PNG Australia Sexual Health Improvement Program (PASHIP)

Monitoring and Evaluation Specialist Input

Monthly Report: March 2012

CONTENTS

Acronyms

ABM	Anglican Board of Missions
ART	Anti Retroviral Treatment
ASHM	Australasian Society for HIV Medicine
AusAID	Australian Agency for International Development
CHS	Catholic Health Services
CHW	Community Health Workers
ChHS	Christian Health Services
COMPASS	Clinical Outreach, Men's Programs, Advocacy and Sexual Health Services Strengthening
EHP	Eastern Highlands Province
EHSCIP	Eastern Highlands STI Clinical Improvement Project
ENB	East New Britain
ENBSHIP	East New Britain Sexual Health Improvement Program
GoPNG	Government of Papua New Guinea
IMR	Institute of Medical Research
IPR	Independent Progress Review
LMIC	Low and Middle income Countries
LNP	Lusa Numini Project
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNH	Maternal Newborn Health
NACS	National AIDS Council Secretariat
NDOH	National Department of Health
NGO	Non-Government Organisation
PASHIP	PNG Australia Sexual Health Improvement Program
PDD	Project Design Document
PICT	Provider Initiated Counseling and Testing
PNG	Papua New Guinea
PNGFHA	Papua New Guinea Family Health Association
QI	Quality Improvement
QAI	Quality at Implementation
SCA	Save the Children Australia
SCiPNG	Save the Children in Papua New Guinea
SHFPA	Sexual Health and Family Planning Australia
STIMP	STI Management Program
SRN	Sexual and Reproductive Health
STI	Sexually Transmitted Infection/s
TA	Technical Advice

Introduction

The PNG Australia Sexual Health Improvement Program (PASHIP) comprises five projects which have been implemented by Australian and PNG partner agencies since 2008. The Program aims to reduce the incidence of HIV in PNG, through the provision of integrated sexual health and STI services to target communities. Under PASHIP, each NGO consortia implements its own activity in one or more locations as outlined in their project designs.

Following the Independent Progress Review (IPR) of PASHIP undertaken in early 2011, AusAID engaged a team of two M&E specialists to work with the PASHIP Secretariat and implementing partners[1]. The main purpose of the work is to strengthen outcomes data, in particular to maximise the likelihood that valuable and reliable data will be collected, analysed and shared, as well as used to inform program work to December 2012. A secondary objective is to identify an agreed approach to a comprehensive review of PASHIP in its last year, to collate lessons learned and as much information as possible about program outcomes, to inform future work in this area.

At the end of the second in-country visit, AusAID staff suggested that further work could be carried out by the M&E Specialists to understand a number of issues in more detail. It was agreed that the topics would include:

a. Exploration of the three PASHIP service models and their relative benefits, and consideration of:
    i. A review of relevant international literature and discussion with partners of the strengths and weaknesses of each model
    ii. Identification of whether one model is working better than another (or combined elements)
b. What is the relative contribution to PASHIP from the various ANGOs – i.e. to what extent does the nature of support being provided to PNG partners have an impact on quality and results?
c. What is the relative impact of stand-alone versus integrated clinics in STI treatment provision?

Analysis of these three topics is intended to assist progress towards PASHIP's second objective of identifying and sharing effective and innovative PNG specific STI service approaches. It also provides monitoring and evaluation information about progress across the Program so far.

PASHIP service models and some of their components are explored in the following three sections of the paper.

- The first section considers the overall organisational and governance structures chosen by each project and how these relate to clinical and community engagement strategies and whether one model is working better than another.

- The second considers in more detail one aspect shared by all five PASHIP projects, the inclusion of ANGO/NZNGO partners and the role they have provided, and
- The third reviews the notion of integration and stand alone health services and their impact on STI treatment provision.

The strengths and challenges of each of these approaches are considered in the context of international literature combined with perspectives collated from telephone interviews held in January and February 2012 with PNG and ANGO participants in each of the PASHIP projects (see Annex 1). Implications for PASHIP's remaining period of operations are considered at the end of each section, and the report also includes recommendations. For ease of reference, these **recommendations** are listed below:

1. That AusAID consider using the World Health Organisation's 2009 NGO Code of Conduct for Health Systems Strengthening as part of their selection criteria for future health projects.
2. That the final evaluation includes an assessment of how well PASHIP projects were integrated into the NDOH system.
3. That AusAID take seriously the learning that relationship-building is crucial to successful projects in Melanesia but that this is a slow process. The longer the positive relationship, the more partners have a history of trust that they can use to achieve capacity development and to solve problems together. Funding of Melanesian programs needs to actively encourage continuity and longevity so that a partnership history is built. Any ongoing funding should seriously consider building on existing projects rather than bringing in new organisations.
4. To learn more about the most effective way to establish high quality STI services, AusAID should give thought to extending the learning of this project beyond the completion date to do a small evaluation in 2014 to evaluate how well each of the models has contributed to sustainability.
5. In assessing applications for future funding in relation to strengthening STI services, as well as the strength of the plan, the following issues need to be considered
    - The strength of the building blocks of the organisations involved,
    - The starting point of the project,
    - The potential for partnership development,
    - The likely demand for services,
    - The sustainability of the proposal,
    - How locally adaptive learning has been included in the design and especially whether sufficient planning, monitoring and evaluation time has been incorporated.
6. In any new AusAID program consideration be given to STI work being integrated into HIV work.

SECTION ONE: MODELS OF ORGANISATIONAL AND GOVERNANCE STRUCTURE WITHIN PASHIP

When PASHIP projects were designed in 2007 considerable flexibility was given to how they should be structured but AusAID set a prerequisite that each project must have an Australian NGO partner. At the PASHIP Program Reference Group (PRG) meeting in November 2011, three different models of governance were identified as being used.

Model One: Long-standing church health services extended to include quality STI clinical provision and strategies that increase community health seeking and preventative behaviour (STIMP, 4AS)

Model Two: With the support of Save the Children Australia, PNG Save the Children established a partnership with a Provincial Government where they jointly manage STI clinical services that aim to build high quality capacity for the Province and work from provincial to local levels to meet created demand (LNP)

(This model was strengthened by outreach activities undertaken by Save the Children which referred clients to the clinic but were not funded from PASHIP sources)

Model Three: A Provincial Government and NGO partnership that:
develops high quality STI capacity in government managed health services and uses community empowerment strategies to increase community health seeking and preventative behaviour (ENBSHIP and COMPASS)

Additional Common Elements

Underlying these three models is a range of activities that have common practice elements. They are in line with National Department of Health (NDOH) expectations about minimum standards for service provision and consistent with learning around what makes good practice. So all five projects:

- Strengthened the capacity of health workers using a range of strategies, including training in syndromic management, follow up training, mentoring, adult learning methods and attachments,
- Used quality improvement (QI) tools developed from NDOH minimum standards to evaluate clinical practice at local and specialist clinics and work towards continuous performance improvement with each service.

In addition:

- Most projects surveyed clients to see if they have been satisfied with the quality of service
- Three projects (those directly managing services (4S, STIMP, SAVE)) worked to improve drug provision by keeping accurate records of supply and demand, liaised through the NDOH

(Adviser, Sexual Health & STIs, Disease Control Branch) to get timely delivery and with the help of ANGOs some kept an emergency supply.

- Two projects also established training and resource strengthening for laboratories.

Literature on the Models of Service used in PASHIP and their Implications

Literature has been found that adds to understanding of PASHIP projects and their outcomes. The first area of literature reviews the models of service used in PASHIP. While these models are not sufficiently defined for there to be specific literature about each model, some useful material is available about church health services and the role of NGOs in health service provision. The second area of literature reviews what is being learnt about strengthening health services in developing countries and provides a basis of good practice comparison with PASHIP.

Model One: Church Health Services

A World Bank, Asia Development Bank and AusAID report of 2007 indicates that church run health services deliver approximately 50% of PNG provincial health services although they are mainly funded by government[2]. They have one third less staff than government health services and these staff are paid two thirds of the salary. It also reports that a costing study in 1989 indicated that the unit costs at mission sub centres tended to be lower than government centres.

A 2010 World Health Organisation report on PNG Health Partnerships argue that churches are the government's main ally in the provision of health services for the rural majority and they offer the best opportunity to rapidly strengthen the health system to meet the Millennium Development Goals[3]. WHO suggest that the contractual arrangements between NDOH and the churches need to give greater recognition of the partnership and ground rules on how the two actors act to each other. Churches need to show greater transparency around how they use government resources while NDOH need to find ways of ensuring more funding to the church sector for projects and health worker positions when financing gaps exist.

Hauch et al, argue that PNG church-based organisations are valued across the country for the reliable services they provide, primarily in health and education, and they enjoy a solid reputation for high standards and efficiency compared with those provided by the government[4]. However, these organisations recognise that they need to address internal management and organisational issues, in particular since they started to accept funding from external sources that require meticulous progress reports and financial accounts. In response, churches have started to strengthen their capacity in management and policy, but they have a long way to go to improve, partly because performance-based management is still not part of their organisational culture.

Hauch et al also identify a range of capabilities shaping PNG church capacity[5]. These include capability to open up public spaces and bring neglected groups into the public domain, to link policy dialogue at the national level with their involvement with service delivery in the community and to bridge across boundaries, especially exchanging with international partners. They argue that the

effective community work done by churches, including the provision of social services, combined with them being rooted in society means that the churches enjoy levels of trust and legitimacy that no other civil society actors have achieved. However they give a note of warning that comes from their interviews. Several church leaders expressed concern that loading additional tasks and responsibilities onto churches too rapidly and without proper support could lead to failure.

Peter Rookes in a PHD thesis exploring Christian Health Services (ChHS) in developing countries provides findings about the strengths and challenges of Model One[6]. He writes about church health services from a broad range of countries but some points are relevant to the PNG context. Many ChHS were originally established in the previous century by western mission partners. In recent decades many ChHS have had to adjust to financial difficulties experienced from widening gaps between the rising costs of health service provision and decreasing income from international mission organisations. This has been exacerbated by the declining income of western churches and the increasing autonomy of developing country churches who wish to be seen as equal partners. Expatriate mission organisations have taken a number of approaches to the health institutions that they bequeathed to the developing country at the time they became autonomous. Along with transferring ownership some completely extricated themselves from responsibility, some provided reduced financial support and others after a gap, are increasingly supporting some programs but at a much lower level than when they originally established the services. Many ChHS sought international links of their own, seeing them as a means of professional exchange, skills sharing and financial support.

Rookes noted that the ChHS are sometimes restricted by having to get church approval for major policies and the over involvement of some bishops in operational decisions, for which it is asserted they have neither the time nor expertise. Service restrictions resulting from doctrine are also sometimes apparent. This is particularly relevant to condom use within the Catholic Church.

Rookes suggests that the benefits for government in gaining assistance of church services in health provision include their assumed greater managerial efficiency, flexibility, cheaper cost and the ability to reach the more marginalized communities. As well a partnership allows high profile health programs such as STI prevention being planned with full participation from all providers. ChHS's are believed to provide a higher level of compassionate caring and treat everyone with dignity associated with Christian commitment. However these advantages may be accompanied by difficulties between governments and ChHS's regarding communication, co-ordination and regulation of their activities.

Where governments assist ChHS's, their support might range from no support other than tax concessions at one end of the continuum, through to provision of medical supplies and payment of salary and operational costs at the other. Governments are not usually willing or able to fund ChHS's to the full cost of their service provision.

Rookes found that where ChHS have a large profile, as in PNG, they tend to have the following characteristics:

- ChHS co-operate more readily with each other and with government
- Governments are more likely to financially support ChHSs and
- Governments involve ChHSs in their policy formation and planning processes.

He concluded that both partners benefit from this closer collaboration; governments from the legitimacy and the substantial service provision of ChHSs particularly to marginalized communities, and ChHSs from the recognition as well as government finance and other resources.

Baser and Morgan suggest that a major strength of ChHS is their commitment to values. Where organisations are loyal to a set of values that participants clearly support, they have the ability to withstand strain and disruption. Such values act as internal scaffolding and a coherence device[7]. The capability for resilience appears to come from the informal, intangible side of the system. Frequently they have a sense of confidence that no matter what the challenges, the organisation had the spirit to overcome them.

A recently published Australian paper reviewed international literature to identify what makes church based health service provision different from government provision and how government engages non-profit providers of primary health care[8]. The relevance of these findings was then considered for PNG. The paper identified a number of themes largely coming from Africa that are particularly relevant to PNG:

- Churches continue to play an important role in many countries in health service delivery, although the distinctions between church and government service providers can be blurred,
- There is a risk that church based health services can become isolated from the health system. A clear definition of roles and responsibilities helps to create a predictable and transparent environment in which they can operate in partnership with Government.
- Sometimes church health services have a vulnerable financial base so formal agreements between Church health services and government can provide a framework for financial stability.
- There are a number of examples where there is a lack of financial transparency between churches and government with churches reluctant to indicate the sources and amount of external funding they receive. Governments find it difficult to judge the appropriate support to not-for-profit providers when the amount of external funding is unknown. This uncertainty can undermine partnerships.
- The literature indicates a number of strengths of church health workers (and NGOs) including strong motivation, a willingness to work in remote areas, a flexible style and close relationship with the community. Church based services also have a history of providing training through specialist colleges and universities.
- Culture and management styles can be very different with government services more hierarchical and church services having a culture more derived from their religious affiliation.

The paper argues that building a strong trusting partnership between government and church based health services is essential. Ways of doing this include contracts that clearly define roles and responsibilities, assured government funding coupled with improved church transparency around financial reporting, involvement of church providers in developing, planning and implementing agreed standards improved human resource management especially around training.

Catholic Church

Twenty nine percent of PNG are members of the Catholic Church[9]. As indicated by Rookes, frequently indigenous churches have long term relationships with expatriate churches and this applies to the Catholic Church in PNG. As part of this history, Caritas and its partner the Catholic Health Service have a substantial history of working together. In recent years Caritas worked closely with the national office of the Catholic Health Service (CHS) on the AusAID funded PNG Church Partnership Program. Largely a positive relationship for both partners, Caritas was eager to work again with CHS but this time at a diocesan level. Together they planned PASHIP so that the CHS managed the STI clinical service staff across three provinces. Caritas' responsibility was for general oversight and management of the program, especially in the areas of compliance and formal communication with AusAID. They also had oversight of the STIMP team which acted as a resource unit to the PASHIP project, especially in research, monitoring, evaluation and community development. As CHS were experienced in running large programs the ANGO staff structured their role to be one of 'behind the scenes support'. Their local PASHIP clinical management team remained relatively stable with little turnover so that project implementation was consistent and strong. Caritas did provide expatriate support but in the form of a highly skilled, multilingual and culturally aware worker who had been in PNG 40 years. He was part of the STIMP research team, and mentored in monitoring and evaluation.

