

Papua New Guinea  
**National HIV and  
AIDS Strategy**  
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**Papua New Guinea  
National HIV and  
AIDS Strategy  
2011-2015**



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Papua New Guinea: National HIV and AIDS Strategy: 2011-2015

Papua New Guinea: National HIV and AIDS Strategy: 2011-2015:  
Monitoring and Evaluation Framework

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# Acronyms

AAP	Annual Activity Plans
ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	anti-retroviral treatment
AusAID	Australian Agency for International Development
BAHA	Business Coalition Against HIV and AIDS
CACC	Central Agencies Coordinating Committee
CBO	community based organisation
CCM	Country Coordinating Mechanism
DAC	District AIDS Council
DPF	Development Partners Forum
DPLGA	Department of Provincial and Local Government Affairs
DSP	Development Strategic Plan
FBO	faith based organisation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	greater involvement of people living with HIV and AIDS
GoPNG	Government of Papua New Guinea
HAMP Act	<i>HIV and AIDS Management and Prevention Act, 2003</i>
HBC	home based care
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
IBBS	integrated bio-behavioural survey
IRG	Independent Review Group
MARP	more-at-risk population(s)
MCH	maternal and child health
MDG	Millennium Development Goals
M&E	monitoring and evaluation
MSM	men who have sex with men
MTDP	Medium Term Development Plan
MTDS	Medium Term Development Strategy
MTP	Medium Term Plan
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NCD	National Capital District
NDoE	National Department of Education

NDoH	National Department of Health
NEC	National Executive Committee
NGO	non-government organisation
NHPS	National HIV Prevention Strategy (2010-2015)
NHS	National HIV and AIDS Strategy, 2011-2015
NHS SG	National HIV and AIDS Strategy Steering Group
NHSIF	National HIV and AIDS Strategy Implementation Framework
NJCC	National Joint Coordination Committee
NRI	National Research Institute
NSP	National Strategic Plan on HIV/AIDS, 2006-2010
OI	opportunistic infection
OVC	orphans and vulnerable children
PAC	Provincial AIDS Committee
PACS	Provincial AIDS Committee Secretariat
PACSO	PNG Alliance of Civil Society Organisations
PCMC	Provincial Coordinating and Monitoring Committee
PEP	post-exposure prophylaxis
PICT	provider initiated counselling and testing
PLHIV	people living with HIV and AIDS
PLLSMA	Provincial and Local Level Service Monitoring Authority
PNG	Papua New Guinea
POC	point-of-care
PPP	public-private partnerships
PPTCT	prevention of parent to child transmission
ProMEST	Provincial Monitoring Evaluation and Surveillance Teams
PSCHA	Parliamentary Special Committee on HIV and AIDS
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organisation

# Prime Minister's foreword

HIV and AIDS threaten the development of our nation and the health of our people. The epidemic demands that we work together and commit ourselves to preventing new infections and care for our brothers and sisters who are infected or affected by HIV. My Government is committed to achieving the Millennium Development Goals in the area of HIV, which are to halt and begin to reverse the spread of HIV and to provide universal access to HIV treatment for all those who need it. We look upon the National HIV and AIDS Strategy, 2011-2015 (NHS) and the work of our many stakeholders as an investment in the future of our nation as we strive towards the goals of Vision 2050.

This new strategy represents a sustained and expanded partnership between our Government, civil society, churches, research organisations, private sector and our development partners. The NHS is based on the spirit of our Constitution, the cultures of Papua New Guinea (PNG), our values and on what we have learned about prevention, care, support and treatment over the last two decades.

The NHS calls for increased leadership from all of us. Men and women from our villages, towns and cities must lead change in their communities. We must own the national response to HIV and AIDS. My Government is committed to increasing our share of the resourcing of the NHS, through our national goals of self reliance and sustainability.

Gender equity is at the heart of our Constitution and is a guiding principle of this NHS. The impact of violence, rape and inequality on the vulnerability of our mothers, wives and daughters is severe and unacceptable. All HIV and AIDS programs must implement interventions that reduce gender-based violence and ensure all citizens have the right to access prevention, care, treatment and support. In particular, men have an important role to play in changing their sexual behaviour – to become faithful, protective and responsible husbands and partners.

People living with HIV and their families are often stigmatised or discriminated against. This harms our efforts to reach more people for testing and treatment. We must all live by the values of unconditional love, care and tolerance, the foundation of our Christian faith and our Melanesian way of life. The churches will continue to play an invaluable role in the national response to HIV, particularly in care, support and treatment services. In addition, we will seek to meaningfully involve people living with HIV and other marginalised groups in the planning, implementation and monitoring of the response. Our Government is committed to ensuring that laws and policies promote social inclusion, respect and dignity by reducing vulnerability to HIV and protecting all our citizens from stigma and discrimination.

The HIV epidemic affects our whole country and this NHS will ensure that provinces and districts have increasing responsibility, resources and control over managing and coordinating prevention and treatment and care services. Communities across PNG, especially in places badly affected by HIV and AIDS, have a duty to mobilise to reduce the risk of HIV transmission and care for those infected. We will work together to unlock the potential of our communities.



Finally, the NHS recognises the importance of our young men and women. We must redouble our efforts to ensure they are given the right information and that they are involved meaningfully in the response to HIV and AIDS. As parents, as communities, and as leaders we must guide, inspire, educate and prioritise our young people. We must talk openly and honestly about sex and sexuality, and about the behaviours that will protect them from HIV.

We have made progress but much more needs to be done. HIV work can be challenging but we must persevere and work together. My Government is committed to the implementation of this new National HIV and AIDS Strategy, 2011-2015 and we will continue to work alongside our development partners and our many stakeholders in the response to the HIV epidemic.

May God bless and strengthen you in your efforts.

A handwritten signature in black ink, appearing to read 'M. Somare', with a long horizontal flourish extending to the right.

