 360's Senior Gender Advisor from HQ, in country. Because her travel to PNG is delayed, she will now be developing the materials remotely. The curriculum is expected to cover topics on couple counselling, counselling of children and family counselling. The gender team made available relevant materials on the local context to guide the Advisor on the development of the final materials. |
| **Activity 3.2.2. Train GBV case managers on case management and trauma counselling.** | • This activity will be conducted only after the training curriculum on trauma counselling is finalized. |
| **Task 3.3. Mobilize community structures/systems to strengthen referrals and strengthen uptake of post-GBV services** | |
| **Activity 3.3.1. Collaborate with UN Women to promote GBV awareness and post GBV service availability.** | • Although this activity was scheduled for Q2, its implementation was delayed due to the sudden disengagement of the program officer who was driving the activity. |
| **Activity 3.3.2. Conduct quarterly gender norms and GBV sensitization training.** | • Three batches of gender norm trainings were conducted during the quarter. The trainings targeted members of Sabama Market, Mahuru in Manu, and Goi Settlement in Badihagwa. See summary table on capacity building for details. |
| **Activity 3.3.3. Provide a coordinated phone-based counselling and referral services.** | • FHI 360's partnership with ChildFund and FSVAC in operating the '1-Tok Kaunselin Helpim' phone counselling service continued through the reporting period. The call center dedicated a significant amount of time to provide trauma counselling support to victims of multiple earthquakes that hit certain parts of PNG, especially the highlands region, during the reporting period.<br>• A total of 706 individuals (including 415 males, 291 females) accessed the hot line service during the quarter. About 68% of callers were survivors, while the rest were either perpetrators or witnesses of GBV. Only one KP member (a PLHIV) accessed the service. A total of 117 callers were referred for shelter/welfare services, 237 for law enforcement/legal services, 123 for counselling services, and 2 for HTC/ART services.<br>• FHI 360's IT Officer provided technical support to the call center to trouble shooting internet issues that were interfering with the functionality of the database. |
| **Activity 3.3.4. Develop a referral protocol for service providers.** | • FHI 360 and other partners are working with the national Family and Sexual Violence Action Committee (FSVAC) to develop a National Referral Guideline. FHI 360 Senior Gender Advisor (Maryce Ramsey) remotely provided technical inputs on the guideline by reviewing the document and writing some sections on support Services for KPs, the elderly and those with disabilities. Her inputs will be incorporated into the final document as annexes.<br>• It is hoped that the document will be finalised and printed in the coming quarter. |

| Planned Activities | Achievements during the reporting period |
|---|---|
| **Task 3.4. Support GOPNG's efforts to strengthen the implementation of the national strategy for GBV** | |
| **Activity 3.4.1. Support the rollout and implementation of the PNG National Sexual & GBV Clinical Guidelines.** | • The first phase of this activity (pilot training on the PNG National Sexual & GBV Clinical Guidelines Daru, Western Province and Arawa, Autonomous Region of Bougainville) was completed in Q4 of FY 2017, and a final report submitted to DFAT and NDoH. The pilot training identified areas for improvement in the overall health system responses to GBV.<br>• FHI 360 is waiting on the Gender Division of NDoH to advise and provide direction on the second phase of the roll-out. This will be one of the agendas for discussion in the second Gender/GBV TWG meeting on April 26th 2018. |
| **Activity 3.4.2. Participate in the Gender/GBV TWG meetings.** | • After several months without a meeting, FHI 360 in collaboration with USAID successfully revived the National Gender TWG meeting. FHI 360 hosted the first meeting of the TWG for FY 2018 in February. The meeting was attended by 10 individuals (6 females; 4 males) from various NGOs, government departments, donor partners and the UN agencies. Key agenda items included the 2018 annual implementation plan (AIP) for the Gender Division of NDoH, development of GBV tools and monitoring & evaluation framework. Discussions on the first agenda point were around capacity building for staff on GBV, mainstreaming gender under leadership, advocacy and governance and gender equity and social inclusion (GESI) Policy. The second agenda point was more about the GBV Curriculum for health workers and the data tools that will be used to capture GBV data at the facility level. The Gender Division stated that there was a training conducted and they would follow up on the effectiveness of that training, review tools, and roll out a reporting template. The next TWG meeting was scheduled for Thursday, 26th April, 2018.<br>• Also, participated in the NCD FSVAC Secretariat meeting held in March during which FHI 360 was highly commended as the only partner to submit a comprehensive report detailing key activities and achievements for the 2017 calendar year. The main action point at the meeting was the need to revised the 2016 – 2018 GBV strategy plan for NCD to align with the national strategy. FHI 360 will work with other partners to support the review process. |
| **Objective 4 (IR 2.4.): To strengthen health systems for HIV/AIDS service delivery** | |
| **Task 4.1. Strengthen monitoring and evaluation system for HIV program in NCD** | |
| **Activity 4.1.1. Facilitate routine data collation and reporting.** | • The expanded M&E team (FHI 360 M&E and the M&E/ACM coordinator embedded in NCDHS) continued to work closely with NCDHS HIV program team to coordinate the efforts of M&E Officers of implementing partner organizations and clinic M&E focal persons towards ensuring timely and complete submission of national HIV surveillance reports from all HIV clinics operating in NCD. NCDHS and FHI 360 provided onsite mentoring support to M&E focal persons on their role of facilitating timely submission of reports to NCDHS and NDoH.<br>• Reporting rates for national surveillance reports continue to improve as highlighted under objective 4 results in the analysis section. |

| Planned Activities | Achievements during the reporting period |
|---|---|
| | • Three TA clinics (Heduru, Tokarara and 9 Mile) also commence reporting GBV data during the reporting period. |
| **Activity 4.1.2. Establish routine province-wide monthly data verification and quarterly data quality audits (DQA).** | • The first province-wide DQA exercise was conducted during the quarter in collaboration with NCDHS, NDoH and USAID. A total of 10 HIV clinics including ART and HTC only sites participated in the exercise. See object 4 section und result analysis for details.<br>• Monthly data verification of core program indictors, using the data verification and improvement tool (DVIT), was sustained through the quarter. |
| **Activity 4.1.3. Support effort to decentralize data entry at to province.** | • FHI 360 in collaboration with CDC continued to work towards the decentralization of data entry into the national SQL database to NCDHS. Significant progress was made, but actual implementation is hindered by challenges with re-configuration of the SQL server at NDoH to allow access at subnational levels. |
| **Activity 4.1. 4. Build capacity of NCDHS M&E team and M&E focal persons on data analysis.** | • This activity was implemented in Q1 in collaboration with CDC. FHI 360 M&E team continued to provide hands mentoring to the NCD M&E team on how to compile, profile, analyze and present data for discussion or decision making purposes. |
| **Activity 4.1.5. Conduct joint supportive supervisory visits.** | • No joint supportive supervisory visit was conducted during the quarter due to competing task. The project prioritized the first data quality assessment exercise for the reporting period. However, onsite mentoring was done for site M&E focal persons and clinicians to strengthen the use of the KP version of the national surveillance tools. |
| **Activity 4.1.6. Support national effort to establish a key population management information system (KPMIS).** | • The expended M&E team continued to persuade and mentor service providers across HIV clinics in NCD to correctly and consistently use the revised version of the 'decision tree tool' and the KP version of the national clinic forms and log books that were rolled out in FY 2017. There are indications that that an increasing number of TA clinics and service providers are now using the tools as evident in the increasing proportion of individuals accessing HTC service who are categorized and reported based on risk groups.<br>• FHI 360 M&E team also provided technical support to DSD clinics in compiling backlog data for entry into the national KPMIS database. All backlog data will be entered during the coming quarter. The outreach component of KP data has already been entered into the database. |

| Planned Activities | Achievements during the reporting period |
|---|---|
| **Activity 4.1.7. Conduct monthly M&E/referral coordination meeting.** | • Two meetings were held during the quarter on Feb 23 and March 16, respectively. FHI 360 and the NCDHS team used the meetings to emphasize the importance of maintaining quality data, and the need adopt a culture of analyzing and using data for decision making especially at the health facility level. The HIV cascade for NCD was also presented and became a key discussion point was focus on efforts at achieving the '90-90-90' global HIV treatment goal. Participants shared their views and recommendations on how best to improve service delivery and quality of documentation to improve the HIV Cascade. FHI360 also provided feedback on the first NCD-wide Data Quality Audit (DQA) highlighting common data quality issues. This also prompted participants share more recommendations for improvements.<br>• NCDHS and participant continued to appreciate FHI 360 its M&E system strengthening efforts in NCD and especially for introducing the M&E meeting which now provides opportunity for to share and learn from the experience of others in data management. |
| **Activity 4.1.8. Conduct quarterly program performance review meeting.** | • The quarterly performance review meeting was held in February, 2018 with a focus on reviewing Q1 results, discussing major challenges encountered and priorities for Quarter 2. Highlight of the meeting was a speech by FHI 360 Country Director to sensitize participants on the project end date and plans for a phased close out of project activities beginning in Q2. Implementing partners were encourage to work toward achieving their FY 2018 targets by the end of the Q3 as activities will be streamlined to essential services needed to maintain PLHIV on care and treatment. Participants also identified priority activities for Q2 |
| **Activity 4.1.9. Strengthen the use of HIV patient Database (HPDB) in all eligible ART clinics in NCD.** | • FHI 360 continued to provide technical assistance to 9 ART clinics in NCD on use of HIV Patient Database (HPDB) through staff onsite mentoring visits and strengthening linkages with other ART sites within NCD. Most of the support was around ensuring that HPDB entries were up to date and facilities can use data from HPDB to improve patient care, and for quality improvement, and to facilitate the implementation of Active Case Management.<br>• FHI 360 also work with CDC to ensure the deployment of an upgrade version of the HPDB which better supports data management for TB/HIV including patient monitoring on IPT. The New version of the HPDB which also include a module on internal DQA was deployed to Kaugere, Koki, Lawes Road and Begabari clinic during the reporting period. |
| **Activity 4.1.10. Conduct follow-up assessment of NCD M&E system.** | • This activity is scheduled for Q3 |
| **Activity 4.1.11 Organise to review NCD IBBS results and discuss strategies to increase coverage.** | • This activity did not take place as planned. However, FHI 360 participated in Global Fund facilitated meeting in March to discuss a new prevention strategy being proposed by a Global Fund (Scott Berry). The peer mobilizer model is being proposed for implementation as part of the respondent driven approach (RDA). FHI 360 also had a follow up meeting with the |

| Planned Activities | Achievements during the reporting period |
|---|---|
| | consultant to better understand the workings of the new model and it main difference from the EOA. As a fallout of this meeting, FHI 360 will be piloting the peer mobilizer model in the coming quarter.<br>• This activity is therefore no longer a priority. |
| **Task 4.2. Improve supply chain management of medical commodities to minimize stock-outs and expiries.** | |
| **Activity 4.2.1 Mentor service providers to effectively monitor stock-outs and expiries of drugs and testing kits.** | • FHI 360 provided ongoing support to all DSD sites |
| **Task 4.3. Prepare implementing partner organizations and provincial governments for seamless transition of Project activities to the Government of PNG** | |
| **Activity 4.3.1 Conduct follow-up NUPAS for 3 implementing partner organizations.** | • FHI 360 reviewed progress on the implementation of post-NUPAS recommendations/interventions with the three implementing partners in NCD (TSA, FSC and FSVAC). While FSC had implemented all the recommendations, TSA was yet to fully migrate its project accounts to the 'attache' software. FSVAC was still reviewing its records management policy. FHI 360 provide ongoing support to all three partners to complete implementation of recommendations.<br>• Follow-up NUPAS will now be conducted in Q3. |
| **Activity 4.3.2. Engage with government and implementing partners on sustainability of program activities.** | • A meeting was held with the Director of Public Health, NCDHS (Dr. Wuatai) on the 13th of March to discuss sustainability of project activities under TSA. The focus of the meeting was to find a way of sustaining salaries of 9 project staff at Koki clinic who had already been transitioned to TSA, as TSA was excluded from CHS funding for health programs in NCD. See section under Challenges for details. |
| **Activity 4.3.3. Hold monthly PEPFAR update meetings for NCD Health Services.** | • Due to non-availability of the public health team of NCDHS, only the one update meeting was held March. See program management section under result analysis for details. |
| **Task 4.4 Document lessons learnt and share best practices** | |
| **Activity 4.4.1 Conduct operational research on selected components of the project.** | • Initial data analysis on ART adherence research showed a violation of the approved protocol in terms of the number of interviews conducted, number of participants and duration of some focal group discussions (FDG) and in-depth interviews (IDI). Additional IDIs will be conducted and new FGDs organized during the coming quarter in a bit to address the violations. Meanwhile, a protocol violation report has been submitted to FHI 360 PHSC for review guidance on the next steps. |
| **Activity 4.4.2 Document lessons learned from M&E systems strengthening.** | • A concept note for a scientific paper on NCD M&E system improvement effort was developed during the quarter. The paper will focus on highlighting lessons learned from the application of the M&E system assessment tool (SAT) and outcomes from interventions implemented to improve the NCD M&E system. The concept is currently undergoing internal review and will be subjected to a non-research determination by FHI 360's PHSC. |