Baser and Morgan note the central importance of values to the work of Christian Health Services. The STIMP STI program was able to take advantage of the Christian values of caring for those who are on the edge of society and the fact that the Church had already responded to the large numbers of people needing HIV care. Staff had already undergone stigma and discrimination awareness-raising so that a level of trust and safety existed for clients from the start of the program.

Justine Mc Mahon the Caritas manager explained that because the project was one based around human behaviour, values and attitudes, Caritas wanted to use an action reflection model to drive evidence based programming. Regular staff discussions at every site reviewed research findings on clinical and community development work outcomes and identified changes needing to be made. A key element was building an organisational learning culture.

Anglican Church

The Anglican Church membership is 3% of the PNG population. Again 4As is an example of a project that is embedded in a long history of indigenous expatriate church relations. The Anglican Board of Mission (ABM) helped establish the PNG Anglican church at the start of the 20th Century and their

120 year relationship has reflected the colonial, independence and re-engagement phases of that one hundred year period. Julianne Stewart from ABM commented: 'At independence we pulled out quickly so there were no missionary agencies to help local people adapt. In a way we abandoned them. We expected them to be mature enough to take on the various roles that needed to be done. This program in a way rectifies this. Perhaps we can work in partnership and help them deliver those services'.

For PASHIP, the 4AS ANGO partnered with two Anglican health services that did not have a strong history of working together, both had recent leadership difficulties and they were geographically a significant distance apart. Resources had to be split between the two and for a long while it was difficult to get cross fertilization of learning between the partners. Jenni Graves from Albion Street commented that all partners had to build trust and skills to be able to work across two complex faith-based systems as well as two provincial government health offices.

Unlike the PNG Catholic church, which has a history of strong in-country expatriate support to local leadership roles, the PNG Anglican church is almost solely an indigenous organisation. Developing a 4AS team involved quite an extended process of identifying within both organisations those with potential for leading a large project and then beginning the slow process of capacity building. ABM felt strongly that to avoid practices established in a long history of missionary involvement it was not constructive to place full time expatriate capacity support in-country for any lengthy period. After an initial in-country visit by a technical assistance (TA) person, most management mentoring to PASHIP co-ordinators happened via phone, email and quarterly visits from Australia although an ABM funded building advisor visited regularly to assist the Oro hospital to get established.

A key issue mentioned in the literature is that clinical organisations frequently do not have in-depth project management skills and performance based management is not part of their culture. This has been particularly relevant for the work of 4AS. A central objective for both 4AS health services was to build or refurbish quite large STI buildings before establishing clinical work. The Oro site had a number of complex social planning issues that needed clarifying particularly negotiating with the Department of Health on the issue of stand-alone versus integrated clinic models and the move from an STI clinic to an overflow hospital for Popendetta. Following a decision for the latter, the task became unexpectedly bigger because 4AS was no longer building a clinic but assisting with finding funding and refurbishing the existing run down hospital. This significantly stretched project management skills and capacity. Neither church health organisation had a pool of experienced building and project management skills so external TA had to be bought in for the bigger Oro site to keep decisions moving. As it took some time to finalise buildings, clinical training could not gain momentum until later in the project. Although their model linked with long standing health organisations, in fact 4AS began from a less consolidated position than the other PASHIP projects and so only in the past 12 months have clinical services been established on Begabari and a temporary clinic at Oro.

The literature argues that one attraction for governments to resource church based health services is that they have the reputation of being both more skilled, efficient and providing better services. However this partly happens in PNG because the salary range of church based health workers is less than government health care workers. This provides the Catholic and Anglican CHS's with a continuing challenge as staff turnover can be high unless the working environment is significantly better than government clinics. This difficulty has been made more difficult recently with government nurses receiving a very substantial pay rise.

A further outcome discussed by church health services was that because it is a church providing the service, patients frequently trust their service more than a government one. Consequently patients are attracted across district boundaries to access the service. This can lead to distortion of workloads and thus burn out of staff. Mingendi Hospital, one of the sites of the STIMP Project, is an example of this where because of improved practices, the mother to child HIV transmission rates have been extremely low[10]. The hospital has had to develop policies to control the demand for service that has gone beyond service capacity.

A recent change in care has come about because the international Catholic Church has recognised the role of condoms in HIV prevention in certain contexts. This has meant PNG workers in the health service are able to distribute condoms within a counseling context. Nevertheless workers have had years of working consistently with previous more restrictive policies sanctioned by moral teaching, so change of practice is not easy.

Model Two and Three: The role of NGOs

Model Two was built on an existing PNG NGO with strong international links partnering with Provincial Government and managing a government clinic. Model Three involved in one case the establishment of a new NGO and in the other the linking to an existing NGO, and these partnering with Provincial Government to capacity build their staff. No literature was found specifically relating to these two approaches but there was substantial material exploring the role of NGOs in developing countries. Historically NGOs have had an internationally significant role in health service provision in developing countries. A 2011 paper by Ejaz, Shaikh and Rizvi identifies some of the reasons for this by reviewing the role of NGOs in strengthening health systems in Pakistan[11]. The authors argue that for many years international and local NGOs have endeavored to fill the gaps in health service delivery, research and advocacy because the health care system has been inadequate and inept in meeting the needs of the ever growing population. They note a number of advantages of involving NGOs. These include:

- NGOs offer financial benefits, bringing money in from international sources,
- They transfer technical knowledge to Government partners,
- Health planning becomes far more participatory and consultative with the inputs of all the stakeholders,
- NGOs complement governments efforts and plug gaps,

- They monitor the activities of many vertical programs,
- At times they can promptly hire more staff (especially female health providers) at acceptable salaries, acquire specialized equipment and execute ideal projects serving a limited population in a specified geographic area.
- They frequently bring sufficient funds and commitment to assist health education, health promotion, social marketing and advocacy including clinical education and accreditation of clinical practitioners.

The authors see the three main domains that NGOs impact on are: complementing and supplementing service delivery (ensuring quality, improved utilization and innovation), advocacy to influence policy, and capacity building of human resources. They also identified challenges in using NGOs, in particular questioning whether their work ensures equity and sustainability and querying how well NGOs integrate vertical and horizontal systems. They suggest that to ensure best practice the World Health Organisation's 2009 NGO Code of Conduct for Health Systems Strengthening should guide the selection of suitable NGOs to work in developing countries[12].

A 2006 South African paper by Schneider et al, considers strengthening health systems and argues that while NGOs and private for-profit organizations have a role to play in strengthening health service systems, they cannot substitute for the core functions of the public health sector both as service providers and managers of roll out[13]. If many new non government services are established and they are not effectively integrated into the government health system there is a risk of establishing vertical structures that drain resources from a crumbling core. Short term needs may be addressed but establishing NGOs does not form the basis of universal access.

Pfeiffer et al wrote that in the last two decades there has been an increasing trend to integrate NGOs into health systems in developing countries[14]. Many observers think this shift to NGOs is linked to World Bank structural adjustment programs which have attempted to limit public sector spending as a strategy to address mounting foreign debt. As public services were cut back NGOs were seen as having a comparative advantage because they could reach poor communities more effectively, they attracted people who wanted to work with the poor, and subsequently provided higher quality services. However Pfeiffer et al go on to argue that many observers, especially in Africa are now questioning this model, as the proliferation of NGOs has led to management burden on local health managers, fragmentation of services, 'brain drain' from the public sector to NGOs by luring workers away with higher salaries and myriads of projects that collapse when NGO grant funds end. They argued that donor aid to developing countries is often disproportionately channeled to international NGOs rather than ministries of health. Projects by NGOs sometimes can undermine the strengthening of public primary health care systems.

Pfeiffer et al also argue that unlike individual NGOs, the strength of national governments is that they are in a position to establish standards of care, ensure equity in service delivery, harmonise information systems, achieve geographical coverage and carry out long term planning based on

local health priorities. National health departments should also in principle be accountable to those they serve because they are controlled through local mechanisms of governance.

The authors recognise that NGOs will continue to play key roles in many developing countries and so an NGO Code of Conduct should be considered. Three components are suggested. The first relates to **Management Burden**. International NGOs often promote projects with idiosyncratic accounting systems, individual reporting systems and objectives distinct from the departments of health. They should instead match their resources and projects to existing government priorities and management capabilities. They should engage in joint planning and implementation, share budgetary information, support the strengthening of existing administration and managerial structures and strengthen management capacity of provincial and national governments.

The second relates to **Fragmentation of the Health Sector**. NGOs are often pressured by donors to produce short term gains (within 1-2 years) in a limited population. Projects are frequently designed as vertical programs with no plans for expansion of sustainability and little integration with local health systems. NGOs can minimize this fragmentation by creatively integrating vertical donor funded projects into existing public sector health systems. The code of conduct should include a commitment to help build local systems and use funding in ways that will most benefit comprehensive primary health care.

The third focus is around **brain drain** because NGOs frequently lure health workers away into highly paid NGO positions. NGOs should strengthen local human resource capacity by working within existing salary structures and complementing local training capacity. NGOs should integrate projects into local systems and fund additional workers in the public health system in accordance with local pay structures. They can support other incentives to retain staff such as payments for over time or extra training.

Lusa Numini Project, ENBSHIP and COMPASS

International literature indentifies advantages and disadvantages of having NGOs involved in health systems of developing countries. A number of these advantages can be seen within PASHIP. AusAID's decision to bring in international NGOs to partner with local organisations offers expertise and financial benefits that PNG might not otherwise have access to and assists them in a small way to close service gaps. Not only is there an AUSAID direct financial contribution to cover the costs of in-country staff and resources but some NGOs provide additional funding from their own sources.

In addition, the way NGOs have been involved within PASHIP addresses a number of the concerns raised by Pfeiffer et al and are consistent with principles and practice of the suggested code of conduct. The first issue relates to **Management Burden**. The designs of ENBSHIP, Lusa Numini Project and COMPASS have emphasized partnering with Provincial Government in joint planning and implementation, sharing budgetary information and the key goal of strengthening the capacity of Provincial Departments of Health administration and managerial structures.

One complementary strategy used by AusAID to try to avoid management burden and strengthen integration for all projects was to appoint a respected former NDOH clinical and management worker whose role, amongst many, was to assist with ensuring PASHIP projects were directly accountable to the National and Provincial Health Departments and in particular used their reporting systems and minimum standards. Whether this was effective should be explored in the final evaluation.

The second issue raised by Pfeiffer et al relates to **Fragmentation of the Health Sector**. They argue that NGOs are often pressured by donors to produce short term gains in a limited population. Baser and Morgan comment that the case studies they reviewed all had references to time and how it exerted a major impact on the unfolding of capacity. At the heart of this time issue lay one of the most difficult capacity challenges, that of combining short term responsiveness, usually in the form of change in performance or technical capabilities with the ability to focus over the long term on the development of more complex capabilities such as slow, incremental collective learning. PASHIP's five and a half years has been more realistic than short term project funding, allowing a broad range of activities and considerable geographic coverage. There are still tasks that are incomplete. For example, despite many attempts COMPASS has not yet been able to get its training program into a university and is in the process of piloting the program. The length of time this has taken has largely been out of COMPASSES control but their persistence deserves support for them to finish the task they set out to do. Likewise ENBSHIP partnered with the province to work with them to build capacity across the total province. For a range of complex reasons, at the four year mark this task still has some distance to go. Ideas coming from the PASHIP learning also warrant more time. The establishment of provincial centres of STI practice excellence, that can become training venues for community health workers in clinical skills, needs further nurturing. Also the work undertaken with ENBSHIP's stret wokers and men and youth in the COMPASS' project, needs further support.

A second part of this critique of the role of NGOs is that projects are frequently designed as vertical programs with no plans for expansion of sustainability and little integration with local health systems. This is not a criticism of PASHIP because PASHIP NGOs have integrated vertical donor funded projects into existing public sector health systems. Save the Children PNG has partnered the management of a provincial health clinic, and COMPASS and ENBSHIP have been working closely with provincial government planners to strengthen the capacity of their community health care workers and provincial managers. The critique around vertical programs is relevant though in one area: the original AusAID vision for PASHIP was to focus the program on one limited set of diseases when it could well have been integrated more broadly, especially more closely with HIV services. This issue will be discussed further in section three.

A third part of this critique relates to sustainability and the observation that NGOs frequently close once funding ceases. There is one PASHIP project (ENBSHIP) that has established a new NGO. The sustainability of their work depends much on future AusAID and Government policy and resource allocation. Burnet had not planned to maintain a long term organisation and had seen it closing at

the end of the project when the task was completed. However development has been slower than anticipated so the work they set out to do may not be finished at the end of PASHIP. Much will depend on whether the ENB Provincial Health Department can improve its capacity in the final year of the program. COMPASS partnered a local small well respected NGO, PNG Family Health Association (FHA) as a sustainability strategy. The NGO has offered local credibility but because it has limited capacity and funding the international NGOs for COMPASS have seen it as important to offer capacity building where possible to this organisation as well. The fourth area argued by Pfeiffer et al was about **brain drain** because NGOs frequently lure health workers away into highly paid NGO positions. PASHIP NGOs did recruit workers from the NDOH system to improve integration of services but these have largely worked within existing salary structures. As well PASHIP projects have largely used NDOH and PHO trainers for basic syndromic management rather than asking their international mentors to do this. Thus, these projects have, to a significant extent, integrated into local systems. This demonstrates good practice according to the international literature.

Literature regarding health service strengthening in developing countries

As PASHIP is primarily a program focusing on health system strengthening, the second area of literature considers the learning of this practice in developing countries. In 2009, David Peters published for the World Bank a book 'Improving Health Service Delivery in Developing Countries, From Evidence to Action' that reviews an extensive range of evidence concerning strategies in low and middle income countries (LMIC)[15]. The methodology systematically reviews hundreds of journals and books, identifying implementation characteristics, validity of findings and strength of evidence. The book has four sections relevant to PASHIP.

The first looks at the **most effective strategies to strengthen health services in low and middle income countries** (LMICs). The most common example of primary health strengthening strategies is the training of health workers. Findings point to:

- The evidence base being weak for claiming success of any particular health service strengthening strategy across LMICs, although how a strategy is implemented is as important as the type of strategy used,
- Strategies that are more effective in strengthening service delivery for the poor involve planning for benefits to reach the poor, ensuring regular measurement of impact on the poor and providing oversight to ensure that the poor benefit.
- Stakeholder involvement and consultation are necessary for effective implementation,
- Successful implementation is linked to interventions to identify and minimize constraints.
- The initial and continuous adaption of the strategy to the local context is associated with more complete strategy implementation,
- Multiple strategies are more effective than single strategies but risk of failure is greater,

- The availability of resources profoundly influences all strengthening strategies so decision makers should not implement a strategy unless they are sure the right resources are available.

