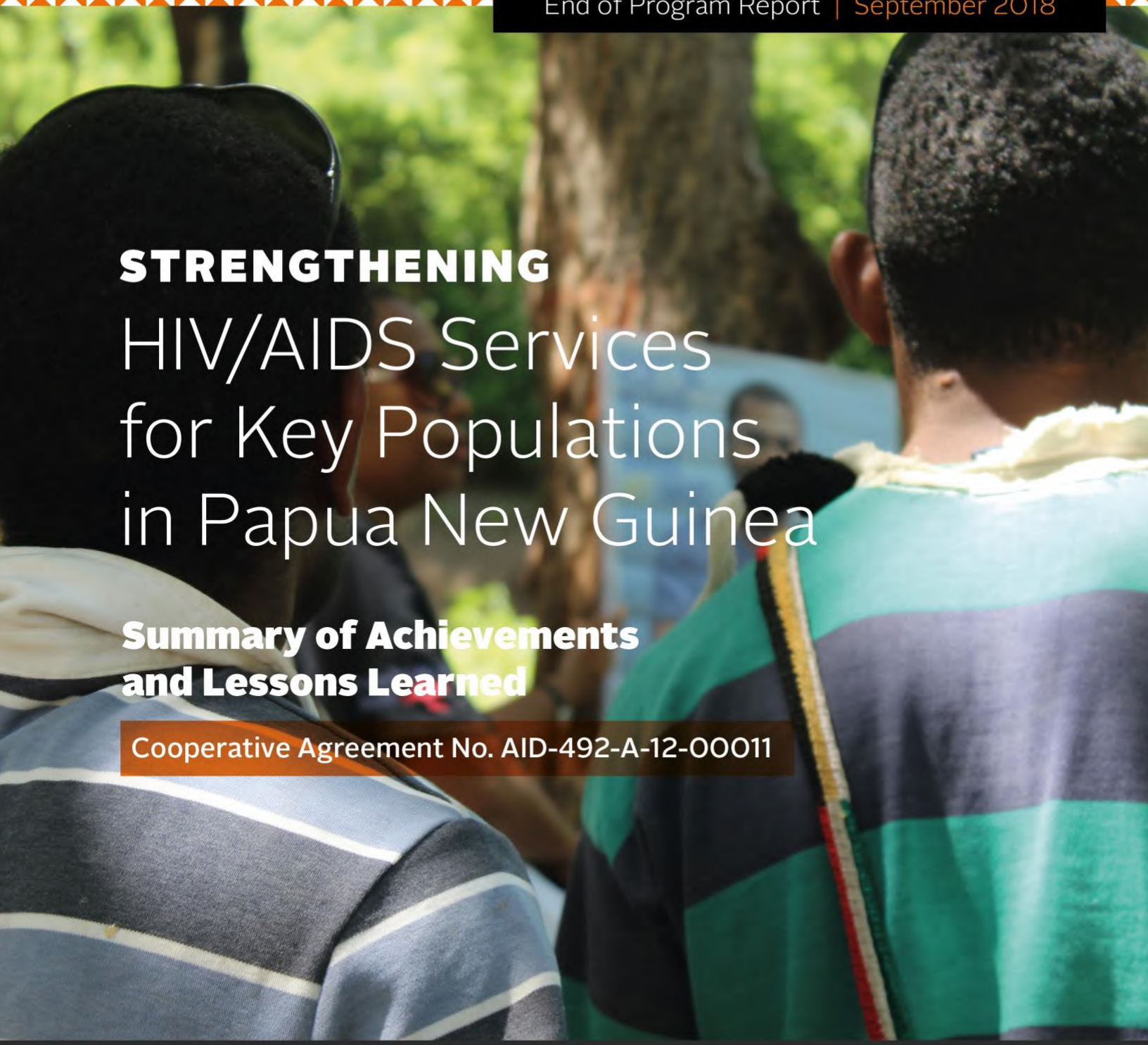
End of Program Report | September 2018



STRENGTHENING HIV/AIDS Services for Key Populations in Papua New Guinea

Summary of Achievements and Lessons Learned

Cooperative Agreement No. AID-492-A-12-00011

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The commitment, support and dedication of our local partners, including the Salvation Army, Living Light Health Ministry, VSO, the Family and Sexual Violence Action Committee, the Modilon General Hospital, and People Living with Higher Aims and their staff and volunteers, have enabled FHI 360 to reach the populations in need and successfully provide quality HIV prevention and treatment services.

Without the expert input and collaboration of the U.S. Center for Disease Control and Prevention, the Joint United Nations Programme on HIV/AIDS and the World Health Organization, the Program would not have accomplished the integration of some of its guidelines and tools into the national response to HIV.

We would also like to express our gratitude and appreciation for the continued support from the U.S. Agency for International Development and its staff, who supported the Program throughout its life both financially and technically.

Finally, we would like to extend our gratitude to all the Program beneficiaries and stakeholders who took time out of their schedules to contribute to this final report by sharing their insights, experience and recommendations.

ACRONYMS AND ABBREVIATION

ACM
active case management

ART
antiretroviral therapy

CBO
community-based organizations

CDC
U.S. Centers for Disease Control and Prevention

CoPCT
continuum of prevention to care and treatment

DFAT
Department of Foreign Affairs and Trade

DSD
direct service delivery

EOA
Enhanced Outreach Approach

FSVAC
Family and Sexual Violence Action Committee

FSW
female sex worker

FY
fiscal year

GBV
gender-based violence

GFATM
Global Fund to Fight AIDS, Tuberculosis and Malaria

HCT
HIV counseling and testing

HR
human resources

IBBS
integrated bio-behavioral survey

IEC
information, education and communication

IMAI
integrated management of adolescent and adult illness

IR
intermediate result

KP
key population

MSM
men who have sex with men

M&E
monitoring and evaluation

NCD
National Capital District

NCDHS
National Capital District Health Services

NDoH
National Department of Health

NGO
nongovernmental organization

PE
peer educator

PEP
post-exposure prophylaxis

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

PHO
Provincial Health Office

PLHA
People Living with Higher Aims

PLHIV
people living with HIV

PNG
Papua New Guinea

Q
quarter

SBCC
social and behavior change communication

SOP
standard operating procedure

STI
sexually transmitted infection

TA
technical assistance

TB
tuberculosis

TG
transgender

TWG
Technical Working Group

UNAIDS
Joint United Nations Programme on HIV/AIDS

USAID
U.S. Agency for International Development

VL
viral load

WHO
World Health Organization

EXECUTIVE SUMMARY

With the support of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), FHI 360 implemented the U.S. Agency for International Development (USAID)-funded Strengthening HIV/AIDS Services for Key Populations in Papua New Guinea Program (The KP Support Program) from October 1, 2012 to September 30, 2018 in the National Capital District (NCD) and Madang province. This Program aimed to: *Reduce HIV incidence among key populations (KPs) in Papua New Guinea (PNG) and mitigate its impact on KPs, their sexual partners and their families*. KPs targeted by the Program were men who have sex with men (MSM), transgender (TG) people and women engaging in transactional sex, including female sex workers (FSWs).

To achieve this goal, the Program had four objectives:

Objective 1 (IR 2.1) Increase demand for HIV/AIDS services among key populations, their sexual partners and their families

Objective 2 (IR 2.2) Increase the supply of quality HIV/AIDS services for key populations, their sexual partners and their families

Objective 3 (IR 2.3) Increase the use of facility- and community-based gender and gender-based violence interventions

Objective 4 (IR 2.4) Strengthen health systems for HIV/AIDS service delivery

To increase the demand for and use of HIV services and the adoption of prevention behaviors (Objectives 1 and 3), the KP Support Program designed and implemented social and behavior change communication (SBCC) activities, including interpersonal communications through peer educators (PEs) and social and media-based communication. The KP Support Program also developed and implemented community-based outreach in target sites in NCD and Madang province. This entailed: (1) integrating program tools into national surveillance guidelines, (2) developing training curricula for PEs and (3) introducing and rolling-out new outreach approaches, including the Enhanced Outreach Approach (EOA) and the "4-3-2" strategy. Recognizing that EOA and the "4-3-2" led to an increase in health care seeking among KPs, the Government integrated these strategies into the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) concept note for implementation across the country.

The KP Support Program strengthened and delivered HIV counseling and testing (HCT), sexually transmitted infection (STI) management and GBV screening services along the continuum of prevention to care and treatment (CoPCT) (Objective 2). Over the course of the Program five antiretroviral therapy (ART) clinics were initiated; viral load (VL) testing services were expanded; STI services were expanded to four sites in the capital; and CD4 count services were integrated into four ART sites. Important initiatives included (1) the roll out of Test and Start to initiate treatment for those found to be infected upon diagnosis; (2) the introduction of mobile testing within communities to reach those at highest risk; and (3) active case management (ACM) to reduce loss to follow-up. Over time, the Program saw a decrease in HIV-related mortality within its clinics: 0.05 deaths per 100 person-years in supported clinics compared to 0.75 deaths per 100 person-years in sites not supported by FHI 360.

Recognizing the widespread occurrence of GBV, and its link to HIV, FHI 360 integrated GBV activities into nine clinics by training clinicians in two provinces to screen all clients for GBV, manage GBV cases, provide post-GBV services, and by implementing a hotline for clients to access information on where to receive services. This integration of GBV services into clinics providing HIV, STI and outpatient services improved accessibility to GBV care. Leveraging existing services and staff also resulted in cost efficiencies, and provided time sensitive services, such as post exposure prophylaxis and emergency contraceptive.

The KP Support Program strengthened the national health system's ability to respond to HIV (Objective 4) by providing technical assistance, such as in the development of operating procedures, guidelines and protocols for HIV, STI and GBV services. To ensure guidelines and procedures were integrated into service delivery, FHI 360 supported national- and provincial-level training for clinicians and other practitioners. FHI 360 also provided technical assistance to strengthen organizational capacity in strategic information, which resulted in, for instance, a reduction in late and incomplete reporting by the NCD HIV program.

By implementing the KP Support Program, FHI 360 learned several important lessons, including the need to constantly adapt and empower recipient communities to provide services for those most at risk. In addition, although PEs and the EOA allowed the Program to reach a higher number of target KP individuals, because the places where people meet sexual partners are constantly changing, FHI 360 recognized the need to also use of social media to identify upcoming events where target populations can be found. Similarly, IEC materials should be adapted, especially in urban settings, to reach sex workers and their clients with key messages.

To effectively implement the KP Support Program, FHI 360 collaborated with the Government, the U.S. Centers for Disease Control and Prevention (CDC) and United Nations agencies, as well as local nongovernmental organizations (NGOs) and community-based organizations (CBOs), particularly for demand generation, direct service delivery (DSD) and technical assistance (TA).

Throughout the Program, FHI 360 strengthened the capacity of local implementing agencies and national programs to deliver high-quality, effective HIV and gender-based violence (GBV) prevention, care, treatment and services. TA was delivered through several approaches, including:

- Formal training using participatory adult education methodologies
- Training of trainer workshops
- Exposure visits
- Ongoing mentorship and supervision
- Assistance in developing information, education and communication (IEC) tools, standard operating procedures (SOPs) and data collection tools and guidelines

During discussions with stakeholders in the preparation of this report, technical assistance (TA) was often mentioned as a core, critical component of FHI 360's work in PNG. Program data demonstrate that the staff is now able to report data more efficiently and deliver services according to SOPs. The Government acknowledged FHI 360's key contributions in providing strategic direction to the national HIV response and recommended FHI 360's efforts be scaled up beyond the two Program provinces.

Several partners expressed a desire to continue collaborating with FHI 360, such as the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), particularly on TA for treatment and laboratory strengthening and in further adapting outreach models.

With the support of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through USAID, FHI 360 has been strengthening HIV response in PNG since 2008. Since the inception of the Program, the country has seen an increase in new HIV cases, predominantly among MSM and FSWs, while at the same time registering a decline in HIV-related mortality as treatment becomes more widely available. Prevalence, at 0.8 percent among the general population in 2011,[1] was at 0.9 percent in 2017.[2] National-level prevalence among FSWs and MSM/TG people in 2010 was at 5.9 percent and 4.3 percent respectively.[3] The 2017 integrated bio-behavioral survey (IBBS)[4] focusing specifically on KPs in Port Moresby shows higher prevalence rates, with HIV prevalence among FSWs and MSM/TG people at 14.9 percent and 8.5 percent respectively. This illustrates the importance of reaching these populations in order to achieve the 90–90–90 global targets for HIV/AIDS by 2020: 90 percent of people living with HIV (PLHIV) diagnosed, 90 percent of diagnosed people receiving ART and 90 percent of those who receive ART reaching viral suppression.

Following the Technical Support for HIV/AIDS Prevention, Care and Treatment project (October 2008 to December 2012), USAID awarded the follow-on Strengthening HIV/AIDS Services for Key Populations in Papua New Guinea Program to FHI 360, which ran from October 1, 2012 to September 30, 2018.

The Program had four objectives:

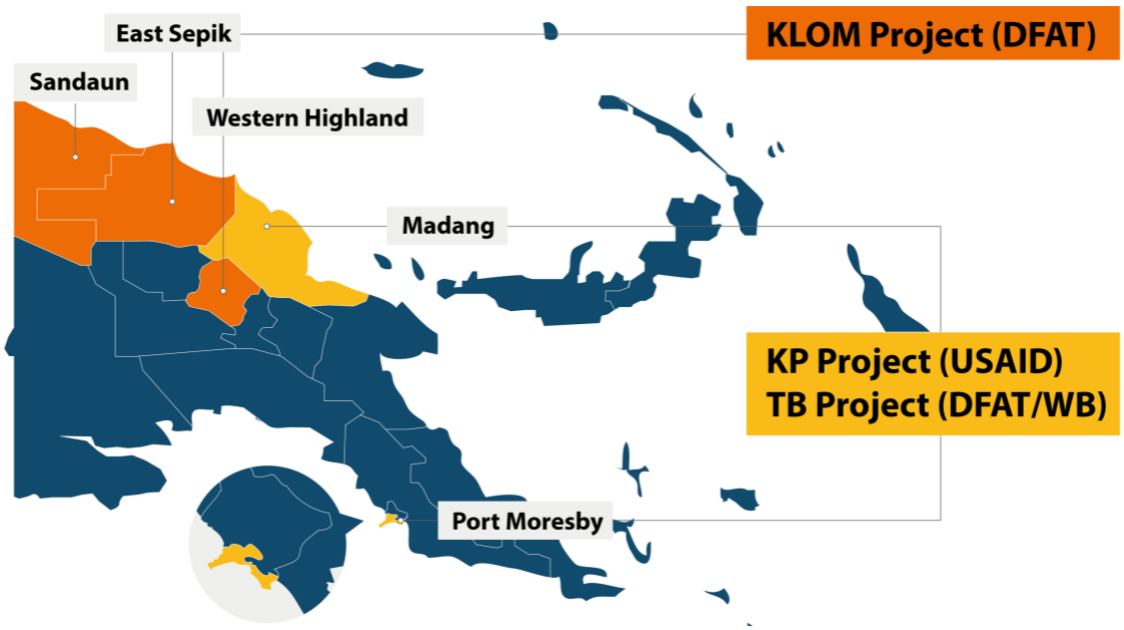
Objective 1 (IR 2.1)	increase demand for HIV/AIDS services among key populations, their sexual partners and their families
Objective 2 (IR 2.2)	increase the supply of quality HIV/AIDS services for key populations, their sexual partners and their families
Objective 3 (IR 2.3)	increase the use of facility- and community-based gender and gender-based violence interventions
Objective 4 (IR 2.4)	strengthen health systems for HIV/AIDS service delivery

The collaborative work and efforts made toward these objectives contributed to the achievement of the Program's overall goal: reducing HIV incidence among KPs in PNG and mitigating its impact on KPs, their sexual partners and their families. KPs targeted by the Program included women engaging in transactional sex, including FSWs, MSM and TG people. Until fiscal year (FY) 2017, when indicator definitions were revised, the Program also targeted priority populations including high-risk men, high-risk women and men engaging in transactional sex. Other Program beneficiaries included the general

[1] UNAIDS. Global AIDS Report 2012. Country Progress Report: Papua New Guinea; Mar 2012. Available from: www.files.unaids.org/es/dataanalysis/knowyourresponse/countryprogressreports/2012countries/file,70682,es..pdf.
[2] UNAIDS. *UNAIDS Data 2017*. Geneva: Switzerland; 2017. Available from: www.unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf.
[3] Papua New Guinea National AIDS Council Secretariat and Partners. UNGASS 2010. Country Progress Report: Papua New Guinea; Mar 2010. Available from: www.aidsdatahub.org/sites/default/files/documents/papuanewguinea_2010_country_progress_report_en.pdf.
[4] Kelly-Hanku A, Willie B, Weikum D, Boli Neo R, Kupul M, Coy K et al. Papua New Guinea Institute of Medical Research and Kirby Institute, UNSW Sydney. *Kauntim Mi Tu Multi-Site Summary Report 2018: Key Findings from the Key Population Integrated Bio-Behavioural Survey Papua New Guinea*; 2018. Available from: www.aidsdatahub.org/sites/default/files/publication/PNG_Kauntim_mi_tu_Multi-Site_Summary_Report_from_the_Key_Population_IBBS_2018.pdf.

population, women affected by GBV, clinicians, outreach workers and government stakeholders who received TA.

Figure 1: Provinces directly supported by USAID.



The Program focused on NCD and Madang provinces. FHI 360 established collaborations with the Government, the CDC and United Nations agencies, as well as local NGOs and CBOs, to work on areas such as demand generation, DSD and TA. Activities in Madang ended in September 2017, in line with a shift in priorities to focus more on high-burden provinces as part of the global effort to attain the 90–90–90 targets. A summary report of the program activities and achievements in Madang was issued in 2017 (see annex 6).

Recognizing the importance of buy-in and ownership to achieve long-term sustainability, the Program worked closely with local NGOs to design and implement activities. Over the course of the Program, FHI 360 partnered with a number of local agencies (see table 1 below and annex 2 for the full list of partners). The Program also leveraged USAID's investment in Enga, Morobe and Western Highlands provinces through the support of Australia's Department of Foreign Affairs and Trade (DFAT) and replicated successful HIV interventions. In doing this, the Program expanded the geographical footprint of USAID's investment beyond the two USAID-supported NCD and Madang provinces.

Table 1: Local partners and their roles in the Program.