The Right Honourable Grand Chief Sir Michael T. Somare,  
GCL, GCMG, CH, CF, K StJ

**Prime Minister of Papua New Guinea**

# Acknowledgements

The National HIV and AIDS Strategy, 2011-2015 was developed through the collaborative efforts of a wide range of individuals and organisations from all parts of PNG. A broad based consultative approach was taken to ensure the new strategy is based on lessons learned and reflects the vision of all stakeholders.

The process used by the National AIDS Council (NAC) to develop the NHS is outlined here for two reasons. Firstly, it is worth documenting as an example of best practice; and secondly, to acknowledge the inputs of all stakeholders at each step along the way.

The NAC established two key groups to develop the NHS, with both operating under the auspice of the National Strategic Plan Steering Committee. These groups were the NHS Core Group and the NHS Technical Support Team. The Core Group was responsible for overseeing the consultation process and ensuring that the inputs of stakeholders were fed to the Technical Support Team. The Technical Support Team, made up of national and international experts, was responsible for conducting an analysis of inputs from the Core Group's stakeholder consultations, plus a separate analysis of recent reviews and evaluations of projects and programs. The Technical Support Team used these analyses to develop an initial outline of the framework for the NHS and then developed a number of drafts for the purpose of further consultation. Both the Core Group and the Technical Support Team received administrative and logistical support from the NHS Secretariat, located in the National AIDS Council Secretariat (NACS).

The key steps in development of the NHS are summarised below:

- A one-day workshop of national level stakeholders to identify what had been achieved under the National Strategic Plan (NSP) and to discuss future directions.
- An initial round of regional consultations and meetings with special interest groups to get their initial inputs on what they wanted to see in the NHS. Special interest group consultations were with sex workers, men who have sex with men (MSM), young people, people living with HIV (PLHIV) and rural communities.
- Development of a Concept Paper by the Technical Support Team which outlined a draft framework for the NHS, along with an analysis of key issues.
- Development of the first draft of the NHS, based on the Concept Paper.
- Consideration of the Concept Paper and the NHS draft by a large National Consultation Workshop of key stakeholders, including the Independent Review Group.
- Development of a second draft of the NHS, based on feedback from the National Consultation Workshop and the Independent Review Group.
- Widespread consultation on the NHS second draft. This was conducted through regional consultation meetings, the development and distribution of a consultation pack to facilitate feedback from a wide variety of organisations and a press advertisement calling for feedback. A total of 87 organisations gave feedback on the second draft of the NHS.

- Development of a third draft of the NHS, taking account of feedback from stakeholders and the Independent Review Group.
- Development of a draft NHS Implementation Framework, setting out major activities that need to be undertaken. The purpose of the Implementation Framework is to guide the development of Annual HIV Activity Plans by each partner. The first draft of the Implementation Framework was developed by a number of specially convened, expert Task Teams.
- Consideration of the NHS third draft and the draft NHS Implementation Framework by a second National Consultation Workshop.
- Development of a final draft of the NHS and final draft of the NHS Implementation Framework, based on feedback from the National Workshop and the Independent Review Group.
- Development of a NHS Monitoring and Evaluation Framework.
- Costing of the implementation of the NHS by a group of international experts.
- Submission of the final drafts of the NHS, Implementation Framework, Monitoring and Evaluation Framework and the costing to the NSP Steering Committee and following that the NAC for their consideration and endorsement.

As can be seen, development of the NHS has been inclusive and highly participatory at every step. In addition to this consultative process the NHS has been informed by a wide range of reviews and evaluations of key projects and programs that have been conducted in recent years. This includes the reports of the Independent Review Group. Another significant input to the development of the NHS was the findings of the NSP Mid-Term Stocktake Workshop, held in early 2009.

The Council and the Secretariat appreciate the contributions from all persons involved in charting the path this nation will take in the next five years in responding to the HIV epidemic. Appreciation is also extended to the members of the Core Group who guided and steered the process throughout and the Technical Support Team and the Task Teams for their high level analysis and production of an excellent NHS. Many thanks also go to the NHS Secretariat staff who worked tirelessly in providing backup support throughout the entire process.

Development of the NHS would not have been possible without the technical and financial support of our development partners who have been an integral part of the process. The Australian Agency for International Development (AusAID) and the Joint United Nations Program on HIV and AIDS (UNAIDS) have, in particular, been at the forefront of supporting the government financially and in providing technical expertise. Appreciation is also extended to other United Nations bodies including the World Health Organisation (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Development Program (UNDP), all of which provided much needed technical input. A word of thanks is also extended to the staff of NACS who contributed to the development of the NHS.



Sir Peter Barter  
**Chair, National AIDS Council**

# Executive summary

The new National HIV and AIDS Strategy, 2011-2015 seeks to build on past achievements and address shortcomings in PNG's response to the HIV epidemic. The NHS replaces the National Strategic Plan on HIV/AIDS, 2006-2010 (NSP). Its overarching goal is to reduce transmission of HIV and other sexually transmitted infections (STI) and minimise their impact on individuals, families and communities.

While there has been considerable progress in the response to HIV and AIDS, particularly considering the difficulties posed by PNG's diverse geography, culture and complex epidemic, the harsh reality is that the HIV epidemic has been outpacing the national response. To address this, this new national strategy is significantly different to the previous NSP.

The key difference is that this new strategy is founded on clear priorities. The two major priority areas are scaling up and improving the quality of firstly, prevention programs; and secondly, counselling, testing, treatment, care and support services. Successful implementation of activities in these two priority areas will have the most impact on achieving the strategy's overarching goal.