The second section of 'Improving Health Service Delivery' focuses on a **review of strategies to improve health care provider performance**. Results suggest that:

- Diverse strategies have been used but most, including 'training only', have small effect,
- There is not a simple solution to improving community health workers' performance. However combining a range of strategies such as availability of printed materials, job aids, training, supervision and skilled management resulted in a greater effect,
- Effect size seemed to vary by scale of implementation with strategies implemented at state, province and national levels generally more successful than those carried out at district level or lower.

Stand alone basic strategies such as running a training course or providing medical resources alone have a smaller effect on performance and may be the least worthwhile. Taking on more complex strategies produces more diverse responses both positive and negative. Consequently the authors argue that each health organisation needs to try and match the complexity or number of strategies with its capabilities. As well, performance needs to be managed very closely and if one strategy is found not to be working, another can be tried.

An article by Rowe et al that explores how to achieve high quality performance of health workers noted that in randomized trials, health-worker supervision as an intervention can improve performance at least in the short term[16]. If correctly done it could be a mechanism for providing professional development, improving health care worker job satisfaction and increasing motivation. Another article by Clements et al looks at supervision practice in a range of countries including PNG[17]. The authors concluded that problem-based learning and continuous supportive supervision do need to be institutionalized but more importantly, that insufficient attempts have been made to understand the supervisor-supervisee interaction and the problems faced by attempting to communicate across social and cultural barriers.

The final section of 'Improving Health Service Delivery' reviews **community empowerment strategies for health outcomes**. The book categorized empowerment strategies under four broad themes and one set of financial approaches that cover several of these themes. They include:

- information and education,
- inclusion and participation in providing care,
- accountability; citizens holding public officials accountable,
- local organisational capacity; citizens capacity to mobilize, and
- financial empowerment; both in term of raising funds for households and communities and turning over control of health services to citizens groups.

Findings suggest:

- Many different types of community empowerment approaches have worked to improve health services and health outcomes. Surprisingly, about 90 percent of all studies using empowerment approaches had a positive primary outcome.
- The most successful approaches included: providing training opportunities for local workers, promoting communication and collective action by communities, supporting community ownership and management of services and holding service providers, officials and private organisations accountable.
- How community empowerment strategies are implemented matters. Partnerships between communities, policy makers and experts have been more successful than approaches that do not create such partnerships. Providing feedback through sharing results with communities, using systems for local adaptive learning, harnessing community resources to support programs and promoting equity are particularly successful.
- Initial conditions, such as the presence of strong leadership and previous community empowerment strategies are important predictors of successful projects.

A large scale 2008 study by Baser and Morgan reviewing capacity development case studies supports this finding by confirming that progress on capacity building depends critically on the level of ownership, commitment and motivation of participants to commit and engage[18].

A more specific PNG study by Ashwell and Barclay, reviewed the AusAID funded Women and Children's Health Project run between 1998 and 2004 that used education, community development and health promotion interventions to improve the health of women and children[19]. The evaluation completed in 2009 suggested that the community health interventions improved the relationship between the community and the health system and concluded that sustainable improvements in health care can be achieved through community led and maintained activity.

A surprising conclusion of a large review by Peters was that there was a distinct lack of evidence to show that comprehensive planning was central to successful implementation of programs. 'The emphasis of international agencies on comprehensive costed plans or well written proposals has little relationship with the successful implementation of those plans and proposals'. (Peters: p281) The authors argue that this is not an indictment of planning as locally adaptive learning processes are seen as a determinant to success, rather planning must not lead to ignoring the need for constant reappraisal and replanning by beneficiaries and implementers. Baser and Morgan had a similar finding[20]. They argued that 'the balance of issues in development co-operation is shifting against predictability and towards complexity and uncertainty'. This complexity in development work does not conform to a linear cause-and-effect pattern so the planning model most commonly applied in development work has limited value in such a context.

Another paper prepared for the World Bank in 2010 'Developing Strategies for Improving Health Care Delivery' looks at how to measure organisational performance in health care delivery[21]. Based on a literature review of peer assessed empirical studies of health care organisational performance

in World Bank client countries, they define six core performance domains. These are quality, efficiency, utilization, access, learning and sustainability and they are seen to contribute to final outcomes of improved status and risk protection at the heath system level. In order to understand how these relate to PASHIP it is important to understand them in more detail.

Quality – Historically much research on health care delivery has focused on clinical quality, investigating whether the care provided to a patient was safe, medically appropriate, and conforms to best clinical practice. Examples of measuring quality include:

- Adherence to clinical guidelines
- Availability of medical supplies and
- Patient satisfaction.

Efficiency – Efficiency is a relative measure that compares inputs used (human, technological, finance) to outputs attained (number and level of service). Examples of measuring efficiency includes:

- Patient visits per day or per health worker
- Cost of patient versus total cost of running the service

Utilisation – is the volume of services delivered or clients served. While straightforward to measure as an outcome, setting standards for the 'right level of utilisation' can be difficult due to the influence of diverse and variable client demand patterns. Utilisation as an organisational performance needs to be relative to organisational capacity or population health characteristics. Benchmarking utilizations across organisations serving similar populations is therefore an important method for assessing this outcome. Examples of measuring utilization include:

- Outpatient visits per provider
- Percentage of pregnant women receiving STI care

Access – is the potential ability of an organisation's potential clients to obtain its services
Examples of measuring access include:

- Availability of transport to clinic
- Geographic distance to service
- Hours of operation
- Affordability of services

Learning – is the process by which an organisation acquires new knowledge and translates this knowledge into organisational practice. Organisational learning generates both changes in knowledge as well as changes in observable processes and organisational culture.
Examples of measuring learning include:

- Quality Improvement measures used
- Presence of patient or staff suggestion box
- Log book of learning

Sustainability – is the organisation's ability to continue delivering needed and valued services. Dimensions include: sustained political support from government officials, sustained community and patient support and predictable access to needed inputs such as finances and training for workers.

Examples of measuring sustainability include:

- Involvement of community leaders in facility planning and monitoring
- Timely, useable and monitored data on facility financial status
- Use of strategic management process to promote organisational fit with environmental conditions.

The authors comment that measuring and improving organisational performance is complex because organisations are diverse and dynamic.

The relevance of these measures to PASHIP will be discussed later. Two other variables found to be important in strengthening health systems are the use of quality improvement approaches and the use of partnerships.

Quality Improvement Approaches

A 2010 article by Leatherman et al points out that the World Health Organisation is identifying quality improvement (QI) as one of the key drivers to improve health outcomes and greater efficiency in health service delivery[22]. Quality improvement denotes both a philosophy based around pursuing continuous performance improvement and discrete technical and management methods. These include systematic examination of processes used in service delivery, operational research, team work, assessment and improvement, use of statistics in daily work, benchmarking and participative management techniques. Effectively used QI closes the gap between actual and achievable service delivery practice and for the health workforce it enhances individual performance, satisfaction and retention.

Partnerships

WHO also reported in 2010 on key strategies in Indonesia to strengthen core capacity for disease surveillance and response systems[23]. Early success came from building partnerships with universities, ministries and international agencies. The most critical factors were developing trusting relationships and clear definitions of the responsibilities of each stakeholder. Much of the literature on health system strengthening reinforces the importance of partnerships. WHO argues that partnerships in the health system are like the glue in a chair which keeps the different parts in alignment with each other and enables the system as a whole to do things that would be impossible for any of the parts to do on its own[24]. The 2008 Accra Agenda for Action, the follow up of the 2005 Paris Declaration on Aid Effectiveness, defines the principles and commitments by which donors and developing countries intend to ensure that aid is as effective as possible in contributing to internationally agreed development objectives[25]. The statement argues that aid is about building

partnerships for development. Such partnerships are most effective when they fully harness the energy, skills and experience of all development actors.

Implications of Health System Strengthening Literature for PASHIP

A number of key themes relevant to PASHIP come from the literature on service strengthening. Many of these affirm the quality of work done in the PASHIP program and that its direction is towards best practice. Others point to ways of extending the learning.

1. The importance of using locally adaptive learning

The first theme is affirming the importance of using systems for locally adaptive learning. This process is an organization-wide continuous process that enhances the workers' collective ability to accept, make sense of, and respond to internal and external change[26]. Organizational learning is more than the sum of the information held by employees. It leads to collective action and involves some risk taking in making changes to direction. Using this approach requires systematic integration and collective interpretation of new knowledge by frequently reviewing the measures of organisational performance (quality, utilization, learning, efficiency, sustainability and access data) as well as reflecting as a team on what is working and what needs changing so that the aim is to constantly improve service provision.

Some PASHIP partners were more aware of the importance of establishing locally adaptive organisational learning across the four years than others, especially in providing close and consistent review of the measures of organisational performance as well as discussions to assist adaptive practice. This difference appears to be partly about how the culture of the organisation was established. Some projects valued this reflection, monitoring and ongoing evaluation and were prepared to resource it and build it into their every day work. A few got caught up in the day to day pressures and appeared to place less emphasis on keeping solid monitoring and evaluation data and building consistent action reflection processes into their every day work. Project participants have suggested that this loss of the reflective overview also happened to AusAID in the early years of the program so that encouragement to stand back, reflect and learn was not emphasized sufficiently from the top. More recent AusAID-initiated opportunities for across-program reflection have been greatly valued.

Another element was that some project designs lent themselves to easier monitoring and learning than others. For example those PASHIP projects trying to work with large numbers of health workers over scattered terrain had a much harder task in monitoring worker standards and improvements in practice, post- training than those projects where health workers were stationed close by.

A further dimension of adaptive learning involves developing strategies to overcome problems and encourage stakeholder feedback to create flexibility and modification. All PASHIP projects have examples of complex problem solving, but those that directly manage their services have greater

opportunity to intervene. For example, where provincial governments such as East New Britain and Morobe were responsible for ongoing management and resourcing, ENBSHIP and COMPASS had to rely on them to improve the service structure and were limited in the intervention they could take on. Impressively, PASHIP projects continued to try to think creatively to solve such limitations but it was difficult for them, particularly if they wanted to avoid setting a precedent that could not be sustained past the end of PASHIP.

These points help to suggest some direction for both project partners and AusAID in future. There is a need to build-in adaptive learning processes more explicitly from the start of a project through to its end. This could be done within individual designs and especially between projects to strengthen partnerships.

2. The Importance of Training Community Health Workers

A second theme is the strong focus on training community health workers (CHWs). It was clear from the Peter's review for the World Bank that training could improve CHW skills but that no training model was found to be clearly better than another. Rowe et al however argue that supervision is a particularly powerful strategy. Both works find that using a number of strategies was most effective and that overly-simplistic strategies such as providing one-off training to health workers tend to fail. Equally, implementing overly complex strategies that outstrip the management capacity of health service provider organisations can also lead to poor results.

PASHIP projects are all using a range of strategies to strengthen skills of community health workers. They all include basic STI syndromic management training and in addition four projects (STIMP, SAVE, 4As, COMPASS) offered ANGO expert supervision/mentoring, while ENBSHIP is offering local mentoring. In addition many projects are also offering advanced training, written materials, logbooks, assessment tools, group reflections and attachments for at least some of the people they had trained. The final evaluation should include an exploration of whether these combined strategies created the change they set out to achieve.

The literature does suggest that providing incentives such as financial rewards, career development opportunities and education and training to health workers has led to better standards of work[27]. PASHIP projects might consider whether there are any other culturally appropriate ways they could without undermining the broader health system.

3. Measuring Performance

Many of the core performance domains referred to in the World Bank's 2010 paper 'Developing Strategies for Improving Health Care Delivery' are being used by PASHIP projects to measure performance. Three measurement areas that are relatively strong are showing service 'quality' and 'learning' with increasing focus on 'utilization'.

Quality

Consistent with WHO's framework, PASHIP projects used Quality Improvement tools originating from NDOH minimum standards to assess performance change in their service delivery and capacity building work. COMPASS and ENBSHIP in particular adapted these tools to make them more relevant to their context and in so doing helped practitioners take them more seriously. Breaking down the Quality Improvement tools into parts gives a greater focus to areas that PASHIP can effect. For example hand washing practice was found to be frequently under used and this is an area that can be impacted on by awareness and supervision. In addition to the QI tool, the three projects directly managing practices monitored their medical supplies and with the exception of one project all are running patient satisfaction surveys or piloting them[1].

DNOH minimum standards audits were encouraged in every clinic that has been part of PASHIP, so as to give a measure of quality that monitored not only staff clinical competency but also infrastructure and resources. Those clinics under direct management of the PASHIP NGO met basic requirements but for ENBSHIP and COMPASS a number of clinics failed, partly to do with health worker skills and partly because of issues out of the control of PASHIP projects. These issues included, for example, lack of male and female cubicles and no running water, both responsibilities of the cash-strapped Provinces. In a creative move COMPASS plan to employ a community mobiliser in 2012 to work alongside DHOs and Clinic Officers in Charge to develop skills in accessing unspent government funds to improve physical infrastructure and resources.

Learning

To measure 'learning', most projects run pre and post syndromic management training testing to assess whether staff have understood the training material. While these tests give some measure of immediate syndromic management learning, the WHO literature and PASHIP experience confirms that one off training is insufficient to build health worker STI capability unless there is follow up mentoring, supervision and sufficient numbers of people presenting with STIs to maintain practical skills. Specific strategies such as in-house supervision, attachments, conference attendance and higher level training courses have aimed to build a pool of skilled practitioners. In particular COMPASS and ENBSHIP's QI tools, 4AS log book and Save the Children's Patient Survey are all tools encouraging an adult education 'self evaluation' approach.

By the end of PASHIP it is anticipated that most of the community health workers in STIMP, LNP and possibly 4As will be assessed as competent in STI management. The two projects working with POH to train up provincial community health workers (Model 3) set themselves a large challenge

[1] Compass has taken on a large utilization data collection and this is being prioritized over completing client satisfaction surveys.

spanning in COMPASS' case, two provinces Sepik and Morobe, and for ENBSHIP the whole of their province. With hindsight it appears at the four year point there may have been some underestimation of the geographical breadth of the task and in ENBSHIP, the capacity of the Department of Health. The trend data that is now being reported on in QAI format shows the discrepancy between those trained and those considered competent. However both projects are aware of this issue, so year five's work may address these issues sufficiently. It could be argued nevertheless that this is still a much higher level of competency in STI practice than existed in all five projects' areas before PASHIP funding.