Partner	Scope of work
Salvation Army	Between FY 2013 and FY 2018, the Salvation Army supported the following activities at Ela Beach and Koki clinics and its women's shelter: • Demand creation • SBCC • Comprehensive HIV prevention, care and treatment • GBV services (counseling and clinical services for HCT, post-exposure prophylaxis (PEP), STI prophylaxis, emergency contraception, vaccination and safe housing) Between October 2012 and October 2015, the Salvation Army also supported outreach work using PEs
Living Light Health Services (Foursquare Church)	Between FY 2013 and FY 2018, Living Light Health Ministry supported the following activities at Kila Kila and Kaugere clinics and its women's shelter: • Demand creation • SBCC • Comprehensive HIV prevention, care and treatment • GBV services (counseling, clinical services for HCT, PEP, STI prophylaxis, emergency contraception, vaccination and safe housing) Between October 2012 and October 2015, the Living Light Health Ministry also supported demand creation using PEs
Family and Sexual Violence Action Committee (FSVAC)	The FSVAC supported the following activities between FY 2013 and FY 2018: • Coordination of GBV response in Madang • Capacity building for journalists
VSO[1]	Between FY 2015 and FY 2017, VSO supported the following activities in NCD: • Demand creation • SBCC
Modilon General Hospital[2]	Between FY 2013 and FY 2017 the Modilon General Hospital provided the following services in Madang: • Demand creation • SBCC • Comprehensive HIV prevention, care and treatment • GBV services (counseling, clinical services for HCT, PEP, STI prophylaxis, emergency contraception, vaccination and safe housing)
Madang Provincial Health Office (PHO)[2]	Between FY 2013 and FY 2017, the Madang PHO supported the coordination of the CoPCT model in Madang
People Living with Higher Aims (PLHA)[3]	In FY 2013 and FY 2014, PLHA supported the following activities in Madang: • Demand creation • SBCC

[1] Contracted in FY 2015 to take the place of PLHA. Sub-agreement terminated at the end of FY 2017 as the organization decided to close their health programs in PNG due to lack of adequate funding.

[2] Sub-agreements with both organizations terminated at the end of FY 2017 in response to USAID's request for an early closeout of the Madang Program component.

[3] Sub-agreements terminated in FY 2014 due to financial irregularities.

Throughout the Program, FHI 360 worked to strengthen the capacity of local implementing agencies and national programs to deliver high-quality, effective HIV and GBV prevention, care, treatment and support services. TA was delivered through several approaches, including:

- Formal training using participatory adult education methodologies
- Training of trainer workshops
- Exposure visits
- Ongoing mentorship and supervision
- Assistance in developing SOPs, data collection tools, guidelines and IEC tools

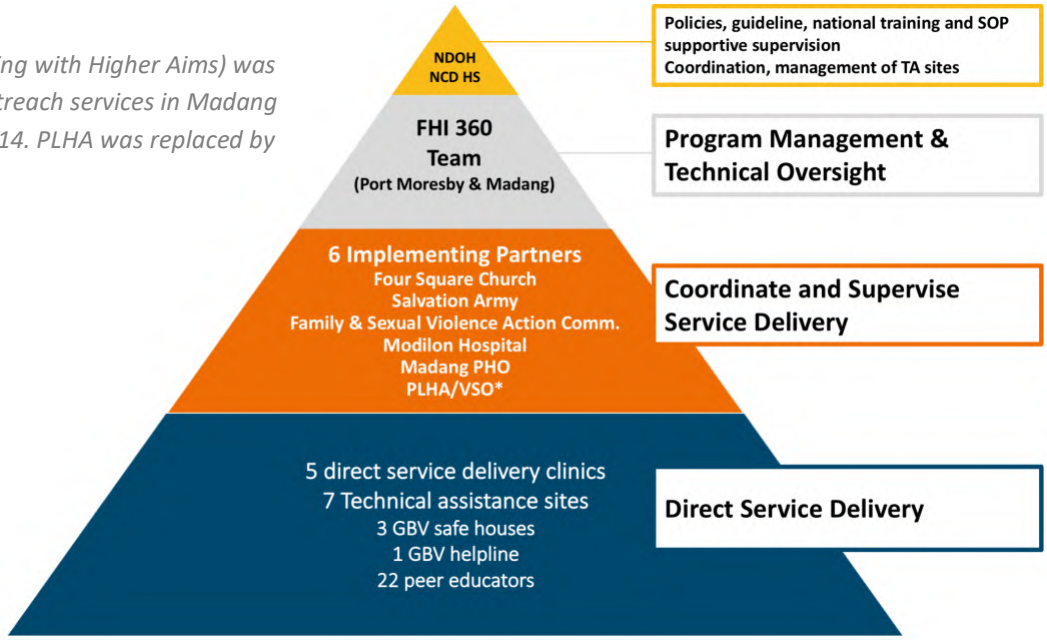
The number and thematic areas of the training sessions conducted between October 2012 and June 2018 under FHI 360's TA are presented in annex 3.

To support national programs, FHI 360 facilitated the development of numerous tools and guidelines (see annex 4 for the full list of documents produced). These included a decision tree algorithm that was approved in 2016 and is now included as part of the national surveillance tools to assist government staff in identifying, tracking and reporting HIV service provision to people with the highest risk of HIV infection. FHI 360 also contributed actively to the revision of the National HIV Care and Treatment Guidelines and the development of VL algorithms and STI treatment guidelines. In relation to GBV, FHI 360 also contributed to the finalization of the national clinical guidelines for GBV case management, the national GBV referral pathways and implementation of shelter (safe house) services.

Figure 2 below illustrates how FHI 360 and its partners worked together to achieve the Program's objectives.

Figure 2: FHI 360 implementation structure.

**PLHA (People Living with Higher Aims) was responsible for outreach services in Madang from FY 2013 – 2014. PLHA was replaced by VSO in FY 2015*



The five-year Program (October 1, 2012 – September 30, 2017) was granted with additional funding during the third quarter (Q) of FY 2016 to extend its work to FY 2018 with the following objectives: (1) delivering a comprehensive prevention package targeting KPs, including PLHIV, (2) providing GBV prevention and post-GBV care services and (3) providing TA for Program partners in NCD to achieve the country's 90–90–90 targets. All activities were planned and delivered according to the principles of stakeholder collaboration, sustainability and optimization of limited resources.

This report was prepared using Program-generated data, data from the latest IBBS on KPs in NCD and information obtained through individual and group interviews with Program beneficiaries and stakeholders. The list of the persons or partners interviewed is provided in annex 5.

The sections below detail the activities implemented and the achievements under each objective over the course of the Program. The final section provides an overview of encountered challenges and recommendations for future programming.

PROGRAM IN BRIEF 1

Ensuring sustainability by working with local stakeholders: the successful handover of Madang services to provincial authorities

U.S. Ambassador, Ms. Catharine Egret-Gray, and provincial authority representative, Mr. Daniel Alois, at the Madang handover ceremony. / FHI 360 on September 28, 2017

Following the successful handover of outreach activities in 2016, the Program entrusted all key interventions to Madang PHO in September 2017, including outreach activities, assistance to the family support center, case management of people receiving HIV treatment, TA to HCT providers and STI services. These activities are now supported jointly by GFATM, Modilon General Hospital and Madang PHO.

The success of this handover was rooted in the strong partnership between FHI 360 and Madang PHO, Modilon General Hospital, KP civil society partners, Friends Frangipani, Kapul Champions and Igat Hope.

The Id Inad Clinic, based within the Modilon General Hospital, was the only program-supported clinic that offered comprehensive HIV care and management for both adults and children. During the Program's midterm evaluation, both government and clinic staff reported that, as a result of FHI 360's capacity-building efforts, the clinic is now recognized as a practical site for integrated management of adolescent and adult illness (IMAI) training. The clinic has so far hosted five batches of IMAI practicums, and it is the first health facility to report ART data on KPs in PNG. The clinic also serves as a reference HIV treatment clinic for ART activities at Gaubin District Hospital, providing TA and drug supply chain management.

The transition process in Madang focused on (1) handing over the TA component to Momase Provincial HIV medical officer and (2) securing government funding for KP outreach services, PEs and six case managers at Id Inad Clinic. The Madang PHO committed 100,000 Papua New Guinean kina annually, while the management of the Modilon General Hospital agreed to integrate the six case managers into its staff structure. In the interim, GFATM continued paying for the salaries of the six case managers and the allowances for the PEs.

DETAILED ACHIEVEMENTS BY OBJECTIVE

Objective 1 (IR 2.1): increase demand for HIV/AIDS services among key populations, their sexual partners and their families

Key contributions to the national program under Objective 1:

- Decision tree tool integrated into national surveillance tools
- Development of PE training curriculum
- Increased health care seeking among PLHIV
- Adoption of EOA and "4-3-2" strategy into GFATM-supported programs
- Health care workers sensitized to be KP-friendly

Under Objective 1, the Program focused on the design and implementation of SBCC activities, including interpersonal communications through PEs and communication through social and other media, with the aim of influencing individual, interpersonal, social, and normative beliefs, values and behaviors. Under this Objective, the program also provided community-based outreach in target sites in Port Moresby and Madang.

Acknowledging the need to target communications to those at greatest risk, the Program continued and scaled up the use of a decision tree tool, an algorithm to help outreach workers and clinicians classify clients and better target their interventions. One government official said about the decision tree tool: "I'm seeing it will help us to capture data we've never captured before." This tool, which has subsequently been integrated into the national surveillance tools, classifies individuals reached into the following categories:

Women engaging in transactional sex (including FSWs): includes women who either self-identify as engaging in sex work as a means of livelihood or who engage in sex for money, other commodities or favors.

Men engaging in transactional sex (including male sex workers): includes men who self-identify as engaging in sex work as a means of livelihood or who engage in sex for money, other commodities or favors.

MSM: men who self-identify as gay or who engage in sex with other men, whether or not in exchange for money, other commodities or favors.

TG women: individuals who are biologically men but self-identify as women. Locally, they are identified as *palopa*.

Other high-risk individuals: men and women who have multiple sexual partners but do not necessarily self-identify as sex workers, MSM or TG or admit exchanging sex for money, other commodities or favors.

PLHIV: individuals diagnosed positive for HIV, irrespective of sexual orientation or population.

Key secondary groups: service providers (outreach workers and clinicians) and owners or managers of venues and sites where KPs (along with members of the general population) seek sexual partners.

Designed SBCC strategies were evidence-based and engaged KPs to ensure that the messaging was appropriately targeted and disseminated using relevant channels. Taking into account the criminalization of sex work and MSM behaviors, as well as the high PNG stigma index of 41 percent,[5] SBCC activities focused on (1) raising awareness about specific circumstances that put different individuals at risk of HIV infection, (2) decreasing perceived barriers to access key services, (3) increasing perceived rewards for accessing such services, (4) facilitating behavior changes and (5) advocating for the rights of people with diverse sexuality and fighting against homophobia.

SBCC activities covered under the Program included:

- Development and dissemination of key targeted messages, including various IEC materials (e.g., posters, leaflets and booklets) on HCT, STI, GBV, PEP, tuberculosis (TB), ART adherence, and stigma and discrimination
- Peer-to-peer interventions to increase awareness, educate target populations and promote behavior change through one-on-one encounters and small group discussions
- Group-level interventions, such as edutainment and mobile HCT programs, to reinforce prevention messages and behavior change and to distribute IEC materials and condoms
- Dissemination of IEC materials through KP social media networks
- Use of special events, such as World AIDS Day and Human Rights Day, to sensitize the public to behavior change and distribute relevant IEC materials
- Use of celebrities to promote the uptake of HTC and STI services
- Condom distribution through implementing partners working with KPs
- Advocating for the rights of people with diverse sexualities
- KP sensitization and capacity building for KP friendliness for programs at all levels

Under the supervision and management of VSO, outreach was delivered through PEs who were KP members and worked within and around known venues and sites in the communities frequented by people seeking sexual partners. Using their network, PEs targeted peers within the Program's catchment areas with preventive interventions, including referrals for health-facility-based interventions.

The Program also used Facebook to reach particular MSM and TG people. The use of social media was, however, limited. In FY 2017, the Program reached 73 KPs and priority populations. In FY 2018, the number dropped to 20 KPs, mainly due to the departure of the program officer responsible for social media.

[5] AIDS Data Hub [internet]. Papua New Guinea: key facts on HIV.
Available from: www.aidsdatahub.org/Country-Profiles/Papua-New-Guinea.

Figure 3: Number of individuals reached (KPs or other priority population) and provided with the minimum prevention package (against targets by FY).

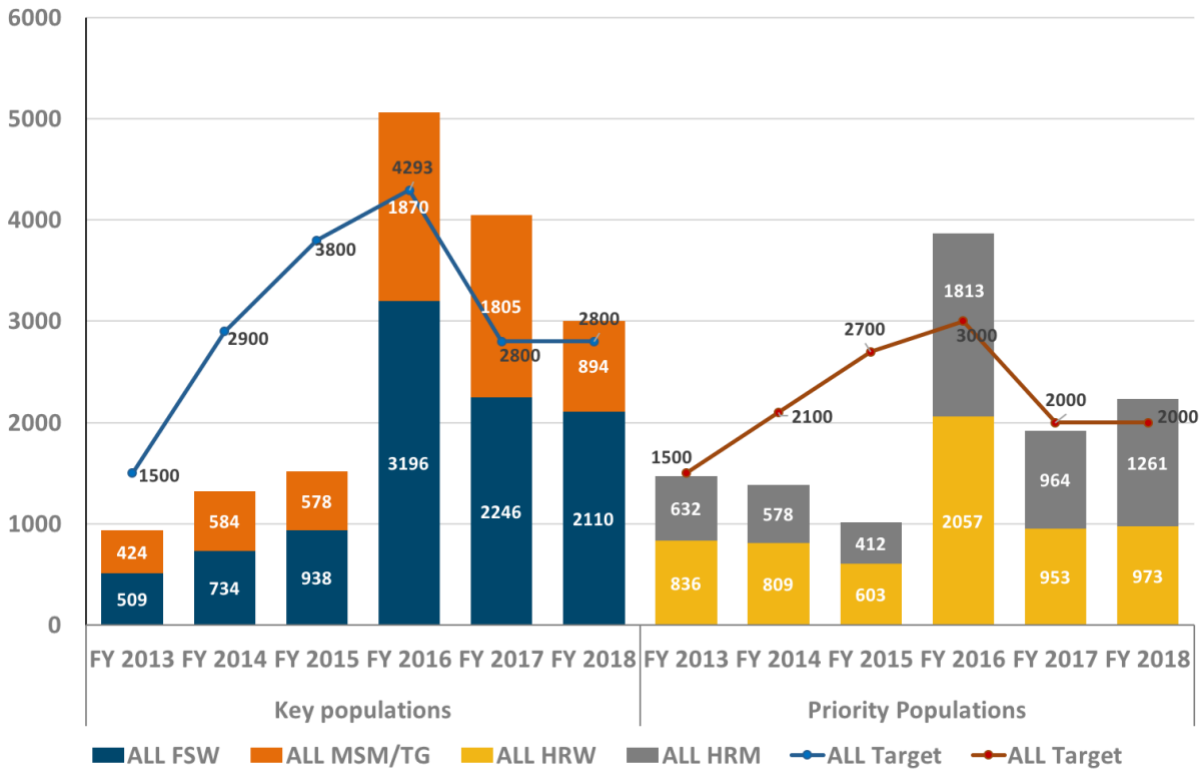


Figure 3 above shows a yearly increase in KPs reached by the Program with prevention programming from FY 2013 to Q3 of FY 2018. As the Program strengthened its focus on targeting KPs, their proportion with respect to the total population (KP and priority populations) increased from 39 percent in FY 2013 to 70 percent in FY 2018.[6]

[6] Data on the proportion of KPs reached in FY 2018 is not detailed here as it only represents the work done in the first two quarters of FY 2018.

PROGRAM IN BRIEF 2

Learning from experience: applying adaptive management to improve outreach results

"Technical assistance to outreach for key populations and to peers was very substantial, and we did manage to reach out to key populations."

- Government official on FHI 360's contributions

Ongoing program data reviews, as well as feedback from PEs in the field, identified issues with achieving successful referral rates and meeting targets among KPs, particularly FSWs, MSM and TG people. To address these important issues, FHI 360 introduced in FY 2015 the EOA, an incentive-based performance system, to boost the results of peer-driven community activities. To further strengthen the EOA, FHI 360 decided to restructure the interventions, partner with new NGOs and increase and retrain the PEs. Starting from FY 2016, the Program began working with a new NGO partner. The new strategy strengthened the Program's focus on reaching KPs and ensuring successful referral to HCT as a way to achieve the 90–90–90 targets. The restructuring of the EOA with improved monitoring and performance management of PEs resulted in a 234 percent increase over FY 2015 results for KPs reached in FY 2016.

With the implementation of the EOA, the Program also began to see an increased focus on reaching more KPs with outreach services. Prior to the EOA, less than 50 percent of those reached were members of KPs (39 percent and 49 percent, in FYs 2013 and 2014 respectively). This proportion increased to 68 percent and 70 percent in FYs 2017 and 2018 respectively (figure 4).

Figure 4: Proportion of KPs among individuals reached and provided with the minimum prevention package by FY.