RESULTS AGAINST THE PERFORMANCE MANAGEMENT PLAN (PMP)

**Table 3: Performance Management Plan Indicators and Achievements (aggregate), Q2 FY 2018**

| Indicator | Q2 Results (Jan. 1 – Mar. 31, 2017) | FY 18 Achievements (Oct. 1 2017 - Sept. 30, 2018) | FY 18 Targets (Oct. 2017 - Sept. 2018) | Justification |
|---|---|---|---|---|
| **Objective 1: To increase demand for HIV/AIDS services by key populations, their sexual partners, and their families** | | | | |
| **IR1.1. Improve knowledge, attitudes, and practices (KAP)** | | | | |
| **# of KPs reached with individual and/or small-group-level HIV prevention interventions that are evidence-based or that are facilitators of evidence-based intervention (KP_PREV).** | **1,180**<br>KP disaggregation: -<br>833 FSW<br>308 MSM<br>39 TG | **1,939**<br>KP disaggregation: -<br>1,339 FSW<br>548 MSM<br>52 TG | **2,800 individuals**<br>1,770 FSW<br>515 MSM<br>515 TG | 69% of FY 2018 target achieved.<br>Project reviewed its '4-3-2' strategy to '5-4-3', hence the increase in quarterly results. |
| **# of the priority populations who completed a standardized HIV prevention intervention including the minimum components during the reporting period. (PP_PREV).** | **773**<br>PP disaggregation: -<br>415 high risk men (including 238 MTS)<br>358 high risk women | **1,450**<br>PP disaggregation: -<br>719 high risk men (including 421 MTS)<br>731 high risk women | **2,000 individuals** | 73% of FY 2018 target achieved.<br>Same explanation as for KP_PREV above. |
| **% of female and male sex workers reporting the use of condoms with their most recent client (PEPFAR P9.2. N).** | | **FSW - 39.4%**<br>**MSM/TG - 30.4%** | **85% among WTS and MTS** | Based on 2017 National IBBS in NCD. |
| **IR 1.2. Improved Health Seeking Behaviours** | | | | |
| **# of individuals who received counselling & testing services for HIV and received their test results (HTC_TST).** | **6,709 (288 HIV+)**<br>Sex disaggregation: -<br>2,114 males, 4,527 females, 68 TGs.<br><br>Risk group disaggregation: -<br>831 KPs, 1,416 high risk,<br>1,109 low risk,<br>3,353 unknown risk group<br><br>PEPFAR support disaggregation:<br>DSD - 1,938 | **11,561 (535 HIV+)**<br>Sex disaggregation: -<br>3,633 males, 7,853 females, 75 TGs.<br><br>Risk group disaggregation: -<br>1,215 KPs, 2,236 high risk,<br>1,714 low risk,<br>6,396 unknown risk group<br><br>PEPFAR support disaggregation:<br>DSD-SDI – 3,266 | **8,258 individuals (534 HIV+)**<br>(DSD-4,820; TA-3,438) | 140% of FY 2018 target achieved (DSD-68%; TA-241%).<br>Large contributions from 3 TA sites (Gerehu, Tokarara and 6 Mile) which were not considered in the 2018 target allocation). FHI 360 requests to revise the targets to reflect expected results from these clinics. |

| Indicator | Q2 Results (Jan. 1 – Mar. 31, 2017) | FY 18 Achievements (Oct. 1 2017 - Sept. 30, 2018) | FY 18 Targets (Oct. 2017 - Sept. 2018) | Justification |
|---|---|---|---|---|
| | TA-SDI - 4,771 | TA-SDI - 8,295 | | |
| **# of individuals who received STI management services (additional indicator).** | **546**<br>Sex disaggregation:<br>174 males, 367 females, 5 TGs.<br><br>Risk group disaggregation:<br>175 KPs<br>356 high risk<br>15 low risk | **941**<br>Sex disaggregation:<br>273 males, 660 females, 8 TGs.<br><br>Risk group disaggregation:<br>302 KPs<br>614 high risk<br>25 low risk | **2,000 individuals** | 47% of FY 2018 target achieved. |
| **# of condoms distributed (additional indicator).** | **120,512 condoms**<br><br>Disaggregation by type:<br>110,903 male condoms<br>9,609 female condoms<br>3,664 lubricants | **287,722 condoms**<br><br>Disaggregation by type:<br>269,205 male condoms<br>18,517 female condoms<br>13,476 lubricants | **500,000** condoms | 57.5% of FY 2018 target achieved.<br>Well above expected 50% due to consistently high demand for flavored condoms. |
| **Objective 2. To increase supply of HIV/AIDS care, treatment and support services for key populations** | | | | |
| **IR 2.1. Quality of HIV/AIDS services improved** | | | | |
| **# of adults and children receiving antiretroviral therapy (ART) [Current] (TX_CURR).** | **3,726**<br>Sex disaggregation:<br>1,472 males; 2,243 females; 11 TG<br><br>Risk group disaggregation:<br>173 KPs, 337 high risk, 2 Low risk<br>3,214 unknown risk.<br><br>Disaggregation by PEPFAR support:<br>DSD – 442; TA – 3,284 | **3,726**<br>Sex disaggregation:<br>1,472 males; 2,243 females; 11 TG<br><br>Risk group disaggregation:<br>173 KPs, 337 high risk, 2 Low risk<br>3,214 unknown risk.<br><br>Disaggregation by PEPFAR support:<br>DSD – 442; TA – 3,284 | **7,941 clients**<br>706 from DSD sites<br>7,235 from TA sites | 47% of FY 2018 target achieved (DSD-63%; TA-45%). With the transition in data sources DSD dropped by 4% and TA by 44%. See challenges for details of factors responsible for drop. |
| **% of adults and children known to be alive and on treatment 12 months after commencement of ART (TX_RET).** | | | **90%** | Measured annually |

| Indicator | Q2 Results (Jan. 1 – Mar. 31, 2017) | FY 18 Achievements (Oct. 1 2017 - Sept. 30, 2018) | FY 18 Targets (Oct. 2017 - Sept. 2018) | Justification |
|---|---|---|---|---|
| **# of adult and paediatric patients on ART with suppressed viral load results (<1,000 copies/ml) documented in the medical records and/or supporting laboratory results within the past 12 months (TX_PVLS - Numerator).** | **275**<br>Koki – 29<br>Begabari – 8<br>Heduru - 238 | **275**<br>Koki – 29<br>Begabari – 8<br>Heduru - 238 | **3,321**<br>318 from DSD sites<br>3,003 from TA sites | 8.3% of FY 2018 target achieved. Only 3 PEPFAR supported are providing VL services. Expansion of the service has been hindered by a combination of HR and logistics challenges at CPHL. |
| **# of adult and paediatric patients with a viral load result documented in the patient medical record or in the facility health information system in the past 12 months (TX_PVLS - Denominator).** | **325**<br>Koki – 38<br>Begabari – 16<br>Heduru - 271 | **325**<br>Koki – 38<br>Begabari – 16<br>Heduru - 271 | **3,691**<br>354 from DSD sites<br>3,337 from TA sites | 8.8% of FY 2018 target achieved. Same reason as above. |
| **IR 2.2. Coverage of HIV/AIDS services improved** | | | | |
| **# of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrolment: clinical assessment (WHO staging) OR CD4 count OR viral load (CARE_NEW).** | **337**<br>Sex Disaggregation:<br>136 males; 197 females; 4 TGs<br><br>Risk group disaggregation:<br>24 KPs, 51 high risk, 3 Low risk 259 unknown risk.<br><br>Disaggregation by PEPFAR support:<br>DSD – 65; TA-SDI - 272 | **611**<br>Sex Disaggregation:<br>254 males; 353 females; 4 TGs<br><br>Risk group disaggregation:<br>49 KPs, 93 high risk, 3 low risk, 466 unknown risk.<br><br>Disaggregation by PEPFAR support:<br>DSD – 130; TA-SDI - 481 | **862 clients**<br>310 from DSD sites<br>552 from TA sites | 71% of FY 2018 target achieved (DSD-42%; TA-87%). Slowdown in testing in Ela Beach affected DSD results while contributions from 6 Mile Clinic and Gerehu (not considered in target allocation for FY 2018) accounts for the high results performance in TA sites. |
| **# of adults and children with advanced HIV infection newly enrolled on ART (TX_NEW).** | **321**<br>Sex Disaggregation:<br>132 males; 185 females; 4 TGs<br><br>Risk group disaggregation:<br>38 KPs, 42 high risk, 3 Low risk, 238 unknown risk. | **530**<br>Sex Disaggregation:<br>221 males; 305 females; 4 TGs<br><br>Risk group disaggregation:<br>64 KPs, 76 high risk, 3 Low risk, 387 unknown risk. | **748**<br>270 from DSD sites<br>478 from TA sites | 70.9% of FY 2018 target achieved (DSD-41.5%; TA-87.4%).<br>Same explanations as for CARE_NEW above. |