Utilisation

'Utilisation' data is now being collected across all projects. Model three projects with large numbers of provincial health sites struggled early with collection but are now on track to revisit records and develop trend data. This is a large task requiring access to data from 32 clinics over 3 years in the case of ENBSHIP and 19 clinics for COMPASS. 4AS took some time to complete clinic building and hospital refurbishment so utilization data in the first three years of the project is low but should increase substantially in 2012. Analysis of utilisation data by itself is complex. Without STI baseline data it is difficult to determine whether high rates of utilization such as those seen in Lusa Numini Project are mainly because there is high prevalence and therefore consistently high demand. Certainly, word of mouth from other projects sending staff for attachments to Lopi and patient satisfaction surveys suggest that these high figures are not only about prevalence but patients being attracted by high quality of care and non discriminatory service provision.

While differences in utilisation data point to greater efficiency of some programs, care needs to be taken in making conclusions, given that programs are so different in themselves. Some programs are attempting to strengthen provincial wide health systems and develop components to prevent STI and reduce stigma and discrimination while others have focused on specific clinical services with variable focus on preventative and community strengthening approaches.

Efficiency

Efficiency has not been a measure used across PASHIP. It is not clear why but could relate to the original design which did not use a shared overall results framework, the complexity of the practice setting, an understandable hesitation to try and measure efficiency and the time it has taken for projects to get utilization data reliably collected. The mid-term review pointed to considerable variation between project efficiencies with LNP (Save the Children) 'emerging as the most efficient model'. This conclusion appears to have been made because Lusa Numini Project had (unlike some other projects) a relatively small percentage of their budget unspent and that a hundred percent of personnel costs were spent in PNG. The report is careful about commenting on broader cost effectiveness and especially caseloads because of lack of baseline or accurate impact data.

Access

Issues of 'Access' have been addressed in many ways within PASHIP. All STI services have been free for clients. A range of strategies have been used to build non discriminatory service provision. Training for staff in syndromic management generally contains some components addressing the impact of stigma. Nearly all services commented however that training alone was not always sufficient to have an impact on attitudes and follow up supervision, or in the case of ENBSHIP direct feedback to staff by stret tokers, were necessary.

All projects have broad awareness campaigns across districts using volunteers. Some projects have undertaken awareness and clinical work with specific groups such as COMPASS with men and youth, STIMP in schools and new men's clinics and Save the Children with vulnerable groups (NB not funded by PASHIP). ENBSHIP, STIMP, and 4As have also integrated STI work into ante natal clinics as a way of increasing the number of people accessing STI services. Transport is a major access difficulty for most projects. Save the Children has provided some transport and has opened a clinic in a more remote but likely high prevalence area.

Sustainability

There are numerous examples of measures taken by PASHIP projects to maximise the 'sustainability' of benefits beyond the life of the Program, demonstrating good practice. These include regular auditing of finances, evidence in three projects of ongoing partnerships with provincial government (Save the Children, ENBSHIP, COMPASS), a beginning partnership in Oro (4AS), capacity building of a partner NGO in COMPASS and political support from community leaders, an outcome of working closely over four years with surrounding communities. STIMP and 4AS are embedded in existing services so sustainability is made easier. Never-the-less, evaluating the strength of PASHIP's work will be significantly determined by what exists 12 months after PASHIP is completed. In order to learn more about the most effective way to establish high quality STI services, AusAID should consider extending the learning of this project beyond the completion date to undertake a small evaluation in early 2014 to identify how well each of the models has contributed to sustainability.

4. **The importance of community empowerment strategies to improve health service outcomes.**

The fourth theme identified is the importance of community empowerment strategies to improve health service outcomes. All PASHIP projects contained elements of community empowerment (although Save the Children's was not funded through PASHIP) but three (ENBSHIP, COMPASS and STIMP) particularly emphasized these strategies as a central component of their work to strengthen health systems. 4As also did some work in this area. All projects used staff that were or became skillful in community development. Marie Mondu from STIMP argues that systems strengthening and community empowerment are equally important. 'You have to strengthen the clinical component so you have good services but equally it's important to work alongside communities to

encourage prevention and increase access'. David Peter's World Bank publication argues that those strategies used by some PASHIP projects such as building partnerships between community, policy makers and technical experts produce some of the strongest outcomes and is a powerful way for communities to keep service providers accountable.

A further outcome of empowerment strategies is giving communities the language to speak about former taboo topics so that preventative strategies can be widely advocated and the direct addressing of fear created by stigma and discrimination. Peters also comments that when a community is actively engaged in managing interventions, such as serving on community boards, running revolving drug funds or deciding on provider bonuses, improved outcomes have been found. These are community development strategies that hand over even greater power and responsibility to communities than has happened in PASHIP. Future designs might consider including these elements.

5. Integrating outside funded programs with nationally driven policy and practice

A fifth theme is the importance of integrating outside funded programs with nationally driven policy and practice. PASHIP projects have been committed to working within National Health Standards and Practices although at times those with less capacity have taken longer to align their clinical practices and statistical reporting. Capacity building practice was guided by nationally determined criteria. While each project handled auditing of clinics slightly differently and frequently adjusted the tools to suit individual circumstances, central to these tools were the national minimum standards. In addition all projects worked with the NDOH to provided STI syndromic management training and all reported their statistics into the National Information System. This commitment to integrating PASHIP work into National Health practices is consistent with the warning from Schneider et al (2006) that sustainability is dependent on the countries' own policies and practices being followed and strengthened. Efforts by PASHIP stakeholders are thus demonstrating international good practice.

6. The importance of partnerships

In PASHIP there are a range of partnerships that have been built or have had the potential to be built.

- Partnerships between the PNG PASHIP organisations and their ANGO partners
- Partnerships between the PNG Projects and the Provincial Government
- Partnerships between the project and the community (ies) it works with
- For some, partnership between the project service provider and another PNG NGO
- Partnerships across the five PASHIP Projects
- Partnerships between AusAID and the PNG and ANGO project partners.
- Partnership between the PASHIP Program and the NDOH

All projects indicate that they aimed to strengthen partnerships. Most have focused on building partnerships with provincial government and in some cases with local communities. In terms of

Provincial Government, Save the Children, ENBSHIP and COMPASS designs reflected the importance of directly strengthening Provincial Government STI services so that the impact was ongoing. All invested in building trusted relationships, planning together, sharing resources and outcome data, and aiming for a change in practice that enabled the provincial government to confidently maintain more skilled STI intervention. COMPASS, ENBSHIP and Save the Children found that working with provincial governments from the outset and being consistent was central to building a strong partnership. All provincial governments were enthusiastic about partnerships although this did not always mean that they had the capacity to follow through with the tasks needed to sustain the partnership. ENBSHIP in particular found that despite extensive sharing and mutual commitment there were still blockages to key auditing and training tasks being carried out. This last year of the program will test both partners to see if new discussions can reactivate areas of difficulty.

For church projects, their model meant partnerships with provincial government were relatively less important. Marie Mondu from STIMP noted that both CHS and the Provincial Governments have long depended on each other. CHS relies heavily on government funding, medical supplies and drugs as well as policy direction while NDoH depend on CHS for sero surveillance studies, HIV/STI statistics, job attachments, shared training and general care provision in remote areas where government presence is non existent. However the level of trust and interworking does have limitations. Disease control officers sometimes do not monitor what CHS is implementing or support new STIMP projects. This may partly be due to lack of co-ordination capacity (finances and skills) to carry out the necessary supervisory visits throughout all government and CHS facilities. Philip Gibbs also from STIMP noted that while the Catholic Health Service has a long history of working with provincial government he wished that they had been more successful in working with one of the two provincial governments where their services were located. One had a history of strong relations but in the other, the relationship had never been strong particularly because there is a history of rapid turnover of staff. Rather than working in a close co-operative way, the church health service had tended to work in parallel.

Partnerships between the five projects appear to have mainly focused on sharing training, attachments and monitoring and evaluation tools. While this sharing should be complemented, there is the potential to extend these relationships. A precedent exists with the AusAID funded Solomon Islands SINPA program (2009 – 13) which was established with the goal of maximizing sharing and support between six projects. Specific funding was allocated to support technical assistance from consultants to improve joint learning among NGO partners. The recent mid review showed that while there was room for the sharing to be done more systematically and strategically, a strong working relationship based on mutual trust has been established between the in country partners.

Partnerships between PNG NGOs and their Australian/International counterparts will be discussed in the next section, the role of ANGOs.

Can one PASHIP model be seen as more effective than another

Reviewing the different models, it is very tempting to ask: is one model more effective than another? Each model brings strengths and risks. The following reviews these and then considers whether the notion of 'model' is sufficient to answer the above question.

Model One

the extension of long standing church health services to include quality STI clinical provision and strategies that increase community health seeking and preventative behavior.

The strengths of Model One are seen as:

- The new clinical and community focus on STIs is part of a long-standing and widely known health service and as the church auspices the program, this gives it credibility and a special position in the local district,
- The ANGO partners provide support, mentoring and monitoring but assume that the PNG partners will take the main initiative in establishment and management of the service.
- The costs of establishing the new service are reduced because it is integrated or part of an existing service structure,
- There are broader resources, skills and programs that the STI program can use and learn from, particularly if HIV work has already been a priority in the service,
- The program raises the profile of STIs among general health workers in the church health service, creating a knowledge flow-on effect and referral pathways,
- This model recognises a variety of awareness-raising and empowerment strategies in communities are central to raising the profile of STIs as a health issue, raise attendance, counter stigma and discrimination and encourage preventative behavior.
- Integrating or placing an STI clinic alongside an existing broader health service contributes to service coherence and integration, and builds referral pathways.
- The service is more likely to be sustained when specific STI funding finishes because buildings remain and if they can be afforded trained staff continued in a successful STI service. If there is a shortage of funds and staff are multi-skilled they can be integrated into mainstream work, with STI work being one component of their role.
- A key evaluation issue is whether the model brings sustainability and the church health services can hold on to skilled staff to fully take the service over when external funding ceases.

The main risks with this model are:

- That despite having an historical depth, the performance of church health services is still dependent on the quality of governance, financial management and service provision that can be provided,

- Being church auspiced, they run as a parallel health system to government so may not be tightly integrated with NDOH practices,
- There may be church based beliefs that make its health practice different from that government believes is best practice, for example the distribution of condoms.

This model works well for STIMP as the long established Catholic Health Service already had experience running a hospital and HIV services. This provided a solid organisational framework on which to graft the STI service. STIMP relied less than some of the other models on building a partnership with the Provincial Health Office although in one of the two provinces, the relationship worked well but in the other, it was less effective. Justine McMahon, the Co-ordinator of STIMP considered that the main achievements of the project are in Simbu Province with the establishment of a men's clinic which has subsequently gained attraction as a model across the country and in the Southern Highlands the establishment of laboratories with trained workers. Marie Mondu from STIMP also noted that research, advocacy and media work that was done significantly contributed to national practice. For example, the election research prompted NDoH better preparing stock for the coming elections, a DVD addressing stigma and discrimination was shown on national television and other STIMP work encouraged NACS to launch a HIV policy on information, communication and education in 2011 Both examples show the capacity of the model to be innovative and cut across established but less effective ways of working.

For 4AS it was initially difficult to build on the strengths that might come with partnering established health services. While this slow start has been frustrating for all involved and it could be argued, as was done in the mid review that it has not given efficiency, in the longer term this slow beginning may have built one of the most sustainable projects. The achievement has been to assist two health projects find the strength and capacity to build quite complex local infrastructure: a stand-alone clinic and a hospital with integrated STI service designed to suit the context, train administrative and clinical staff and create a stronger relationship with Australian partners. The investment on both sites is a long term one with a strong likelihood of sustainability if staff turnover can be minimized and ongoing STI training and in house supervision maintained. The advantages of this model are only likely to become evident in 2012 as both services get properly established.

Both STIMP and 4As ANGOs recognise that their partners are distinct mature organisations so they have taken care to respect their autonomy and to wait for them to provide negotiated direction rather than always leading the discussion. Relationships and services are envisaged as continuing beyond the end of any AusAID project funding.

Model Two

With the support of Save the Children Australia, PNG Save the Children established a partnership with the Eastern Highlands Provincial Government where they jointly manage STI clinical services that aim to build high quality capacity for the Province and work from provincial to local levels to meet created demand.

This model is built around an established local NGO with strong institutional capacity and governance using expatriate managers to lead local staff. Its effectiveness is strengthened by other Save the Children outreach projects which refer clients to the clinic but are not funded from PASHIP sources and therefore do not have to be managed through PASHIP.

The strengths of this model are identified as:

- Where a strong and trusting partnership built over three decades exist between the NGO and Provincial Government, the skills and resources of both partners are bought to establish the service and build the strength of government managers to eventually take over the service.
- By embedding the work directly into local government the hope is it will impact on every health clinic in the province and so contribute to long term sustainability.
- Integrating or placing an STI clinic alongside an existing well known service contributes to service coherence, integration and helps spread the word that the service exists.
- Rural outreach services are established alongside to extend skills and clinical provision so that the central clinic does not carry the full demand.
- A variety of awareness-raising and empowerment strategies in communities are central to raising the profile of STIs as a health issue, to counter stigma and discrimination, to build relationships with vulnerable and hard to reach groups and encourage preventative behaviour. Much of Save the Children's work on these issues is funded outside of PASHIP but is critical to the success of the model.
- The costs of establishing the new service are reduced because it is integrated or part of an existing service structure (even if it is not a large one),
- There may be broader resources, skills and programs that the STI program can use and learn from, particularly if HIV work has already been a priority in the service,
- The program raises the profile of STI among general health workers in the provincial base and surrounding clinics so that there can be a flow on of referrals,
- The NGO has strong international networks that can provide support and resources,
- The service is more likely to be sustained when specific STI funding finishes because buildings remain and if they can be afforded, trained staff may be continued in a successful STI service. If there is a shortage of funds and staff are multi-skilled they can be integrated into mainstream work, with STI work one component of their role,
- This approach, when working well, brings steadiness and a depth of experience that allows immediate problem solving and monitoring of progress. Problem solving has addressed difficult issues of handling extensive demand, avoiding staff burnout and ensuring continuity of medical supplies.
- The model could move to being a centre of excellence that can train other provincial community health workers in the future.

The key risks for this model are

- That long term sustainability is not achieved. Crucial will be whether the provincial government truly feels the project is theirs and they can hold on to skilled staff who have the capacity to run the centre independently, once the project is handed over.
- There is a critique that placing expatriate management in a project for the full length of its life is not always the most effective way to pass on skills[28].
- The ongoing program will be dependent on the quality of governance, financial management and service provision that can be provided, and service quality may fall.