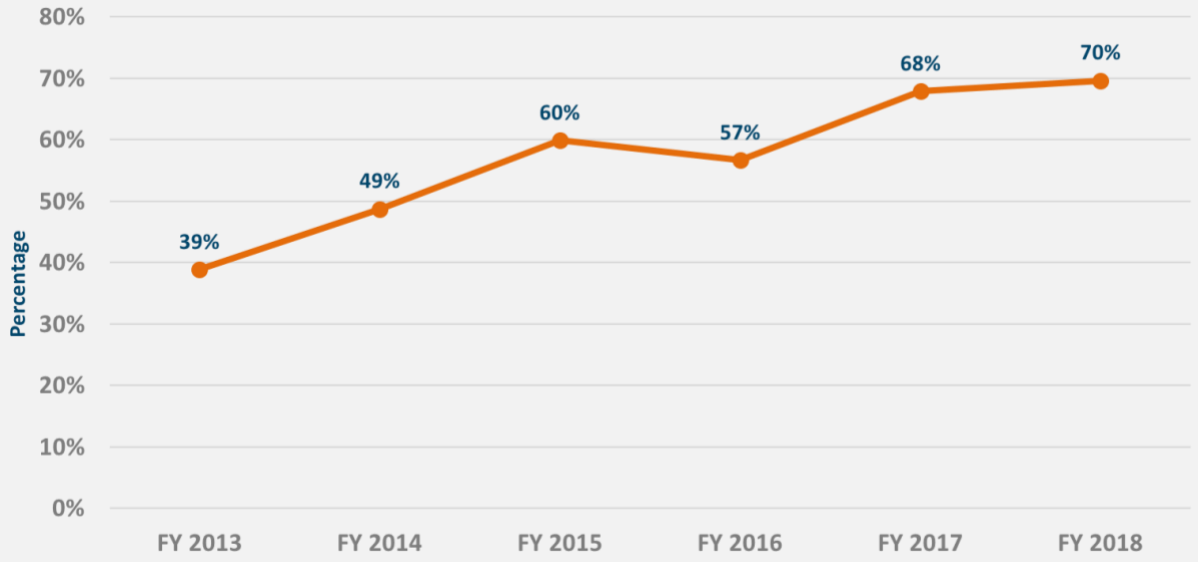
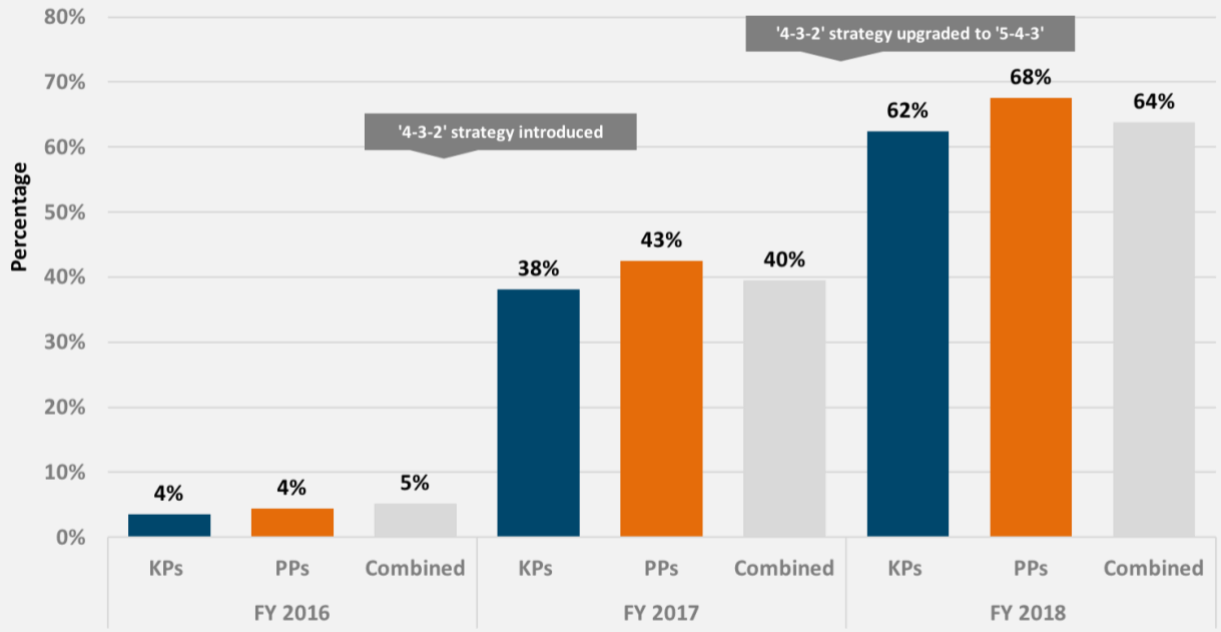


Figure 5: Proportion of KPs and other priority populations successfully referred for HCT and STI services in FYs 2016–2018.

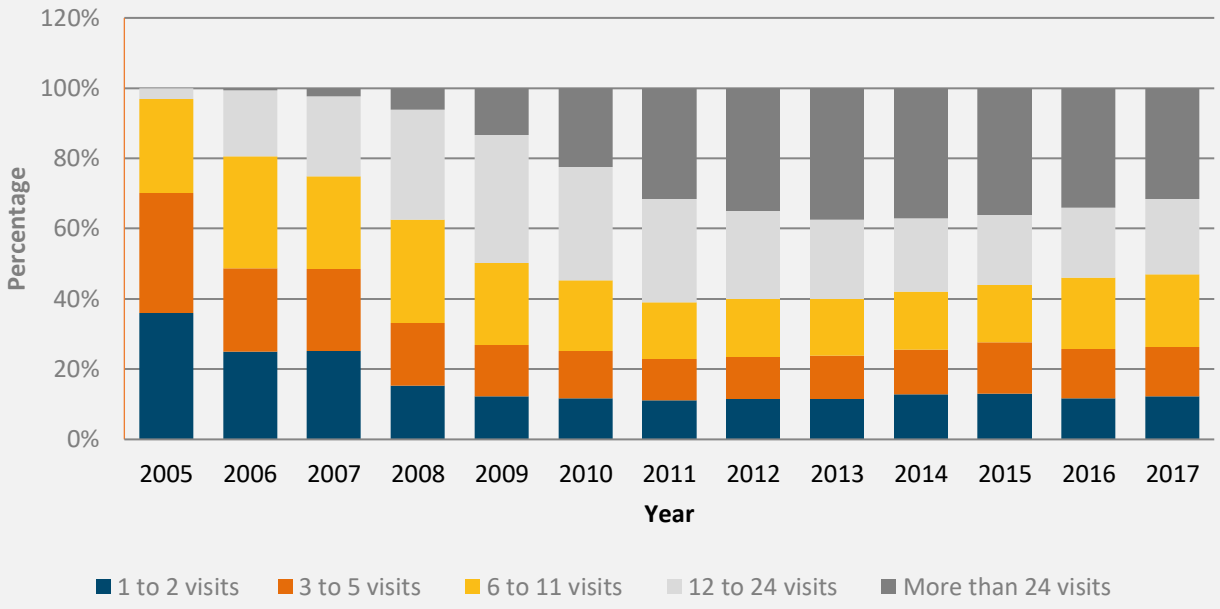


While the initial EOA structure contributed to a sharp increase in the number of KPs reached with prevention interventions, further review of Program data showed that not much was achieved in terms of successful referrals of target populations for HIV testing. Only 3.5 percent of KPs were successfully referred for HIV testing in FY 2016. To address this weakness, PE performance management was redesigned to set three targets for the PEs: reaching four KPs, referring three and having two access the services (the so-called "4-3-2"strategy). This approach also reinforced microplanning and strengthened supportive supervision. The approach proved to be a success, and successful referrals among KPs increased to 38 percent and 62 percent in FYs 2017 and 2018 respectively (figure 5). Data on the proportion of individuals belonging to KPs reached and provided with the minimum prevention package (figure 4) also illustrate the effectiveness of this approach.

Based on the review of field performance, the "4-3-2" strategy was modified to a "5-4-3" strategy in FY 2018 for further improvement. This resulted in an additional increase in successful referral rates across all populations (64 percent in FY 2018, as shown in figure 4), as well as a higher proportion of KPs among all individuals being reached. A national government official indicated that this approach had been very useful; as a result, the "5-4-3" strategy was adopted by the national program in the GFATM proposal for the current TB/HIV grant for implementation in the high-burden provinces in the country.

SBCC and IEC material targeting PLHIV also contributed to enhanced health-care-seeking behavior among PLHIV accessing services at FHI 360-supported sites. A consistent increase could be seen in the number of visits per year for each PLHIV since USAID began investing in PNG in 2005 and since FHI 360 started implementing its programs as shown in figure 6 below.

Figure 6: Number of PLHIV visits by year for each PLHIV at FHI 360-supported sites.



DETAILED ACHIEVEMENTS BY OBJECTIVE

Objective 2 (IR 2.2): increase the supply of quality HIV/AIDS services for key populations, their sexual partners and their families

The Program delivered services based on the CoPCT model that was developed under the previous USAID-supported and FHI 360-led project (Technical Support for HIV/AIDS Prevention, Care and Treatment; 2007 - 2012). This model was recommended to be scaled up in July 2012 during the midterm review of the National HIV strategy (2011–2015). At the clinical level, prevention services included HCT, STI management and GBV screening.

Improved service delivery was supported through clinical services at five sites receiving DSD support and providing HCT, ART, CD4, VL, TB, STI and GBV-related services. In addition, seven other sites were supported through TA only to improve service delivery (see figure 7 below for the list of sites and services).

Key contributions to the national program under Objective 2:

- Advocacy by government partners to scale up the CoPCT model nationwide as part of PNG's new HIV strategy
- Added five ART clinics (three DSD and two TA clinics) plus one satellite ART clinic
- Revised 2015 and 2017 National HIV Care and Support Guidelines
- Expansion of VL services to eight clinics in NCD
- Introduced STI services in four clinics in NCD
- Introduced lab services in one clinic and CD4 count in five ART sites
- Rolled out Test and Start strategy for all populations in NCD
- Strengthened TB/HIV integration to improve TB case finding among PLHIV
- Piloted innovations including lay counselor-assisted testing, mobile HCT, ACM and index client partner testing
- Decreased mortality among PLHIV in FHI 360-supported clinics (0.05 deaths per 100 person-years) compared to other sites (0.75 per 100 person-years)

Figure 7: List of sites supported by FHI 360 for DSD or TA for service delivery improvement and description of the services provided.

Partners	Clinic	Start Year	HTC	ART	CD4	VL	TB	STI	GBV/ HIV
Direct Service Delivery (DSD) Clinics									
Modilon General Hospital	Id Inad Clinic*	2012	✓	✓	◆		✓	✓	◆
Foursquare Church	Kilakila Clinic**	2012	✓	✓	◆	◆	✓	◆	◆
	Kaugere Clinic	2012	✓	◆	◆	◆	✓	◆	◆
Salvation Army	Koki Clinic	2012	◆	◆	◆	◆		◆	◆
	Ela Beach Clinic ***	2012	✓	◆		◆		◆	◆
Technical Assistance for Service Delivery Improvement (TA-SDI) Clinics									
National Department of Health	Heduru Clinic	2016	✓	✓	✓	✓	✓	✓	◆
	Gerehu Hospital	2017	✓	◆			✓	✓	
National Capital District Health Services	6 Mile Clinic	2017	✓	✓	✓	◆	✓	✓	
Anglicare/DFAT	Begabari Clinic	2016	✓	✓	✓	◆		✓	
National Capital District Health Services/ Hope World Wide/ Global Fund	Lawes Road Clinic	2016	✓	✓	◆	◆	✓	✓	◆
	9 Mile Clinic	2016	✓	✓	◆	◆	✓	✓	◆
National Capital District Health Services/ Seven Day Adventist	Tokarara Clinic	2017	✓	◆		◆	✓	✓	◆

** - Support ended in September, 2017 with close out of Madang component of the project. ** - Clinic closed in mid 2017. *** - Satellite ART site*
✓ - Services already available prior to USAID/FHI 360 support ◆ Services introduced under to USAID/FHI 360 support

The Program aimed to integrate general sexual health, TB and GBV services into existing HIV services to facilitate access for those in need. In sites where not all services could be provided, a referral pathway was created to facilitate referral of clients between services, ensuring cross-referral between HCT-STI, HIV-TB and GBV-related services.

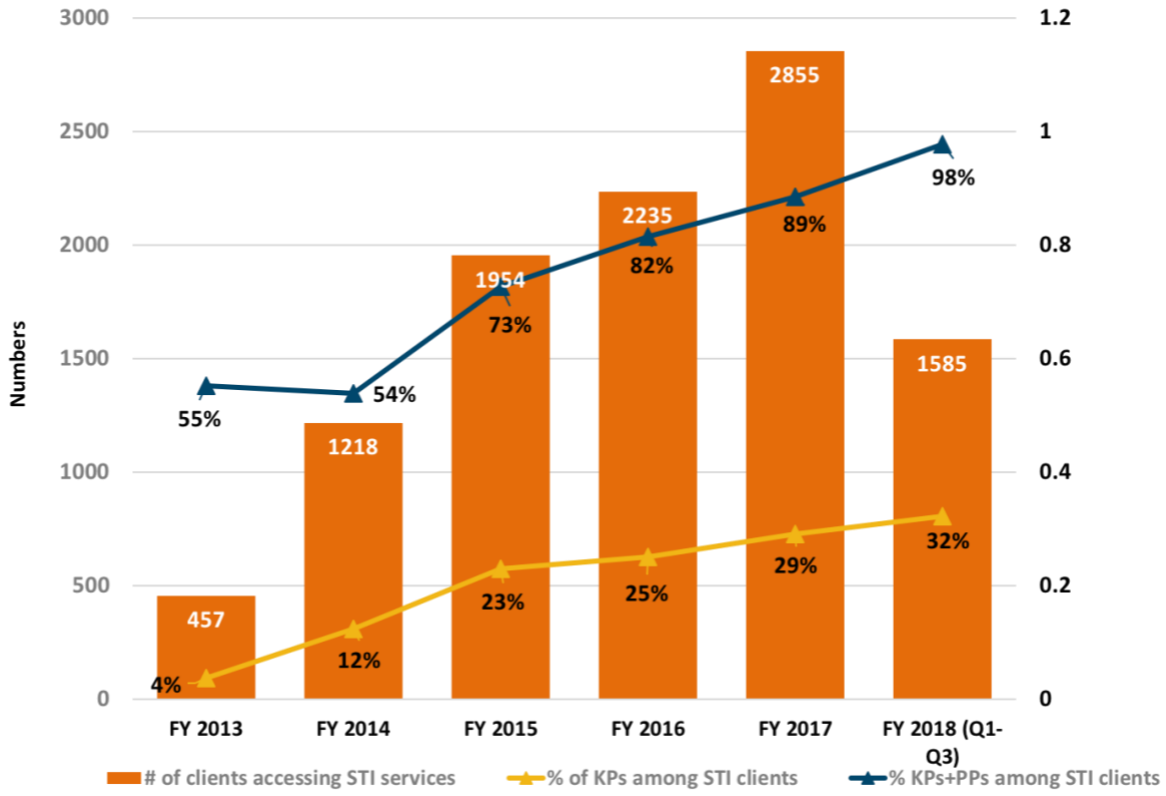
Five DSD- (including a satellite clinic at Ela Beach) and seven TA-supported clinics provided HIV care and treatment services based on national guidelines. Service providers included nurses, medical officers and community health workers trained on the IMAI and certified as ART prescribers. Case managers (mostly PLHIV) provided adherence counseling support and facilitated tracking of defaulting clients in the DSD clinics. The strategic approach included:

HCT provider and client at an FHI 360-supported site.
Sandrine Eveille/FHI 360

- Test and Start for all populations
- Provision of first-line fixed-dose combination HIV treatment
- Provision of treatment for one to three months depending on patient adherence history (differentiated care model)
- Baseline and six-month follow-up laboratory testing for all patients
- WHO clinical staging at each visit
- Screening for treatment failure at each visit
- Provision of opportunistic infection prophylaxis
- TB clinical screening at every visit
- VL testing in selected clinics
- Screening for GBV at every visit and post-GBV care

As part of its activities, the Program provided clients with STI testing and treatment services and imparted training to clinicians on STI management. As shown in figure 8 below, the number of individuals accessing STI management services under DSD support raised from as little as 437 in FY 2013 to 2,855 in FY 2017. As the Program became more focused on reaching the primary target populations over time, the proportion of individuals (referred and walk-ins) who were KPs or priority populations increased from 55 percent to 98 percent between FY 2013 and FY 2018. The proportion of KPs only increased from 4 percent to 32 percent over the same period.

Figure 8: Number (and proportion) of individuals who received STI management services at DSD sites by FY.



PROGRAM IN BRIEF 3

Piloting innovations to achieve the 90–90–90 targets: active case management, finger-prick testing and improved access to viral load services

"Testing and care TA has been the most successful [in terms of TA areas], and the initiation of Test and Start and introduction of ACM have really helped towards the 90–90–90 goals."

- Government official

In FY 2016, the National Capital District Health Services (NCDHS) endorsed the concept of ACM as a district-wide strategy to improve linkages to HIV care and treatment services and retention. FHI 360 supported this by sponsoring a five-day study visit to Cambodia on the operationalization of ACM. Following the study visit, FHI 360 and NCDHS developed a concept note describing the roll-out of ACM in NCD. The concept note was presented to and endorsed by the national HIV Technical Working Group (TWG).

To operationalize ACM, FHI 360 sponsored the recruitment of a coordinator for ACM and monitoring and evaluation (M&E) under NCDHS. The Program also developed SOPs for ACM, established case management teams, trained and mentored clinicians and case managers, and facilitated monthly coordination meetings with clinic teams to exchange information and feedback on the model. Review of ACM data and feedback from participants showed success at Begabari, Kaugere and Koki clinics. Kaugere stands out as a center of excellence for the model.

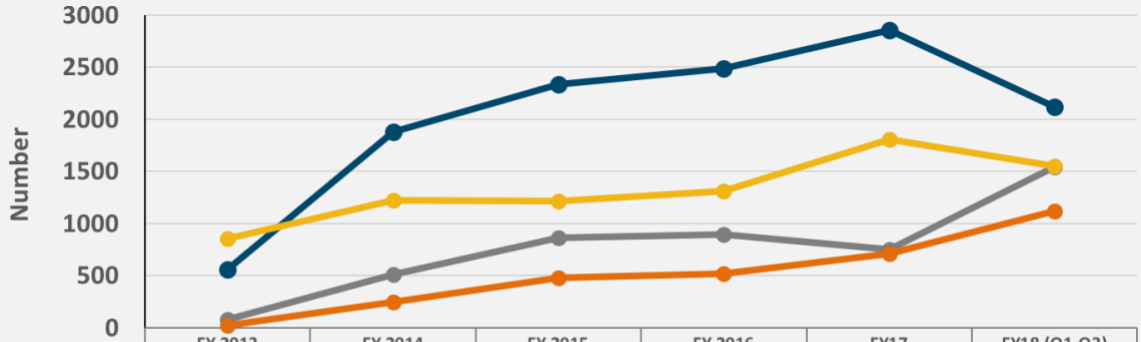
To facilitate access at the community level, FHI 360 also introduced mobile testing and finger-prick testing (lay counselor-assisted testing). The two testing models were presented to and endorsed by the national HIV TWG. Finger-prick testing in particular was new to PNG. PEs were trained in counseling and testing using this approach and started offering KPs and other people in the communities HCT as part of the outreach services. The PEs used Determine HIV 1/2 as the first serial test and, if individuals were found to be reactive, they were referred to a nearby HCT site for further counseling and confirmatory testing using STAT-PAK®. Patients confirmed to be HIV positive were enrolled into care and treatment clinics at ART sites.

FHI 360 supported the country's expansion of VL services through active participation in the VL subcommittee and by facilitating the phased roll-out of VL services using wet samples to Heduru, Koki and Begabari clinics in FY 2016. The stock-outs and human resources (HR) issues that hampered roll-out in FY 2017 were resolved and, throughout FY 2018, FHI 360 continued to support the strengthening of VL services by providing mentoring and on-the-job training, organizing site visits for clinicians to learn from each other and developing SBCC materials to promote VL literacy. Eight sites currently provide VL testing in NCD.

As the Program became more focused on reaching people who are most at risk of transmitting HIV, from FY 2013 to FY 2018, the proportion of individuals tested for HIV who belong to a KP increased compared to low-risk populations. The number of FSWs, MSM and TG clients tested is likely to be higher than reported (see figure 9 below), given recent IBBS data indicating that over 45 percent of FSWs and 48 percent of MSM and TG people do not disclose their behaviors when accessing services. These individuals may be captured under high-risk populations, as the large number of individuals in this category suggests.