| Indicator | Q2 Results (Jan. 1 – Mar. 31, 2017) | FY 18 Achievements (Oct. 1 2017 - Sept. 30, 2018) | FY 18 Targets (Oct. 2017 - Sept. 2018) | Justification |
|---|---|---|---|---|
| | Disaggregation by PEPFAR support: DSD-54; TA-SDI-267 | Disaggregation by PEPFAR support: DSD-112; TA-SDI-418 | | |
| **% of ART patients who completed a standard course of TB preventive therapy within the reporting period (TB_PREV).** | | | **65%**<br>**Num – 99 (DSD-36, TA-63)**<br>**Den – 149 (DSD-54, TA-95)** | |
| **% of PLHIV who were screened for TB symptoms at last clinical visit to an HIV care facility during the reporting period (TB_SCREENDX).** | **92.5%**<br>Site Disaggregation:<br>Kaugere 78.8%<br>Koki 99.0% | **94%**<br>Site Disaggregation:<br>Kaugere 86.2%<br>Koki 98.6% | **90%** | 104% of FY 2018 target achieved.<br>Results reflect situation in DSD sites where routine TB screening is done religiously and well documented. |
| **IR 2.3. Local capacity of service delivery enhanced** | | | | |
| **# of staff trained in service delivery (additional indicator).** | **119**<br>Disaggregation by Sex:<br>90 males; 24 females; 5 TGs<br><br>Disaggregation by Type:<br>Sexual and Rep Health 14; TB 18; Index Partner Testing 43; Couple Counseling 19; GBV Data Tools 11 and; GBV Screening Protocol 14. | **173**<br>Disaggregation by Sex:<br>110 males; 54 females; 9 TGs<br><br>Disaggregation by Type:<br>25 GBV sensitization; 29 M&E training (data analysis); Sexual and Rep Health 14; TB 18; Index Partner Testing 43; Couple Counseling 19; GBV Data Tools 11 and; GBV Screening Protocol 14. | **200 individuals** | 86.5% of FY 2018 target achieved. |
| **Objective 3. To increase the use of facility and community-based gender and gender-based violence interventions** | | | | |
| **Gender norms within the context of HIV/AIDS: # of people completing an intervention pertaining to gender norms that meets minimum criteria (GEND_NORM).** | **68**<br>Disaggregation by Sex: 33 males, 35 females | **95**<br>Disaggregation by Sex: 49 males, 46 females | **75 individuals** | 127% of annual target achieved.<br>3 batches of gender norms trainings were conducted during the quarter. |

| Indicator | Q2 Results (Jan. 1 – Mar. 31, 2017) | FY 18 Achievements (Oct. 1 2017 - Sept. 30, 2018) | FY 18 Targets (Oct. 2017 - Sept. 2018) | Justification |
|---|---|---|---|---|
| **# of referrals from HIV-related interventions to GBV services (additional indicator).** | **98**<br>Disaggregation by Sex:<br>26 males (including 12 MSM/TG),<br>72 females (including 12 FSW). | **152**<br>Disaggregation by Sex:<br>35 males (including 19 MSM/TG),<br>117 females (including 22 FSW). | **250 clients** | 61% of FY 2018 target achieved.<br>Implementation of SOP for community GBV empowerment and resumption of activities at Meri Seif Haus contributed to increase in results. |
| **Gender-based Violence (GBV) Care: # of people receiving post-GBV care (GEND_GBV).** | **199**<br>Disaggregation by Sex: 41 males (including 17 MSM/TG), 158 females (including 48 FSW)<br><br>Disaggregation by PEPFAR support:<br>DSD - 120<br>TA-SDI – 79. | **281**<br>Disaggregation by Sex: 50 males (including 17 MSM/TG), 231 females (including 52 FSW)<br><br>Disaggregation by PEPFAR support:<br>DSD - 202<br>TA-SDI – 79. | **250 individuals**<br>200 from DSD sites<br>50 from TA sites | 112% of FY 2018 target achieved (DSD-101%; TA-158%). Improved referral linkages accounts for the high performance. 3 TA sites also started report during the quarter. |
| **Objective 4. To strengthen health systems for HIV/AIDS service delivery** | | | | |
| **IR 4.1. Monitoring & Evaluation (M&E) improved** | | | | |
| **# of PEPFAR-supported testing facilities with capacity to perform clinical laboratory tests (LAB_CAP).** | **5**<br>1 DSD sites; 4 TA sites | **5**<br>1 DSD sites; 4 TA sites | **7** | 71% of FY 2018 target achieved.<br>Close out of project activities in Madang and closure of Kilakila Clinic affect results. |
| **# of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or that have achieved a minimal acceptable level toward attainment of accreditation (LAB_ACC).** | **5**<br>1 DSD sites; 4 TA sites | **5**<br>1 DSD sites; 4 TA sites | **7** | 71% of FY 2018 target achieved.<br>Close out of project activities in Madang and closure of Kilakila Clinic affected results. |
| **# of PEPFAR-supported DSD and TA sites (SITE_SUPP)** | **10 sites** | **10 sites** | **10** | 100% of FY 2018 target achieved. |

| Indicator | Q2 Results (Jan. 1 – Mar. 31, 2017) | FY 18 Achievements (Oct. 1 2017 - Sept. 30, 2018) | FY 18 Targets (Oct. 2017 - Sept. 2018) | Justification |
|---|---|---|---|---|
| | Breakdown[6]<br>9 ART (2 DSD, 6 TA);<br>9 HTC sites (3 DSD, 6 TA);<br>4 Lab sites (1 DSD, 3 TA);<br>6 CD4 Services (2 DSD, 4TA) | Breakdown[7]<br>9 ART (2 DSD, 6 TA);<br>9 HTC sites (3 DSD, 6 TA);<br>4 Lab sites (1 DSD, 3 TA);<br>6 CD4 Services (2 DSD, 4TA) | | |
| **% of PEPFAR-supported clinical service sites with quality improvement activities implemented that address clinical HIV program processes or outcomes and that have documented process results for the last six months (QI_SITE).** | **80% (8/10)** | **80% (8/10)** | **100%** | 80% of FY 2018 target achieved.<br>Close out of project activities in Madang and closure of Kilakila Clinic affected results. |
| **% of PEPFAR-supported laboratories and testing sites that participate in and successfully pass proficiency testing (PT) program (LAB_PT).** | | | **100%** | No External Quality Assurance (EQA) was conducted in Q1.<br>NDOH has reduced PT to twice a year. |
| **IR 4.2. Supply chain management improved** | | | | |
| **# of facilities reporting no stockout of ART, opportunistic infection (OI), or STI drugs in the last three months (additional indicator).** | | | **100%** | |

Note: The primary data sources are EOA forms, clinic log books, GBV screening forms, care & treatment track logs, HPDB, training reports, and monthly narrative reports. Care and treatment data for all TA sites were generated from the HPDB courtesy NDoH. HTC data for all TA sites were sourced from the national surveillance forms submitted to NCDHS.

[6] Some sites fall in more than one category. For example, all the ART site are also HTC sites.
[7] Some sites fall in more than one category. For example, all the ART site are also HTC sites.

# RESULT-BY-RESULT ANALYSIS

## General Program Management

### *I. Visit by Deputy Mission Director, USAID Philippines*

The Deputy Mission Director, USAID Philippines Mission, Clay Epperson, visited the project on 5th and 6th February, as part of his monitoring visit to USAID funded programs in PNG. Highlights of his visit included: a presentation by FHI 360 program team highlighting FHI 360's portfolio in PNG and progress with the KP project implementation; a meeting with TSA project management team to understand their role and contributions to the project; walk-through visits of the service delivery points at Koki and Ela Beach clinics, and an interactive session with the gender team at the 'House of Hope' shelter in Ela Beach.

Clay's visit to 'House of Hope' shelter, Ela Beach


James (Counsellor at Ela Beach) explains client flow to Clay and others

### *II. Technical documentation of project results and Closeout report*

As the project approaches its end date, a significant amount of time was devoted to technical documentation of project results and lessons learned from implementing various strategies, approaches and models implemented over the life of project. Technical documentation on lessons learned from implementing the KP friendliness assessment exercise as quality improvement process, and mVCT (including the lay counsellors assisted approach) as a strategy for increasing access to HTC service among KPs, were completed during the quarter with remote support from FHI 360 HQ. The Senior Strategic Information Advisor, FHI 360 HQ (Gina Etheredge) was also in-country in March to provide technical assistance on scientific writing. During her visit, three abstracts (on TB-ICF, GBV/HIV integration and EOA) were developed and are currently being reviewed for submission for the 2018 International AIDS conference taking place in Amsterdam from July 23-27. She also supported the development of concepts notes on 6 topics being considered for peer review publications. The concept notes will be submitted for non-research determination by FHI 360 Protection of Human Subjects Committee (PHSC).

An international consultant (Shanthi Noriega) has been engaged to assist with the final closeout report writing for the project. Shanthi will be in-country in May to begin work on the report.

### *III. Compliance with USG Protecting Life in Global Health Assistance and Statutory Abortion Restrictions - 2018*

Following the release PLGHA policy, FHI 360 took steps to enlighten its staff and implementing partner organizations on the requirements and implication of the policy. FHI 360 program, M&E, technical, finance, and grant management personnel were subjected to a mandatory online certificate course on the policy. To ensure compliance to the policy, a half-day orientation meeting was held with implementing partner organizations under the project to educate them on the provisions of the policy and the compliance standard to observe. FHI 360 sub-agreements with each implementing partner was subsequently amended to incorporate relevant clauses on the policy and due diligence checks carried out with each partner to ascertain their eligibility/compliance prior to amendments.

To monitor compliance with the policy, FHI 360 staff carry out routine checks (using a standardized checklist) as part of their site visits and review of contractual documents including, monthly progress reports and monthly sub-agreement financial reports.

### *IV. Implementation of new strategies*

During the quarter, the project commenced implementation of Index Client Partners Testing (ICPT) as a strategy to increase testing yield. Outreach workers and clinicians from the three DSD project sites participated in an orientation workshop to introduce them to the concept and operational design. Although this intervention is being introduced only 6 months to the close of the project, it is expected that lessons learned from its implementation will inform the design of the follow-on project. Initial success with the implementation of ICPT in Koki clinic is captured in the snapshot story. Prior to the implementation of ICPT, the project funded couples counselling training, in collaboration with the NDoH and NCDHS as index partner testing will engage couples and partners.

Similarly, FHI 360 also commenced preparation to pilot the Peer Mobilizer concept in line with the proposal from Scott Berry as part of the strategy for increasing coverage on KP testing, using the Enhanced Outreach Prevention Approach. A pilot design has been developed and will be rolled out in the coming quarter.

### *V. PEPFAR update meeting with NCDHS*

Only the March, 2018 edition of the monthly PEPFAR update meeting with NCDHS was held during the quarter. No meetings were held in January and February as the leadership of the Public Health Department at NCDHS was unavailable for the meeting. NCDHS, the GF team (now represented by World Vision), USAID and CDC maintained active participation at the meeting.

Key highlights of the meeting include; an update on the decentralization of data entry into the national surveillance database to NCDHS; presentation of the final report on the service availability mapping (SAM); progress on FHI 360'sTA activities in NCD; presentation on the NCD epidemic snapshot by CDC; and discussion on the EOA flow chart and incentive structure. Key resolution was as follows;

- Shift the deadline for the commencement of data entry into the national server to March 30
- The final report on Service Availability Mapping exercise is excellent and NCDHS would get the City Manager for the National Capital District Commission (NCDC) to co-sign the forward with the director of public health

- FHI 360 to work with the regional medical officer for the southern region to commence Art service at Gerehu Hospitals
- FHI to present the EOA flow charts and incentive structure for consideration at the Global Fund facilitated stakeholders' meeting with Scott Berry.

### *VI. Updates on project sustainability*

Refer to annex 2 for update on progress.