To effectively achieve the goals of these two priority areas, the national response will also need to make a concerted effort to address a range of key cross-cutting issues. These include:

- gender inequality
- the meaningful involvement of people living with HIV
- reducing HIV-related stigma and discrimination
- capacity building and mobilisation of people, communities, and organisations
- effective use of research, surveillance, and monitoring and evaluation (M&E) data
- sustained and visible leadership at all levels
- improved coordination at national and sub-national levels.

The NHS has grouped strategic priorities relating to each of these cross-cutting areas under a third major priority area of 'systems strengthening'.

Figure 1 below illustrates the key elements of the NHS which are the overarching goal, the three priority areas, and the goals and strategic priorities for each of the priority areas.

To further reinforce the importance of prioritisation, for the first time the NHS has identified the 'top 10 interventions'. These are drawn from each of the three priority areas. They are the 'must do' or most important areas of work that, if implemented successfully, will make a real difference in combating the HIV epidemic in PNG (see Top 10 interventions section, page 5). Indicators and targets have been set for each of these top 10 interventions (see Headline national targets section, page 7).

The NHS also places an emphasis on prioritising prevention programs and treatment, care and support services in locations with the highest prevalence. Based on available evidence, it is these places where the risk of HIV infection is greatest and where treatment, care and support for people living with HIV are most needed. This does not detract from the need for a truly national response involving all provinces, but it does recognise the need to prioritise the allocation of resources.

Other key features of this NHS that will drive a more effective response to HIV and AIDS in PNG over the next five years are:

- A strong focus on scaling-up a comprehensive prevention response, moving beyond awareness and prioritising evidence-informed interventions. The comprehensive approach to prevention of sexual transmission of HIV will include reducing the number of concurrent sexual partners, delaying the sexual debut of young people, and promoting correct and consistent condom use, especially for those at higher risk of HIV
- A greater emphasis on improving the quality and accessibility of health services
- Strengthening the programmatic response outside of Port Moresby in recognition that this is where the majority of infections are occurring and where most of the prevention, treatment, care and support needs exist
- Ensuring a stronger emphasis on gender issues and tackling gender-based violence by fully integrating gender into all aspects of the national response
- Promoting the meaningful involvement of people living with HIV and more-at-risk populations, not just as the recipients of services but as equal and valued partners in planning, implementation and M&E
- Placing a greater emphasis on the roles, rights and responsibilities of young men and women in all aspects of the national response
- Promoting meaningful local-level involvement in the response by building the capacity of communities and families to effectively mobilise
- Developing new approaches to building capacity to improve implementation (organisational, management, financial, planning and technical capacity), including increasing technical support at provincial, district and local levels
- Investing in 'knowing our epidemic' and measuring the effectiveness of the national response through improved surveillance, social and behavioural research, and M&E.

In addition to this strategy, there are for the first time two important companion framework documents.

The first of these is the NHS Implementation Framework. The Implementation Framework will provide an invaluable guide to all partners in developing their Annual HIV Activity Plans and budgets. By setting out the major activity areas that need to be implemented for each of the NHS strategic objectives to be achieved, the Implementation Framework gives guidance to partners on the types of activities and indicators they need to be including in their Annual HIV Activity Plans. It is the link between the NHS and the annual plans of partners.

The second companion document is the National Monitoring and Evaluation Framework. This framework sets out systems for regular monitoring, evaluation and surveillance of the HIV epidemic. It also contains a select number of key national indicators that will be used to measure and report on progress in implementing the NHS. The development

of an integrated framework for these key areas of strategic information will significantly strengthen capacity for the effective collection, analysis, dissemination and use of key data to guide the response.

In addition to these two new documents, the NACS has developed updated annual planning guidelines for all implementing partners: Implementation of the National HIV and AIDS Strategy 2011-2015: Reference Guide for Annual Planning and Budget.

In conclusion, partners must not lose sight of the fact that the behaviours that put men and women at risk of HIV are shaped by the unique cultural and socio-economic environment of PNG, and especially by complex gender issues. Many of these factors present ideal conditions for the transmission of HIV and other STIs. All sectors of society need to work together by taking positive steps to address the epidemic. The NHS provides an overarching framework to facilitate a strong and sustained response across the whole country. International experience has clearly demonstrated that countries can reverse significant HIV epidemics if they are prepared to make a concerted effort and deploy proven strategies. We know it can be done and over the next five years we will demonstrate that it will be done in PNG.

**Figure 1: The Key Elements of the National HIV and AIDS Strategy**

<b>NHS overarching goal</b> To reduce the transmission of HIV and other STIs and minimise their impact on individuals, families and communities.		
<b>Priority area 1: Prevention</b>	<b>Priority area 2: Counselling, Testing, Treatment, Care and Support</b>	<b>Priority area 3: Systems Strengthening</b>
<b>Goal</b>  To reduce the transmission of HIV and STIs in PNG using a combination of prevention approaches.	<b>Goals</b>  1. To increase the number of people who know their HIV status and are screened for STIs by expanding access and demand for quality, user-friendly and stigma-free counselling and testing services.  3. To improve the quality of life of people living with and affected by HIV through expanded access to quality, user-friendly and stigma-free care and support services.	<b>Goals</b>  1. To improve the collection, management, analysis, dissemination and use of strategic information to guide the response.  2. To strengthen systems and organisations through ensuring the meaningful involvement of people living with HIV and addressing gender inequality.  3. To strengthen leadership of the HIV response at all levels.  4. To reduce stigma and discrimination against people living with HIV and groups thought to be at higher risk of HIV infection.  5. To build the capacity of people, communities and organisations to mobilise, coordinate and implement the HIV response at all levels.
<b>Strategic Priorities</b>  1. Reduce the Risks of HIV Transmission.  2. Address factors that Contribute to HIV Vulnerability.  3. Create Supportive and Safe Environments for HIV Prevention.	<b>Strategic Priorities</b>  1. Scale-up HIV Counselling and Testing (HCT).  2. Expand Treatment, Care & Support Services.	<b>Strategic Priorities</b>  1. Improve Strategic Information Systems  2. Strengthen the Enabling Environment for the National HIV Response  3. Strengthen Organisational Human Capacity for Coordinating and Implementing the NHS

# NHS top 10 interventions

A comprehensive approach is needed to effectively deal with the complex range of social and health issues posed by the HIV epidemic. The NHS and its Implementation Framework sets out the elements of PNG's comprehensive national response. It contains 105 strategic objectives and approximately 400 major activities. While all of these strategic objectives and major activities are important, with many being interlinked, it is essential to identify the top priority areas of work. They are the 'must do' things that, if implemented successfully, will make a real and significant difference in combating the HIV epidemic in PNG.