Using a combination of clinic-based and mobile testing, 28,388 individuals were reached with HIV testing services through DSD support as at June 2018, 71 percent of them being populations that are most at risk of contracting the virus. A total of 1,417 PLHIV were identified.

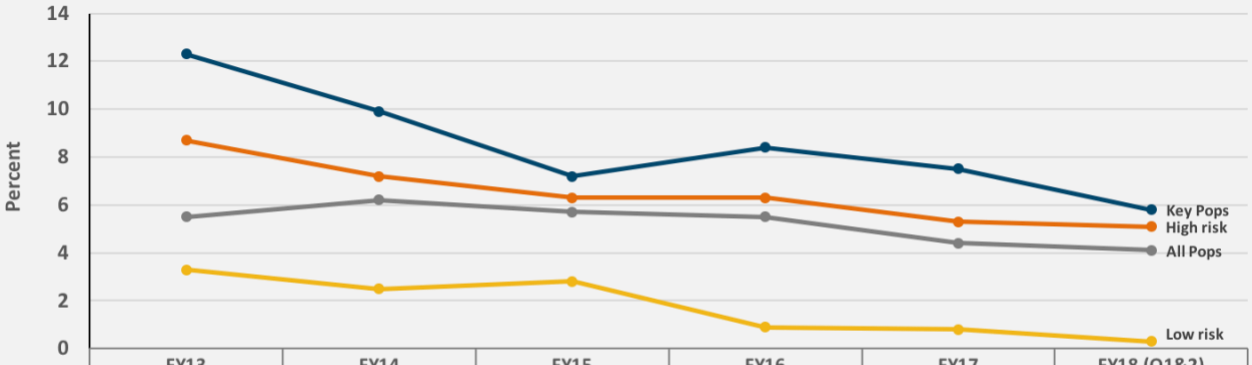
Figure 9: Number of individuals who received HCT and test results at DSD sites by risk group and FY.



	FY 2013	FY 2014	FY 2015	FY 2016	FY17	FY18 (Q1-Q3)
FSW	82	513	861	892	751	1545
MSM/TG (inc. MTS)	23	247	477	516	715	1115
high risk (men & women)	563	1881	2333	2488	2854	2120
low risk (men & women)	853	1219	1211	1307	1805	1549

Data from DSD sites show that HIV positivity rates declined over time across all the populations that accessed the services.

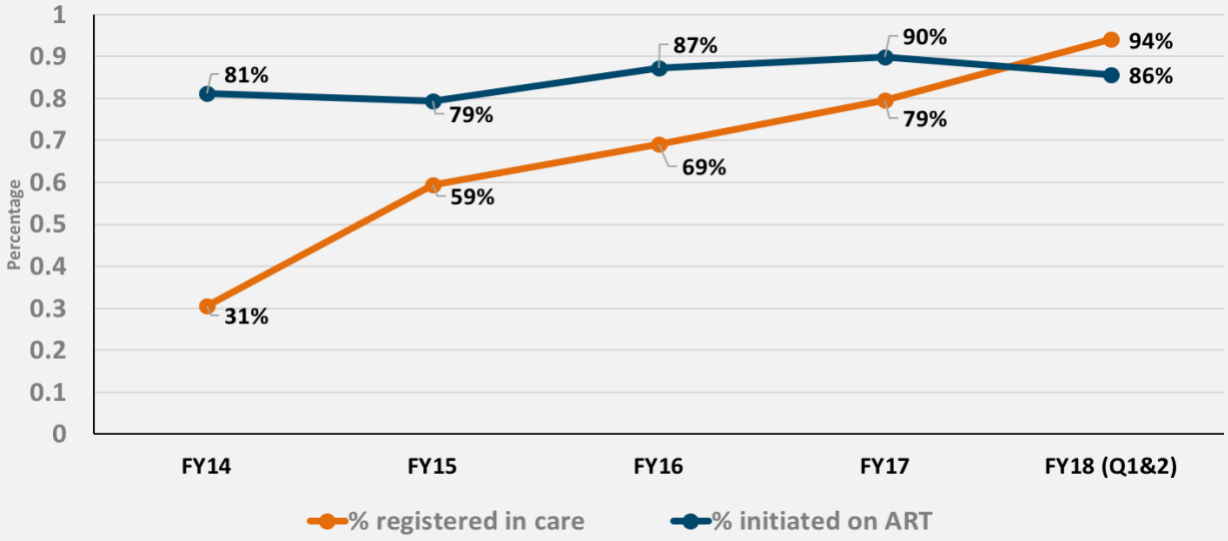
Figure 10: HIV positivity rates (DSD sites) by risk group and FY.



	FY13	FY14	FY15	FY16	FY17	FY18 (Q1&2)
KPs	12.3	9.9	7.2	8.4	7.5	5.8
HR	8.7	7.2	6.3	6.3	5.3	5.1
LR	3.3	2.5	2.8	0.9	0.8	0.3
ALL	5.5	6.2	5.7	5.5	4.4	4.1

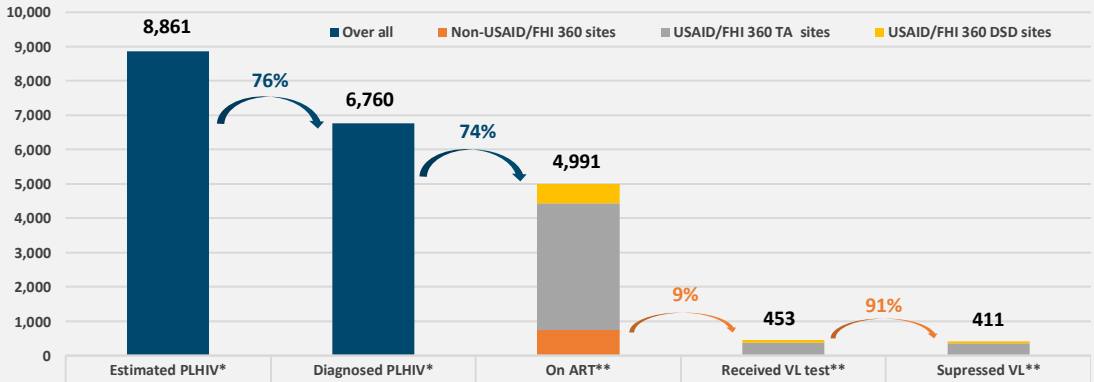
A trend analysis of the HIV care and treatment cascade indicates a progressive increase in the proportion of PLHIV enrolled into these services among those diagnosed HIV-positive, from 31 percent in FY 2014 to 94 percent in FY 2018 (see figure 11 below). The proportion of registered PLHIV who were initiated on ART also increased slightly within the same period, from 81 percent to 86 percent.

Figure 11: Proportion of PLHIV enrolled in care among those identified HIV-positive and proportion of those enrolled who were initiated on ART at DSD sites by FY.



While the NCD HIV care and treatment cascade for 2017 indicates the need for more in the province to achieve all three "90s" of the global treatment target, it is noteworthy that PEPFAR-supported sites contributed significantly to achievements under the second and third "90s" (figure 12). USAID- and FHI 360- supported DSD and TA sites contributed to 85 percent of PLHIV on ART and 99 percent of those tested for VL in 2017.

Figure 12: 2017 NCD HIV care and treatment cascade.

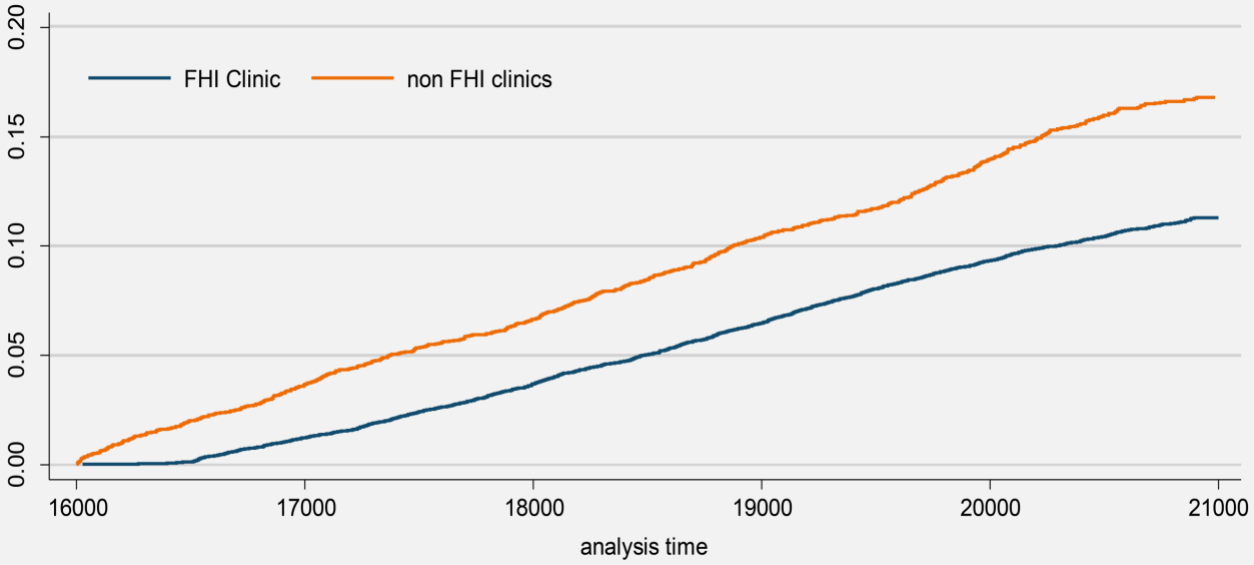


	Estimated PLHIV*	Diagnosed PLHIV*	On ART**	Received VL test**	Supressed VL**
USAID/FHI 360 DSD sites			550	72	58
USAID/FHI 360 TA sites			3,701	377	349
Non-USAID/FHI 360 sites			740	4	4
Over all	8,861	6,760			

*Data source: *National estimates; **National HIV Patient Data base*

An important contribution of the Program has been the reduction of HIV-related mortality. The Nelson-Aalen cumulative hazard estimates calculated with support from the WHO country office revealed that the likelihood of mortality registered at FHI 360-supported clinics was significantly lower (P<0.001) as compared to non-FHI 360-supported clinics.

Figure 13: Nelson-Aalen cumulative hazard estimates related to the likelihood of death registered at FHI 360- and non-FHI 360-supported ART sites.



Another major contribution to the national program was the rollout of Test and Start for all populations. After playing an active role in the review of the PNG national HIV care and treatment guidelines to pave the way for Test and Start for all PLHIV, the Program, in collaboration with NDoH, WHO and CDC, facilitated two major clinical refresher training sessions on the new guidelines for ART prescribers in Madang and NCD. In addition, the Program developed, printed and disseminated a job aid on the revised ART regimens and a flowchart on Test and Start to guide clinicians on patient evaluation for ART readiness and rapid initiation. A patient brochure on Test and Start was also produced to educate PLHIV on the benefits of early ART initiation. Analysis of the Program following these interventions indicates that 72 percent of PLHIV who were newly identified in the Q3 of FY 2018 were initiated on ART within seven days of confirmation, with all sites except Tokara (a relatively new TA clinic) achieving at least 50 percent (table 2).

Table 2: Distribution of new PLHIV by time of ART initiation: Q3, FY 2018 (numerators for each data element by site in parenthesis).

Time of ART Initiation	DSD Sites		TA Sites						
	Koki (n=23)	Ela Beach (n=6)	Kaugere (n=14)	9 Mile (n=31)	Lawes Road (n=35)	Tokarara (n=18)	Six Mile (n=28)	Begabari (n=53)	Heduru (n=25)
ART start: same day of HIV test	56.5% (13)	33.3% (2)	28.6% (4)	32.3% (10)	37.1% (13)	0% (0)	17.9% (5)	69.8% (37)	36.0% (9)
ART start: 2–7 days after HIV test	8.7% (2)	16.7% (1)	21.4% (3)	38.7% (12)	20.0% (7)	44.4% (8)	67.9% (19)	22.6% (12)	40.0% (10)
ART start: 7–30 days after HIV test	13.0% (3)	16.7% (1)	14.3% (2)	29.0% (9)	14.3% (5)	22.2% (4)	14.3% (4)	7.5% (4)	24.0% (6)
ART start: > 30 days after HIV test	8.7% (2)	0.0% (0)	0.0% (0)	0.0% (0)	8.5% (3)	11.1% (2)	0.0% (0)	0.0% (0)	0.0% (0)
Not yet on ART	0.0% (0)	0.0% (0)	35.7% (5)	0% (0)	20.0% (7)	0.0% (0)	0% (0)	0.0% (0)	0.0% (0)
No information/loss to follow-up after testing	13.0% (3)	33.3% (2)	0.0% (0)	0.0% (0)	0.0% (0)	22.2% (4)	0% (0)	0.0% (0)	0.0% (0)

DETAILED ACHIEVEMENTS BY OBJECTIVE

Objective 3 (IR 2.3): increase the use of facility- and community-based gender and gender-based violence interventions

"In the beginning, I tried to access services, but I was threatened not to go. I was told, 'If you go down to the station, I will make sure you go six feet underground.'"

- GBV survivor

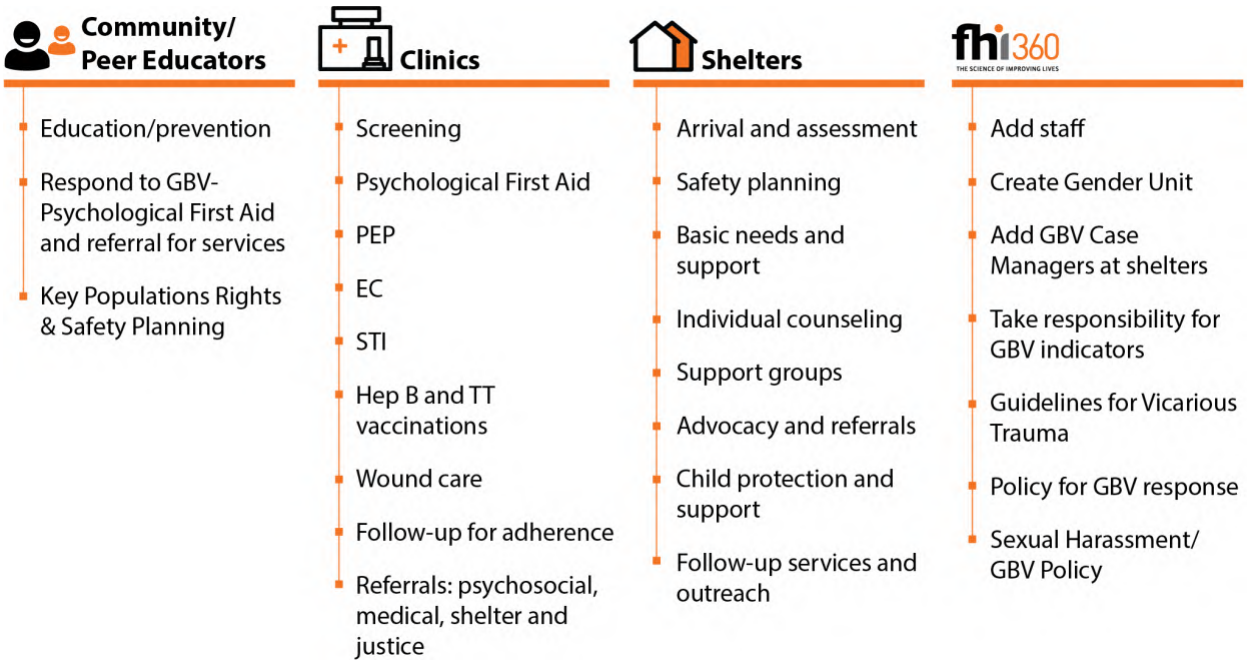
Key contributions to the national program under Objective 3:

- Development of national sexual and GBV clinical guidelines
- Development of a GBV screening protocol
- Piloted sexual and GBV clinical training manual in two districts (Daru, Western Province, and Arawa, Bougainville)
- Supported GBV hotline service (Tok Kaunselin Helpim Lain)
- Expanded access to post-GBV care outside family support centers

Past research supported by FHI 360 documented high levels of GBV in PNG[7] and served as evidence to advocate for the inclusion of GBV programming into FHI 360's current body of work. Service sites conducting GBV screening grew over time, from two DSD sites in FY 2015 to four in FY 2016, and five in FY 2017. Although the total number of individuals screened increased over time from 718 in FY 2015 to 8,427 in FY 2017, the number of GBV survivors identified through these screenings remained low (25 in FY 2015 and 384 in FY 2017). These Program data resonate with recent IBBS findings reporting that 60 percent of FSWs and 90 percent of MSM and TG people who were victims of physical or sexual violence did not access GBV services.[4] It is likely that factors such as sociocultural barriers related to gender roles and fear discouraged survivors from disclosing GBV. For women engaging in transactional sex, MSM and TG people, this is compounded by fear of stigma and discrimination related to their behaviors. In our interviews with clients and recipients as part of the preparation for this report, it was apparent that fear is a significant barrier to accessing services, together with the feeling that they will not be believed. FHI 360 implemented GBV services addressing prevention and response to GBV at different levels, as shown in figure 14.

[7] Wong CM and Noriega S. FHI 360. Exploring Gender-Based Violence Among Men Who Have Sex With Men, Male Sex Worker and Transgender Communities in Bangladesh and Papua New Guinea: Research Report; 2013. Available from: www.fhi360.org/sites/default/files/media/documents/GBV Study report_Final.pdf.

