

# TECHNICAL ASSISTANCE COMPLETION REPORT<sup>1</sup>

Division: PAHQ

TA No., Country and Name			Amount Approved: US\$450,000	
TA 4208-PNG: Establishment of Pilot HIV/AIDS Care Centers			Revised Amount: US\$356,000	
Executing Agency: Department of Health		Source of Funding: TASF	Amount Undisbursed: US\$60,137.19	Amount Utilized: US\$295,862.81
TA Approval Date: 30 Oct 2003	TA Signing Date: 12 Dec 2003	Fielding of First Consultants: 2 May 2004	TA Completion Date Original: 31 Mar 2006	Actual: 31 Dec 2008
			Account Closing Date Original: 31 Mar 2006	Actual: 20 Mar 2009
<p><b>Description</b></p> <p>Since the first HIV infections were reported in 1987, Papua New Guinea (PNG) witnessed an alarming increase in the rate of HIV prevalence. In mid-2002, it was categorized as a country with a generalized HIV epidemic. The rapid increase in prevalence called for a national response to provide treatment in addition to prevention. The weak national health system could not cope with the burden of the disease, failing to provide necessary care and treatment to the affected population. PNG Government's proposal to the second round of the Global Fund to Fight AIDS, Tuberculosis and Malaria was rejected for its failure to program HIV treatment and an excessive portion of government spending in the budget. PNG submitted a revised proposal to the fourth round in May 2003 which was successful but funding was expected to arrive in the third quarter of 2005. The Government requested ADB support in addressing the gaps identified in a joint UN-USAID review of the 1998–2002 PNG National HIV Medium-Term Plan, combined with the World Health Organization's (WHO) assistance. The technical assistance (TA) objective was to assist the government in developing a model care and treatment center and building capacity to run it.</p> <p><b>Expected Impact, Outcome and Outputs</b></p> <p>The goal of the TA was to develop a more supportive environment for people living with HIV and AIDS (PLWHA) and to expand access to care and treatment. The purpose of the TA was to (i) develop an HIV/AIDS care model that would be sustainable over the long term, (ii) strengthen capacity for clinical management of HIV/AIDS patients, and (iii) strengthen capacity for community support for care and counseling of HIV/AIDS patients.</p> <p>The expected outputs of the TA included: (i) pilot day-care centers to be established at the Port Moresby General Hospital (PMGH) and in a church-based facility, (ii) staff trained to provide services to PLWHA, (iii) referral systems and partnerships to establish a center outreach network, and (iv) formulation and implementation of national treatment guidelines. By 2005, the TA aimed to support treatment of 3,000 patients through the two pilot care centers.</p> <p>The model was to be sustained and replicated in high prevalence areas with funding from the Global Fund once it became available. Within the framework of the TA, WHO took the responsibility of engaging community organizations for outreach and counseling, and providing technical assistance to the Department of Health (DOH) in building capacity for treatment and care of PLWHA.</p> <p><b>Delivery of Inputs and Conduct of Activities</b></p> <p>The TA inputs included (i) 11 months of international consultant support; (ii) training and workshops; (iii) drugs and laboratory reagents; and (iv) equipment for the model treatment center, amounting to \$450,000. WHO provided complementary inputs in (i) international consultant for 3 months, (ii) drugs and laboratory reagents, and (iii) training and workshops. The Government provided office accommodation and counterpart staff.</p> <p>An HIV/AIDS expert was fielded from 2 May 2004 to 28 February 2005 to provide technical support on HIV/AIDS care, treatment, and counseling. A final report was submitted before the end of his 11-month assignment. According to the report, planned guidelines, forms for recording cases, and the monitoring and procurement system were all developed and in place, but actual usage was not up to the expected level. He made 11 recommendations identifying areas for further work.</p> <p>The fund allocated for antiretroviral (ARV) and Opportunistic Infection (OI) drug purchase has been disbursed through an advance payment facility through an imprest account established under the Health Improvement Program since May 2004. This allowed a quick response to urgent needs for key medicines. Due to poor management and lack of system at the established care center, critical medicines were out of stock without plan for procurement in early 2005. An urgent action was taken with the support of WHO to procure new supply and build better management system and monitoring of stock.</p>				

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An HIV/AIDS care center (Heduru Clinic) was established at the PMGH by DOH supported by ADB and WHO. This has provided HIV care services on selected weekdays since July 2003. By April 2005, 134 patients were undergoing treatment. No permanent doctor was assigned to the clinic. By March 2006, 300 patients were undergoing treatment with more than 600 on the waiting list. With limited capacity at Heduru Clinic, it was found to be impossible to provide treatment to 1,500 patients as projected. An additional facility to expand overall capacity was identified and agreed to among partners in September 2006, but did not materialize. At the end of the TA, the disbursement rate was 66 percent.