This section lists the top 10 interventions in the NHS. The question used to select these areas was 'what are the areas of work that will make the most significant impact in combating HIV and AIDS in PNG?' Funding allocations by the Government and development partners need to give priority to funding the top 10 interventions. The interventions are *not* listed in priority order.

People living with HIV need to be fully involved in all aspects of implementation of the top 10 interventions, consistent with one of the core guiding principles of the NHS, that of the meaningful involvement of PLHIV.

Gender issues need to be identified and appropriate responses integrated into each of the top 10 interventions.



NHS Top 10 Interventions	Most Relevant Strategic Objectives
<b>Priority area 1: Prevention</b>	
Develop and scale-up combination prevention programs for addressing multiple concurrent sexual partnerships in locations where this behaviour is common	1.1.2 & 1.1.4
Develop and scale-up targeted HIV and STI combination prevention interventions for more-at-risk populations (MARPs) (see Glossary for definition of MARPs)	1.1.6 – 1.1.9
Significant improvement in the availability and accessibility of male and female condoms through condom social marketing and distribution (this must include addressing stigma, myths and misinformation around condom use)	1.1.2 - 1.1.3
Develop specific interventions to reduce HIV vulnerability associated with gender-based violence and sexual violence against women and girls	2.1.2 – 2.1.4
Ensure that all pregnant women and their partners have access to the full range of prevention of parent to child transmission (PPTCT) interventions through strengthened maternal and child health (MCH) service delivery	1.2.1 – 1.2.5
<b>Priority area 2: Counselling, testing, treatment, care and support</b>	
Significantly increase availability of point-of-care (POC) rapid testing, with an emphasis on provider initiated counselling and testing (PICT), STI and tuberculosis (TB) services	1.1.1 – 1.1.3 1.1.7 & 1.1.10
Increased access to adult and paediatric antiretroviral treatment (ART) and opportunistic infection (OI) and TB management at the district and local level in high prevalence provinces (this does not preclude ensuring that ART is available in all other provinces.)	2.1.2 – 2.1.3 2.1.10
<b>Priority area 3: Systems strengthening</b>	
Strengthen and expand second generation surveillance systems (biological and behavioural surveys, case reporting and STI surveillance)	1.1.1 – 1.1.2 1.2.1 – 1.2.2
Significantly increase technical assistance and organisational capacity development at the sub-national levels for key organisations	3.1.3 – 3.1.5
Strengthened and better functioning NACS and Provincial AIDS Council Secretariats (PACS), with an initial emphasis on PACS in high prevalence provinces	3.1.1 – 3.1.2