### *VII. 90:90:90 Pivot*

***Table 4: 90:90:90 Pivot (Q2 activities & achievements)***

| 90 % Status Known | 90 % On ART | 90 % VL suppressed |
|---|---|---|
| ➢ Supported couples counselling training for NCD to pave the way for partner testing.<br>➢ Commenced implementation of ICPT.<br>➢ Developed design to pilot Peer Mobilizer model under RDA approach. | ➢ Continued monthly interfacility ACM review meeting with NCDHS | ➢ Re-oriented Igat Hope case managers to focus on tracking missed appointment/ defaulters at Heduru Clinic |
| **Crosscutting** | | |
| ➢ Commence reporting GBV service statistics from three TA sites (Heduru, 9 Mile and Tokarara)<br>➢ Continue TA support on GBV/HIV integration at Begabari and Lawes Road Clinic<br>➢ Organised first NCD wide DQA in collaboration with NDoH, NCDHS, and USAID<br>➢ Continue NCD-wide, monthly data review meetings | | |

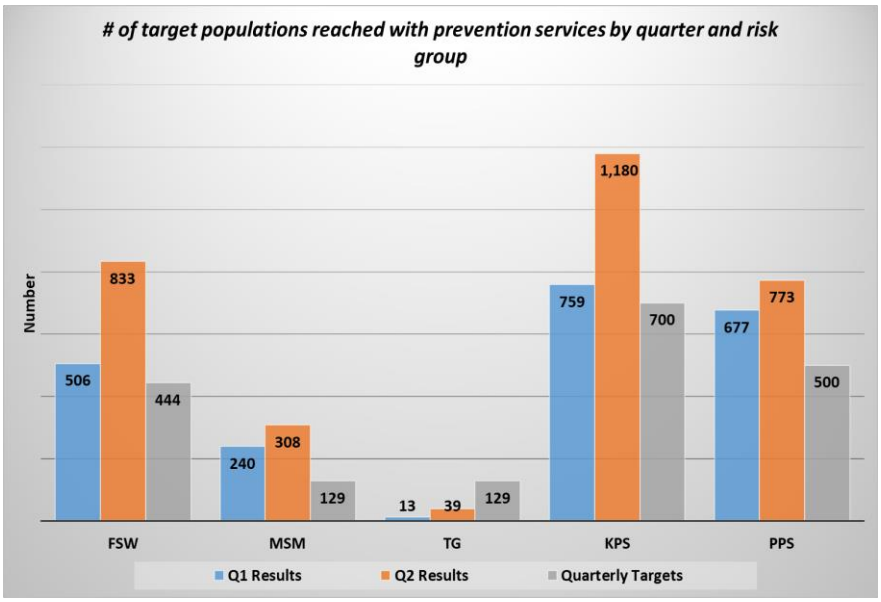
TA activities implemented in Q2 are summarized in the table below. A detail progress report on FHI 360's technical support to the 7 TA sites is provided in a separate report.

**Progress by Objectives**

**Objective 1: To increase demand for HIV/AIDS Services by KPs, their sexual partners, and their families.**

***IR1.1. Improve knowledge, attitudes, and practices (KAP)***

This intermediate result (IR) includes the PEPFAR Outputs KP_PREV[8] and PP_PREV[9].




The Project has now achieved a cumulative of 69% and 73% of FY 2018 targets for KP_PREV and PP_PREV, respectively, as there were significant improvements over Q1 results across target populations, especially female sex workers (FSW) (64% increase). More KPs than PPs were reached this quarter compared to Q1. The overall improvement is not unexpected, as project activities usually would pick up in Q2 after the usual slow down associated with the Christmas season in Q1. The increase reflects the impact of new innovations introduced in Q1 to increase coverage of outreach services in response to results of the 2017 IBBS in Port Moresby. The main innovation was the review of the '4-3-2' strategy to '5-4-3' to reach more KPs and improve successful referrals.

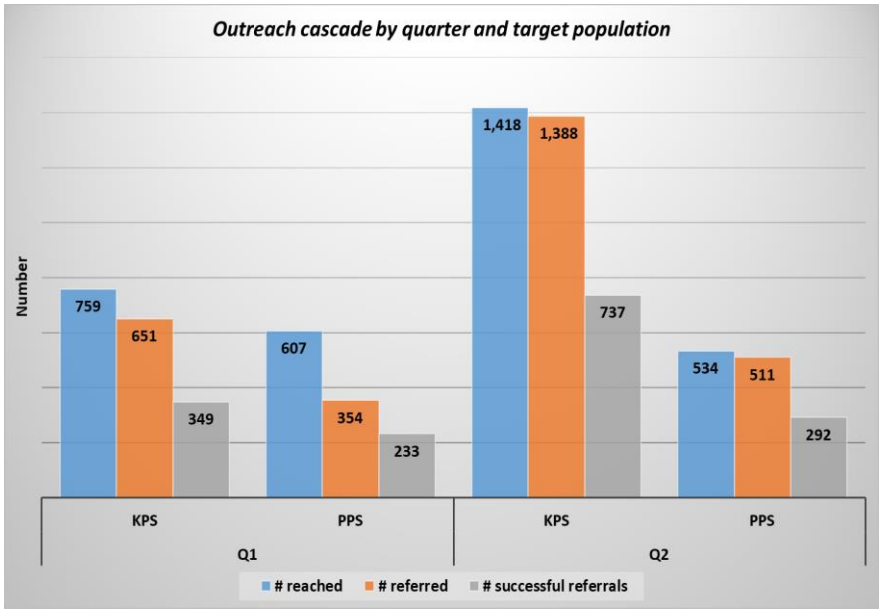
Despite the significant increase across KP groups, the cumulative number of TGs reached at the end of semester represents only 40% of the FY 2018 target of 129. Though reaching TGs is a huge challenge, the project will take advantage of the peer mobilizer model which will be piloted in Q3 to reach more TGs.

**Linkage of Outreach to Clinic**

A close look at the outreach (referral) cascade shown below also indicates a significant increase in the proportion of individuals reached with prevention messages and were referred over Q1 results, as 98% of KPs and 96% of PPs who were reached by PEs in Q2 were referred for clinical services.

[8] Three KP groups are identified under the project; (1) Female Sex Workers (FSW) also referred to as women in transactional sex (WTS) (2) men who have sex with men (MSM) including those involved in sex work, and (3) Transgender people including those involved in sex work category.

[9] In context of the project 'Priority Populations' includes (1) High Risk Men (HRM) - men (excluding MSM and TG) who have had more than one concurrent sexual partner in the past twelve months, do not meet the criteria to be categorized as KPs; (2) High Risk Women (HRW) - women who have had more than one concurrent sexual partner in the past twelve months, do not meet the criteria to be categorized as KPs; and (3) Men in transactional sex (MTS) who are not MSM/TGs, but exchange sex for favors. Unlike in other countries where KPs would be a distinct and static group, in PNG there is fluidity between the "high-risk" group and the KPs as many people will engage in transactional sex on needs basis. Also, due to the legal environment (homosexuality and transactional sex being illegal) KPs especially FSW and MSM are less likely speak openly about their sexual behaviors and more likely to be picked up as 'High Risk' individuals.



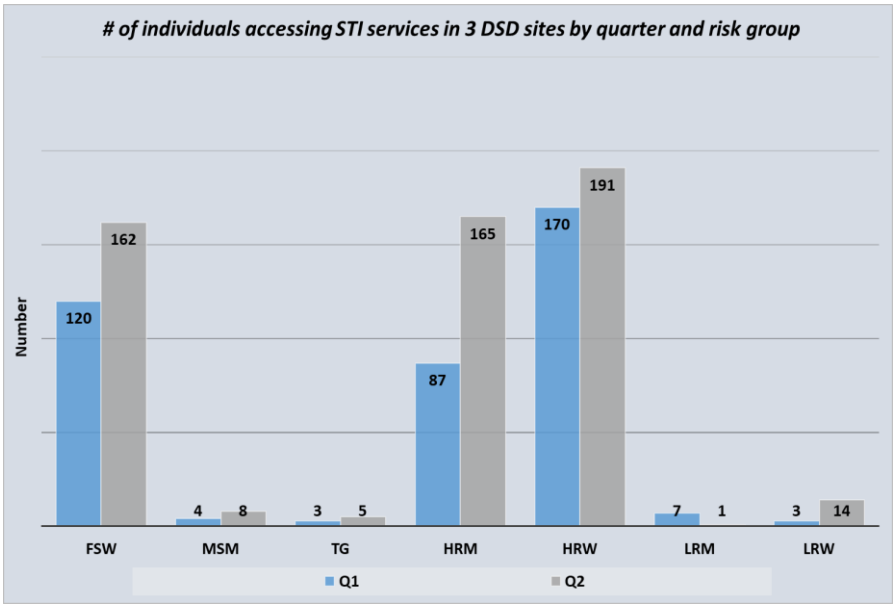

However, proportion of PPs who were successfully referred for HTC/STI services by PEs, dropped from 66% in Q1 to 57% in Q2. This drop was less significant among the KPs (from 54% in Q1 to 53% in Q2). The project will continue to strengthen the implementation of its '5-4-3' strategy to ensure further improvements in successful referrals in the coming quarter.

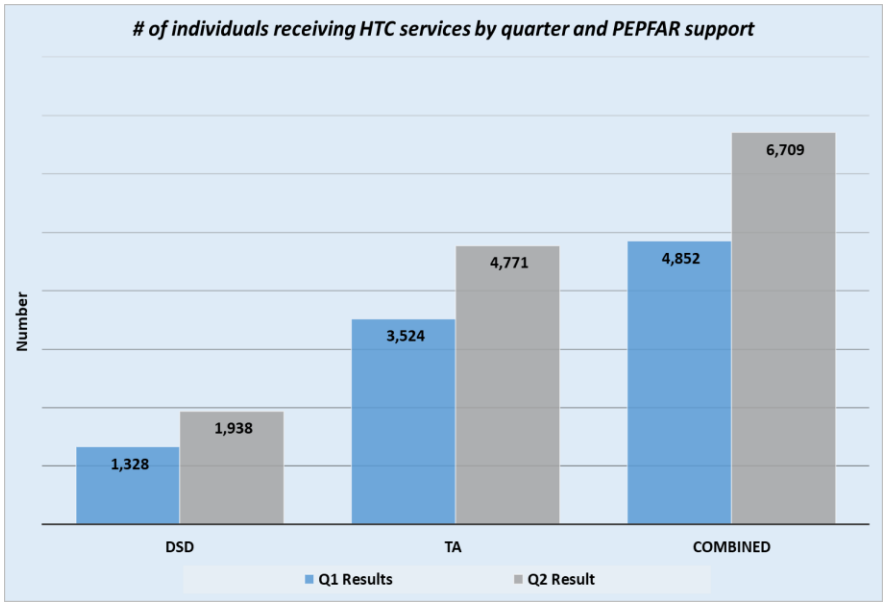
***IR1.2. Improved health-seeking behaviors***

This IR includes the PEPFAR indicator HTS_TST, HTS_TST_POS as well as STI service uptake and condom distribution.

STI results represent contributions from the 3 DSD sites in NCD (Kaugere, Koki and Ela Beach). The number of individuals accessing STI management services in Q2 increased significantly over Q1 results across all risk groups, except for low risk men. This increase was more significant among other high risk men (HRM) (90%; n=78) and the FSW (35%; n=42).

Despite the improvement, accumulative results for FY 18 stills at 47% of the FY 2018 target of 2,000. As part of efforts to boost achievement in STI management, the project had conducted STI refresher training for both TA and DSD clinics in Q4 of FY 2017 to improve the skill of clinicians to provide quality STI services. During the reporting period the project also orientated its outreach workers on STIs and the close association between HIV and other STIs. However, frequent stock out of STI drugs and lab reagents and consumables continues to impact on STI services.






All the existing 10 sites (3 DSD and 7 TA-SDI sites) contributed to HTC results during the quarter. Overall, there was a 46% and 35% increase over Q1 results for DSD and TA sites, respectively. Cumulative FY 2018 results at the end of Q2 represents 140% of the FY 2018 target of 8,258. Although achievements at the DSD stands at 68% of FY target, The TA sites largely account for the huge over-achievements (241% of FY target) due to contributions from 6 Mile, Tokarara, and Gerehu which were not assigned any targets for FY 2018. The three sites accounted for 49% of TA-SDI results.