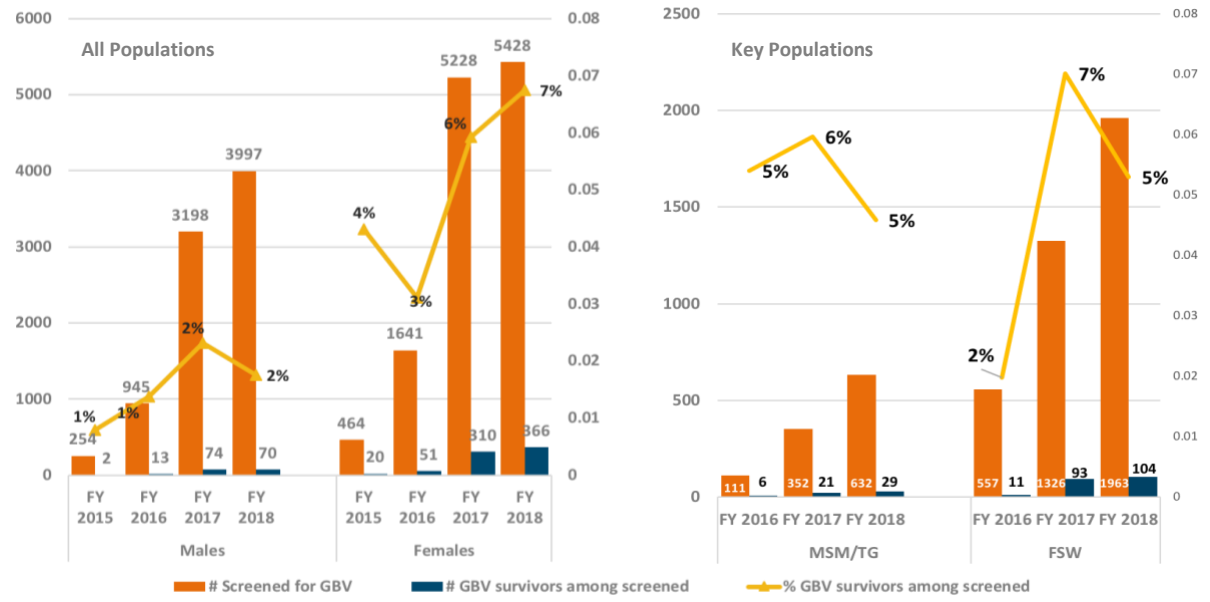
Figure 14: GBV services provided under FHI 360 Program support.



As part of the Program and in partnership with ChildFund and FSVAC, FHI 360 supported a GBV hotline active between 7am and 7pm seven days a week. The hotline functioned primarily as a directory of services to provide callers with information on where to access services within their geographical areas. Other services included telephone counseling, information on rights and service referrals. Over 4,900 individuals accessed the telephone service since its inception in August 2016. Among them, more than 3,000 were referred for post-GBV-related services, including law enforcement and justice, welfare and shelter, counseling services, clinical care and HIV-related services.

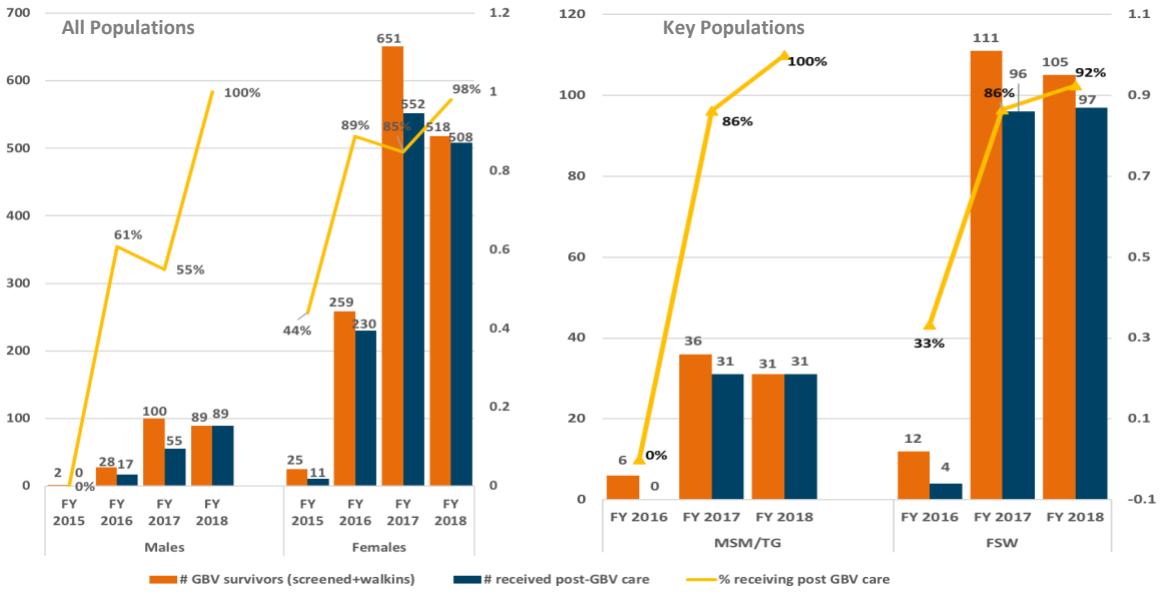
Once service integration was fully established in FY 2016 and PEs provided information during outreach (including accompanying survivors to the sites), the demand for GBV screening and care services increased, and tracking of GBV service uptake by KPs was introduced. Between FYs 2015 and 2017, the percentage of GBV cases among those screened (both men and women) increased. Less than 1 percent of men screened in FY 2015 were GBV cases, compared to just under 2 percent in FY 2018. Of the cases confirmed, those receiving post-GBV care increased from 0 percent in FY 2015 to approximately 100 percent in FY 2018.

Figure 15: Number of people screened for GBV and GBV cases identified at DSD sites by FY, sex and risk group.



GBV cases were higher among women, with just over 4 percent of those screened in FY 2015 reporting GBV increased to approximately 7 percent in FY 2018. Of those identified cases, 44 percent received post-GBV care in FY 2015, compared to 98 percent in FY 2018. Rates of GBV cases were slightly higher among KPs, with 5 percent of women engaging in transactional sex and 6 percent of MSM reporting GBV in FY 2018. Of these, 92 percent of women engaging in transactional sex and 100 percent of MSM received post-GBV care.

Figure 16: Uptake of post-GBV care among GBV survivors (both screened and walk-ins) at DSD sites by FY, sex and risk group.



PROGRAM IN BRIEF 4

Overcoming gender-based violence through service integration

Key strategies for the integration of gender and GBV into available services included prevention, response, coordination and advocacy, and M&E. These strategies were implemented at three levels: national, clinical and safe house, and community level.

National-level activities focused on (1) TA through the Gender TWG, (2) support in the development of guidelines and SOPs for the services, (3) strengthening of GBV monitoring systems, (4) strengthening of quality assurance systems and (5) close collaboration and support from FSVAC, the United Nations Development Programme and the Department of Community Development in implementing strategies.

At the clinical level, activities focused on (1) integrating GBV into existing STI and HIV clinical services, (2) provision of TA, including one-to-one mentoring and training on routine screening for GBV, (3) provision of psychological and medical first aid to GBV survivors, (4) safety planning and child protection to site staff, (5) support to strengthen quality assurance and monitoring systems, (6) support to use the shelter service SOPs and (7) strengthening of referral systems for survivors.

Community-level activities involved (1) gender sensitization training sessions in catchment areas, (2) capacity building for PEs to enable them to educate their peers on GBV, (3) safety planning and effective referral and (4) linkages with support group members to ensure survivors had social support to reintegrate into their communities without fear of stigma and discrimination.

DETAILED ACHIEVEMENTS BY OBJECTIVE

Objective 4 (IR 2.4): strengthen health systems for HIV/AIDS service delivery

"FHI has been involved in almost all aspects of technical areas for the department and the country program. It is a very strong partnership. Technical support is very sound from FHI [360]."

- Government official

Objective 4 focused on TA to organizations, clinicians and stakeholders in PNG. This assistance covered three main areas: (1) organizational capacity development for local implementing partners and their staff, (2) support for the development of national tools and program guidelines and (3) technical support in the areas of service delivery, M&E, laboratory and supply chain.

Key contributions to the national program under Objective 3:

- Development of SOPs, guidelines, protocols and tools to guide HIV, STI and GBV service delivery
- Funded national- and provincial-level training sessions on provider-initiated counseling and testing, IMAI, Alere Pima™ CD4 test, post-GBV care, research and surveillance
- Developed capacity of five CBOs to provide PE-driven HIV outreach for KPs
- Developed organizational and financial management capacity of two CBOs
- Establishment of KP management information system

Table 3 below summarizes the TA package offered to partners toward achieving the 90–90–90 targets.

Table 3: TA package, strategies and measures provided by FHI 360 to the national program to achieve the 90-90-90 targets.

	Component	Subcomponent	Strategy	Measure
First 90: 90 percent of PLHIV diagnosed	Service uptake by populations at risk	Identification of at-risk populations	• Use of decision-making algorithm for HIV risk identification	Increased identification of at-risk populations
		Acceptability of services to at-risk populations	• Sensitivity training • Quality indicators for friendliness	Friendliness assessments

	Component	Subcomponent	Strategy	Measure
Second 90: 90 percent of diagnosed people receiving ART	ART initiation and maintenance	Timely ART initiation	• Mentorship on guidelines for initiation HIVQUAL8 review meetings	ART initiation data point
		Retention on ART	• Strengthen case management – structured adherence monitoring and counseling • System for early identification of missing patients and tracking • Support linkage to NCD Active Case Management (ACM) system	Documented case management systems in place for identifying and tracking missing patients Retention in care data point
Third 90: 90 percent of those on treatment reach viral suppression	Treatment failure management	Identification and management of treatment failure	• Treatment failure/enhanced adherence counseling training • System for identifying, managing, counseling and following up for suspected treatment failure	Documented treatment failure assessment and system activation
		Routine VL monitoring	• VL training • Implement system for VL testing	VL sampling done VL data point
Monitoring Data	Data management	Data management for at-risk populations (for PNG management information system)	• Upgrade patient data collection tools to have necessary information	Collection of data for at-risk population services provided
		Overall data management and review	• Integrate key HIVQUAL measures into existing tools • Integrate national HIV patient database • HIVQUAL mentorship • Data quality assessments	HIVQUAL implementation and progress on indicator National HIV patient database integrated DQA results
Laboratory	Laboratory improvement for HIV	Laboratory testing for HIV/STI • VDRL test • VL sampling • TB sputum • Alere Pima™ CD4	• Equipment purchase • Training for laboratory testing integration and mentorship • System for VL sample transfer between HIV clinic and the Central Public Health Laboratory	Equipment procured Laboratory tests integrated
		Quality assessment for laboratories	○ Develop external and internal quality control strategies	External and internal quality assessments done regularly

[8] A performance measurement and quality improvement approach developed by the New York State Department of Health with support from U.S. Health Resources and Services Administration and adapted for international use by the CDC in Thailand.

"We came in with nothing. With the support from FHI 360 and the Government, our staff were put to training."

- Clinician at an FHI 360 DSD site

"Because of the way FHI 360 has built my capacity over the years, I am very confident in my role as a government staff. I find it easier to plan, implement my tasks and deliver results."

- Former M&E officer/project coordinator

"FHI 360's work helped the country better understand the who, what, where and when."

- Government official

At the CBO level, FHI 360 provided TA in financial management and proposal development. The support resulted in the successful submission of a proposal by HOPE Worldwide, who were able to obtain a grant to continue services. The proposal writing support, provided under a partnership with the Local Capacity Initiative by the CDC, was mentioned by other CBOs that participated as being particularly relevant and useful. Overall, local partners responded favorably to the TA provided and indicated that it was delivered appropriately and that the topics covered were needed. At the CBO level, participation in M&E activities (such as the friendliness assessment, where volunteers were trained to be mystery clients) was mentioned by several organizations as an example of FHI 360's inclusive approach.

At the clinical level, FHI 360 provided significant mentoring and support to clinicians and service managers. The topics covered included ACM, M&E, IMAI, finance training, GBV, CD4/VL, provider-initiated counseling and testing, and couples counseling. A five-day study tour to Cambodia was organized in Q4 of FY 2016. The primary objective of the visit was for the team of five (composed of representatives of the National Department of Health (NDoH), NCDHS and FHI 360 and ART clinicians) to learn about how FHI 360's program implemented ACM in Cambodia. During the visit, the team also had the opportunity to experience the implementation of lay counselor-assisted testing and learn about Cambodia's approach to the roll-out of VL services and implementation of KP Program. Following the visit, the team developed an implementation plan for ACM in NCD, starting with five clinics in Q1 of FY 2017.

Clinicians were particularly positive about the TA received, indicating that it provided them with opportunities for professional growth as well as an incentive to work harder and deliver quality services. While the clinicians interviewed for this report indicated that they were comfortable continuing with their jobs in the absence of future TA, they felt that FHI 360's ongoing support and collaboration would be an essential component in assuring sustainability and would benefit more clinics in the country.

Participants in the FHI 360-supported training on research and surveillance.

"When the friendly assessment thing happened, we broke the barriers with FHI 360."

- Local partner

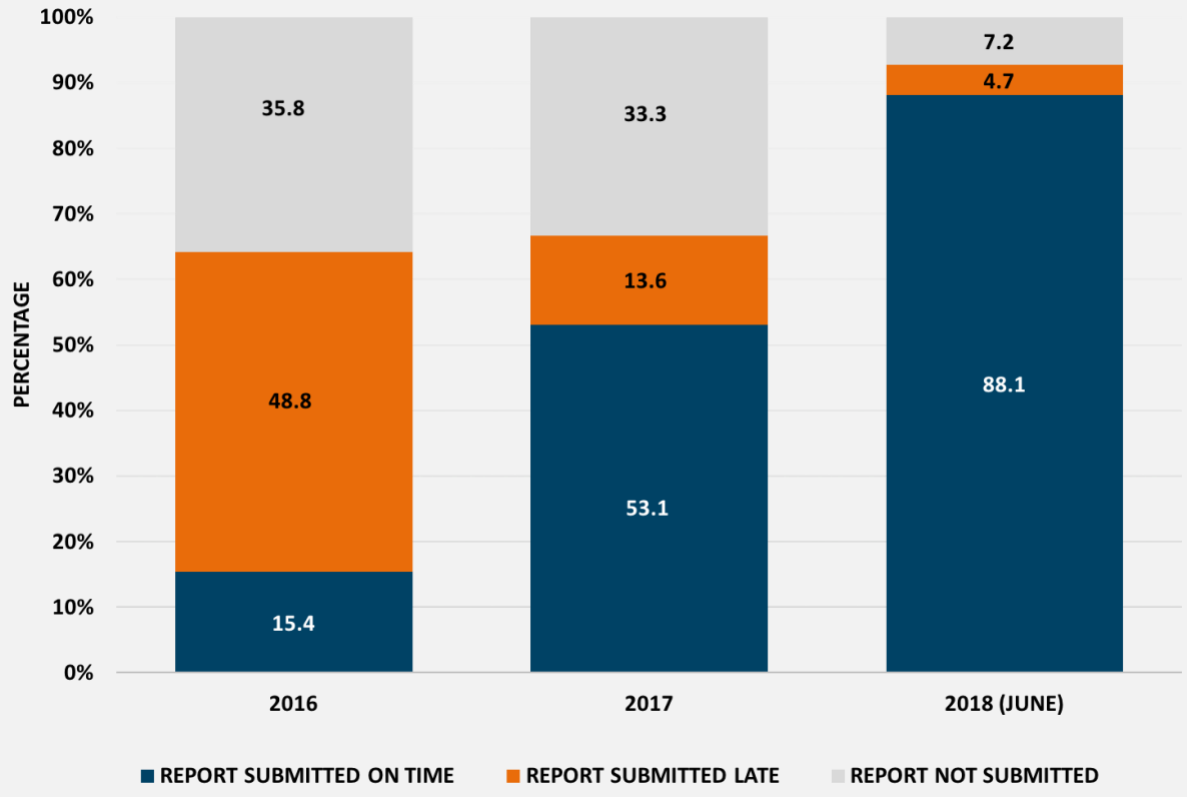
At the national level, FHI 360 continued its participation in the National Gender TWG and the National HIV/AIDS TWG and its sub-TWGs (VL and Strategic Information). All national counterparts that were interviewed referred to this participation as being critical to FHI 360's contribution, particularly in the translation of its practical experience and technical expertise into national tools and guidelines. Key products that government counterparts felt were particularly relevant were (1) the decision tree tool, which has helped the national program better classify individuals at highest risk, (2) FHI 360's support and contributions to the improvement of National HIV Care and Support Guidelines and national STI management guidelines and (3) its support in improving reporting by clinics. Advocacy in using evidence to justify a targeted approach has also been noted, as stated by a NDoH official: "FHI 360 helped the country better understand the epidemic and know who, what, when and where." As a result, FHI 360's work has helped guide the development of the new national HIV strategy. Friendliness assessments were introduced as quality improvement interventions. These were prompted by the need to address concerns and complaints from PEs about KP treatment at clinics. Through engagement with local CBOs and KPs, the assessments included the training of CBO staff and KPs to conduct clinic visits and be mystery patients so that the clinics could be evaluated by the target population without the knowledge of the services provider. Findings were shared with FHI 360 staff, who then provided feedback to clinic management teams and worked with them to address gaps and implement recommendations. Initially conducted among four clinics in 2015, by 2017, 11 clinics were part of the friendliness assessments. Among clinics that participated in all rounds, the Program noted important improvements relating to clinician friendliness and acceptance of KP clients. Community members commented on how this process empowered them and gave them valuable skills and highlighted the importance of these assessments in giving clinics feedback to improve services for marginalized populations.

PROGRAM IN BRIEF 5

Technical assistance to improve reporting and ensure availability of data to inform Program strengthening and policymaking

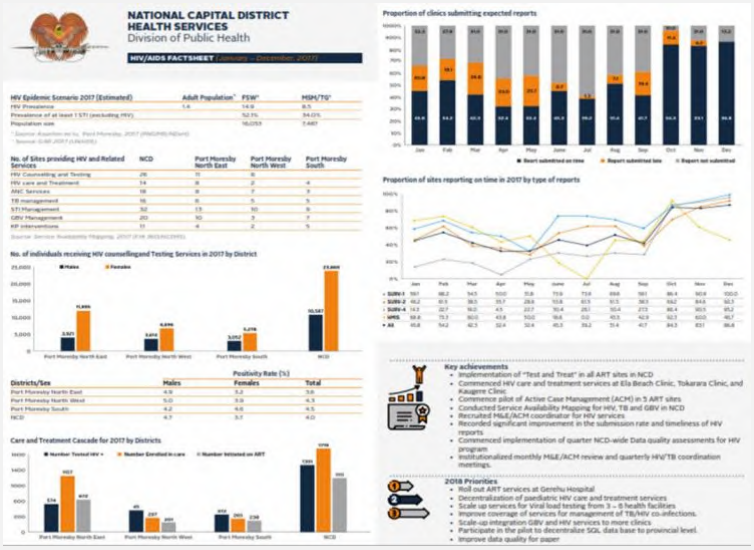
FHI 360's support to help clinics improve reporting resulted in increased timely reporting to government authorities in NCD by HIV clinics operating within its jurisdiction. In 2016, just over 15 percent of all expected reports from HIV clinics in NCD were submitted on time; the proportion increased to 88 percent by June of 2018.

Figure 17: Timeliness (annual average) of expected reports submitted by HIV clinics in NCD from 2016 to June 2018.