The Save the Children project (LNP) service was built on strong past practice and relationships, in an area that Save the Children had been working on for thirty years. They had a long history of working with Eastern Highlands Provincial Government and considerable trust had already been built. In addition, with at least a decade of HIV awareness and treatment, there were already quite large numbers of people seeking STI services before LNP started. Highlanders are generally aware of HIV and STIs and have a language to speak about STIs so tend to be more comfortable than lowlanders in seeking out service. The service was made more accessible by being near a central transport route and in addition Save the Children arranged transport to the service. The project was also co-ordinated with Save the Children's other HIV and AIDS outreach projects, the Poro Support Project, Youth Outreach Project and Tingim Laip project so that work could be focused on vulnerable groups.

Save the Children was committed to developing a locally adaptive learning organisation. Monitoring and evaluation processes were built in from the start and this data was regularly discussed with staff so that they could adjust their practice to the patterns they observed. Tools such as the client satisfaction tool were developed as they went. A local program quality officer was appointed to oversee data collection and analysis, and this has helped to support and facilitate this learning.

Save the Children Australia believes it is cost effective to have skilled managers on the ground, able to immediately monitor work. Given the difficulty of finding local managers with the right skills, expatriates are employed. As progress in PNG can be delayed by many factors, they believe that remote management only "gives half a picture". The in-country manager is able to work closely alongside both the clinical workers and the Provincial Diseases Officers, taking a capacity building approach, talking daily to clinical staff and meeting regularly with Provincial staff. A clear plan that hands management tasks to local workers has progressively been rolled out over a number of years.

Model Three

A Provincial Government and NGO partnership: develops high quality STI capacity in a large number of government managed health services and uses community empowerment strategies to increase community health seeking and preventative behavior

The strengths of this model are identified as:

- A partnership built with the Provincial Government Health Department to upgrade the STI clinical skills of large numbers of health workers employed by Provincial Government in most districts, so strengthening existing services.
- Providing ongoing skill training and mentoring for some of these workers. COMPASS also developed and piloted an STI graduate level sexual and reproductive training course.
- Raising the profile of STI among general health workers, helping them be more alert to STI diagnosis and treatment and to refer to specific STI specialist clinics,
- Training a pool of local community leaders and volunteers to do ongoing work in their communities to raise STI awareness, reduce stigma and discrimination, encourage preventative behaviour and provide referrals to clinics where trained STI health workers practice.
- Broader goals also focus around building civil society to have greater ownership of health services, be confident to advocate for good practice and engage with government planning processes.
- Building strong trusting relationships with the DOH office is crucial to this model. Various strategies have been used including regular meetings, shared training, MOU's, inclusion of STI goals in Provincial DOH annual plans, and employing a staff member who originally worked for DoH to help extend knowledge and linkages.
- The ANGO partners provide support, mentoring and monitoring but look to the PNG partners to take the main initiative in establishment and management of the service.
- An unexpected but impressive outcome has been the level of ownership by volunteers and the request by many to stay involved. Provincial Health Officers have been supportive, seeing the volunteers as having the potential to take on broader health awareness roles as well as build stronger relations between government and communities.
- By embedding the work directly into local government the hope is it will impact on every health clinic in the province and so contribute to long term sustainability.

The risks of this model are:

- That in attempting to have an impact on most provincial community health workers the model is spreading itself too thinly. It has focused on relatively large numbers of workers based in remote communities who have low level skills in responding to STIs and a reasonably high turnover rate. Working with high numbers means in some places it has been difficult to provide consistent supervision and follow up training as well as basic resources to ensure workers reach a confident level. For example ENBSHIP realized that the inclusion of 32 general health centres at the outset was ambitious, and while they have provided basic syndromic training to all CH workers, in their final year they have decided to focus on 6 STI-specific clinics at district level.
- If provincial governments are under-resourced and not able to provide elements of their agreed roles, especially in terms of supervision and monitoring, the numbers of trained workers may fall and STI management loses momentum.

- That it does not take account of the fact that awareness-raising and community empowerment strategies require a longer-term approach, are more difficult to manage than clinical work and thus a project needs to be realistic about what can be achieved in short time-frames.
- Volunteers who have had a positive experience may expect to have an ongoing role that was not built into the original design. This needs to be both valued as a reflection of the impact of the project but also a problem that is solved so volunteers do not feel abandoned.

ENBSHIP & COMPASS

ENBSHIP established a new NGO that partnered with the East New Britain Provincial Government. COMPASS partnered with an existing NGO, the PNG Family Health Association, and with Morobe and Sepik Provincial Governments. In partnership with provincial government staff, STI syndromic management training was done with health care workers across Morobe and Sepik for COMPASS and East New Britain for ENBSHIP, with the follow up of some workers through further training, mentoring and attachments. ENBSHIP worked with 32 health services in East New Britain and a number in Sepik and COMPASS worked with 19 health services in Morobe Province. In addition, extensive work has been done in both projects to directly strengthen the practice of provincial governments. COMPASS also developed a new sexual health curriculum that is in the process of being piloted. When finalised in late 2012 that course will be handed to the NDOH for them to decide how best to use it.

Both projects were based in provinces that did not have a long history of working with HIV and STI so in comparison with the Highlands, communities were not comfortable talking about "taboo" issues. A major strength of this model was the building of awareness and public advocacy skills either using gender-based strategies such as camps and coffee nights for males or by working with a large numbers of volunteers who were well trained on STI issues, and acted as awareness-raisers for their communities. These mobilization strategies increased the profile of STIs, preventative behaviours were encouraged and people began attending clinical services for STI assessment. Word of mouth and feedback from both Provincial Governments suggest that this work also helped reduce stigma and discrimination.

ENBSHIP's work to build the skills of community volunteers, the stret tokers, has had major impact not only on opening up community discussion about the risk of STIs but has given the Provincial Government new ideas about relating to their communities. Andrea Fischer from Burnet identified that a major achievement has been the change of community attitudes to STIs, the increase in condom distribution and growing clinic attendance to seek STI service. Based on international and PNG experience, ENBSHIP allocated a greater percentage of their funds to empowerment strategies rather than clinical work. This decision came from a philosophical position that recognised the importance of building civil society capacity to enable community based solutions to health care delivery. Now, with hindsight, Andrea reflects that the clinical strengthening work probably needed more budget than originally allocated .

At PASHIP's start Burnet Institute assumed that in establishing a new NGO, they were not building a long term structure but rather one that completed the task and then finished. However after 4 years, even though there has been major development, the work is not completed. Some aspects of working with Provincial Government have proved challenging, especially the building of relationships with provincial health and disease officers. Relationship-building in Melanesian culture takes years and is not something that can be hurried. Burnet Institute had also hoped that the Provincial Government would be able to take up more of the supervision and monitoring role than has eventuated.

Andrea Fischer is aware that they have possibly underestimated the time and energy it takes to get significant change in a health system. If Burnet Institute were starting again she suggests they would have strengthened work with the formal health sector including health administrations, hospitals and other health services in ENBSHIP. They are also aware that working with 32 clinics was challenging. it might be argued that the project over-estimated the capacity of the provincial government partner and over extended the size of the activities to be completed. Geraldine Wambo, the ENBSHIP Team Leader, reflects that instead of a working with 32 clinics, it could have been more effective to have started with a smaller group such as six, build their STI clinical skills to a high level and then use them as sites of excellence to act as mentors and places of attachment for training the rest of the community health centre workers. These reflections should not detract from ENBSHIP's impressive work in getting STIs on the PHO agenda and into the language of the community.

COMPASS had a broad agenda of change. By the end of the fourth year using a TOT model where provincial district health officers were trained to take on the role of providing syndromic training and auditing minimum standards, there have been improvements in both DHO work and community health workers handling of STIs. Helen Smith, the ANGO Co-ordinator for COMPASS noted that the main achievements of the program have been the collaboration between the project and Morobe Provincial Government and to a lesser extent Sepik Provincial Government so that staff are far more confident about their enabling role in training and auditing. From this it is clear that STI community health workers clinical skills have improved. Key to this has been the development and use of the Quality Assessment tool. As well there had been some creative work done with men and boys, two groups which are notoriously difficult to engage in sexual health discussion. Formal evaluation of this work is still to come.

The two areas she felt needed rethinking were the geographic breadth of the project and whether a full-time in-country position was required for continuous capacity building. Managing the project in the Sepik and a proposed small component in East New Britain that was later dropped had been very difficult and probably stretched project capacity too far. As well with hindsight Helen felt that the project needed a full time in-country capacity builder to support local management and establish a monitoring and evaluation approach that encouraged reflection and accurate data collection from the start. Having a skilled doctor as a volunteer was fortuitous, but continuity of skill and experience was needed across the project in a capacity building role.

Sometimes projects perform far better than the context would predict. COMPASS is an example of this because while engaging fully in many change strategies, it had enormous misfortune throughout the project. The death of the manager and of its strong supporter, the senior official in the provincial health department , serious illness of staff family members, tribal fighting, town eruptions, a cholera epidemic, extensive staff turnover both in country and in Australia, were all coped with. The project has had an unexpected resilience which points to great determination by stakeholders and participants.

Is one model more effective than another?

This exploration of PASHIP projects makes it clear that the notion of 'model' is insufficient to explain differences in PASHIP outcomes. The complex tasks associated with the design and implementation of a project is not only influenced by its use of a particular model but a range of other variables. Thus effectiveness is the result of the sum of many variables, which may interact with each other in different and sometimes unpredictable ways in different places and at different times. This section considers some of these 'other' variables.

1. **Diversity in their starting point and their context**

Each project was designed for its context and began from a different starting point.

- STIMP was grafted on to an established, relatively well-functioning organisation that gave it a strong start,
- ENBSHIP created a new NGO with strong volunteer backing, and with the Provincial Government, built a new partnership working across a large number of sites,
- 4AS had to manage two complex, long term building projects before establishing or reestablishing each of the organisations and beginning clinical service,
- COMPASS, as part of an existing NGO, established a new broad ranging project across two provinces with enthusiastic support of the provincial governments but experienced enormous difficulties, many beyond its control, and
- LNP partnered with a strong province where a trust relationship was already established and began service in an area of high demand that they had worked in for some years.

In addition to different starting points there is great diversity in the geographic, political and cultural context of the projects. Remote rural clinics bring different challenges to clinics in urban settings, cultural differences between the highlands and lowlands and regions that regularly experience intertribal conflict, all mean different ways of practicing.

These differences contributed significantly to how easy or difficult it was to start implementation and how quickly outputs could be achieved and outcomes occurred.

2. **How well the building blocks of an organisation function**

There are a range of internal and external variables that influence how well a health project develops. In 2007, WHO provided a framework for action to strengthen health systems[29]. It described six building blocks. These are:

1. Service delivery
2. Health Workforce
3. Health Information Systems
4. Medical products, vaccines, products and technologies:
5. Health financing system
6. Leadership and governance

These six areas refer to the essential core components that need to function well for a service to be strong. Service quality can be undermined if any one of these is struggling with capacity, or if one building block is not in synergy with the others. For example, looking at one building block; in a health clinic the health workforce needs to be sufficiently trained to effectively manage key illnesses, large enough to respond to the need, stable enough to have workers always in attendance, managed well enough to maintain morale and have access to medical resources to do the task properly.

When the five PASHIP projects are reviewed, it is clear that a significant factor in how the project is managing depends on how these building blocks are functioning. So for example, a project may have potentially an effective model but if leadership in the organisation is weak, or the finance worker is not skilled or if sufficient training and support to health workers is not given then the model cannot show its potential.

An example showing why the impact of the model by itself is insufficient to explain effectiveness can be seen with the STIMP project. STIMP's impressive work is not only about grafting an STI service onto an established health service. It's innovation and strength is particularly dependent on the quality of its group leadership and the fact that they advocate the use of strong action research and empowerment strategies. These have built locally adaptive learning to drive service direction, improve service quality and ensure ownership within the Catholic Health Service and surrounding communities. This component is not a characteristic of the model chosen. 4AS use a similar model but do not have the same interest in action research; rather they have used other approaches.

3. **The functioning of partnerships**

Another variable in determining effectiveness is the strengths of partnerships. If the relationship with key partners does not go well, this can undermine the work done and the model chosen. COMPASS and ENBSHIP used similar models. Both had enthusiastic support from their provincial government, both invested significant time in relationship building but in the end one provincial government health office has so far been able to provide stronger on-the-ground support and follow up. The difference is particularly in the skills of the provincial diseases officers and their

capacity to monitor, train and supervise their staff, as well as the capacity of the more senior staff to problem solve issues.

4. Demand for service

Demand for service also appears to be significant in how well staff can build their skills and therefore service quality. Where there was a constant flow of patients, staff were able to identify a range of different STIs, and using supervisors, receive immediate feedback on their practice. This builds confidence and enthusiasm. Provincial disease officers reported that where a clinician only had occasional people with an STI come for care they were less experienced and more likely to be inaccurate in diagnosis.

5. Sustainability

Another variable in determining effectiveness is related to sustainability. The speed with which outcomes are achieved may not necessarily reflect sustainability. Hypothetically, a project getting good outcomes but not having passed on the skills sufficiently may collapses once funding finishes. Whereas a project that develops slowly but with strong capacity building, may be more sustainable over time. While exit strategies give some understanding of how well projects are planning their project's completion, AusAID really needs to review the outcomes 12 months after the project to get a clearer understanding of effectiveness in terms of sustainability.

Earlier the question was asked: is one model more effective than another? When the models are looked at by themselves the answer is no. A much broader understanding of each project is needed to understand why one project may be more effective than another. PASHIP projects have been developed in response to a diverse range of environments so what might be an effective model in one setting may not be in another. Baser and Morgan argue that what matters most in shaping capacity is in fact a combination of internal factors, stakeholder demand, external contextual factors and the complex interactions between them[30].

SECTION TWO: ROLE OF ANGOS

This section explores the relative contribution to PASHIP from the various ANGOs and whether the nature of support being provided to PNG partners has an impact on quality and results. There is a small amount of literature on ANGOs and some of this is reviewed. The section also includes feedback within interviews with ANGO and PNG based PASHIP workers.

Literature

Tear Australia in their submission to Aid Effectiveness Review in 2011 argued that ANGOs are a critical component of the aid program. They provide an efficient use of resources, they have strong accountability to supporters, government and communities, they partner well with local organisations with local knowledge and contacts and they provide the potential for innovation[31].

AusAID has been using Australian NGOs (ANGOs) to partner with in-country NGOs for some years. The 2009 final report of the AusAID Australian Partnership in African Communities Program identified that the ANGOs' core roles with its in country partners was building capacity, providing knowledge of AusAID requirements, managing the relationship with AusAID, providing technical assistance (through ANGO staff, or consultants), and building new links between implementing partners and NGOs[32]. These roles are clearly essential elements in any effective partnership-based, donor-funded program.