FHI 360 proposes an upward review of the FY 2018 target for TA-SDI sites to include expected results from three sites.

***HIV testing yield by type of PEPFAR support and risk group***

| *Risk Group* | DSD Sites | | | TA Sites | | | All sites | | |
|---|---|---|---|---|---|---|---|---|---|
| | # tested | # HIV+ | % HIV+ | # tested | # HIV+ | % HIV+ | # tested | # HIV+ | % HIV+ |
| *WTS* | 461 | 33 | 7.2% | 124 | 17 | 13.7% | 585 | 50 | 8.5% |
| *MSM/TG* | 184 | 4 | 2.2% | 62 | 3 | 4.8% | 246 | 7 | 2.8% |
| *High-risk men* | 385 | 17 | 4.4% | 352 | 26 | 7.4% | 737 | 43 | 5.8% |
| *High-risk women* | 378 | 15 | 4.0% | 301 | 33 | 11.0% | 679 | 48 | 7.1% |
| *Low-risk men* | 151 | 0 | 0.0% | 189 | 0 | 0.0% | 340 | 0 | 0.0% |
| *Low-risk women* | 379 | 0 | 0.0% | 390 | 4 | 1.0% | 769 | 4 | 0.5% |
| *Unknown men* | 0 | 0 | 0.0% | 859 | 51 | 5.9% | 859 | 51 | 5.9% |
| *Unknown women* | 0 | 0 | 0.0% | 2,494 | 85 | 3.4% | 2,494 | 85 | 3.4% |
| *Total* | **1,938** | **69** | **3.6%** | **4,771** | **219** | **4.6%** | **6,709** | **288** | **4.3%** |

Overall positivity rate for all risk groups tested in both the DSD and TA-SDI sites was 4.3%. This is a drop from 5.1% recorded in Q1. On the whole, positivity rates remain highest among FSW and other high risk women. The project continues to see relatively lower positivity rates in FSW and MSM/TG compared to findings from the 2017 IBBS in Port Moresby. The relatively higher positivity rates among KPs in the TA-SDI sites is because of the small volume of KP data reported by the TA-SDI sites. Secondly, some of the TA sites (especially Begabari and Heduru) are referrals sites for most stand-alone VCT sites. Hence these two clinics receive lots of referrals for confirmatory testing and retesting of already confirmed cases who present for ART enrolment without results of testing from the testing sites. Lastly, many clients tested at TA sites are patients who may be presenting with other medical problems, but accessing HTC services as part of their evaluation. These clients are more likely to test positive compared to those accessing services at the DSD site who are mainly referrals from PEs. Gerehu Hospital is a high-volume testing site (25% of TA-SDI results) and serves as a reference Basic Management

Unit (BMU) for TB services (including MDR-TB). The site tested significant number of TB patients and has a high yield. These patients are often reported under the low risk or uncategorized group and therefore account for the relatively high positivity rate among these groups in TA-SDI sites compared with the DSD. FHI 360 will be working with NDoH to introduce ART services in the facility in the coming quarter.

***Mobile Voluntary Counselling and Testing(mVCT) and Lay counsellors assisted testing for improving access for the target population***

With the more promising results coming through the lay counsellor assisted HTC, the Project focus more on this mode of testing during the reporting period. As shown in the table below, most of those reached with mobile testing through the lay counsellor's approach (79%). Although the overall testing yield was lower (4.9%) compared to Q1 (7.4%), the yield from lay counsellor's assisted testing (which is facilitated by PEs) remains higher compared to that from mVCT events facilitated by the clinic teams. Fourteen out of the 259 reached through the lay counsellor assisted approach were reactive to determine. Ten out of the 14 were eventually confirmed HIV positive and linked to HIV care and treatment.

***Individuals reached with mobile HIV test services***

| Risk Group | mVCT (by clinic Teams) | | | Lay counsellor assisted Testing (by PEs) | | | Combined | | |
|---|---|---|---|---|---|---|---|---|---|
| | No. Tested | No. Reactive | % | No. Tested | No. Reactive | % | No. Tested | No. Reactive | % |
| *Key Populations* | 27 | 1 | 3.7 | 186 | 13 | 7.0 | 213 | 14 | 6.6 |
| *High risk men & women* | 28 | 1 | 3.6 | 71 | 1 | 1.4 | 99 | 2 | 2.0 |
| *Low risk men & women* | 13 | 0 | 0.0 | 2 | 0 | - | 15 | 0 | 0.0 |
| *Total* | **68** | **2** | **2.9** | **259** | **14** | **5.4** | **327** | **16** | **4.9** |

FHI 360 will continue to strengthen its mVCT program, especially the lay counselor assisted component and use is as a vehicle to drive ICPT among KPs and other high risk individuals.

***Condom Distribution***

| *Quantity of Condoms and lubricants distribution by outlets* | | | | |
|---|---|---|---|---|
| **Organization** | **Mode of Distribution** | **Male** | **Female** | **Lubricants** |
| **FHI 360 Outreach team** | Outreach by PEs & various community outlets. | 68,900 | 6,468 | 2,216 |
| **Foursquare Church** | Clinic visits and mVCT. | 4,249 | 565 | 1,125 |
| **The Salvation Army** | Clinic visits and mVCT. | 16,000 | 512 | 270 |
| **Other stakeholders** | Clinic and community outlets. | 21,754 | 2,064 | 53 |
| | **Total** | **110,903** | **9,609** | **3,664** |

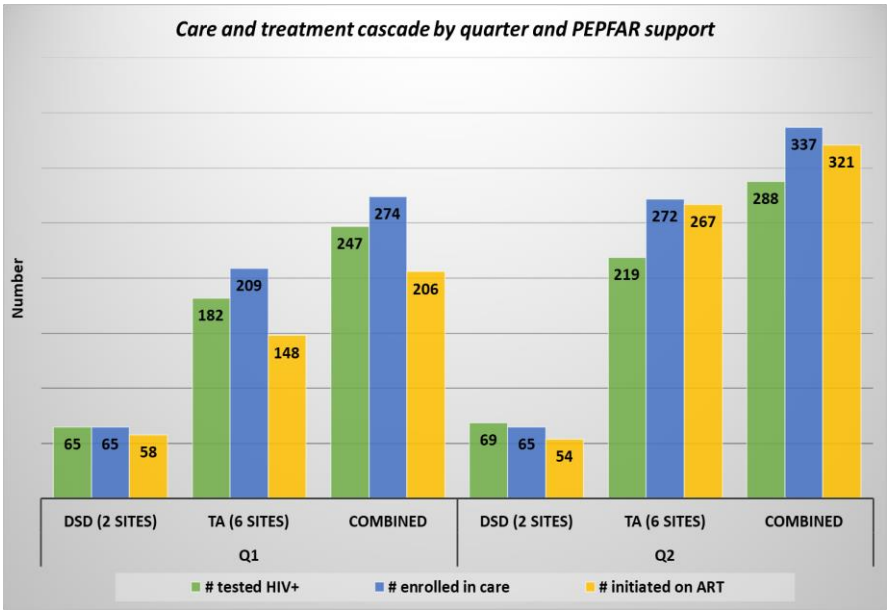
Most of the condoms and lubricants were distributed by PEs during outreach events and through other partners not directly supported by the project. The clinic partners (i.e. FSC and TSA) also distributed condoms at the health facilities as well as during mVCT and other community based events. About 20% of condoms and 2% of lubricants distributed were through other partners as there was shortage of condoms in the country during the quarter in addition to the high preference and demand for the scented brand of condoms distributed by FHI 360.

FHI 360 and USAID are in discussion with the government of PNG, through the office of the Deputy Secretary of Health and Director of NACS, to find a lasting solution the recurrently challenges supply chain for condoms in the current. At the request of the government USAID will be providing TA to the government in this regard.

**Objective 2: To increase the supply of HIV/AIDS services for KPs, their partners, and their families**

***IR2.2. To increase supply of HIV/AIDS services for KPs, their sexual partners, and their families***

This IR includes the PEPFAR indicators CARE_NEW, TB_SCREEN, TB_PREV, TX_NEW, TX_CURR, TX_RET and TX_PVLS.




Two DSD sites and six TA-SDI sites in NCD contributed to care and treatment results in Q2. As per the care and treatment cascades, there were slight drops in the proportion of PLHIV who were newly registered into care (94%) and proportion of those newly registered who were initiated on ART (83%) in the DSD sites compared to Q1 results (100% and 89%, respectively). TA sites continued to register more than 100% of PLHIV identified into care because some of them, especially Heduru, Begabari, and 6 Mile, receive many referrals from other testing sites that are not supported by the project. Heduru and Begabari do very little testing, but receive lot of referrals. However, there was a major improvement in the proportion of newly registered PLHIV who were initiated on ART (from 75% in Q1 to 98% in Q2).

**Viral Load**

VL services resumed in Q1 with the three sites supported under the project (Koki Begabari and Heduru). Although VL services were also rolled out at St Joseph's Clinic in Q2, FHI 360 was not involved in this effort. Achievements on VL from the three FHI supported clinics for Q2 are summarized in the table below.

***# of VL test by site.***

| Clinic | # of individuals tested for VL | # of VL results <1000c/ml | % Virally suppressed |
|---|---|---|---|
| **Heduru** | 271 | 238 | 88% |
| **Begabari** | 16 | 8 | 50% |
| **Koki** | 38 | 29 | 76% |
| **Total** | **309** | **267** | **86%** |

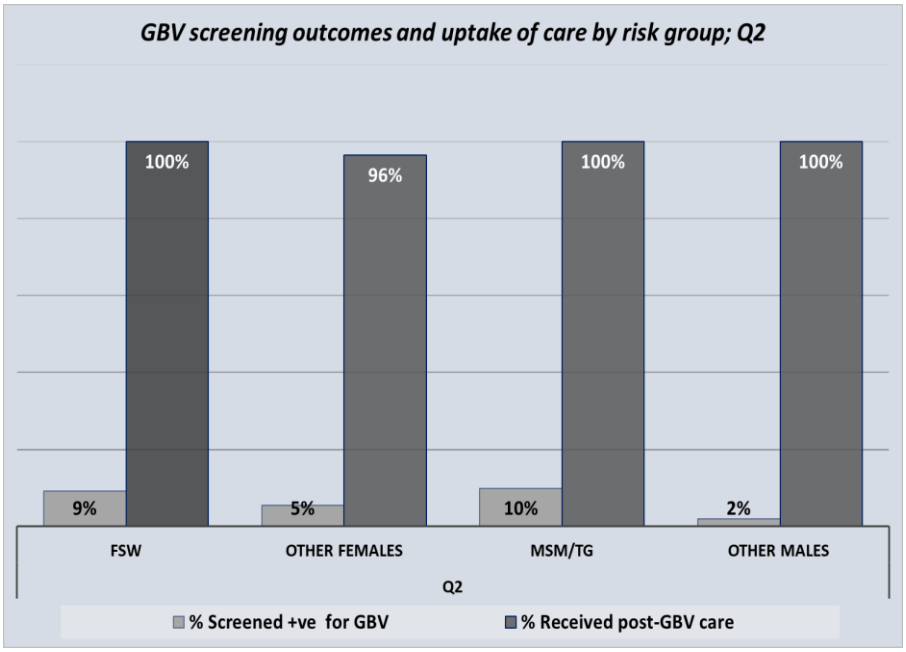
**Objective 3: To increase use of community and facility-based Gender and GBV interventions**

This objective includes the PEPFAR indicators GEND_NORM and GEND_GBV, and an additional indicator for referrals.