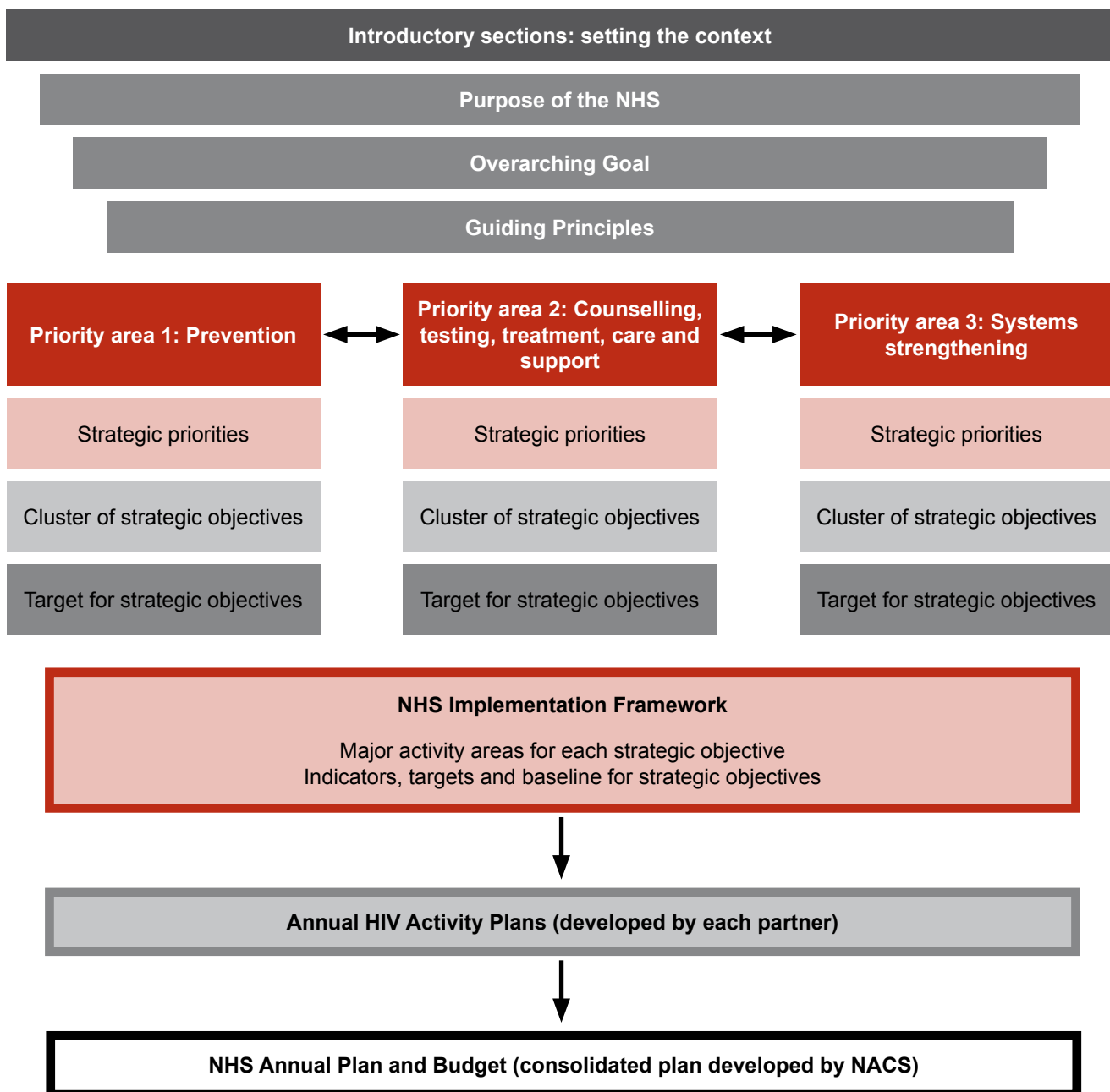
# Headline national targets

The following headline national targets are a selection of key targets in the NHS Implementation Framework and NHS Monitoring and Implementation Framework. With the exception of the first target which relates to prevalence, all the other targets relate to the Top 10 Interventions. However, in addition to the Headline National Targets, other targets have also been set for the Top 10 Interventions. These are in the Implementation Framework and the Monitoring and Evaluation Framework. All targets are to be achieved by December 2015, unless otherwise indicated.

Subject	Target to be achieved by December 2015
Prevalence	Stabilise prevalence in adults at 0.9% by 2015
Prevention: multiple partners	80% of men and women aged 15-59 who had more than one sexual partner in the past 12 months report the use of a condom during last intercourse
Prevention: more-at-risk populations	90% of female and male sex workers report the use of a condom with their most recent client
Vulnerability associated with gender-based violence	80 operational Family and Sexual Violence Action Committees
PPTCT	80% of pregnant women are tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status
Point-of-care HIV testing	100% of TB clients have an HIV test result recorded in the TB register
ART access	80% of adults and children with advanced HIV infection receive antiretroviral therapy
Strategic information	By 2012, 50% of the Provincial Monitoring, Evaluation and Surveillance Teams (ProMEST) are able to effectively collect, analyse, report and disseminate data
Technical assistance	75% of total technical assistance is deployed to support NHS implementation at the sub-national level
Decentralisation	90% of provincial governments report to PLSSMA on their specific HIV responsibilities under the Determination on Service Delivery

# Outline of the structure of the NHS and definitions of key terms

Figure 2: Outline of the Structure of the National HIV and AIDS Strategy



This section outlines the structure of the NHS and defines the key terms used in Figure 2 in the order in which they appear in the diagram.

The **overarching goal** defines what the NHS aims to achieve in the next five years. This is followed by a set of **guiding principles** which are the foundation for the response to HIV and AIDS in PNG, based on an agreed approach and shared values of all partners.

The NHS is made up of three interlinked **priority areas**:

1. Prevention
2. Counselling, testing, treatment, care and support
3. Systems strengthening

Each **priority area** has at least one **goal**. These goals define what the NHS aims to achieve in this priority area in the next five years. These goals are more specific than the NHS overarching goal.

For each priority area, a number of **strategic priorities** have been identified. They define the key areas of action that need to be taken to achieve the **goal** for that priority area. For example, for priority area 3, Systems strengthening, one of the strategic priorities is to “improve strategic information systems.”

Each strategic priority contains one or more **clusters of strategic objectives**. A **cluster** is a grouping of **strategic objectives** by subject area. For example, the strategic priority of “improve strategic information systems” has five clusters of strategic objectives for different subject areas. Two of these clusters are “Monitoring, evaluation and surveillance” and “Social, behavioural and operational research”. Each strategic objective describes an intended outcome. If all the strategic objectives for each priority area are achieved this will mean that the priority area goal(s) are also achieved.