Anderson, writing about the AusAID funded PNG Church Partnership Program notes that AusAID cannot always fund PNG NGOs directly because they do not meet NGO accreditation standards and so they disburse funding through accredited ANGOs[33]. Similarly ANGOs need organisations in PNG to work with, the churches in this instance, in order to achieve their organisational mandates. In the church-ANGO partnership discourse, the ideal of partnership is a relational one imbued with the moralities of mutuality, equality and solidarity. The ANGOs act as brokers, they read the complex AusAID language and translate it into the different institutional languages of their PNG partners. In the case of churches, relationships are envisaged as continuing beyond the end of any AusAID funding but this may not be the case for all ANGO partnerships with local NGOs , as some are sustained just for the life of the funding.

This role can be quite complex. Clarke's article referring to the same PNG CPP program, notes that institutional strengthening or 'higher-level' capacity issues were not previously part of church organizational culture and were not seen as priority areas for PNG churches to address. For the ANGOs, as intermediaries between the donor and the churches, the challenge has been to create opportunities for more strategic or 'higher level' capacity building without imposing their own agendas. This has to be done whilst meeting donor requirements and empowering PNG churches (rather than disempowering and increasing their dependence with unrealistic monitoring and reporting demands they cannot meet).

ANGOs have carried significant responsibility for supporting new Pacific NGOs and churches which have received AusAID funding. Generally their role has been seen positively, and as ANGOs continue to take on this role it is assumed that they become more experienced and skillful in carrying out the tasks. However in a recent 2011 Mid Term Review of the Solomon Islands AusAID funded program (SINPA) it was reported that the weakest links in the program were identified as the partnerships between Australian based NGOs and their Solomon Islands based partners[34]. The report comments that support provided by the Australian based NGO staff varied but was generally found to be insufficient. In many cases support was limited to submitting reports and monitoring visits which often do not result in concrete evidence of improvements made after the visits. It notes that ANGOs need to engage in a stronger capacity building role and provide support to the SI based office on project management and technical aspects of the program. Strong project management skills, such as proper planning with communities, risk management and financial management were lacking. The reviewers noted that the best performing SI based office is where the Australian counterpart has been taking an active role in providing advice, technical assistance, building the capacity of Solomon Islands staff and developing concrete tools such as monitoring, evaluation and reporting. They concluded that there is a need for ANGOs to provide more project management and technical support.

One issue that has long been debated between donors working in the Pacific has been around the most constructive way to support partners. Baser and Morgan distinguish between direct and indirect intervention[35]. "Direct" refers to approaches where external actors take on direct responsibility for implementing or designing a development intervention. "Indirect" is a more facilitative supportive role where external partners work indirectly through country actors. They do not have independent responsibility or an area of action. Baser et all point out that the direct method of intervention has a number of limitations as an effective approach to capacity building because it does not appear to be as effective in contributing to the skills development by the local workers.

Land, in a 2007 review of the use of technical assistance (TA) personnel concludes that a key determinant of TA effectiveness is country management of that staff member[36]. Decisions about recruitment and their role should ideally be a country responsibility and once appointed, the TA personnel should be unambiguously accountable to the host organisation they serve. In countries where the pre-conditions for successful management of TA personnel are largely absent, interim actions are needed to help empower country partners based on greater accountability of TA personnel to host country supervisors.

There also needs to be equal focus on ANGOs contribution to partner's own capacity development processes, as there is on them supporting service provision, with this reflected in the budget. Baser and Morgan argue that it is not unusual for NGOs to assume that supporting capacity development requires no special individual or organisational skills or dedicated internal units. Yet capacity development requires expertise in areas such as political analysis, management theory and practice and change management, skills that have frequently been in short supply in such agencies. The

implication here is that any TA personnel, whether living in country or traveling in, needs to be highly skilled and work from an explicit theory of action with an understanding of how different models of change affect the chances of success in capacity development.

Implications for PASHIP

The five PASHIP projects based in PNG involved partnerships with Australian NGOs and two also had New Zealand partners (COMPASS and Save the Children). Four of the projects had their ANGO staff based overseas while the Lusa Numini Project based at Save the Children (SCiPNG), a PNG NGO, was a little different. SCiPNG is a joint program of Save the Children New Zealand (SCNZ) and Save the Children Australia (SCA), who are members of the International Save the Children Alliance. They centered the full management of their program at SCiPNG by integrating the ANGO and local management responsibilities into a role managed by an expatriate manager.

A number of issues arise for PASHIP from the literature and interviews.

Effective support for in country NGOs

There has long been debate in the Pacific as to how ANGOs can best support local implementing partners. Some PASHIP projects have largely provided monitoring and support of the program from a distance, with strategic short term visits by technical advisors (TAs). Others have placed an expatriate mentor in country and in Save the Children's case an expatriate manager.

A number of issues are being weighed up in this debate:

- The first is how to accurately judge the level of assistance needed in country, especially if it is the first time for the NGO to work with AusAID.
- The second is estimating effectiveness in advance, in terms of costs versus benefits. In-country expatriates are generally more expensive than using Australian based monitoring, but potentially they are able to provide constant highly skilled mentoring, training and support.
- The third is about the best way to contribute to local capacity development without creating dependence. If the organisation is not strong, asking it to take on the complex and stringent AusAID accountability requirements without close support can make the organization vulnerable, slow to meet objectives and create unfair stresses on staff. However having expatriate staff in country means unless they are skillful in avoiding it, they risk local people relying on them and not extending themselves, meaning that capacity is not developed as much as it could be.

The Mid Review noted a lack of connection between some PNG based projects and their Australian Based management. There are a range of variables that influenced the support given by PASHIP ANGO's and are likely to have contributed to this lack of connection.

a. Approaches to management

Each ANGO managed their project differently in terms of how tightly they monitored development, whether they used in country expatriate staff or relied primarily on local staff with regular visiting from Australia and how much expatriate volunteers were used. Annex two and three summarise some of these differences. The records indicate that all PASHIP projects used some in-country expatriate support.

- All projects placed expatriate staff in a variety of roles in country at the start of PASHIP. Two projects had short (up to 12 monthly) clinical TA personnel (4AS, ENBSHIP), and COMPASS had a volunteer doctor. Save the Children had a manager and M and E worker and STIMP an M and E adviser who had lived in PNG forty years.
- Two projects (STIMP and Save the Children) maintained this expatriate in country presence over most of the project.
- For 4AS. having TA personnel or missionaries in-country in the last century for long periods, they could see a danger of slipping into this same pattern, one they believed was no longer appropriate in the 21st Century. They focused on avoiding this and slowly worked towards building the skills of local managers, with most support coming from Australia.
- Volunteers contributed to PASHIP. ENBSHIP used two VIDA volunteers across the program, 4As had an M and E volunteer who worked with a number of health programs and provided some time to PASHIP, and COMPASS had a volunteer doctor who was mentioned above. While expatriate volunteers have played important roles, organisations do not always have control over their quality. It was noted by one ANGO that volunteers were valuable in supporting community components but there was a danger if the organisation relied on using them to manage a full project, as they may not have the skills or experience needed.
- In addition a range of short term consultants were brought in by the ANGO's, for example to assess security and to assist with building projects.
- Four projects had 3-4 visits each year from STI specialist personnel. The fifth, ENBSHIP, as part of a strategy to build sustainability, purposely used NDOH and local skilled staff for their clinical expertise.
- ANGO staff all visited at least twice a year and frequently more often. In addition there were a number of examples of the ANGOs staff travelling into PNG especially to respond to unexpected project difficulties including deaths, illnesses, epidemics, tribal fighting, resource shortages and complex building tasks.
- Projects frequently mention difficulty in recruiting competent people for ANGO and local positions with some experiencing quite long gaps in local positions, until suitable candidates were found. The shortage of a suitable pool of people was exacerbated by recruitment from other PASHIP partners.
- Interviews with PNG based PASHIP partners found that they were generally happy with support from their ANGOs. All recognised that their skills were significantly stronger than when they first started. Geraldine Wambo from ENBSHIP explained: '*Burnet control things but they do get our input and there is always room for discussion regarding whether*

something is feasible to implement. We usually talk weekly via phone or email and they come quarterly to visit so we feel like we're part of a team. In our culture face to face is much better. I would like them to hand over more responsibility so I can learn more. On the other hand it's good for them to be on top of things as there is an issue in PNG of corruption so being honest and transparent and doing things openly is good learning'.

Staff from four of the five projects commented that to effectively manage a complex new program it was important to have a skilled in country person (TA) to support local managers in at least the first years of the project. This conclusion was not so much a reflection on the skills of local managers, because there were a number doing excellent work, but the complexity of managing a reasonably large AusAID project. STIMP and Save the Children purposely built in ongoing in country support that has so far lasted four years. Burnet and COMPASS had early expatriate support but now feel that it would have been preferable to have a longer expatriate presence to assist managers set up systems (especially M and E) and support them as they gained confidence. It should be noted that the projects that specifically built in ongoing monitoring and evaluation resourcing were able to gather more accurate data from the start of the project. Three staff commented that the person providing TA does not have to be in a management role themselves, but are primarily there to provide explicit capacity building training and mentoring. The length of support is dependent on the skills of the management team they are working with and the complexity of the task, but is likely to be needed across a number of years.

b. Level of ANGO staff capacity building skills

Whether a local or expatriate is employed as the technical advisor the level of their capacity building skill is important. A highly skilled worker can be far more effective than an inexperienced one. Philip Gibbs from STIMP argues that it does not have to be an expatriate playing the TA role, but to find local people with this level of expertise and attitude is difficult because such a person can easily find a highly paid job in the PNG resources sector. It is not possible as an outsider to accurately comment on the level of skill of workers and especially ones in the past but the five projects will be aware of the difference it makes to have someone who is highly skilled on staff.

The literature identifies that part of the capacity building task is to bridge cultures in terms of management learning and especially to create opportunities for more strategic or 'higher level' capacity building without imposing ANGO agendas. This has to be done whilst meeting donor requirements and empowering PNG NGO's (rather than disempowering and increasing their dependence with unrealistic monitoring and reporting demands they cannot meet).

Each of the PASHIP projects clearly articulated from the start of the program that capacity building would be needed for staff to effectively manage each project and community health workers and general practitioners to improve their STI skills. Consequently in an appropriate response to the learning in the literature, a range of capacity building strategies was built in from the beginning. Many of these are discussed in Section One. One approach with staff used across most projects was giving attention to strengths. Affirming good work and vision was seen as far more effective, than

focusing on limitations and gaps. Strengths based practice is particularly effective in Melanesian communities as it is a culture that avoids face to face criticism. This does not mean that problems should be ignored but they do not become the total focus and make those workers who are in the process of building skill and capacity feel bad about their work. Such criticism can deeply undermine confidence, and confidence is one of the most critical elements of capacity.

Feedback was also sought from the PNG PASHIP organisations regarding the capacity building work contributed by their ANGO clinical partners. There was general agreement across all four projects using international STI experts that once each party had dealt with the many cross cultural differences, the mentoring, training and supervision had been most beneficial and provided the basis for many local workers to now be able to train their peers. This is a credit to both partners and to the personal and professional qualities of all PASHIP staff.

c. Continuity of support

The significance of PNG and Australian worker continuity should not be under estimated, particularly in terms of maintaining organisational knowledge, building trust, and providing staff with a safe environment for reflection and difficult problem solving. The 2008 ANCP Pacific Cluster Evaluation Report notes that staff turnover poses challenges because it requires the reestablishment of trust and working relationships, as well as an 'education process' for the new officer to ensure their appreciation for the project context, purpose and strategy[37].

In a five year long project it is to be expected that there will be some turnover of staff but in PASHIP this has been a significant element. Three projects (STIMP, SAVE and ENBSHIP) had relatively consistent management with little staff turnover at the ANGO co-ordinating level or with PNG staff. Two projects (4As and COMPASS) had a number of people filling the ANGO co-ordinator's role and by the end of the fourth year they both had almost totally changed teams in PNG. This lack of continuity impacted on the achievement of goals.

Three projects had used volunteers at some point in their five years and all were pleased with their contribution. However volunteer contracts usually only cover a year or two and so inevitably also contribute to the impact of staff turnover, particularly if they are acting as the main in country link to the ANGO.

Staff turnover, and death especially at management level, whether in or out of country, can be quite destabilizing. Avoiding it is not easy but because of its negative impact it is important that projects that were particularly impacted review what has happened to see if it can be minimized. Turnover is complex but may relate to issues around job satisfaction, conditions, management or payment.

Continuity is not only relevant to intra-project issues but also between program cycles. To maximise sustainability of benefits, particularly in terms of PNG capacity to reduce the prevalence of STDs and thus HIV, consideration should be given to using second and third phases of programs to build

on the successes of early phases rather than seeing them as quite independent. While it is understandable that donor agencies change policies from time to time, the risk of their efforts being wasted because of unfinished work is very high. In this case, PASHIP has made a substantial contribution to the development of capacity in responding to STDs in PNG, but to ensure this capacity translates into sustainable reductions in STDs, continued effort is required at minimum until the STD rates have been substantially reduced in all sites and the GoPNG is able to apply new processes across the country, building on existing partnerships and lessons learned

A number indicated that if there was another round of funding they would not need the level of support that the ANGOs had provided during this phase of PASHIP. This did not mean they wanted to totally 'go it alone'. Rather they looked to a down-scaling of support and in COMPASS's case the support to go more to the PNG NGO that would manage COMPASS rather than directly to COMPASS.

The mid review feedback that that there was a lack of connection between some PNG based implementing partners and their Australian based management was taken seriously by the ANGO's, so that by the start of 2012 there had been considerable improvement in these relationships.

Does the nature of ANGO support have significant impact on quality and results?

From the interviews, particularly with PNG NGOs, the annual reports, observation and literature, it is clear that the nature of ANGO support provided to PNG partners has a significant impact on quality and results. The importance of this support is in direct relationship to the strength of the NGO they are partnering. Where the organisation is not experienced in managing a large donor funded project and is relatively low in capacity, the support of the ANGO is most important. Where an ANGO is slow to respond to this need or does not have the capacity themselves the project may fall behind. The following gives an understanding of the most crucial tasks the ANGO fulfills.

1. **The ANGO helps set the philosophy of development for the project.**

ANGO facilitation using participative strategies is essential to help workers build the culture of the organisation, conceptualise their task, and identify their philosophy of development; the key values that will drive their practice.