**GBV screening and post-GBV care**

***GBV Screening outcomes by PEPFAR support***

| | DSD | | | TA Sites | | | All Sites | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Males** | **Females** | **Total** | **Males** | **Females** | **Total** | **Males** | **Females** | **Total** |
| **# Screened for GBV** | 783 | 1,401 | 2,184 | 208 | 411 | 619 | 991 | 1,812 | **2,803** |
| **# Screened +ve for GBV** | 24 | 66 | 90 | 7 | 52 | 59 | 31 | 118 | **149** |
| **# Walk-in GBV Cases** | 4 | 26 | 30 | 6 | 18 | 24 | 10 | 44 | **54** |
| **# GBV survivors (Screened & Walk-ins)** | 28 | 92 | 120 | 13 | 70 | 83 | 41 | 162 | **203** |
| **# received post GBV Care** | **28** | **92** | **120** | **13** | **66** | **79** | **41** | **158** | **199** |




Three DSD and three TA sites in NCD contributed to results on GEND_GBV for the quarter. The three TA sites (Heduru, 9 Mile and Tokarara) reporting data for the first time since the Project started TA expansion activities in FY 2016. Overall, there was an increase in the proportion of screening for GBV at various HIV service delivery points from 3% in Q1 to 5.3% in Q2. This increase was mainly driven by the TA sites where 9.5% of those seen screened positive for GBV compared with 4.1% in the DSD sites. GBV positivity was highest among MSM/TG and FSW; 10% (15/151) and 9% (47/516), respectively. Ninety-eight percent (98%) of GBV survivors seen during the quarter (including survivors among screened and walk-ins) received post-GBV care. Except for the general female population group, other groups recorded 100% uptake of post GBV-care.

Cumulatively, 281 survivors of GBV have received post-GBV care, representing 124% of the FY 2018 targets. FHI 360 is proposing an upward review of the FY 2018 target as more TA sites are expected to start report in the coming quarter.

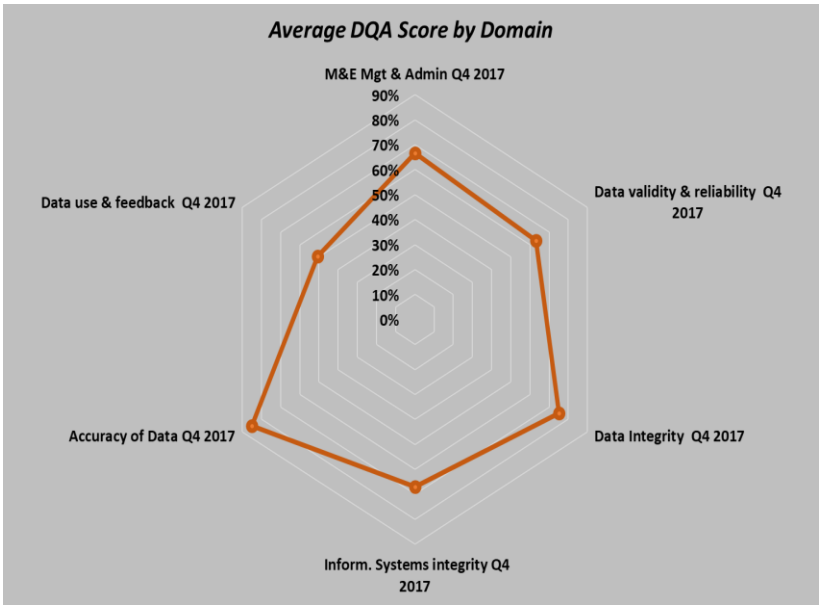
**Objective 4: To strengthen health systems for HIV/AIDS service delivery**

***IR4.1. Monitoring & Evaluation (M&E) improved***

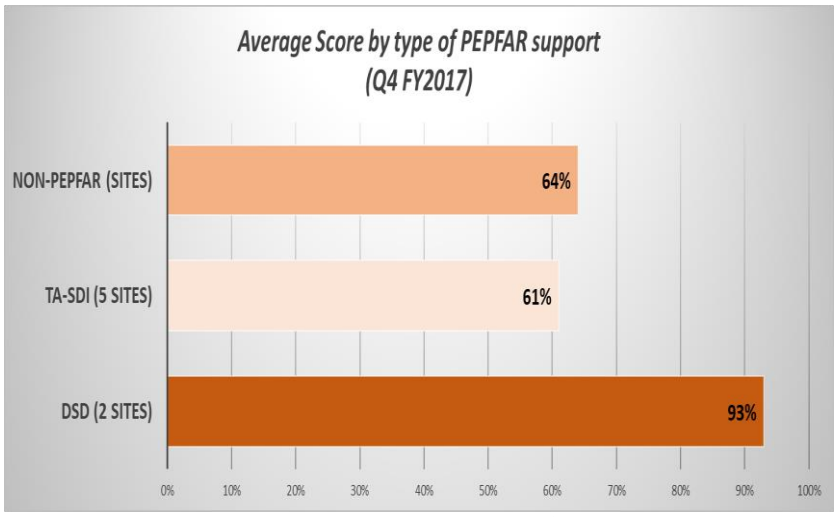
This intermediate result includes several PEPFAR indicators measuring laboratory capacity (LAB_CAP, LAB_ACC, LAB_PT), quality improvement (QI_SITE and SITE_SUPP), and M&E strengthening.

***NCD M&E System Strengthening***

**NCD-wide Data Quality Audit (DQA)**



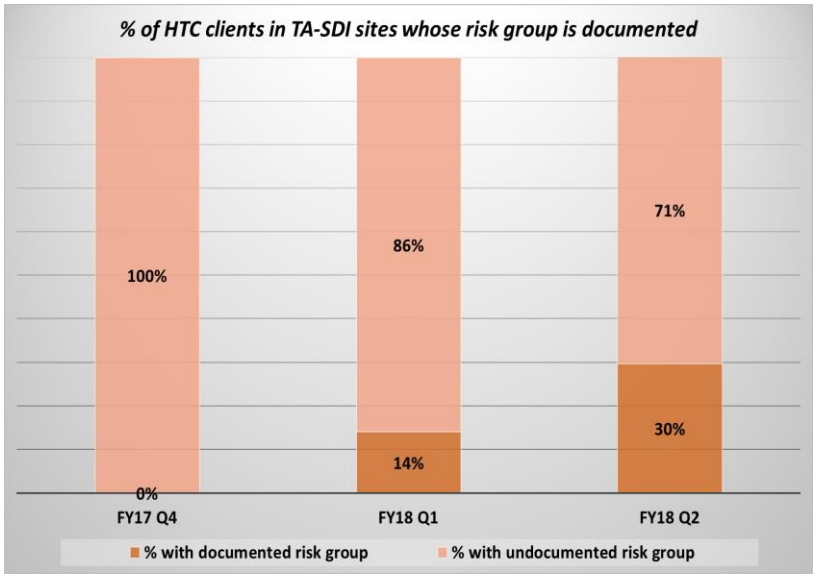

The Project continued to make significant progress with its M&E system strengthening activities in NCD. the first NCD-wide data quality audit (DQA) was conducted with participation of NCDHS, NDoH and USAID. The exercise was conducted in 10 clinics (including 2 DSD sites, 5 TA sites and 3 other non-PEPFAR supported sites). The exercise was carried using the M&E system assessment tool (SAT) developed by FHI 360. The tool which was endorsed by NDoH and WHO for purpose of piloting the DQA, looks at 6 mains domains.




Findings show that the main gaps are with data use & feedback, validity & reliability of data generated by sites, the integrity of information systems, as well as the over management and administration of M&E activities. Most of the sites seem to have high level of data accuracy. This is likely due to regular monthly data verification activities driven by the M&E/ACM Coordinator for NCDHS and FHI 360 M&E Officer. Both officer use the data verification and improvement tool (DVIT) developed by FHI 360 to verify data reported by clinics for key indicators on monthly basis. Further analysis of results by type of PEPFAR support indicates that the two DSD had a much higher average score compared to the TA and non-PEPFAR supported sites. This is expected as the DSD have benefitted from a longer more comprehensive M&E technical assistance from FHI 360.

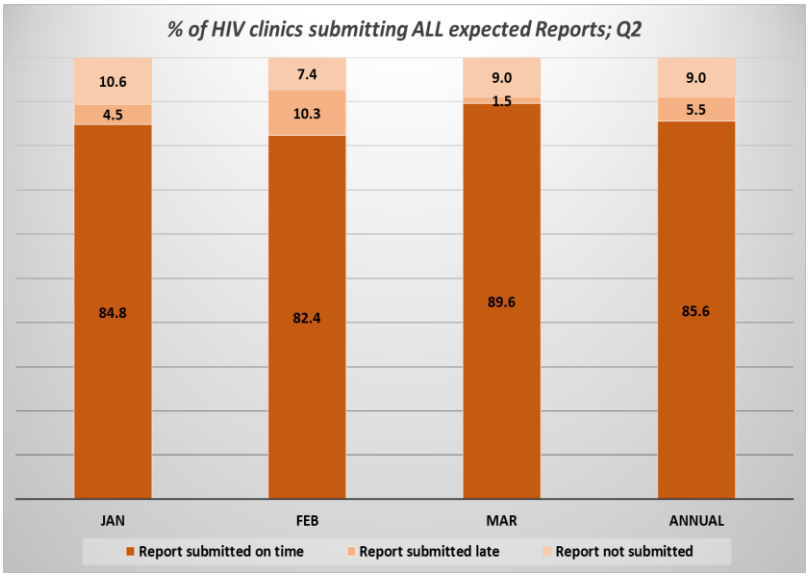
FHI 360 will continue to work closely with NCDHS, NDoH, USAID and CDC to strengthen the weak components of data quality.

**Data disaggregation by risk group.**




The proportion of HTC clients seen in TA sites whose risk group is documented more than doubled the Q1 results in Q2 as clinicians in the TA sites are increasingly using the decision tree tool to determine the risk groups of clients and document appropriately using the KP version of the national clinic forms and logs books. 30% of clients who received HTC services in the 7 DSD sites into appropriate risk groups using the decision tree tool. This categorization (into KP, high risk, low risk or unknown) is primarily for the purposes of monitoring the epidemic trends and reporting to the national KPMIS. This is the result of persistent mentoring and persuasion of clinicians in the TA sites on the relevance and use of the tools which were adopted as national tools by the HIV TWG in FY 2017. FHI 360 continue to support TA-SDI sites on the use the KP version of the national tools in the coming quarter.

**Reporting rates**




Report rates remain high during the quart as the ACM/M&E Coordinator who is embedded in NCDHS office and the facility M&E focal persons become more familiar with their roles and in ensuring timely availability of program data for decision making. The proportion of expected monthly reports that are submitted by HIV clinics (within 30 days after the end of the reporting period), increased gradually from 89% in January to 91% in March. Proportion of expected reports submitted on time (within one week) increased to 85% to 90% within thein same period. results for the indicators represent an improvement over Q1 results.

## FOCUS FOR THE NEXT QUARTER

In quarter 3 of FY 2018, FHI 360 and partners will focus on the following priorities;

- Scale up of VL Services to three more sites
- Propose and support the review of HPDB focusing on TX_CURR to verify the number of people on active on ART in NCD
- Facilitate commencement of ART services at Gerehu Hospital
- Support NCDHS to decentralize ART Services in NCD
- Organize a stakeholders' meeting with USAID to discussion sustainability of the project
- Commence phased close of project activities/IA sub-agreements and preparation of final project close-out report
- Continue Technical documentation of project results
- Completing data analysis and disseminate results of operations research on treatment adherence
- Support NCDHS to commence decentralized data entry at provincial level.