This result was achieved through close support for NCDHS and included the recruitment of a M&E coordinator (who also served as the case management coordinator in NCD), selected in collaboration with NCDHS and embedded within their offices. As part of their M&E role, the coordinator oversaw the timely collection and reporting of HIV-related data from all HIV clinics in NCD. To ensure sustainability, NCDHS agreed to absorb the position into their structure. In parallel, M&E focal points responsible for monthly data collation and report submissions to NCDHS and NDoH were identified in all clinics.

Throughout this process, FHI 360 provided TA and mentoring, helped track completeness and timeliness of the reports submitted and monitored improvement over time. Targeted assistance was provided for clinics where data were not being completed in a timely manner, or where issues of data quality arose. Joint M&E review and coordination meetings were held monthly to discuss issues and reinforce messaging around the importance of complete and timely reporting. As an incentive, an award system was created to reward sites that improved their ability to provide complete, high-quality reports on time.



NCD HIV program fact sheet; Dec. – Jan. 2017

In addition to the joint M&E review and coordination meetings, the Program also implemented the quarterly program performance review meetings with its implementing partner organizations, with participation of clinicians from DSD and TA sites as well as government officials from NCDHS, NDoH and NACS. A key activity during both meetings was the review of program results against performance targets with in-depth discussion on the HIV care treatment. These forums helped to develop the skills of clinicians, M&E staff and Program coordinators on data analysis and presentation. FHI 360 and CDC also provided training and mentoring support to program officers and the M&E coordinator at NCDHS on data management and analysis. With TA from FHI 360, the team produced the first fact sheet covering the period from January to December 2017.

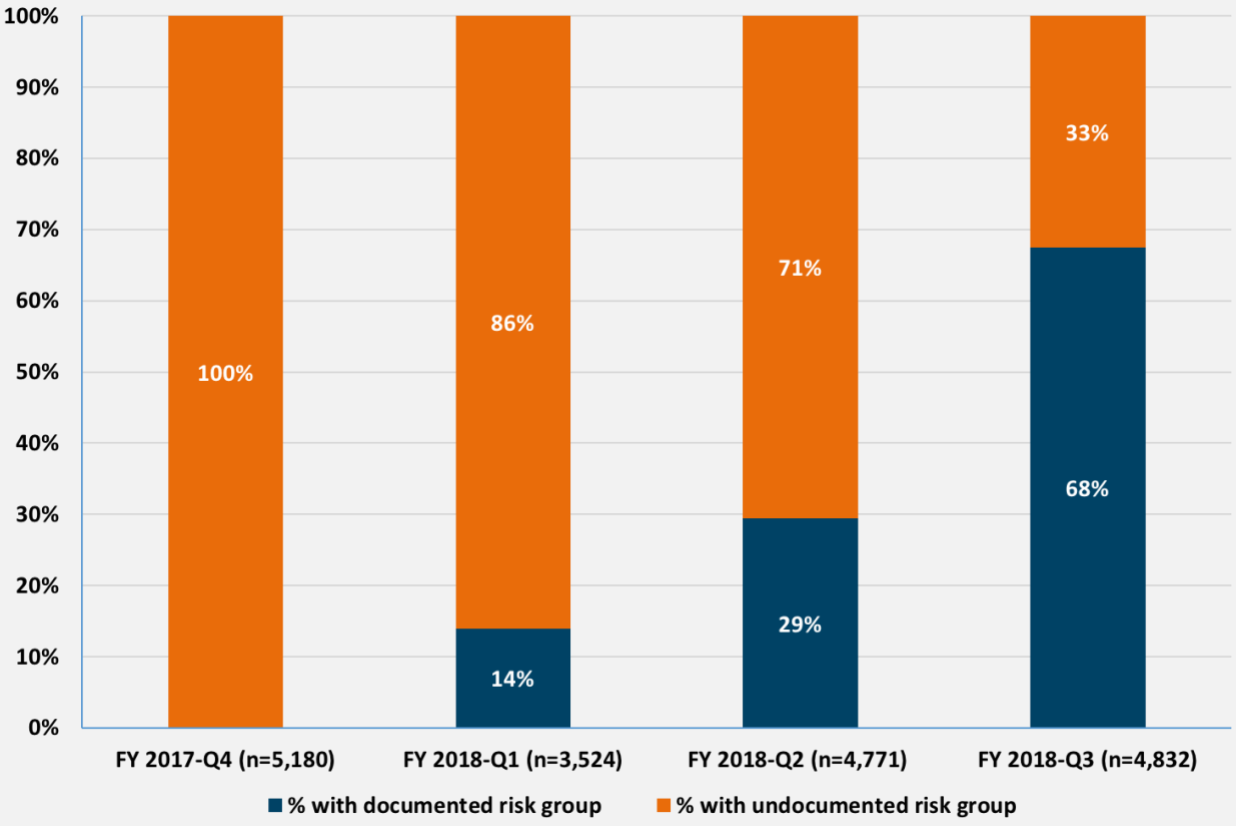
To minimize the delays of getting surveillance reports entered into the national SQL server hosted at NDoH and to reduce the frequency of missing reports associated with the transmission of paper-based reports from provincial to national level, FHI 360 worked in close collaboration with the CDC and NDoH surveillance team to decentralize the data entry process to NCDHS. This decentralization process was completed in June 2018, following which NCDHS commenced data entry directly into the national server at the provincial level, starting with data for May 2018 reporting period.

In FY 2016, the Program intensified TA in NCD in order to support the Government of PNG in achieving the global 90–90–90 targets by 2020. Expansion initially included five sites selected in collaboration with NCD health officials: Heduru Clinic, supported by the Government, Anglicare Clinic, supported by DFAT, Six Mile Clinic, managed by NCDHS, and 9 Mile and Lawes Road clinics, both supported by Hope Worldwide. A baseline assessment was conducted at each site. During the debriefing sessions, priority areas to target were identified, and a minimal package of TA was agreed upon (see table 3). In all sites, M&E systems were targeted, with a focus on the importance of reporting, data quality and data use. As

part of this, the staff was trained on the use of the decision tree tool and on data collection and reporting. By 2017, Gerehu and Tokarara clinics were included.

While the decision tree tool was rolled out and fully embraced by DSD clinics (with 100 percent of HIV and STI clients now categorized by risk groups), the tool was introduced to TA clinics only after being adopted by the HIV TWG as part of the surveillance tools in FY 2017. Since then, analysis of disaggregated data from TA clinics has shown a gradual increase in the proportion of HCT clients whose risk groups were documented, from 0 percent in Q4 of FY 2017 to 68 percent in Q3 of FY 2018, as more service providers apply the tool (see figure 18 below).

Figure 18: Proportion of HCT clients in TA sites whose risk group is documented.



"We need to be looking in the near future on having programs for KPs running alongside the normal health-sector-driven response. We should have KP programs established in major provinces, like the six or seven high-burden provinces, and if I had it my way, I would seek the support of PEPFAR funding for FHI [360] to move into, apart from Moresby, establish operations in Lae, Mount Hagen as well, for a start. And then that's a way of moving forward and getting the KP programs well-established so that when we are looking at data from general population and KPs, that will give us a very good chance of looking at the HIV epidemic in terms of geographical coverage and population coverage, subpopulation coverage. That's a gap that exists. And if the situation improves, we should get FHI [360] to go out and provide assistance to replicate this model in other parts of the country."

- Government official

While the Program made important achievements, as illustrated in the previous sections of this report, FHI 360 and its implementation partners faced a number of challenges, including:

Service delivery

The Program has faced many challenges in achieving its aim of providing quality HIV/AIDS services at some clinics, especially those where FHI 360 provided TA only. This hampered the Program's ability to hold staff accountable, and significant work had to be conducted with clinic management to ensure the staff complied with scopes of work and remained committed to service delivery in line with Program SOPs.

In some cases, the challenges were beyond the Program's control. For example, some clients gave false or non-specific addresses and phone numbers, and home visits to facilitate their follow-up process were not possible.

While the Program made significant progress in integrating services, challenges related to this process included the need to recruit specialized staff and train existing staff on integration. The Program focused on facilities that were strong performers and worked closely with other sites where issues were observed in order to provide ongoing support and facilitate the process as much as possible.

Human resources, infrastructure and logistics

HR was a challenge throughout the whole duration of the Program, especially at the clinical level. In FY 2016, VL services were temporarily unavailable due to staff shortages at the Central Public Health Laboratory. After the recruitment of two new laboratory staff, services were restored in Q4 of FY 2016 at Heduru, Begabari and Koki clinics. In some sites, the role of FHI 360 as a TA-only provider resulted in lower motivation among the staff. This was particularly the case with Id Inad Clinic in Madang. The Program had to work closely with the Modilon General Hospital on HR issues to ensure clinic staff remained committed and performed their scopes of work. In some sites, staff attrition was a challenge and resulted in the Program needing to invest heavily to recruit and retrain staff.

The Kila Kila clinic was shut in FY 2017 to make way for the expansion of an adjacent primary school. ART patients from this site were transferred to Kaugere, Begabari and Heduru clinics to continue treatment. However, the majority of clients opted for Kaugere clinic, which put pressure on the site due to space

constraint. FHI 360 assisted in the movement of modular housing units to the site to increase space and accommodate the new patient load. The Program addressed issues related to the increased staff size by reassigning staff to other sites to ensure that they had places to conduct their clinical services.

In FY 2017, the Ela Beach clinic experienced flooding and low electricity supply resulting in the need to temporarily stop service provision. Services were restored within a quarter, but the electricity supply remained a challenge beyond the control of the implementing partner.

Service provision was also challenged by stock-outs. In FY 2016, a stock-out of EDTA tubes at the Area Medical Store affected the ability of the Program to provide VL services. FHI 360 supported the procurement of 1,500 EDTA tubes as a stopgap before regular VL services could resume. In FY 2016, FHI 360 had to procure 1,000 CD4 cartridges and 1,100 rapid HIV test kits in response to a national stock-out of both laboratory supplies. In FY 2018, a stock-out of ART also proved a challenge; the Program continues to collaborate with UNAIDS and WHO to address the situation.

Strategic information

In FY 2013, due to budget constraints, the Program had to cancel its plans to roll out a more sophisticated electronic medical record system that would allow for cohort analysis. However, the Program continued to seek solutions and introduced standardized spreadsheet-based systems in all of its clinics. While Microsoft Excel is not the ideal software for cohort analysis, all sites were able to use the system and improve reporting overall. The Program subsequently transitioned to the national HIV patient database in FY 2017.

The Program introduced CommCare as part of the EOA, with the goal of moving from a paper-based data collection system to a digital one, improving data quality for PEs and clinics, increasing the timeliness of data availability and tracking referrals from community prevention activities to clinic-based services. After a three-month trial, the application was rolled out in October 2016. Despite close monitoring and continuous user support, the implementation of the application experienced a lot of challenges, including frequent loss of smartphones (eight phones lost and three damaged), lack of commitment to real-time data entry, duplication of effort, inconsistencies in client Unique Identifier Codes, clients' concern with confidentiality etc. Due to these significant challenges, and with very little value added to Program results, FHI 360 decided to discontinue the use of the application with effect from Q1 of FY 2018.

The roll-out of the EOA posed additional challenges related to the introduction of new data collection tools, which resulted in incorrect filling out of the referral booklets and confusion regarding roles and responsibilities among staff. Misinformation and misunderstandings on the incentive-based approach resulted in a decrease of individual contact through outreach. Additional support and mentoring were provided to PEs and field support officers to help them use referral booklets more efficiently and understand the importance of the newly introduced Unique Identifier Codes. With the restructuring of management and supervision of the EOA in FY 2016, a significant improvement in outreach results was observed. However, second- and third-wave referrals in the EOA remained ineffective.

Multiple partners working in one geographic area also posed a challenge, especially when PEs worked across partners. This resulted in suspected double counting of clients. A mapping of the catchment areas

was conducted, and an agreement between partners was attained in order to reduce this possibility. However, attribution remained a concern across partners.

Population size estimates based on the most recent IBBS indicated the presence of 16,053 FSWs and 7,487 MSM and TG people in NCD. These data varied significantly from routine Program data, where the highest number of KP members who were reached with prevention services in a single FY was 5,066 (number reached in Moresby South in FY 2016), while Save the Children International reported registering 2,500 KP members in its program (which covered most of Moresby North-East, North West and parts of Moresby South). Based on interviews conducted with key informants during the hotspot review exercise carried out in Q1 of FY 2017, the estimated population of KPs in the 34 hotspots visited was approximately 1,700. FHI 360 believes the IBBS largely overestimates the population sizes because participants received incentives, but the Program continued to try to improve outreach and work with stakeholders to increase coverage.

Notwithstanding, the unique count of individuals (de-duplicated by using the NUIC) indicates that the Program reached a total of 8,582 KP members (including 6,152 FSWs, 1,974 MSM and 456 TG people) and 5,833 priority population members (including 1,718 male sex workers, 1,848 other high-risk men and 2,267 other high-risk women) with the minimum preventive intervention packages between March 2016 and June 2018 in NCD. These results represent 38.3 percent of the estimated FSW and 32.5 percent of the estimated MSM/TG populations respectively. These numbers reflect the results for the period from FY 2016 to FY 2018, as the NUIC was rolled out in FY 2016. Therefore, KPs reached who were never reached prior to FY 2016 are not accounted for.

Despite the challenges described above, the Program drew attention to several important lessons, including the need to constantly adapt and empower recipient communities to provide services to reach those most at risk. The use of PEs and the introduction of the EOA allowed the Program to reach a higher number of target KP individuals. Moving forward, however, more needs to be done. Data from the recent IBBS in NCD indicate that, while half (53.6 percent) of FSWs were reached in the last year, one-third has never been reached by a peer outreach worker in their lifetime. Reasons may include mobility as well as the need to identify PEs who can access KP pockets especially free-lace mobile or hotel-based FSW. As put by a stakeholder interviewed for this report, "When you do the outreach, you will see that a peer educator who is an Islander will not go to a particular province or village." The "4-3-2" strategy proved to be effective in encouraging KPs to get HIV tested. Its flexibility makes it quite amendable to meet the desired outcomes. Experience from index client partner testing, which was piloted toward the end of the program, also showed promising results and would be a useful strategy to encourage more KPs to test.

The places where people meet sexual partners are constantly changing, and outreach needs to take this into account and increase the use of social media to identify upcoming events where target populations can be found. Similarly, IEC materials should be adapted, especially in urban settings, to reach out to sex workers and their clients with key messages. Service providers and stakeholders recommended setting up more mobile clinics to reach people in need.

While significant work has been done to reduce stigma and discrimination, these barriers persist along with the travel costs for people going to clinics to access services. Mobile HCT and/or expansion of PE-provided finger-prick testing in the field can help overcome these challenges by providing more anonymity and bringing services to people in their communities. The friendliness assessment exercise has proved to be a useful approach for meaningful involvement of primary beneficiaries of the Program in continuous quality improvement and could be a cost-effective way of identifying and addressing some of the barriers to service uptake among KPs.

When discussing HIV care and treatment, stakeholders expressed a desire for continued support as well as scaling up to seven more targeted provinces through TA and DSD, with a focus on continuous mentoring and sensitization of staff. However, NCD 2017 HIV cascade analysis showed that more target efforts are needed to address the barriers to realizing the 90–90–90 targets in NCD, while applying lessons learned through the Program in scaling up TA to other high-burden provinces.

GBV programming, although significantly more developed than before, still needs to evolve. More work needs to be done to sensitize the population and change cultural norms, as well as to include service provision with work involving law enforcement. These changes will help overcome the barriers to service access and will provide continued sensitization among this group. Aside from the fear of repercussions from accessing services, one stakeholder pointed out that there is a "complete disengagement of men." This is an area in which the Program could expand its work.

TA was often mentioned as a core, critical component of FHI 360's work in PNG. Program data demonstrated that the staff is now able to report data more efficiently and deliver services according to SOPs, and stakeholders acknowledged the importance of this work. The Government in particular acknowledged the key contributions FHI 360's work has made in providing strategic direction to the national response to HIV. It was also suggested that the work FHI 360 has done should be scaled up beyond two provinces.

While work has been done in this area, with the leveraging of USAID-supported work with DFAT programs, the adoption of several initiatives into the ongoing and planned GFATM work demonstrates the technical expertise FHI 360 brings to the table. FHI 360's role was also crucial in assisting implementing partners and the Government with scaling up, especially by guiding implementation at GFATM sites, developing tailored programming through the provision of TA on specific approaches, tools and guidelines and helping partners identify which tools were suitable for their programming. The Government also acknowledged FHI 360's contribution to national strategic information and expressed its desire for continued support on this within the context of achieving the 90–90–90 target. When discussing the Program's contribution to national strategic information, one stakeholder pointed out that FHI 360's work in this area was significant and helped the Government understand that, "if you cannot measure, you cannot manage it."

At the CBO level, FHI 360's work in organizational strengthening produced outcomes that assisted some of these organizations in leveraging financial resources to support their programming. CBO stakeholders expressed their gratitude during the interviews and indicated that they would like future support from FHI 360, particularly for pooled funds, which could be used to support specific initiatives and continue CBO involvement in activities related to program monitoring, including friendliness assessments.

Several partners expressed a desire to continue the collaboration with FHI 360 in the future. Specifically, WHO is willing to collaborate on TA for treatment and laboratory strengthening; UNIAIDS would like to offer its support on modifications and adaptations to outreach models; and local CBOs, including Igat Hope, would like to work with FHI 360 so that it is "running alongside health services," as expressed by one government stakeholder.

ANNEX 1: REFERENCES

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Implementing agency name	Scope of work	Funding by the U.S. Government (by fiscal year, in U.S. dollars)					
		FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Salvation Army	1) Demand creation 2) SBCC 3) Comprehensive HIV prevention, care and treatment 4) GBV response	259,318	502,707	681,180	990,151	1,121,351	1,225,693
Living Light Health Services (Foursquare Church)	1) Demand creation 2) SBCC 3) Comprehensive HIV prevention, care and treatment 4) GBV response	248,478	505,818	654,423	824,633	996,188	1,075,820
Family and Sexual Violence Action Committee	1) Coordination of GBV response 2) Capacity building for journalists	54,334	95,063	41,016	102,327	101,855	118,943
VSO[1]	1) Demand creation 2) SBCC			447,148	1,163,660	1,842,700	
Modilon General Hospital[2]	1) Demand creation 2) SBCC 3) Comprehensive HIV prevention, care and treatment 4) GBV response	41,756	66,429	56,357	64,475	83,920	
Madang Provincial Health Office[2]	Coordination of CoPCT	16,619	35,919	53,542	46,037	68,996	
People Living with Higher Aims[3]	1) Demand creation 2) SBCC	77,232	195,649				

[1] Contracted in fiscal year 2015 to take the place of People Living with Higher Aims. Sub-agreement terminated at the end of fiscal year 2017 as the organization decided to close their health programs in Papua New Guinea due to a lack of adequate funding.