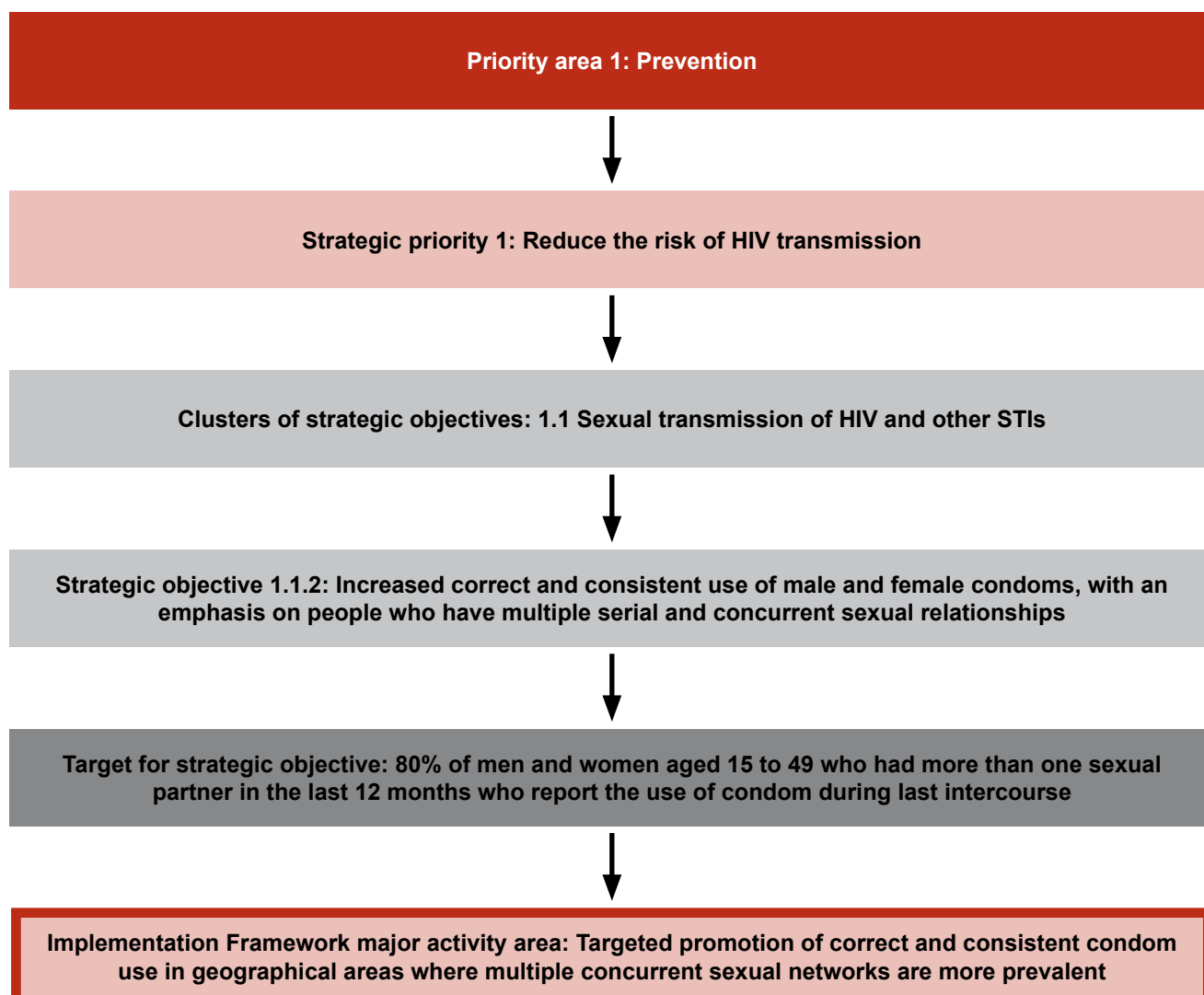
A **target** has been set for each strategic objective. A target specifies what will be achieved by the NHS for a particular strategic objective. Targets are **Specific, Measurable, Achievable, Realistic, and Time-bound (SMART)**. Unless otherwise specified, the timeframe for achieving the target is the end of the NHS implementation period, which is December, 2015.

The **NHS Implementation Framework**, (which is in a separate document), specifies the major activity areas that need to be implemented for each strategic objective. **Major activity areas** are brief summaries of the key areas of action that need to be taken over the next five years to achieve the strategic objective. They are stated quite broadly and not in the level of detail that would be used in annual work plans. The key purpose of the NHS Implementation Framework is to guide the development of Annual HIV Activity Plans by each partner. By indicating the major activity areas needed to achieve the NHS strategic objectives, the Implementation Framework gives guidance to all agencies on the types of activities they need to be including in their Annual HIV Activity Plans. These plans are submitted to NACS and consolidated into the **NHS Annual Plan and Budget**.

The NHS Implementation Framework contains the same targets that are in the NHS. The Implementation Framework also contains **indicators** which measure in a quantifiable way progress in achieving each strategic objective. **Baseline** data, where available, shows the current level of achievement for each indicator so that progress can be tracked against this.

Figure 3, below, illustrates the structure of the NHS by taking an example from the priority area of prevention.

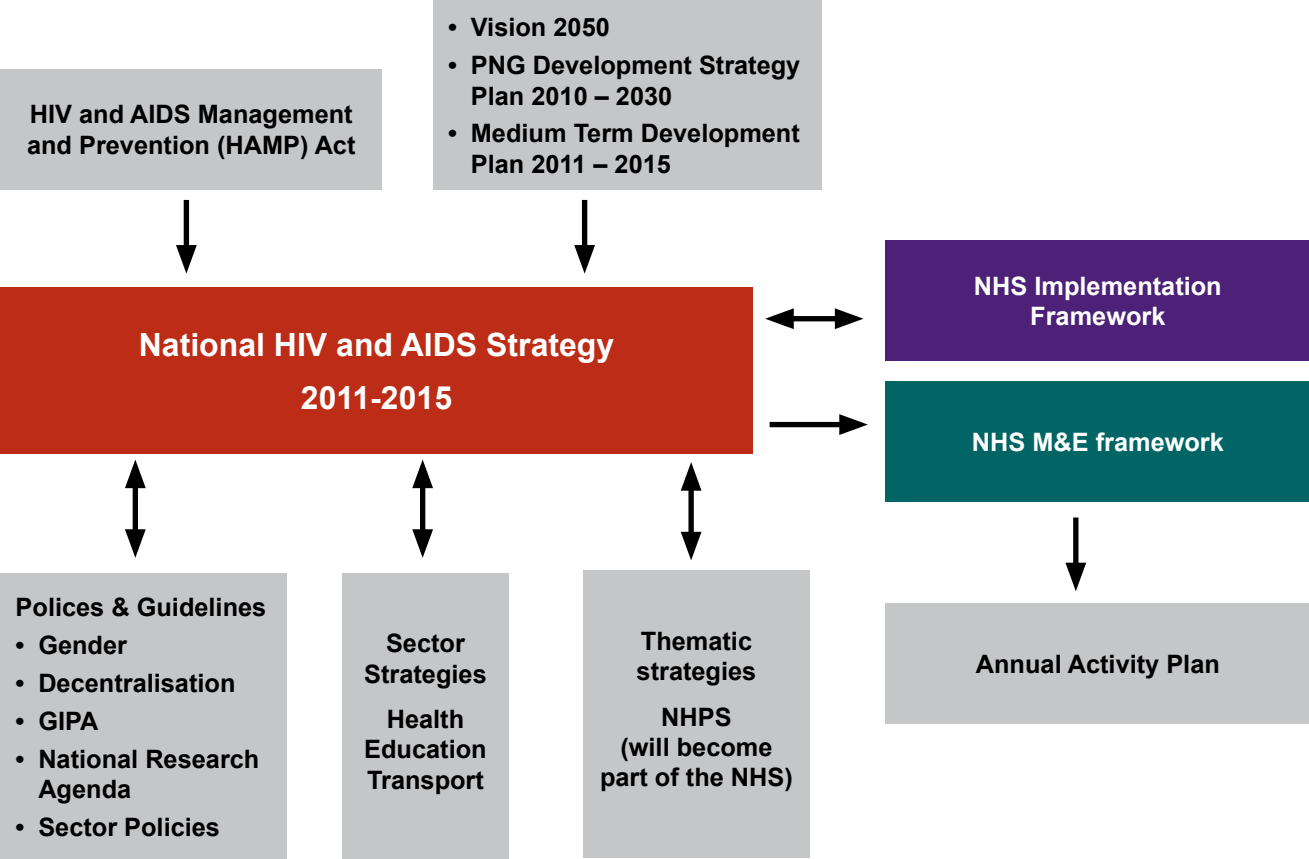
**Figure 3: The structure of the NHS using an example from the Level of a priority area down to a major activity area**