## FINANCIAL SUMMARY

The remaining balance for all objectives is within the generally accepted ± 10 percent. There is no explanation included to justify the difference between budget and actual expenditure

| Period Budget (USD) | Period Actuals (USD) | Remaining Balance (USD) | Explanation |
|---|---|---|---|
| **Objective 1 (IR 2.1.): To increase demand for HIV/AIDS services by KPs, their sexual partners, and their families** | | | |
| 145,605 | 134,630 | 10,974 | |
| **Objective 2 (IR 2.2.): To increase supply of HIV/AIDS services for KPs, their sexual partners, and their families** | | | |
| 153,626 | 139,219 | 14,406 | |
| **Objective 3 (IR 2.3.): To increase use of facility- and community-based Gender and GBV interventions** | | | |
| 142,730 | 133,183 | 9,548 | |
| **Objective 4 (IR 2.4.): To strengthen health systems for HIV/AIDS service delivery** | | | |
| 124,428 | 127,439 | (3,011) | |
| **Total Indirect Cost** | | | |
| **165,096** | **160,942** | **4,154** | |

USAID | PACIFIC ISLANDS

## SNAPSHOT: Index Client Partner Testing (ICPT); an innovation to boost HIV testing yield.

The Strengthening HIV/AIDS Services for Key Population in PNG, project targets communities and populations with the highest needs for HIV testing and prevention interventions. However, the positivity rate from program data was declining contrary to results from recent Integrated Bio-behavioral Survey (IBBS) conducted in Port Moresby (2017). This implies that there are still many undiagnosed people living with HIV (PLHIV) who need to be reached, tested and enrolled on antiretroviral therapy (ART). To address this gap, the project introduced index client partner testing (ICPT) services. The ICPT is a voluntary process whereby a PLHIV received at the facility acts as a contact to reach out to other individuals within their network who do not know their HIV sero status, offer them HIV testing and consequently provide them HIV prevention and treatment services. The PLHIV whose network is used to reach others is referred to as the index client. The index client may be newly diagnosed or a known PLHIV already in HIV care and treatment.
The Project was further inspired to integrate ICPT based on lessons shared at the FHI 360, 2017 Global Leadership Meeting where other country projects shared best practices in working towards achieving the 90:90:90 global treatment targets. Country programs implementing ICPT had registered significant improvements in HIV case finding and were in better positions of achieving the first '90' of the global (i.e. 90% of PLHIV know their HIV sero status).


*Service providers undergoing orientation prior to the roll out of ICPT*

In preparation for the roll out of ICPT, the country office implemented a series of activities to orient its staff on concept, get buy-in from sub-grantees and train of service providers (outreach team and health workers form three clinics providing HIV care and treatment services). Relevant standard operating procedures (SOP), job aides and monitoring tools were adapted from other FHI 360 programs for use. Actual implementation started in February, 2018.

Two months into implementation, the innovation is showing already showing promising results. A 26-year-old high risk man who came to receive treatment sexually transmitted infection (STI) tested positive for HIV and was offered ICPT. His first wife lives in the village. While living in the city the man met his second wife and they now have two children. His first wife did not know about his second wife and children. After he found out about his HIV (positive) status, he quickly brought in his first wife for testing. His first tested positive and they are both on treatment currently. He also promised to bring his second wife and their two children for HIV testing services too. In another instance, a 45-year old woman on ART accepted ICPT. In PNG women find it very difficult to invite their partners for HIV testing due to the consequences it may have on their relationship and fear of domestic violence. With the training the health workers received on ICPT, they offered adequate counselling support and assisted her plan on how to disclose her HIV sero status to her partner and invite him for testing. Her husband, a 36-year-old security guard accepted to come for testing and tested HIV positive. The husband was also offered ICPT services. When partner elicitation was done, it was discovered that he is a male sex worker and frequently indulges in group sex. Among other sexual partners, he has seven regular female sexual partners living in the neighborhood. He accepted to reach out to sexual partners and refer them for testing. Their residence is one of the hotspots where the HIV prevention outreach team regularly visits. They will continue to target the area with HIV testing and prevention activities.

So far, the innovation is proving to be a successful approach in targeting undiagnosed PLHIV and offers opportunity for the project to extend beyond primary beneficiaries and reach out sexual partners/clients and their families. It is anticipated that, integrating ICPT services into the existing programs will contribute to higher testing yield.

# Annex 1: Summary of Q2 Results on Core Indicators by Site

| Indicator Code | FY 17 Target | FY 17 Results: Koki | Ela Beach | Kila Kila | Kaugere | Id Inad | 9 Mile | 6 Mile | Lawes Rd | Begabari | Gerehu | Tokarara | Hedur u | VSO | Total | FY 18 Target | FY 18 Q2 Results: Koki | Ela Beach | Kaugere | 9 Mile | 6 Mile | Lawes Road | Begabari | Hedur u | Gerehu | Tokarara | Prevention | Total | FY 18 Cumulative: Koki | Ela Beach | Kaugere | 9 Mile | 6 Mile | Lawes Road | Begabari | Hedur u | Gereh u | Tokarara | Prevention | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HTS_TST: DSD | 4,820 | ### | 1,188 | 1,189 | 2,056 | | | | | | | | | | 5,726 | 4,820 | 342 | 496 | 1,100 | | | | | | | | | 1,938 | 805 | 598 | 1,863 | | | | | | | | | | 3,266 |
| Tested HIV Positive: DSD | 299 | 79 | 69 | 35 | 67 | | | | | | | | | | 250 | 299 | 14 | 23 | 32 | | | | | | | | | 69 | 35 | 27 | 72 | | | | | | | | | | 134 |
| HTS_TST: TA-SDI | 4,438 | | | | | 662 | 2,090 | 3,196 | 1,525 | 2,533 | 1,373 | 278 | 220 | | 11,877 | 3,438 | | | | 709 | 729 | 697 | 976 | 45 | 1,174 | 441 | | 4,771 | | | | 1,166 | 1,570 | 818 | 1,603 | 108 | 2,150 | 880 | | 8,295 |
| Tested HIV Positive TA SDI | 309 | | | | | 62 | 42 | 114 | 93 | 140 | 58 | 7 | 47 | | 563 | 235 | | | | 17 | 33 | 39 | 44 | 8 | 68 | 10 | | 219 | | | | 39 | 69 | 46 | 98 | 23 | 107 | 19 | | 401 |
| TX_NEW: DSD | 337 | 137 | - | 60 | - | 97 | | | | | | | | | 294 | 270 | 39 | | 15 | | | | | | | | | 54 | 65 | - | 47 | | | | | | | | | | 112 |
| TX_NEW: TA-SDI | 478 | | | | | | 47 | 116 | 46 | 194 | | | 269 | | 672 | 478 | | | | 23 | 29 | 31 | 93 | 83 | - | 8 | | 267 | | | | 48 | 65 | 35 | 128 | 128 | | 14 | | 418 |
| TX_CURR: DSD | 941 | 283 | | 151 | | 428 | | | | | | | | | 862 | 706 | 285 | | 157 | | | | | | | | | 442 | 285 | | 157 | | | | | | | | | 442 |
| TX_CURR: TA-SDI | 6,947 | | | | | | 227 | 231 | 391 | 1,470 | | | 3,626 | | 5,945 | 7,235 | | | | 200 | 199 | 243 | 913 | 1,714 | - | 15 | | 3,284 | | | | 192 | 182 | 193 | 866 | 1,722 | | 8 | | 3,163 |
| CARE_NEW: DSD | 262 | 165 | | 88 | | 107 | | | | | | | | | 360 | 310 | 46 | | 19 | | | | | | | | | 65 | 78 | | 52 | | | | | | | | | | 130 |
| CARE_NEW: TA-SDI | 44 | | | | | | 58 | 135 | 58 | 277 | | | 372 | | 900 | 552 | | | | 20 | 36 | 92 | 84 | 30 | - | 10 | | 272 | | | | 53 | 67 | 98 | 149 | 96 | | 18 | | 481 |
| KP_PREV: DSD | 2,800 | | | | | | | | | | | | | 4,051 | 4,051 | 2,800 | | | | | | | | | | | 1,180 | 1,180 | | | | | | | | | | | 1,939 | 1,939 |
| PP_PREV: DSD | 2,000 | | | | | | | | | | | | | 1,917 | 1,917 | 2,000 | | | | | | | | | | | 773 | 773 | | | | | | | | | | | 1,450 | 1,450 |
| TB_PREV: DSD (num) | 70 | 12 | | 8 | | 17 | | | | | | | | | 37 | 36 | | | | | | | | | | | | - | - | | | - | | | | | | | | | - |
| TB_PREV: DSD (den) | 108 | 46 | | 12 | | 28 | | | | | | | | | 86 | 54 | | | | | | | | | | | | - | - | | | - | | | | | | | | | - |
| TB_PREV: TA-SDI (num) | 48 | | | | | | - | 3 | - | 5 | | | 30 | | 38 | 63 | | | | | | | | | | | | - | | | | - | - | - | - | - | - | - | | - |
| TB_PREV (den): TA-SDI (den) | 96 | | | | | | - | 31 | - | 9 | | | 190 | | 230 | 95 | | | | | | | | | | | | - | | | | - | - | - | - | - | - | - | | - |
| TX_PVLS: DSD (num) | 231 | 13 | | - | | - | | | | | | | | | 13 | 318 | 29 | | | | | | | | | | | 29 | 29 | | | | | | | | | | | | 29 |
| TX_PVLS: DSD (den) | 257 | 20 | | - | | - | | | | | | | | | 20 | 354 | 38 | | | | | | | | | | | 38 | 38 | | | | | | | | | | | | 38 |
| TX_PVLS: TA-SDI (num) | 2,868 | | | | | | - | - | - | 12 | | | 187 | | 199 | 3,003 | | | | | | | 8 | 238 | | | | 246 | | | | - | - | - | 8 | | | 238 | | 246 |
| TX_PVLS: TA-SDI (den) | 3,187 | | | | | | - | - | - | 19 | | | 221 | | 240 | 3,337 | | | | | | | 16 | 271 | | | | 287 | | | | - | - | - | 16 | | | 271 | | 287 |
| TX_RET: DSD (num) | 286 | 76 | | 56 | | 82 | | | | | | | | | 214 | 243 | | | | | | | | | | | | - | - | | | - | | | | | | | | | - |
| TX_RET: DSD (den) | 316 | 96 | | 89 | | 146 | | | | | | | | | 331 | 270 | | | | | | | | | | | | - | - | | | - | | | | | | | | | - |
| TX_RET: TA-SDI (num) | 430 | | | | | | - | - | - | - | | | - | | - | 430 | | | | | | | | | | | | - | | | | - | - | - | - | - | - | - | | - |
| TX_RET: TA-SDI (den) | 478 | | | | | | - | - | - | - | | | - | | - | 478 | | | | | | | | | | | | - | | | | - | - | - | - | - | - | - | | - |
| GEND_GBV: DSD | 150 | 110 | 156 | 22 | 78 | 241 | | | | | | | | | 607 | 200 | 17 | 58 | 45 | | | | | | | | | 120 | 44 | 74 | 84 | | | | | | | | | | 202 |
| GEND_GBV: TA | 100 | | | | | | - | - | - | - | | | - | | - | 50 | | | | 73 | - | - | - | 1 | - | 5 | | 79 | | | | 73 | - | - | - | 1 | - | 5 | | 79 |