[2] Sub-agreements with both organizations terminated at the end of fiscal year 2017 in response to a request by the U.S. Agency for International Development for an early closeout of the Madang Program component.

[3] Sub-agreements terminated in fiscal year 2014 due to financial irregularities.

Training Sessions Conducted from October 2012 to June 2018

Thematic area	Number of training sessions/ refreshers	Number of participants			
		Males	Females	TG	Total
Outreach prevention	40	299	419	30	748
HIV counseling and testing	5	41	68	0	109
STI management	5	26	78	2	106
HIV care and treatment	14	67	144	0	211
Gender and GBV	39	242	449	2	693
Strategic information/M&E	17	103	167	8	278
Laboratory services	1	3	5	0	8
Financial management	4	9	15	1	25
Organizational management	6	37	49	2	88
Others (records mgt., livelihood skills etc).	7	25	66	11	102

Note: The number of participants is a summation of all participants completing training activities under each thematic area; it is not a unique count of beneficiaries.

ANNEX 4: INDEX OF DOCUMENTS PRODUCED

No	Document title	Document type	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
SBCC Materials								
1	Radio talkback shows on GBV (two in NCD, and one in four additional provinces)	Radio talk shows	X					
2	Sexual health cards in English and Pidgin	SBCC material	X					
3	STI check-up booklet in Pidgin and Motu	SBCC material	X					
4	HIV risk assessment cards	SBCC material	X					
5	Chili peppers edutainment shows	SBCC material		X				
6	Two radio talkback shows on GBV	SBCC material		X				
7	National HIV Care and Support Guidelines	National program guidelines			X			
8	Outreach booklets	SBCC material			X		X	
9	TB Prevention (infection control) poster	SBCC material			X			
10	PEP poster (in English, Tok Pisin and Motu)	SBCC material			X			
11	Clinic service information card	SBCC material			X			
21	GBV 72-hour poster	SBCC material			X			
22	GBV “talk to me” badge	SBCC material			X			
12	2015 Pacific Games HCT jingle	SBCC material			X			
13	Adherence flip chart (adapted from CDC)	SBCC material				X		
14	Human rights poster	SBCC material				X		
15	Male PLHIV poster (in English and Tok Pisin)	SBCC material				X		
16	Female PLHIV poster (in English and Tok Pisin)	SBCC material				X		
17	TG human rights brochure	SBCC material				X		
18	TG human rights poster	SBCC material				X		
23	Tok Kaunselin Helpim Lain (GBV hotline) wallet card	SBCC material				X		
19	Patient rights posters (in English and Tok Pisin)	SBCC material					X	
20	Test and Treat booklet	SBCC material					X	
21	Viral load poster	SBCC material						X

Technical Documents

1	National clinical operating guidelines	Guidelines	X					
2	Care and Treatment Gap Analysis and Technical Support	Report		X				
3	Program Technical Quality Assessment Report	Report		X				
4	SBCC Strategy	Strategy		X				
5	Hotspot Mapping Report	Report		X	X		X	
6	Enhanced Outreach Approach Handbook for Clinicians	Guidelines			X			
7	Enhanced Outreach Approach Handbook for Peer Educators	Guidelines			X			
8	Friendliness Assessment Report	Report			X	X	X	
9	GBV screening protocol	Guidelines			X			
10	Gender and GBV Technical Assistance Report	Report			X			
11	Care and Treatment Follow-up and Technical Support	Report			X			
12	Technical strategy documents by thematic area	Brief				X		
13	Concept note on active case management	Guidelines				X		
14	Technical Assistance Package for TA sites	Report				X		
15	Key sensitivity training manual for health care workers	Manual				X		
16	Minimum Standards for Safe Shelter	Guidelines				X		
17	Report Baseline Assessment for Clinical (TA) Sites	Report				X		
18	NDC Expansion Plan	Report				X		
19	Mobile HCT concept note	Concept note				X		
20	Strategies and Lessons from Implementing Mobile HCT	Report				X		X
21	Madang closeout video documentary	Video					X	
22	Madang human impact stories	Success story					X	
23	Madang Technical Report	Report					X	
24	Lessons Learned from Implementing CommCare	Report					X	
25	Lessons Learned from GBV Integration into HIV Services	Report					X	
26	Protocol for Adherence Study	Protocol					X	
27	Baseline Assessment of NCD M&E System	Report					X	

28	Lessons from Implementing KP Friendliness Assessment	Report						X
29	Service Availability Mapping for HIV/STI/GBV/TB	Report						X
30	Intensified TB case finding	Abstract						X
31	GBV integration into HIV services	Abstract						X
32	Enhanced Outreach Approach	Abstract						X
33	Concept notes for technical papers on various interventions	SI tool						X
34	GBV integration report	Report						X
35	Increasing access to post-GBV care through integration	Success story						X
36	Improving HIV testing uptake through adaptive Management	Success story						X
37	Papua New Guinea (PNG): Improving data driven decision making	Success story						X
38	Posters on various innovations/strategies	Report						X

Tools/job aids

1	Referral cards	SI tool	X					
2	Decision tree tool	SI tool	X					
3	Friendliness assessment tool	SI tool			X			
4	Baseline assessment tool for TA support	SI tool			X			
5	GBV screening flowchart	Job aid			X			
6	Clinic appointment card	SI tool				X		
8	Client access cards	SI tool					X	
9	GBV SOP	Job aid					X	
10	GBV safety planning tool kit	Job aid					X	
11	Decision tree tool	SI tool					X	
12	Test and Start	Job aid					X	
13	ART flowchart for early initiation	Job aid						X
15	Various data collection and reporting tools (new and modified)	SI tool	X	X	X	X	X	X

Contractual documents

1	Annual Implementation Plan	Program report	X	X	X	X	X	X
2	Performance Monitoring Plan	Program report	X	X	X	X	X	X
3	Quarterly Progress Report (with snapshot stories)	Program report	X	X	X	X	X	X
4	Quarterly Federal Financial Statement (SF 425)	Financial report	X	X	X	X	X	X
5	PEPFAR Annual Progress Report	Program report	X	X	X	X	X	X
6	PEPFAR Semiannual Progress Report	Program report	X	X	X	X	X	X
7	PEPFAR Quarterly Progress Report	Program report				X	X	X
8	PEPFAR Expenditure Analysis	Financial report				X	X	X

Other

1	Program fact sheet			X	X	X	
2	Quarterly newsletter			X	X	X	X
3	Abridged Quarterly Progress Report (for stakeholders)				X	X	

ANNEX 5: LIST OF INTERVIEWS

List of Interviews Conducted to Inform the Final Report

Government of Papua New Guinea	
Dr. Nick Dala	Director, National AIDS Council Secretariat
Dr. Morimai Ipai	Disease Control Officer, National Capital District Health Services
Dr. Gideon Nano	Southern Region Medical Officer, National Department of Health
National-level stakeholders	
Dr. Anup Gurug	Team Leader HIV/AIDS, World Health Organization
Mr. David Bridger	Country Director, Joint United Nations Programme on HIV/AIDS
Mr. Isu Tau	Southern Regional Representative, Kapul Champions
Ms. Rose Kunjip	Program Officer, Igat Hope
Ms. Kathy Ketepa	Program Manager, Friends Frangipani
Program beneficiaries	
Clinicians	
Recipients of services for people living with HIV	Salvation Army (implementing partner)
Gender-based violence service beneficiaries	
FHI 360	
Mr. Daniel Tesfaye	Country Director and Chief of Party, FHI 360
Dr. Ignatius Mogaba	Deputy Country Director and Deputy Chief of Party, FHI 360
Mr. William Yeka	Monitoring and Evaluation Officer, FHI 360
Ms. Roselyn Nopa	Gender-Based Violence Advisor, FHI 360
Mr. Nique Spencer	Peer Educator Coordinator, FHI 360

Celebrating Partnership:

Implementing partners established a continuum of care in PNG, and now it takes its place in the health system

OBJECTIVES OF THE PROJECT

- to increase demand for HIV/AIDS services by KPs, their sexual partners, and their families;
- to increase the supply of quality HIV/AIDS services for KPs, their sexual partners, and their families;
- to increase the use of facility- and community-based gender and gender-based violence (GBV) interventions and;
- to strengthen health systems for HIV/AIDS service delivery.

FHI 360 provides technical assistance and support for the project, Strengthening HIV/AIDS Services for Key Populations in PNG, with funding from the President's Emergency Plan for AIDS Response (PEPFAR) through the United States Agency for International Development (USAID). Working with PNG national institutions such as the National Department of Health (NDOH) and National AIDS Council Secretariat (NACS), international partners such as Voluntary Services Overseas, and sub-national-level partners such as Modilon General Hospital and Madang Provincial Health Office in Madang province, the Project team has established linkages along the HIV Continuum of Prevention to Care & Treatment (CoPCT).

This project has now been extended to 2018, but implementation will end in Madang in 2017, in line with a shift in donor priorities to focus more on high burden provinces as part of the global effort to attain UNAIDS' 90:90:90 goals. In 2016, the Project already successfully handed over outreach in Madang to Government of PNG (GoPNG) services under a Global Fund grant, and the case management component in Madang will also transition to the Global Fund grant in October 2017. In December, Modilon General Hospital and the Madang Provincial Health Office (PHO) will absorb the six case managers currently on the Project into their human resource structure.

Project highlights | FHI 360 has been providing program management and technical oversight: to VSO for outreach services; to *Id Inad* and the Family Support Center at Modilon General Hospital for clinic-based, HIV, STI, and GBV services: and to Madang PHO for CoPCT coordination.

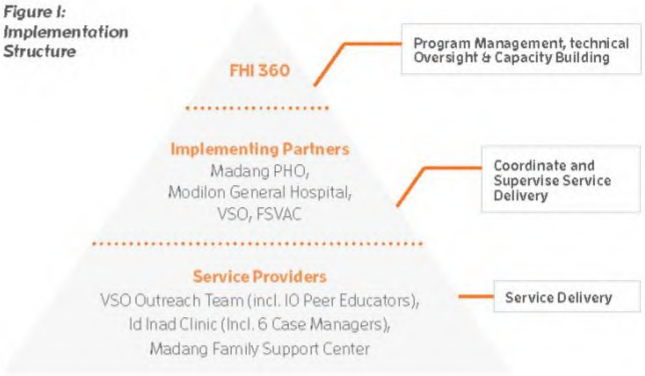
VSO has been providing HIV prevention services targeting KPs and other high-risk groups, and *Id Inad* and the FSC at Modilon have been providing an integrated package of STI/HIV and GBV services in conjunction with the Madang PHO.

At the national level, FHI 360 has also been providing technical assistance to NDOH and NACS to develop and implement protocols, standard operating procedures and guidelines and tools to maintain service quality for KPs.

PROJECT EVOLUTION

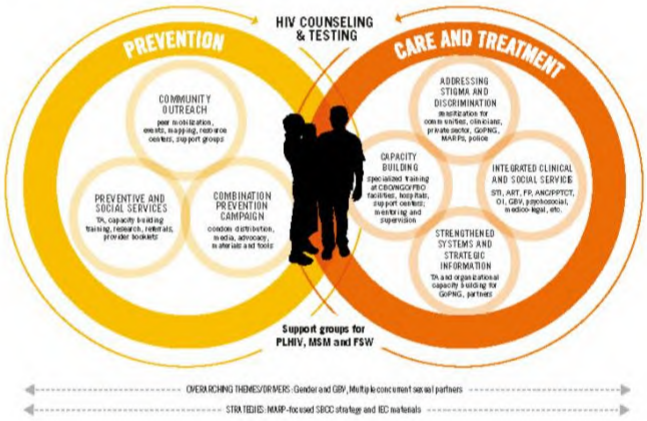
- **2003 -** USAID began supporting Papua New Guinea's national response to HIV/AIDS.
- **2007 -** Representatives from partners, USAID, U.S. CDC, the PNG National AIDS Council Secretariat and Provincial AIDS Council Secretariat, FHI 360, the WHO, the Clinton Health Access Initiative, UNAIDS, DFAT, and the Papua New Guinean PLHIV group, Igat Hope, carried out site assessments.
- **2007 to 2012 -** FHI 360 implemented the project, Technical Support for HIV/AIDS Prevention, Care, and Treatment
- **2012 -** USAID awarded a five-year follow-on project, from 2012 to 2017. This becomes the Strengthening HIV/AIDS Services for Key Populations in PNG project.
- **2016 -** This Project successfully handed over outreach in Madang to GoPNG under a Global Fund grant.
- **2017 -** In October, the case management component in Madang will transition to the Global Fund grant, and in December Modilon General Hospital and Madang PHO will absorb the six case managers currently on the Project into their human resource structure.

Figure I: Implementation Structure



The CoPCT developed by FHI 360 describes the core technical approach of this project. It augments the PNG National HIV/AIDS Strategy (NHS), and in project areas has already created: access to a spectrum of community- and health-facility-based STI, HIV, and GBV prevention services; access to HIV Counseling & Testing; linkages among, and retention of, PLHIV in HIV Care & Treatment services; and access to integrated post-GBV services.

Figure 2: Continuum of Prevention to Care & Treatment (CoPCT) Model



The success of the Project in Madang is rooted in the strong partnership between FHI 360, Madang PHO, Modilon General Hospital and KPs civil society partners, such as People Living with Higher AIMS (PLWHA), Friends Frangipanies, Kapul Champions and Igat Hope. Through peer-driven outreach interventions, initially implemented by PLWHA and later by VSO, the Project has reached over 1,000 individuals who are most at risk of contracting HIV, including members of KPs and other high-risk individuals, yearly, with a minimum preventive intervention package that includes: HIV/STI awareness raising; condom promotion and condom use demonstration; referral to HIV Testing & Counseling and referral ; STI screening; GBV and other services as applicable. And these results only increased with the introduction of the Enhanced Outreach Approach (EOA) in the second quarter of FY 2015, an incentive-based strategy.

Uptake of Care & Treatment, and of STI management services, also increased significantly over the Project years, as did referrals from Outreach services, with the increasing awareness of these services among target populations. Figure 3 on the next page shows number of individuals receiving HIV Testing & Counseling (HTC) and STI services annually, by risk group.

Of the 4,084 individuals tested between FY 2013 and the third quarter of FY 2017, 13 percent were KPs and 41 percent were "other high-risk individuals", while 46 percent were low-risk individuals. Proportion of those tested who were KPs rose from 0.8 percent in FY 2013 to 27.3 percent in FY 2016, before declining to 13.3 percent in FY 2017 after the transition of outreach services to Global Fund. And when disaggregated by sex, the data showed that 53 percent of all those tested for HIV were women and 47 percent were men or transgender.

Loss to follow-up for registered PLHIV in Care & Treatment at *Id Inad* also declined, from 14 percent in 2008 to 1 percent in 2011. This is due to adherence counseling initiated by the Project, use of tracking logs, and active follow-up for treatment "defaulters" using the case management approach. Overall, the proportion PLHIV tested at *Id Inad* who were successfully enrolled in Care & Treatment increased from 46 percent in FY 2014 to 96 percent in FY 2017, while the proportion of registered PLHIV initiated on ART also increased, from 83 percent in FY 2014 to 92 percent in FY 2017.

Figure 3: Individuals receiving HIV Testing & Counseling (HTC) and STI services annually, by risk group

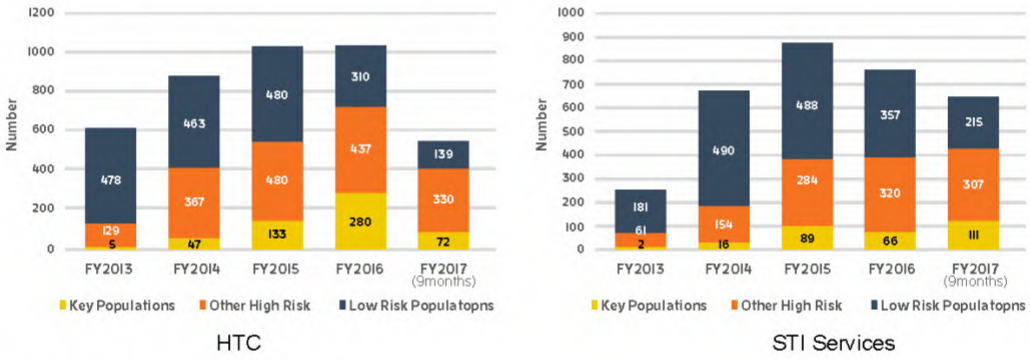
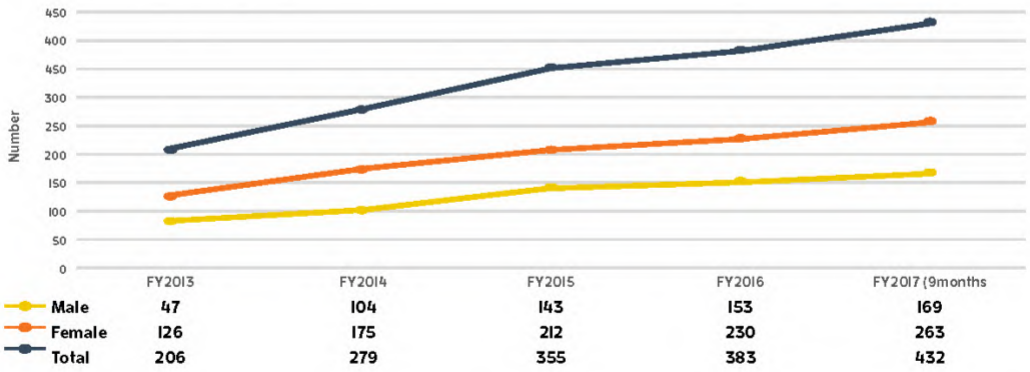
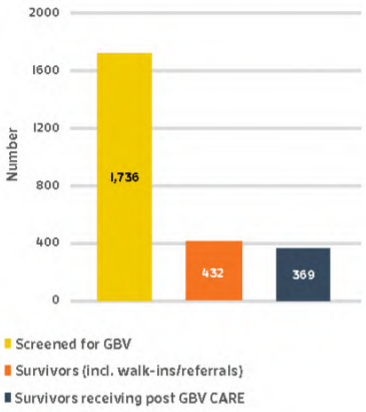


Figure 4: Number of PLHIV active on ART



Excluding transfers to other services, of the 908 PLHIV registered at *Id Inad* since inception of the Project, 749 (82 percent) were initiated on ART and 432 (57.7 percent) are still active on treatment; 161 clients reported as lost to follow-up include those who self-transferred to other ART sites without notifying their clinicians and those who opted out of ART for alternative care, usually spiritual or herbal. Despite this loss, the number of PLHIV active on ART increased by 108 percent overall between FY 2013 and FY 2017. Figure 4 above shows number of PLHIV active on ART.