# How the NHS fits into Papua New Guinea's laws, policies, and other strategies

The NHS is not a stand-alone document. It has a close relationship to a number of PNG laws, policies, and other strategies, as outlined in this section and summarised in Figure 4, below.

**Figure 4: Relationship of the NHS to PNG laws, policies and other strategies**



# Legislative framework

*The National AIDS Council Act, 1997 (amended 2009)*: This Act established the Council and its Secretariat (NACS). Combined, the NAC and NACS are mandated by law as the national authority responsible for the formulation, review and revision of national policy for the prevention, control and management of HIV and for monitoring and coordinating the implementation of the NHS. <sup>i</sup>

*The HIV and AIDS Management and Prevention Act, 2003 (HAMP Act)*: The HAMP Act provides a comprehensive basis in law to support public health provisions for the control of HIV (for example, confidentiality regarding HIV testing); provides guarantees for the protection of human rights for people infected and affected by HIV and AIDS; and provides a legal framework for situations where people are placing others at risk of contracting HIV. <sup>ii</sup>

## Overall Government of Papua New Guinea strategies and key documents

*Vision 2050*: Vision 2050 is the Government's prioritised, strategic national reform and development plan. It addresses PNG's low social and economic indicators by focussing on three core areas: service delivery, wealth creation, and human capital development. Its strong emphasis on decentralisation and how services shall be developed and provided will influence the national response to HIV. In addition, the longer term impacts of HIV and AIDS on the social and economic situation in PNG will directly influence the expected outcomes of Vision 2050. The aim of Vision 2050 is to reduce HIV prevalence among the population aged 15 to 49 to 0.1% by 2050. <sup>iii</sup>

*PNG Development Strategic Plan (DSP), 2010-2030*: The DSP is the Government's master strategy for PNG's development over the next 20 years. It provides more specific details than are outlined in Vision 2050. <sup>iv</sup>

*Medium Term Development Plan (MTDP) 2011-2015*: The MTDP is the Government's policy driven plan of action. The first MTDP will cover the period 2011-2015, followed by subsequent five year plans through to 2030. Each plan will contain five year targets which will be drawn from sector plans which will be in alignment with the DSP. These five year targets will be broken into annual targets to guide implementation by each sector. <sup>v</sup>

*The Determination Assigning Service Delivery Functions and Responsibilities to Provincial and Local-Level Governments (2009)*: The determination assigns specific functions and responsibilities to provincial and local-level governments. It has been made for key sectors such as health and education, and also specifically for HIV and AIDS. It is a legal document that explains the areas of service and funding for which each level of government is accountable. The NHS and its Implementation Framework are consistent with the Determination. <sup>vi</sup>

# National AIDS Council policies

The achievements under the NSP 2006-2010 are the foundation upon which the NHS is built. Since 2006, several important policies and strategies have been developed which have fed into this NHS. These sought to address some of the gaps identified in the NSP. These policies and strategies include:

*The National HIV Prevention Strategy (NHPS)(2010-2015)*: The NHPS was approved by the NAC in late 2009. The NHS reflects the strategic priorities and objectives of the NHPS, although the opportunity has been taken to revise these priorities and objectives in the NHS. As such the NHS replaces the NHPS. However, the textual components of the NHPS provide useful additional contextual analysis. <sup>vii</sup>

*National Gender Policy and Plan on HIV and AIDS (2006-2010)*: This important gender policy and plan was developed as a subsidiary to the NSP. Gender has now been integrated into the NHS by addressing gender in all priority areas. <sup>viii</sup>

*Greater Involvement of People Living with HIV and AIDS (GIPA) Position Statement (draft)*: A GIPA position statement is under development for approval by the NAC. The GIPA principle is a core part of the new NHS. As with gender, GIPA is integrated in to all priority areas. <sup>ix</sup>

*Strengthening PNG's Decentralised Response to HIV and AIDS (2009)*: The purpose of this document is to guide and strengthen the sub-national response to HIV and AIDS. Strengthening the decentralised response is reflected in the NHS by addressing systems and capacity development at the sub-national level. <sup>x</sup>