**Reporting Frequency**

- Quarterly
- Semi-annually
- Annually
- Not available
- Not applicable

## Annex 2: Progress Update on Sustainability

| Partner | Status | Challenge | Recent actions | Next steps |
|---|---|---|---|---|
| **Salvation Army (TSA) – Koki clinic, Ela Beach Clinic & House of Hope Shelter.** | TSA commenced payment of salaries of 9 project staff at Koki at the beginning of FY 2018. | TSA not be able sustain this as Christian Health Services (CHS) did not provide any funding to their health programs in NCD for the 2018 calendar year. | Met with National Capital District Health Services (NCDHS) to discuss this development. | NCDHS to meet with CHS and TSA to discuss the way forward. |
| | Fate of 4 project staff at Ela Beach Clinic is still uncertain, but NCDHS is willing to absorb some project staff after it transitions to Provincial Health Authority (PHA) by which time they would have created more vacancies. | Delays in transitioning NCDHS to a PHA status. | Follow up meetings with NCDHS | Continue follow up with NCDHS.<br><br>Will be discussed in a wider stakeholders' meeting on May 18 to discuss sustainability of the entire project. |
| | Oil Search Foundation (OSF) has indicated interest to continue support for the shelter. | | | Continue discussing with OSF on the transition plan. |
| **Four Square Church (FSC) - Kilakila & Kaugere Clinic** | Kilakila clinic was closed by the government in FY 2017. A new Kilakila District is being constructed at a new location. The 2 STI nurses were transitioned to the NCD Community Based TB Treatment project (funded by DEFAT), the other health staff (1 counsellor, 1 ART prescriber, 2 case managers) and support staff (project coordinator, M&E Officer, hygienist, driver, Fin & Admin Officer) were transferred to Kaugere Clinic. | | | |
| | FSC has already reserved 4 clinical positions from its current allocation from CHS to absorb 4 project staff at the end of the project. | | | Follow up with FSC to implement the transition of the 4 staff before the project end date. |

| | | | | |
|---|---|---|---|---|
| | FSC also submitted a request and budget to CHS for additional position to absorb the rest of the staff. | The leadership of CHS changed recently and the new management is yet to respond to FSC request for additional positions. | | FSC to follow up with CHS on this. |
| | NCDHS is willing to absorb some project staff after it transitions to Provincial Health Authority (PHA) by which time they would have created more vacancies | Delays in transitioning NCDHS to a PHA status. | Follow up meetings with NCDHS | Continue follow up with NCDHS.<br>Will be discussed in a wider stakeholders' meeting on May 18 to discuss sustainability of the entire project. |
| | OSF also indicated interest to continue support for the shelter. | | | Continue discussing with OSF on the transition plan. |
| **Family Sexual Violence Action Committee (FSVAC)** | Institute of National Affairs (INA), the parent body for Consultation Implementation and Monitoring Council (CIMC) under which FSVAC operates has issued a latter of commitment to absorb the two project officers attached to FSVAC at the end of the project. | | | Follow up with INA to implement the transition of the 2 staff before the project end July. |
| **Out-reach Team** | Business plan for registration of CBO drafted and undergoing review.<br>15 PEs successfully completed two skills acquisition trainings with Ginigoada. | In the absence of DFAT, PEPFAR and GF funding for HIV outreach services in NCD after Dec 2018, there is no likelihood of funding support for the CBO. | Sustainability of outreach component of the project was discussed during the April PEPFAR update meeting with NCDHS where it was agreed that NCD will organize a stakeholders' meeting of NACS, Global Fund, FHI 360 and USAID to discussion options for sustaining outreach services. | Support CBO registration.<br>Follow up with NCDHS to organize the stakeholders' meeting.<br><br>Will also be discussed in a wider stakeholders' meeting on May 18 to discuss sustainability of the entire project. |
| **GBV phone counselling service.** | ChildFund plans to assume full support for the hotline after end of FHI 360 project. | | | Following meeting with ChildFund to discuss exit. |
| **National District Capital Health Services (NCDHS)** | FHI 360 paying salaries of M&E/Case Mgt. Coordinator (currently embedded in NCDHS) for now. NCDHS committed to | NCDHS is yet to create the position in their structure. | | Continue follow up with NCDHS to create appropriate position to for M&E/Case Mgt. Coordinator |

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| | absorbing the position at the end of the project. | | | |
| **7 Expansion (TA) sites.** | No staffing nor funding commitment as support is limited to technical assistance only. | | | Continue onsite mentoring support and plan for a technical handover. |
| **Cross Cutting** | | | | |
| **Organizational and Financial mgt. capacity** | Post NUPAS interventions completed for all 3 organizations. | | | Conduct follow-up NUPAS assessment in Q3. |
| **Costing analysis** | Project costing exercise is completed and report is currently undergoing internal review. | | | Finalize and disseminate report. |
| **Technical capacity** | Service providers have been trained and are conversant with national guidelines, protocols, and SOPs for service delivery. Relevant tools, guidelines, SOPs, protocols and job aids developed, and have been adopted as national tools. | Continues mentoring support to supply of relevant tools, guidelines, SOPs, protocols and job aids may not be sustain beyond the life of project. | | Continue onsite mentoring support and plan for a technical handover. |

## Annex 3: MTE Recommendations and Actions Taken *(New development in blue font)*

| Recommendation | Action taken |
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| ***Peer education outreach*** | |
| 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. | Negotiated with USAID to reduce targets for outreach while increased the number of PEs in the Project in NCD to a maximum of 30. |
| 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. | Conducted a crude estimate of the number of KPs in Moresby South Electorate using enumeration method as part of the hotspot mapping exercise. This was done pending the results of the recent KP IBBS exercise in NCD.<br>Outreach targets have also been segregated by KP types and small teams assigned to focus on reaching specific KP groups.<br>Data collection and reporting tools have been revised to allow disaggregation of MSM and TG.<br>Engaged more MSM and TGs as PEs to increase reach to MSM/TGs populations.<br>Social media (Facebook) also introduced to enhance contacts with more KPs, especially MSM/TG groups. |
| 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. | Introduced Gender and GBV orientation into PE trainings to build their capacity to support GBV prevention and referral services particularly among peers.<br>An SOP has been developed for community GBV services. The document provides a step by step guide for PEs to engage with peers on issues of GBV, its relationship with HIV, GBV prevention and access to post GBV services. |
| 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. | Trainings for new PEs are conducted separately from refresher training for old PEs.<br>Refresher trainings are now organized to address specific gaps and capacity needs of PEs.<br>Core PE training sessions are held differently for FSW PEs, and MSM/TG PEs with quarterly KP forums are held with each group to discuss sensitive issues that affect behaviors and access to services among different groups. |
| 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. | Decision Tree Tool revised to align with government definition of KPs, while maintaining the identification of other high-risk individuals. The tool has been adopted by the NHTWG for use in KP-focused clinics. The tool has been piloted and rolled out. |
| 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. | The decision tree Tool which is a primary tool under the EOA has been presented to the TWG and adopted for national use. |

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| 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. | Decision Tree Tool revised to align with government definition of KPs, while maintaining the identification of other high-risk individuals.<br>The tool has been adopted by the NHTWG for use in KP-focused clinics. It is currently in use. |
| ***Care & treatment services:*** | |
| 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. | Project facilitated supportive supervision visit By Central Public Health Laboratory (CPHL) to outreach testing and all facility based testing sites. Visit focused on adherence to guidelines and quality assurance protocols. |
| FHI 360 should request IAs to remove all judgmental posters from patient areas in clinic settings and ensure that all job aids are accurate. | Posters deemed judgmental of KPs have been removed from all DSD sites and KP sensitization trainings conducted for FHI 360 supported sites. |
| FHI 360 should augment mobile HTC with other sexual health service delivery, in collaboration with other groups conducting mobile outreach services. | STI symptomatic screening has now been integrated into mobile HTC services.<br>The project will explore the possibility of also integrating TB screening and family planning counselling services. |
| 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. | A protocol for ART adherence study has been developed.<br>Ethical clearance for the protocol has been granted by the PNG Research Advisory Committee of NAC, and FHI 360 Institutional Research Board and Protection of Human Subjects Committees. Data clerks have been recruited and orientation on qualitative research done. Data collection begun in quarter 4.<br>A cost analysis of different components of the project was started with support from FHI 360 HQ team. |
| 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. | Upgraded Ela Beach to a satellite HIV care & treatment clinic. ART and STI services are integrated in the clinics with the two clinicians there trained to provide both ART and STI management services. |
| 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. | Clarification provided to implementing partners on responsibilities for the procurement of commodities and the role of partners in ensuring proper inventory management and early requisition for supplies. |
| FHI 360 should address the training gaps most commonly reported during interviews: couples counseling, advanced counseling skills, counseling for children, nutrition and GBV. | Trainings organized for service providers to address skill gaps in nutrition and GBV counselling. |
| ***Gender-based violence*** | |
| 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. | The government of PNG has developed GBV strategy which takes into cognizance PNG's culture. FHI 360 provided technical assistance in the development of the document which has been approved for implementation. |

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| USAID and FHI 360 should broaden their GBV programming to include interventions that address homophobic violence against MSM and TG, and violence directed to WTS by their clients. This needs to be accompanied by a greater emphasis on community GBV prevention programming. | Introduced Gender and GBV orientation into PE trainings to build their capacity to support GBV prevention and referral services particularly among peers. An SOP has been developed for community GBV services. The document provides a step by step guide for PEs to engage with peers on issues of GBV, its relationship with HIV, GBV prevention and access to post GBV services. A GBV safety planning tool is also being developed. The SOP and safety planning tool will be integrated into a two day GBV training package for PEs. The national PE training manual will be revised to incorporate a session on GBV. |
| 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. | PE received additional training on GBV focusing on the GBO prevention SOP and GBV safety planning tool |
| FHI 360 should facilitate training of staff at the project-supported GBV safe houses on counseling and support for children of victims of GBV. | GBV case management conducted for staff of *Meri Seif Haus* and *Haus of Hope*. Training package incorporates counseling and support survivors and children. FHI 360 and implementing partner staff also received orientation on the PNG *Lukautim Pikinini* (Child Protection) Act. |
| ***Monitoring & Evaluation (M&E)*** | |
| FHI 360 should provide timely and more complete feedback to clinics on performance and key indicator data. | Regular feedback on key performance indicators was provided to implementing partners during the monthly implementing partner team leaders' meeting organized by FHI 360, at monthly M&E review meetings organized by implementing partners, and at the quarter program performance review meeting organized by FHI 360.<br>Monthly NCD-wide M&E coordination meeting introduced with participation of all HIV clinics. Feedback is provided on reporting rates and program results. |
| FHI 360 should work with clinical IAs to establish a system for tracking internal and external referrals consistently. | Internal referral systems have been strengthened with the introduction of "blue card" and client ID codes. e-Cascade has also been rolled out to facilitate tracking of referrals by PEs from the community to health facilities. Its implementation will be discontinued due to overwhelming changes. |
| ***Supply chain*** | |
| 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. | FHI 360 is providing TA to 5 expansion sites. The TA package includes support on stock management for commodities and medicines using the bin cards as a monitoring tool. |
| 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. | The capacity of staff at Id Inad Clinic has been built on stock inventory management. Currently, In Inad Clinic manage stock for smaller HIC clinics in the province. |
| ***Exit Planning*** | |
| 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 | |

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| 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 component of the project has been successfully transitioned to the Provincial Administration. Global Fund is currently funding outreach services and case management activities.<br>See Annex 2 for update on efforts and outcomes. |
| 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. | |