Figure 5: Number of individuals receiving GBV services



Involvement of key populations and PLHIV in service delivery | The Project has increasingly involved the primary beneficiaries, KPs and PLHIV, not only in development of strategy, but also in direct service delivery to end users, as peer educators to provide outreach services, and as case managers, to provide adherence counseling as "expert clients" and to track fellow PLHIV who missed clinic appointments. Their capacity also developed over the life of the Project to enable them to take on additional responsibilities, such as providing Care & Treatment, HTC, routine documentation and data management, triage of clients, and taking client vital signs. Some beneficiaries also served as program officers with FHI 360 at different times.

GBV service integration and strengthening of referral pathways | GBV is a major factor contributing to the HIV epidemic in PNG. Two out every three women in PNG experience GBV and some socio-cultural norms discourage survivors from seeking medical attention, hence the low uptake of post-GBV medical interventions prior to FY 2015. In response, the Project introduced a protocol for routine GBV screening of all clients accessing HIV/STI services in supported clinics, accompanied by trainings on 'psychological first aid' and development of referral pathways to facilitate linkages for GBV survivors to other non-clinical services. About 40 health care workers in Madang have been trained on the use of GBV screening protocols and on the provision of five essential services to survivors, including basic counseling and trauma counseling. The figure below shows individuals receiving GBV services.

The case management program | Case managers at *Id Inad* now perform a broader scope of activities compared to other sites in NCD, and in addition to supporting adherence counseling, tracking of defaulters and LTFU, they support other clinical processes, including strengthening referrals, HIV testing & counseling, triage, TB clinical screening, and data management. The lessons learned have paved the way for task shifting in HIV Care & Treatment and the concept has been adopted by other partners and clinics in Madang and other provinces in the country.

Id Inad clinic as a training center for IMAI | *Id Inad* is the only Project-supported clinic that offers comprehensive HIV care and management for both adults and children, and during the mid-term evaluation of the current project, both government and clinic staff reported that, as a result of FHI 360's capacity building efforts, the clinic is now recognized as a practical site for integrated management of adolescent and adult illness (IMAI). The Project has also started training district healthcare workers, who are completing IMAI sessions. The clinic has so far hosted five batches of IMAI practicum, and it is also the first health facility to report data on KPs in PNG. The clinic staff provide technical assistance to newer ART clinics in the province.

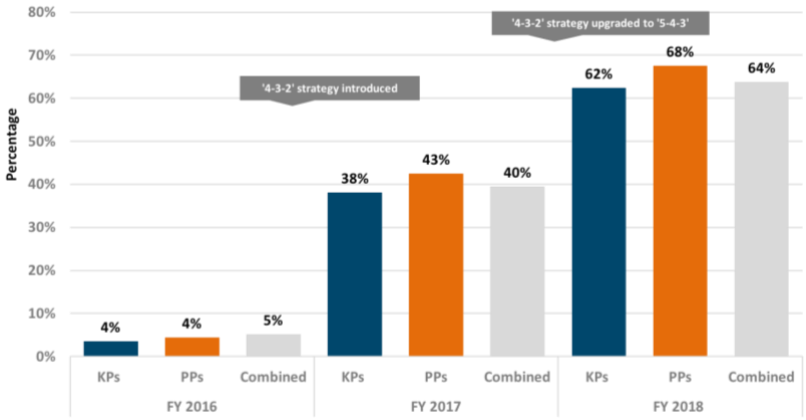
Sustainability | Exit planning for Madang has focused on securing government funding to sustain the peer educators and the six case managers attached to *Id Inad*, and Madang PHO has committed 100,000 *kina* annually starting with Outreach, while the management of Modilon General Hospital has agreed to absorb the six case managers at *Id Inad* into its staff. In the meantime, Global Fund will support both activities through the end of 2017.

Improving HIV Testing Uptake through Adaptive Management

A peer educator engages with a peer during a night intervention event

In Papua New Guinea (PNG), HIV prevalence is highest in select geographies and among particular populations (collectively known as key populations)—female sex workers (FSW) and men who have sex with men (MSM)/transgender people (TG) —who have a 14.9% and 8.5% HIV prevalence rate respectively, compared to the national prevalence of 0.9% (NDoH, 2017). Yet reaching FSWs, MSM and TG with HIV prevention services is hampered by the criminalization of sex work, widespread stigma and discrimination, and the lack of meeting places where such individuals can readily be found. In response, under the USAID-funded "Strengthening HIV/AIDS Services for KPs in PNG" project, FHI 360 is employing innovative strategies, such as the Enhanced Outreach Approach. This approach uses performance-based incentives, rather than stipends or other payments, to engage peer educators to reach and assist individuals to test for HIV and, if HIV positive, to enrol and be retained in HIV care and treatment and other services.

In 2016, USAID employed the Enhanced Outreach Approach and surpassed annual targets for the first time since the project inception in 2012. However, only 5.5% of individuals referred received HIV services. To fix this leak in the HIV service cascade in 2017, The USAID funded project implemented by FHI 360 introduced "4-3-2" as a target setting strategy within the Enhanced Outreach Approach. With "4-3-2", peer educators were tasked with reaching at least 4 individuals, referring at least 3 to HIV testing, and ensuring at least 2 of the 3 accessed HIV services. This strategy encouraged peer educators to support their peers in accessing HIV testing. According to Ms. Daera Lahui, an outreach team field support officer, *"Before FHI 360 introduced '4-3-2' my team members were more concerned with reaching their peers with prevention messages and did not bother much about getting them to go for testing. But now they realise that they should get as many of their peers as possible to go for HIV testing. Some of them even go the extra mile and accompany their peers to the testing site".*



Proportion of Key Populations (KP) and other priority populations (PP) successfully referred to HIV Testing services (FY 2016-2018

By 2017, the "4-3-2" strategy increased the successful referral rate to 30.8%. There was also a slight increase in the HIV positivity rate among key populations successfully referred—from 4% in 2016 to 5% in 2017. To have even greater success, in 2018, FHI 360 shifted from "4-3-2" to a "5-4-3" strategy. This resulted in a 62% successful referral rate.

Recognizing the success of this approach, the Government is replicating it more broadly through the Global Fund program, as explained by Dr. Ahmed Munir, Program Manager (Global Fund), Oil Search Foundation: *As partners working with key populations, we believe FHI 360's achievement with the Enhanced Outreach Approach and the '4-3-2'strategy are quite impressive and that is why we adopted the approach and strategy in the concept note for the new Global Fund grant.* Building on this success, USAID will provide technical assistance to Global Fund recipients and other civil society organizations to scale up the implementation of the "4-3-2" and adjust it, for example, to "5-4-3" as the approach is further enhanced.

Increasing access to post-GBV care through integration

Two-thirds of women in Papua New Guinea experience gender-based violence (GBV) in their life-time. Among key populations (KPs) including female sex workers (FSW), men who have sex with men (MSM) and transgender people (TG) 41%-45% reported sexual violence in the last 12 months during a 2017 integrated bio-behavioral survey in the country. Sociocultural factors inhibit GBV disclosure and service uptake by survivors. Laws criminalizing sex work and sodomy heighten this inhibition in KPs. Access to post-GBV services was limited to one family Support Clinic (FSC) each in the PEPFAR-supported areas of Port Moresby and Madang. Services were mainly focused on family-based and sexual violence among women and children; KPs felt unwelcomed.

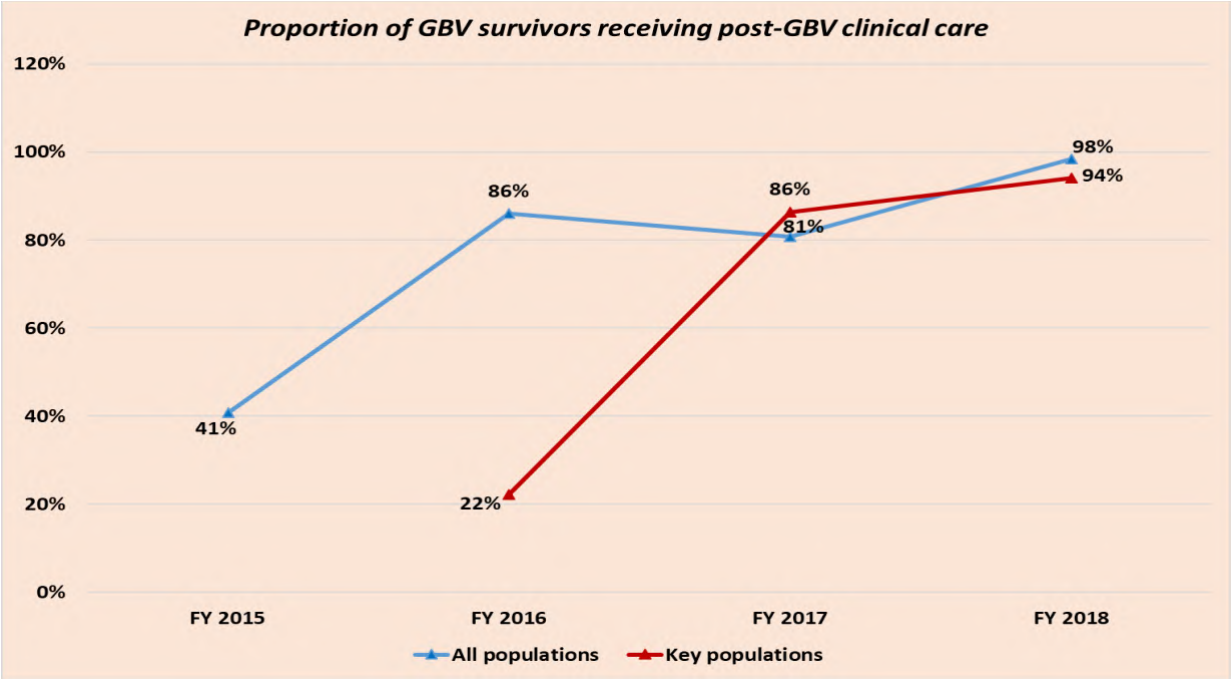
In 2015, USAID through its implementing partner FHI-360, supported the integration of gender and GBV services into HIV and Sexually Transmitted Infection (STI) services under the "Strengthening HIV/AIDS services for KPs in PNG Program." Initial interventions prepared service providers to offer KP-friendly, comprehensive post-GBV clinical services and then moved to GBV prevention, awareness and referral. A key component of this integration was the introduction of routine GBV screening for clients accessing STI, HIV testing and counselling, and HIV care and treatment services in five clinics (one in Madang and four in NCD) supported by the project. Survivors identified through screening, as well as those who walked-in voluntarily or were referred were offered post-GBV care. Survivors of sexual violence including rape, were offered a minimum package of care which included psychological first aid, Provider

GBV 72-hour poster developed to promote early clinic visits following rape and other kinds of sexual violence, and to raise awareness on post-GBV services.

Initiated Counselling and Testing (PICT), Post Exposure Prophylaxis (PEP), emergency contraception, STI prophylaxis, and vaccination against tetanus and hepatitis B.

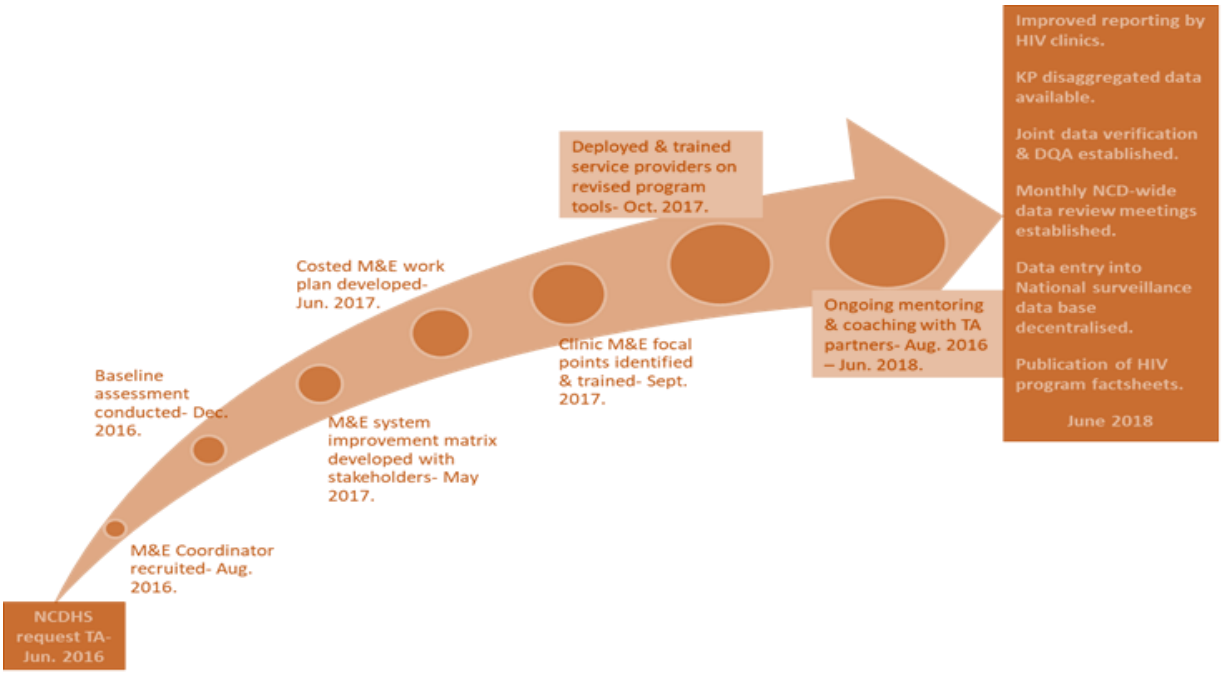
Health care workers were trained on the protocol for GBV screening, psychological first aid counselling, sexual diversity and KP sensitization, and documentation of services. Since the integration commenced, there has been a significant increase in the number of STI and HIV clients screened for GBV between FY 2015 and FY 2018. Although GBV case identification among those screened could still be low, the percentage of GBV survivors identified who received post-GBV care increased sharply for both sexes from 41% in FY 2015 to 98% in FY 2018. This increase was more dramatic among KPs; from 22% in FY 2016 to 94% in FY 2018.

Increasing the number of service points, providing integrated KP-friendly and comprehensive GBV services combined with community awareness, had a dramatic impact on the uptake post-GBV care among survivors. This result did not pass unnoticed by the leadership of National Capital District Health Services NCDHS as Dr. Niko Wuatai, Director of Public Health requested support to scale up the model to other HIV clinics operating within NCD; *"For us, GBV is a major concern and we will appreciate and support USAID's effort through FHI 360 to introduce this model in other clinics."* Responding to this request, USAID provided TA to integrate post-GBV services in four additional HIV/STI clinics in the NCD as part of its technical assistance expansion program.



Papua New Guinea (PNG): Improving data driven decision making

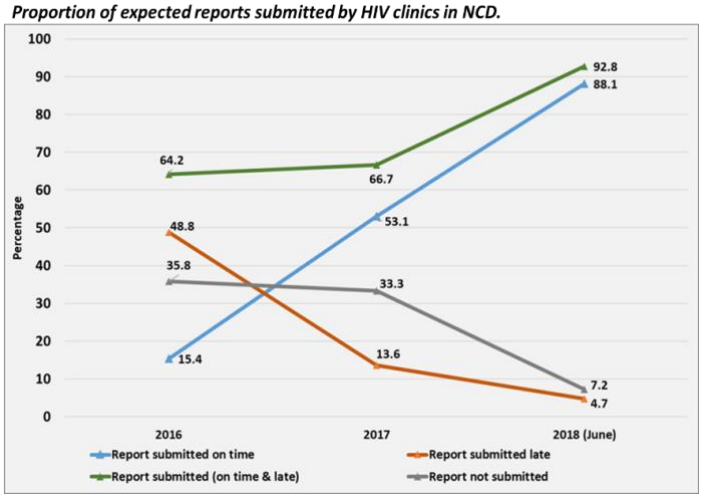
According to the PNG National Department of Health (NDoH) report, from 2016-2017 the National Capital District reporting performance was at 50%. In 2016, even when 64.2% of all expected reports for the HIV program and Health Information System (HIS) were submitted by HIV clinics, only 15.4% of them were submitted on time (within one week of the start of a new month). Furthermore, there was no evidence of data quality audits or data consultation at the provincial and health facility levels. These findings prompted the Public Health Unit of National Capital District Health Services (NCDHS) to request for technical assistance (TA) to strengthen its M&E system from USAID's "Strengthening HIV/AIDS Services for Key Populations in PNG project" implemented by FHI 360. The project assessed the NCDHS monitoring and evaluation system using the FHI 360 M&E system assessment tool (SAT). Subsequently, a joint stakeholders' workshop to develop an M&E system improvement matrix with key mile stones and a costed M&E workplan was facilitated for NCDHS and additional TA was provided, as per the following infographic:



The workplan was implemented in collaboration with NCDHS, NDoH, The Centres for Disease Control and Prevention (CDC), and Global Fund. TA was provided to oversee the timely collection, verification and reporting of HIV-related data from all HIV clinics in NCD, while also providing onsite mentoring support to service providers. In parallel, M&E focal points responsible for monthly data collation and report submissions to NCDHS and NDoH were identified in all clinics.

The twenty three clinics that submitted a total of seventy two reports increased their timely reporting from just over 15% of expected reports in 2016 to 88% by 2018. In this same time period, the proportion of expected reports submitted (including those submitted late) increased from 64% to 93%.

Proportion of expected reports submitted by HIV clinics in NCD.



Data collected in the HIV clinics is now being utiolized for decision making, whereas in the past, it was only reported up. This is expressed by Michael Latimer, an M&E Focal Point at Heduru Clinic, *"I thank USAID for introducing the provincial data review meetings... This is the first time I'm getting to know my contribution to HIV services. Me and my colleagues will work hard to improve reporting from our clinic.'*

In addition to improving reporting rates and data use, the TA provided has ensured the availability of key population disaggregated HIV data. Since 2016, clinics are also now documenting the HIV Counseling and Testing clients' risk group (e.g., female sex worker). While no data was disagregated in the fourth quarter of FY 2017, 68% of the reported data carried this disaggregated data by the third quarter of FY 2018. The availability of this data will help to improve the focus on key populations at the national level. The technical assistance provided by the project has helped with the decentralization of data management systems headed by CDC at the national level showing how inter-institutional coordination can help to minimize reporting delays and reduce the frequent loss of paper based reports during transmission from clinics to the NDoH.

The leadership of NCDHS expressed its determination to sustain these achievements by incorporating the qualified assistance into the cadres of the NCDHS. Dr. Morimai Ipai, Coordinator for Disease Control at NCDHS expressed, *"We are impressed with the outcome of this technical assistance. Now we have a system to collect and understand our HIV program data."*

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