The way the ANGO enters initial discussions on design with potential PNG partners, makes clear its preferred developmental style and theory of change. For example, ENBSHIP team leader Geraldine Wambo explained that Burnet Institute made sure the initial design was done in the province with the government and leaders so that from the beginning people were talking about 'our project' even though the province was not implementing all the activities. From that start Burnet Institute worked from a strengths-based approach and refused to carry out roles that the province was capable of doing. For example, they refused to provide speculums because the province could procure them themselves through normal health provisioning systems.

ANGO involvement can encourage staff to use locally adaptive learning strategies so that across the organisation monitoring and evaluation tools are established early, regular reflection and analysis is done together, and workers make sense of and feel they can respond appropriately, to internal and external change. Caritas' work is an example of this. It emphasized the importance of using a participatory reflective approach to STIMP's work by establishing a resource unit. Staff skilled in facilitation encouraged PASHIP staff to meet regularly, to analyse project data and together assess what was being achieved. They shared decision-making around the day to day running and broader directions of the project.

2. Overseeing the project cycle and problem solving capacity

The ANGO anticipates timelines, tasks, and accountability requirements as well as providing a back-up problem-solving capacity. This assists local staff to build skills to manage the day to day program cycle. The level of support early on in the program is particularly important as it frequently takes time for a project to gain momentum. Establishing a project requires sophisticated leadership and management, as well as skillful politics. Unless ANGO support is empowering, culturally appropriate, and continuous, it is easy for an NGO to feel overwhelmed in this early phase.

The ANGO role is frequently bureaucratic and time consuming with attention to detail needed and considerable control maintained. Central to this role is helping to sort out program difficulties. Each project has a range of examples as to how important this role is. Save the Children worked with staff to find ways to cope with work overload created by huge client demand. STIMP staff were asked how Caritas could add value to support the Catholic Health Services run a new STI program. They replied that because Caritas is not involved in the day to day running of the service, from their distance, they are able to give a fresh response to difficult issues. COMPASS project staff had to manage the death of the project leader and the ANGO had to step in to provide strong support at this time. 4AS found that it had major difficulties managing two large building projects and so the ANGO employed a building expert to visit regularly over some years to assist local staff manage this phase. ENBSHIP found that despite strong commitment from the Provincial Government, it did not have sufficient capacity to audit clinics. The ANGO worked closely with ENBSHIP staff to find ways to solve the problem. When projects are based in contexts such as PNG, where unexpected happenings occur; illness, fighting, disasters, staff turnover, the ANGO has to be always ready to respond to the unexpected.

3. The ANGO acts as a broker between AusAID and the PNG project

The ANGO acts as a broker interpreting AusAID expectations into PNG concepts and PNG practice into AusAID outputs and outcomes. AusAID has its own donor and government language that has to be interpreted, its reports need to be written in English, (often at least a second language for many PNG PASHIP staff), and it works to a western linear planning framework. All of this work requires forward planning and anticipation of the issues AusAID will want to clarify. The ANGO has a key role in preparing the NGO to respond. If they are not keeping a close eye on these agendas the NGO can fall behind. The ANGO also has to speak to AusAID about issues that the local PNG partner might

find hard to broach; issues of practice dilemmas, requests for special consideration and difficulties with funding or culture.

4. Overseeing Quality Control

The ANGO oversees quality control, especially in terms of compliance on human resource management and financial procedures and evidence of quality of outcomes. It needs to accurately anticipate project capacity and avoid over reaching and spreading capacity too thinly. It also has a major responsibility in getting a robust monitoring and evaluation system in place.

In summary, ANGOs might benefit from sharing experiences regarding their role, what they have learnt and what they believe is good practice. While every project has its own context there do appear to be some common themes emerging from PASHIP's ANGO work. In particular:

- That many ANGOs who are working with new or small indigenous organisations have concluded that it most effective to place continuous highly skilled personnel in-country, with excellent capacity building approaches. It is recognised that this approach is hampered by being relatively expensive.
- That if there were a second phase of funding and existing staff stayed on, a rethinking of how the ANGO role should be modified would be appropriate, in order to affirm and build on the capacity development achieved to date by PNG organizations and individuals.
- That much effort needs to go into contributing to the capacity development processes of local staff, especially an organization-wide, continuous approach of adaptive learning that challenges staff to constantly be thinking not only how they roll out a service but what they are learning about the effectiveness of the strategies they use. Alongside this, strong monitoring and evaluation strategies built from staff discussion and learning, are also critical.

SECTION THREE: WHAT IS THE IMPACT OF STAND-ALONE VERSUS INTEGRATED CLINICS IN STI TREATMENT

The strengths and weaknesses of integrated versus stand-alone services is an issue dating from the 1960's. It is addressed in indigenous, ethnic and sexual health literature. More recently it is part of a much broader international debate about vertical and horizontal programming that has come from a substantial rise in external funding for priority health interventions and especially those to achieve Millennium Development Goals. This paper reviews definitional issues and looks at the international debate before considering the specific evidence around stand-alone and integrated STI services.

Literature

Defining 'integrated' and 'stand-alone' approaches

The definition of "integrated" approaches is much more complex than one would first imagine and reflects the complexity of health service systems. Dehne et al argued in 2000 that there was a lack of uniformity about what is meant by integration and in the last decade this situation does not appear to have improved.[38] To start at the simplest point, literature exploring the linking of STI and other services defines 'integration' as:

'*offering a range of services that could meet several needs simultaneously, usually at the same time, same venue and through the same provider*'.[39]

So integrated approaches focus on the individual, use generalist staff who deal with multiple symptoms and conditions, respond to user needs as well as demand and are more holistic in scope, often with inter and intrasectoral links[40].

Some writers see that integration is not just about whether one provider such as a lone community health worker, is providing the service but that integration can happen in the one facility but with a range of providers. Church et al refer to

- 'Provider level integration' – meaning a provider offering a full range of services, or
- 'Facility level integration' where the client is referred to more specialised providers within the same facility[41].
- In practice though, integrated services are not always offered under one roof. If they are provided from a different site, strong referral systems are required to ensure that clients receive high quality service[42]. This is called 'Vertical' integration.

Beyond this notion of service provision comes a range of more complex notions of integration. A recent UNICEF and World Health Organisation publication argues that integration of health services has several dimensions[43].

- Integration 'across time' relates to continuity of care across the life cycle.

- 'Gender' integration refers to encouraging greater engagement of men in sexual, reproductive, maternal and child health prevention and care services, and
- 'Horizontal' integration relates to providing a range of different sexual, reproductive maternal and child health services at the same facility with the aim being to improve access to important services as well as efficiency and effectiveness.

Atun et al in a 2010 systematic review of the evidence on integration of targeted health interventions into health systems identifies yet another way of considering integration. They explore how intervention elements are integrated into general health system functions of governance, finances, planning, service delivery, demand generation, monitoring and evaluation[44]. Their analysis showed few instances of full integration of a health intervention or where an intervention is completely not integrated. Health systems combine both non integrated and integrated interventions, but the balance of these interventions varies considerably.

The literature also has a wide range of suggestions about what the HIV/STI services should be integrated into. Some focus on family planning, others tuberculosis, reproductive, maternal and newborn child and adolescent services while others are referring to any primary care service. Integration can be STI services integrating with another such as HIV or HIV service integrating with STI. Since the 1994 International Conference on Population and Development, the configurations receiving most focus are those integrating STI and HIV prevention with Family Planning and maternal and ante natal care.

There are two main rationales for integrating services[45]. First, many clients have needs for several services simultaneously, and second, there is an expectation providing integrated or linked services can be more efficient for the health service than providing services at separate visits. Shelton and Fuchs note that in order to justify integrating services it should fulfill certain principles of integration[46]. First the interventions being integrated should both be effective. Second the interventions need a common field of operation (e.g. within clinical services or community empowerment) as well as common target audiences. Finally there should be synergies between the two interventions that enhance the impact of both. In each context, the circumstances may differ, so decisions about the appropriateness of integrated approaches will need to also differ. For example, health workers are often too poorly paid and lack training and supervision in developing countries and it is important to take care before adding yet more duties to the typically over-burdened primary health worker.

In terms of defining stand-alone or vertical approaches, Atun et al argue that stand-alone programs focus on the population need for a particular disease, use specialist staff (who generally manage one condition), typically have separate administration and budgets, dedicated resources and operate in a project mode with clear objectives to be achieved in defined and often short time scales[47]. Stand-alone services can take many forms. They may be defined by the type of service provided (e.g. sexual health), by the population they serve (e.g. sex workers) or by both. In practice

few programs are entirely vertical. Most health services combine both vertical and integrated elements[48].

Recent international concerns about vertical and horizontal integration

As mentioned, the issue of integrated versus stand-alone STI services is part of a much broader international debate. In the last decade, in a bid to address worldwide health risks such as HIV, malaria and tuberculosis most aid has been allocated to disease specific projects (vertical programming) rather than to broad based investments in health infrastructure, human resources and community oriented primary health care services (horizontal programming)[49]. Atun et al also argue that another reason for the re-emergence of stand-alone programs is that general health services in low income communities have often failed to deliver high priority interventions, encouraging many multilateral organisations to invest in disease specific health programs[50]. While attempting to reduce prevalence of these diseases, there have been unintended negative consequences. For example, De Maeseneer et al report that while HIV clients in some countries receive free care, others with more routine diseases receive poor care and still have to pay[51]. Salaries of health care providers working for donor-funded vertical programs are often more than double those of equally trained government workers in the fragile public health sector. This lures government workers to the higher paying vertical programs creating an internal brain drain away from under-funded primary health care clinics that care for all diseases which take many more lives than HIV, tuberculosis and malaria. Because of these growing discrepancies, a major campaign has been launched by four international health organisations arguing that a new global strategy is needed to reinforce community focused primary health care in developing countries[52].

A major theme emerging from studies exploring the advantages and disadvantages of integrated and stand-alone clinics is the lack of clear evidence to make very clear conclusions about whether one is more effective than another. It has taken a decade to develop research that starts to give guidance as to whether integration is wise and how it should happen.

Arguments for and against Stand Alone Clinics

Atun et al assert that the arguments for stand-alone clinics are mainly driven by the assumption that concentrating on a few well-focused interventions is an effective way to maximize the effect and time response of the available resources rather than waiting for changes in the health system so that delivery of better services will be viable[53]. The arguments against stand-alone clinics tend to assert that they are value-driven, often have limited chance of sustainability and have negative spillover effects on health systems and non-target populations.

The literature on stand-alone clinics is much smaller than on integrated services. The following arguments for and against stand-alone services are presented by Atun et al.

Arguments for Stand-alone Clinics

1. **Greater service specialization and concentration:** The most important rationale for stand-alone clinics is driven by the assumption that concentrating on a few well-focused interventions is the most effective way of maximizing impact. The assumption is that it would take too long to strengthen the health system to deliver better services.
2. **Increased profile for a high priority disease:** A stand-alone clinic focusing just on a single disease raises its profile and the resources spent on it.
3. **Better accountability:** Stand-alone clinics make clear who is responsible for delivering and financing the service and allow greater transparency.
4. **More rapid results in weak health systems:** this is the case simply because there is not an attempt to strengthen the whole system.
5. **Better chance of success in weak states:** Where health systems are disintegrating, stand-alone programs may be the only means of ensuring the delivery of at least one priority service.

Arguments against Standalone Clinics

1. **Value-driven:** Vertical programs have been extensively criticized for lacking an empirical foundation and excessively focusing on efficiency gains. Many are externally driven and top down in approach so that local people do not feature significantly in the planning process. They can distort priorities, undermine local ownership and the responsiveness of local health services to the needs of service users.
2. **Negative spillover effects:** They are criticized for leading to service fragmentation, cause waste and inefficiency, crowd out prevention and access to general services for the majority of the population.
3. **Reduced chance of sustainability:** It is argued that stand alone clinics encourage duplication and inefficiency and may over-burden staff with multiple reporting channels. They may create unjustifiable differences in pay and status leading to employee dissatisfaction in other services and they may not be sustainable once specific funding finishes.
4. **Groups opposing health system reform:** Stand-alone clinics can create vested interest groups who may obstruct later reforms for integrated services.
5. **Discouraging comprehensive approaches:** They hinder the development of comprehensive approaches needed to tackle social inequality and create fragmentation.
6. **Responsive to disease and not the users of services:** If the disease being focused on has multiple causes (e.g. someone with HIV is taking drugs, has TB and is engaged in sex work) the client may not be able to get a full range of services in one place at one time.

Atun conclude that stand-alone clinics make sense in three specific circumstances. [54]. In particular

- where rapid response is needed to cope with public health emergencies such as a flood or flu epidemic or

- where the service is urgently needed but the health system is too weak to provide it through regular channels or
- the target client group are vulnerable and may not be easily accessible because of stigma, geographic barriers and so targeted interventions are needed.

Interestingly, in the case of PASHIP, while it was envisaged as an "emergency" response to a particular type of disease, many of the approaches taken by AusAID, NDOH and the partners, were not consistent with an emergency situation, but rather were oriented to systemic and sustainable improvements in capacity and practice.

Arguments for and against Integrated Clinics

As indicated, the literature exploring integrated services is quite extensive. One of the most detailed is by Church et al who look at 44 studies written from 1999 - 2009 that examine the effectiveness of integrating family planning and STI/HIV services across 27 countries[55]. Overall they conclude that presenting solid conclusions about the most effective models of service integration is difficult partly because of the context-specific nature of the effectiveness of health care systems but also because of limitations within and across the studies providing the evidence. Most studies in the review focus on the small scale picture by evaluating specific interventions rather than models of care.

In terms of client satisfaction, generally clients reported appreciation for being able to gain access to a broader range of services within one clinic or by means of a single visit to one provider. Because of courtesy bias, demand for services may be a better indicator of client satisfaction than exit interviews. Some programs reported increased service uptake after integration. Service integration has the potential to lead to a greater breadth of care, that is, increase to the range of care through cross utilisation of services and reduced need for referral. It may be particularly helpful for reaching clients who otherwise might not seek HIV/STI services.

A common concern regarding integrated services is that clients would boycott services that attract people living with HIV/AIDS (PLWH), men and sex workers. Although no evidence collaborates these fears, Church et al report that the findings for reaching non-traditional clients are mixed, showing variations according to country and program design. Other evidence suggests that integrated services are not effective for young people who fail to use services for a variety of reasons. Although reports from specialized services were not reviewed, the authors conclude that evidence demonstrates that reaching these groups may be best done by targeted facilities such as youth friendly clinics, male sexual health services and outreach programs for sex workers.

The weight of evidence demonstrates that integrated services offer a less stigmatizing environment than do stand alone STI services by reducing the risk of social stigma for clients. Clients appreciate the anonymity of an integrated service but this value is dependent on the degree to which services are able to maintain confidentiality.