Executing agency's performance is assessed as less than satisfactory because it could not assign full time staff for the care center and establish an additional pilot location. ADB's performance is rated as satisfactory. It took timely remedial actions to address key management issues in consultation with the executing agency and WHO.

#### **Evaluation of Outputs and Achievement of Outcome**

Outputs of the TA were partially delivered against the set targets in the care center pilot and for the number of patients receiving treatment. The day care center at the PMGH was established as a model for wider replication once the Global Fund resources became available. Despite the constraint in human resources (no permanent staff assigned from the beginning until WHO provided five staff in 2006) and lack of management and communications, the center treated up to 300 patients in less than 3 years' time and had a long list of patients indicating a high demand for its service. The TA closing date was extended twice to support further replication. However, a replication at a church-based health facility was not implemented, and the efforts to expand the capacity by renovating a government clinic also did not materialize despite commitments of all parties involved. The TA amount was reduced by \$94,000 in an October 2007 spring cleaning exercise.

The consultant accomplished all deliverables described in his ToR including (i) review of the existing situation and initiatives in HIV/AIDS treatment; (ii) national guidelines adapted for PNG situation; (iii) training of health practitioners and NGOs; and (iv) development of referral, surveillance, and monitoring and evaluation systems. The consultant's performance in fulfilling the ToR was rated as highly satisfactory while report quality was rated as satisfactory by both ADB and DOH. However, his deliverables were not fully institutionalized for sustained usage after his departure in February 2005. This led to a situation of no stock of ARV and OI medicines in April 2005. Some of his recommendations highlighted the need for continued efforts in capacity building and compliance monitoring. Considering the challenges in pioneering treatment centers and building capacity of health workers, a longer duration of consultant engagement, or intermittent engagement, for the entire duration of the TA could have resulted in better adherence to the guidelines.

With regard to the purpose (outcome) described in the TA Framework, the TA piloted an HIV/AIDS care center adopting international best practices with the aim to prove a model for a wider replication by the Global Fund. A set of guidelines were developed adapting international best practices and were tested in the PNG context. These guidelines could be further improved and adopted by the other new centers to come under the Global Fund. Seventeen NGOs were engaged in a mapping exercise to strengthen the referral system with rationalized coverage. From the available documentation, however, the effectiveness of the referral system and partnerships with NGOs, churches, and private sector could not be determined.

#### **Overall Assessment and Rating**

The TA is assessed as partly successful. The purpose (outcome) was achieved through a replicable model despite the fact that output targets were not fully met and this caused delay and underutilization of the budget. This is mainly due to ambitious output targets without a careful consideration of existing facilities and human resource capacity. The TA could have improved the human and institutional capacity by engaging the consultant for a longer period. It should be noted that the TA pioneered a model center and national guidelines, and also produced useful lessons learned for the Executing Agency, DOH, which was also responsible for the Global Fund implementation as the Principal Recipient. The Heduru clinic is still operating, and it is the best treatment and counseling center in the country, funded by the government (GF resources).

#### **Major Lessons**

The lessons learned from this TA include: (i) the need to set realistic output targets and timeline accounting for local capacity based on the assessment of EA or other partners' capacity; (ii) a longer period of consultant engagement to ensure consultant deliverables are internalized as routine process; (iii) quicker response to partners' commitment to avoid loss of momentum; and (iv) more than one pilot location to produce more experience as a pioneer initiative.

#### **Recommendations and Follow-Up Actions**

Official documentation for this TCR was very limited. BTORs are sporadic and more issue-based rather than providing a systematic monitoring of progress against the DMF. The TA Performance Report should be strengthened to provide structured assessment of progress. Stronger role of RMs in monitoring and facilitating the TA implementation should be considered especially for TAs that require close stakeholder communication.