Integrating a new service component into an existing service has the potential to improve quality of care by increasing the breadth of care provided, or to diminish quality as breadth is achieved at the expense of depth[56]. Church et al found that there was a lack of comparisons between integrated and specialized services in terms of clinical quality to draw any conclusion about whether quality of care improved. One study showed that although providers reported greater continuity of care and reduced duplication, disjointed provision of services remained as clients had to wait in separate lines for different services. So integration can be achieved by having the one building, but clients can be still waiting for different elements of the service if they have more than one illness.

Studies from around the world identify poor or insufficient training and motivation (linked to poor supervision and management), heavy workloads, staff burnout and lack of incentives as important constraints in the provision of integrated services. These problems may be a result of increased demand after service integration, or the provision of a more complex package of services, for which providers may be poorly trained and equipped. Despite these constraints a few studies have documented program improvements and successes where service integration is properly supported and supervised and sufficient time is allotted to deal with procurement, reporting and training requirements.

In 2004 a study by the Population Council in Zimbabwe and Kenya showed that many MCH/FP clinics said they were providing STI and /or HIV services but in reality few clients were receiving these services[57]. Fewer than half of facilities had appropriate equipment, drugs, checklists or client records and the majority of service providers had not attended a refresher course on STI and HIV services. The Population Council concluded that significant systems-level re-organisation is usually needed (e.g. training, guidelines, equipment) if integrated service delivery is to be programmatically institutionalized and sustainable. A major reason why staff said they did not systematically assess and council MCH/FP clients on STI/HIV were the lack of a checklist and record keeping system that would facilitate an integrated consultation. Following the introduction of a checklist the vast majority of clients received systematic counseling on key STI/HIV topics.

In 2010 The Population Council in reviewing 40 studies on integrating services concluded that[58]:

- there is often a need for Family Planning Information to be integrated when people are receiving STI care,
- Offering services in one place, at one time and by the same provider may generally be preferred by clients, ensuring their needs are met in one visit. Referring clients to services elsewhere may be more feasible and less costly but this may reduce effectiveness in ensuring clients actually receive services.
- Job aids, focused training and regular supervisory feedback are key for improving providers' ability to provide more comprehensive services,
- Concerns about over-loading providers are real, but rigorously testing and costing carefully selected combinations of service can demonstrate which interventions are feasible and which lead to increased service use.

The Population Council especially looked at the integration of HIV/STI and Family Planning services in Kenya and South Africa and found that clients and providers were pleased with the service and quality of care improved significantly.

In 2004 the Population Council developed guidelines for integrating STI services into other sexual and reproductive services in primary health care settings [59]. By 2006 they worked with the Kenyan Ministry of Health to develop national guidelines and then evaluated their role out. The intervention included revision of the original training materials and job aides, training of health providers, modification of MOH registers, strengthening commodity logistics, enhancing supportive supervision as well as regular monitoring. Overall the results showed that integration of STIs/RTIs into reproductive health services is feasible, acceptable to clients and providers. There were significant improvements in the quality and range of care in all four of the family planning, antenatal, maternity/delivery and postnatal/postpartum care services observed.

In summary the main arguments that come from the literature exploring the strengths and weaknesses of integrating are:

Arguments for Integrated services

1. **People frequently need more than one service:** so a broader range of services is able to reach more people,
2. **Clients respond positively to integrated services:** being treated on one site saves time and travel, and they feel less stigmatised because people cannot identify they are going for a STI service.
3. **Integrated clinics see many people who may not come for STI diagnosis:** but infection is diagnosed and treated,
4. **Integrated into the existing health system:** improves co-ordination and support of the existing health system,
5. **May be cost effective and efficient:** use existing staff, equipment, IEC materials, with some upgrading, avoids duplication,
6. **Effective for non educated in rural and remote areas:** where stand alone clinic for one illness is not cost effective, and is stigmatizing,
7. **More able to be sustained:** when specialized funding stops.

Arguments against integrated services

1. **May increase workload**: because of greater public access and staff are managing a full range of illnesses,
2. **Service quality and staff motivation are compromised:** if staff do not have sufficient STI clinical skills. Staff need to be trained in STI management and be open to talking about sexual issues without discrimination.

3. **Vulnerable groups may not want to attend:** as they may feel different or discriminated against .
4. **Staff skilled in STI may be diverted into other clinical areas**: unless the clinical system prioritises STI to make sure there is a consistent service provided.
5. **STI up-skilling:** The most suitable person to drive the continual STI up-skilling may sit low down in the line of authority and find it difficult to initiate training or discuss issues around quality with the provincial diseases officer. Money may not be put aside in the budget for training.

Level of integration in PASHIP

If we take the definition of integration that is commonly used in the literature: *'offering a range of services that could meet several needs simultaneously, usually at the same time, same venue and through the same provider'*, and compare it to PASHIP projects the picture is rather complicated.

Organisation	Stand alone or Integrated	Finances	Governance	Service Delivery	Demand Generation
Save the Children	An STI clinic in the same venue as community health clinic (integrated physically) but separately managed	Stand alone	Stand alone	Integrated	Integrated
4As Begabari	A standalone STI clinic working alongside standalone HIV clinic with referrals between them	Stand alone	Stand alone	Stand alone	Integrated
ORO	STI clinic integrated into hospital	Stand alone	Integrated	Integrated	Integrated
STIMP	STI clinic integrated into hospital/clinics work and into antenatal work but Stand alone men's clinic provided	Stand alone	Integrated	Integrated with stand alone men's clinic	Integrated
ENBSHIP	Provincial clinics with STI integrated and where possible consultation in a separate room	Stand alone	Integrated	Integrated	Stand alone
COMPASS	Provincial clinics with STI integrated and where possible consultation in a separate room	Stand alone	Integrated with exception of STI specialist service Friends	Integrated with exception of STI specialist service Friends	Stand alone

As the literature points out, services are rarely totally integrated or stand alone. They may be largely one form but have components of the other. Most PASHIP STI services are physically integrated with a clinic or hospital. 4As Begabari is the only stand alone service but even it is sitting next to a HIV service where referrals are made back and forth. 4As felt that a stand-alone service was appropriate in an urban setting where education levels were higher than the average population and issues of discrimination were less likely to be a problem to service access.

All services have stand-alone financial components because the handling of money is done by ANGOs and not integrated into other services. Governance is mostly integrated but Lusa Numini Project while working in a physically integrated clinic manages the STI service separate from the rest of the clinic. In terms of demand generation or activities to raise STI awareness, most are integrated with the rest of the services being provided but ENBSHIP and COMPASS are seen as stand-alone because the work is not integrated and based from the clinics where STIs are handled, rather the two PASHIP services run this component themselves.

The November 2011 PASHIP PRG meeting noted that another form of integration that could be encouraged was building stronger work links between clinical and community empowerment elements of projects.

Feedback from the interviews with PASHIP stakeholders indicates that there is strong support for integrated STI clinics in PNG, especially in remote rural areas but also recognition that at times stand-alone clinics have their place. STIMP point out that establishing men's clinics was a move to a stand-alone service within an integrated model. The men's clinic was initiated so that the men did not feel uncomfortable about seeking service by attending outpatients and having to sit with women and children. Now more and more men feel so comfortable about attending the clinic that they bring their wives. STIMP, ENBSHIP and 4As recognise that integrating STI services into antenatal services is an important way of diagnosing STIs. Lusa Numini Project has learnt that while working towards integration of services has benefits, there is still a need for some separate facilities, e.g. for those who are most at risk. It may be inappropriate for mothers and children attending some clinics to be in waiting rooms with sex workers and men who have sex with men. Feedback has consistently confirmed that separate facilities are more likely to encourage all parties to attend services. 4AS have recognised that a stand-alone clinic such as Begabari may be suitable for urban areas where there are sufficient people attending to warrant a specialized service, where people can easily access community health care for other illnesses, and a more educated populace means people do not feel stigmatised to attend a specialized STI service.

Generally there is broad agreement within PASHIP that integrated clinics are most suitable:

- in rural area where people do not have easy access to general health services and so look to any health service to meet their broad health requirements,
- where there may not be enough people with STIs to warrant a fully staffed clinic and
- where stigma causes people to feel ashamed to attend a specific STI service.

Recommendations

1. That AusAID consider using the World Health Organisation's 2009 NGO Code of Conduct for Health Systems Strengthening as part of their selection criteria for future health projects.
2. That the final evaluation includes an assessment of how well PASHIP projects were integrated into the NDOH system.
3. That AusAID take seriously the learning that relationship-building is crucial to successful projects in Melanesia but that this is a slow process. The longer the positive relationship, the more partners have a history of trust that they can use to achieve capacity development and to solve problems together. Funding of Melanesian programs needs to actively encourage continuity and longevity so that a partnership history is built. Any ongoing funding should seriously consider building on existing projects rather than bringing in new organisations.
4. To learn more about the most effective way to establish high quality STI services, AusAID give thought to extending the learning of this project beyond the completion date to do a small evaluation in 2014 to evaluate how well each of the models has contributed to sustainability.
5. In assessing applications for future STI funding as well as the strength of the plan the following need to be considered
    - The strength of the building blocks of the organisations involved,
    - The starting point of the project,
    - The potential for partnership development,
    - The likely demand for service
    - The sustainability of the proposal,
    - How locally adaptive learning has been included in the design and especially whether sufficient planning, monitoring and evaluation time has been incorporated.
6. In any new AusAID program consideration be given to STI work being integrated into HIV work.

Annex 1: Contacts

Organisation	Person	Contact	Date of contact
4as	Mildred Laksen Marcia Kalinoe Robert Luna	Workshop on M and E	9/11/11
	Julieanne Stewart & Beth Sneddon	Conference Call	11/1/12
	Jenni Graves (Albion St)	Phoned	16/1/12
Save	Dr.Rana Prahalad	Phoned	19/02/12
STIMP	Philip Gibbs	Conference call	12/1/12
	Marie Mondu		12/1/12
	Justine McMahon	Phoned	15/1/12
ENBSHIP	Geraldine Wambo	Phoned	11/1/12
	Andrea Fisher	Visited Burnet Melbourne	5/1/12
COMPASS			
	Helen Smith	Phoned	20/1/12
	Merilyn Gairo	Phoned	25/1/12

Annex 2: Range of Management Support in each project

Save the Children	• a temporary expatriate management position for 5 months, • then an expatriate project manager who was promoted in 2009 and replaced by another, both of whom are still involved, • an M and E in country advisor who worked alongside staff for 6 months and • a range of external and NDOH clinical technical advisors including one international STI expert who visited consistently across the project, twice a year to start with and now once a year.
STIMP	• in country M and E technical adviser (an expatriate who had lived in PNG for 40 years) working with the program for most of the first four years, and local national co-ordinator and M and E adviser, • Team of national and international STI and laboratory experts who visited consistently across the project and • quarterly ANGO monitoring visits from the same person throughout the program, with email and telephone contact
ENBSHIP	• An expatriate in country clinical advisor for the first 12 or 18 months, and • a short term in country clinical advisor for a further five months, • two VIDA volunteers carrying management roles across 4 years, and • members of the ANGO team (BURNET and IWDA) visiting quarterly as well as email and telephone contact with at least one consistent for the first four years and a senior manager consistent right through • other visits from technical staff such as finance advice. • An external clinical ANGO was not appointed as Burnet wanted to use NDOH resources as much as possible and also had backup from the clinical TA .
COMPASS	• an expatriate volunteer medico who provided clinical and management support for the first 2 years, • Canberra Sexual Health Centre visited regularly across the project and • a range of short term TAs provided specific training and advice (e.g. security). • The two A/NZNGO's SHFPA and NZFPI visited at least quarterly with continuity of one person for 3 years replaced by another when going on maternity leave, as well as email and telephone contact
4As	• An Australian medico appointed as a PASHIP clinical co-ordinator in country for 12 months, • 2 short term technical advisors, • Albion Street visiting quarterly to mentor, train and run workshops , • an expatriate TA (funded through ABM) skilled in building construction visiting many times a year, • ANGO staff visiting quarterly (a number of changes) as well as email and telephone contact • M and E volunteer doing some work for PASHIP

Annex 3: ANGO Management Approaches in 2012

ANGOs have a range of management approaches that have been created in response to the capacity of the staff and organisations they are overseeing. These approaches varied in intensity across the project but the following describes what they look like in 2012.

Burnet Institute: Closely manages the ENBSHIP project, handling main management responsibilities from Australia (finances, resources, manual writing, monitoring etc) but a local manager in PNG handles the day to day issues with close support from Australia. They also have used VIDA volunteers to provide support in finance and monitoring and evaluation. Regular contact is kept between countries via email, phone and visits.

ABM: Closely manages the 4AS project, with a full time person based in Australia handling main management responsibilities (finances, resources, manual writing, monitoring etc) but local PASHIP manager in PNG increasingly handling day to day issues with close support from Australia. Regular contact is maintained via email, phone and visits

Caritas: The ANGO team leader provides STIMP with leadership development/support, keeps track of financial spending and liaises with AusAID. She has consistent contact via email, phone and makes regular visits. Most other things, especially clinical work are managed by Catholic Health Services. Justine McMahon describes her role as fairly hands off, especially because the CHS has been running programs for decades and has strong clinical expertise. A local women is employed to strengthen the monitoring and co-ordination role. Two Caritas workers, one a local women and the other a New Zealander who has lived in PNG for 40 years have run a resource unit to the project and CHS. They have driven the action reflection process, researched, and contributed to the capacity building of PASHIP staff.

SHFPA: closely oversees the COMPASS project as the Partner NGO does not have experience in handling AusAID requirements. A local co-ordinator, fairly new to the position, manages the day to day work of staff in the office. The ANGO closely supports the manager and keeps track of finances. Phone and email contact happen weekly and there are regular visits to work sites. The PNG co-ordinator feels she has a lot of autonomy but is still learning and needs regular support. There is no ANGO currently in country but the current manager feels COMPASS should have placed an experienced worker (probably needing to be expatriate) in country some years back to provide more continuous support. She also believes an experienced M and E person should have worked with the team from the start to get good systems in place.

Save the Children Australia: oversees the LNP project in partnership with Save the Children in PNG and the Eastern Highlands Provincial Government Health Department. They visit twice yearly but maintain close management control by employing an in-country, experienced full-time expatriate manager who works within Save the Children in PNG. It has been a tightly planned project with clear goals and actions that grow out of the consultative discussions between partners. A monitoring and evaluation consultant provided early advice for six months (shared with other SCiPNG projects) in setting up the M and E system and capacity building a local program quality officer.

[1] Deborah Rhodes and Lesley Hoatson were appointed as the M&E specialist team

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