*National Research Agenda for HIV and AIDS in PNG (2008-2013)*: The National Research Agenda identifies priority areas for research under three sub-theme areas: 1) increasing knowledge of the drivers of the epidemic and understanding the lives of those directly infected and affected by HIV and AIDS; 2) evaluating the effectiveness and appropriateness of the national response to HIV; and 3) measuring the impact of the epidemic on sectors and civil society. Production, collation, dissemination and use of research findings is a key part of this NHS. <sup>xi</sup>

## Sector policies and plans

*The Health Sector Strategic Plan for STI, HIV and AIDS (2008-2010)*: The Health Sector Strategic Plan was purposefully designed to finish at the end of 2010 so that its time frame would be in alignment with the end of the NSP. The next Health Sector Strategic Plan for HIV, AIDS and STIs will be developed to be in line with the priorities of this NHS. <sup>xii</sup>

*HIV and AIDS Policy for the National Education System (2005)*: The National Department of Education (NDoE) has an HIV and AIDS Policy which is currently being implemented through a five year plan. This policy and plan support the NHS in addressing the education sector's important response. <sup>xiii</sup>

*Protection, Care and Support for Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in PNG 2008-2011, Department for Community Development,(2008)*: The Department for Community Development is implementing its strategy to reduce the impact of HIV on most vulnerable children. <sup>xiv</sup>



This strategy and the child protection principles of the *Lukautim Pikinini Act, 2009* have fed into the development of the NHS.

Other important sectors with significant policies and activities include the Law and Justice Sector, the Transport Sector, Defence, the Treasury Department, the Department of National Planning and Monitoring, the National Youth Commission and the large private sector, led by the Business Coalition Against HIV and AIDS (BAHA). The HIV and AIDS policies and work of the churches have also been used in the development of the NHS.

## International obligations and declarations

PNG is a signatory to several key international conventions and declarations which are relevant to the national response to HIV:

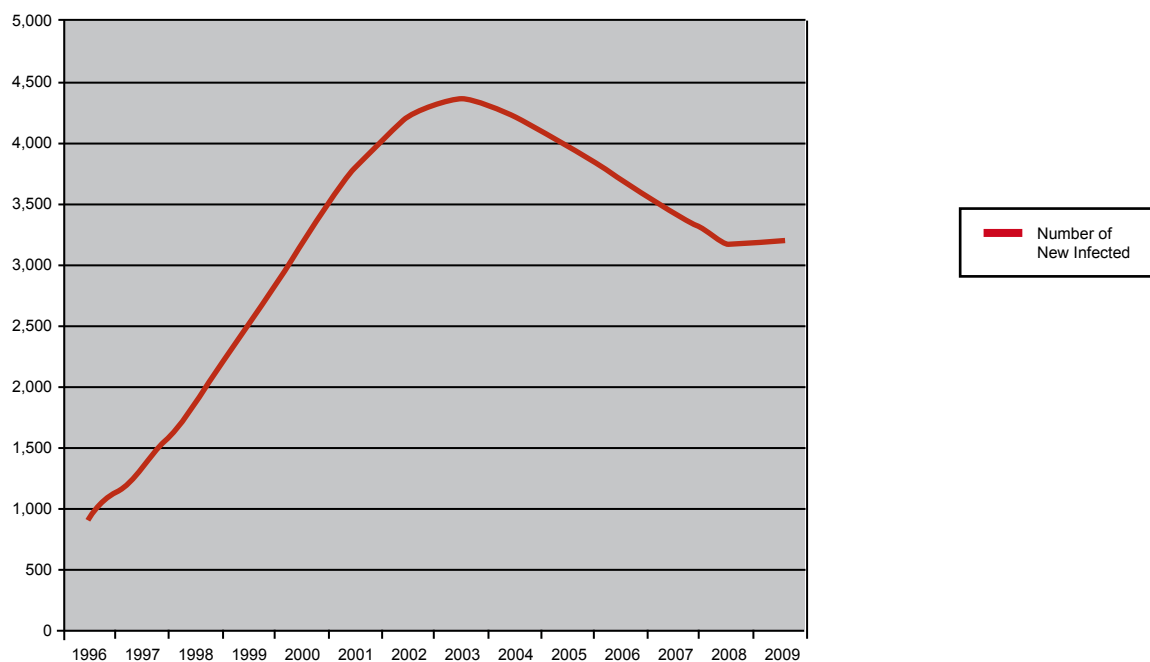
- The Declaration of Commitment on HIV/AIDS, issued by Heads of State at the UN General Assembly Special Session on HIV and AIDS (UNGASS) in 2001. <sup>xv</sup>
- The Millennium Declaration, adopted by 189 nations in 2000. The Millennium Development Goals (MDG) are drawn from actions and targets contained in the Declaration. There are eight goals to be achieved by 2015 that respond to the world's main development challenges. Combating HIV and AIDS forms part of one of the eight goals. <sup>xvi</sup>
- The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) <sup>xvii</sup>
- Convention on the Rights of the Child (CRC) <sup>xviii</sup>
- PNG also has a bilateral agreement on HIV with Australia (PNG-Australia Partnership for Development, Priority outcome 3 on health (2009) and Priority outcome 7 on HIV (2010).

# The HIV epidemic in Papua New Guinea

In December 2009, the total number of people living with HIV in PNG was estimated to be 34,100 (31,000 adults aged 15 or more and 3,100 children and adolescents). This was equivalent to a national prevalence of 0.9% in the 15 to 49 age group. It was estimated that approximately 3,200 people were infected with HIV in 2009, while around 1,300 people were estimated to have died from AIDS in that same year. To the end of 2009, a cumulative total of 11,520 people were estimated to have died because of HIV-related illnesses and 5,610 children had become orphans, (losing one or both of their parents), as a result of the epidemic. <sup>xix</sup>

Based on the 2010 estimates and projections exercise, the period of the most rapid increase in new HIV infections was between 1999 and 2005, (see Figure 5).

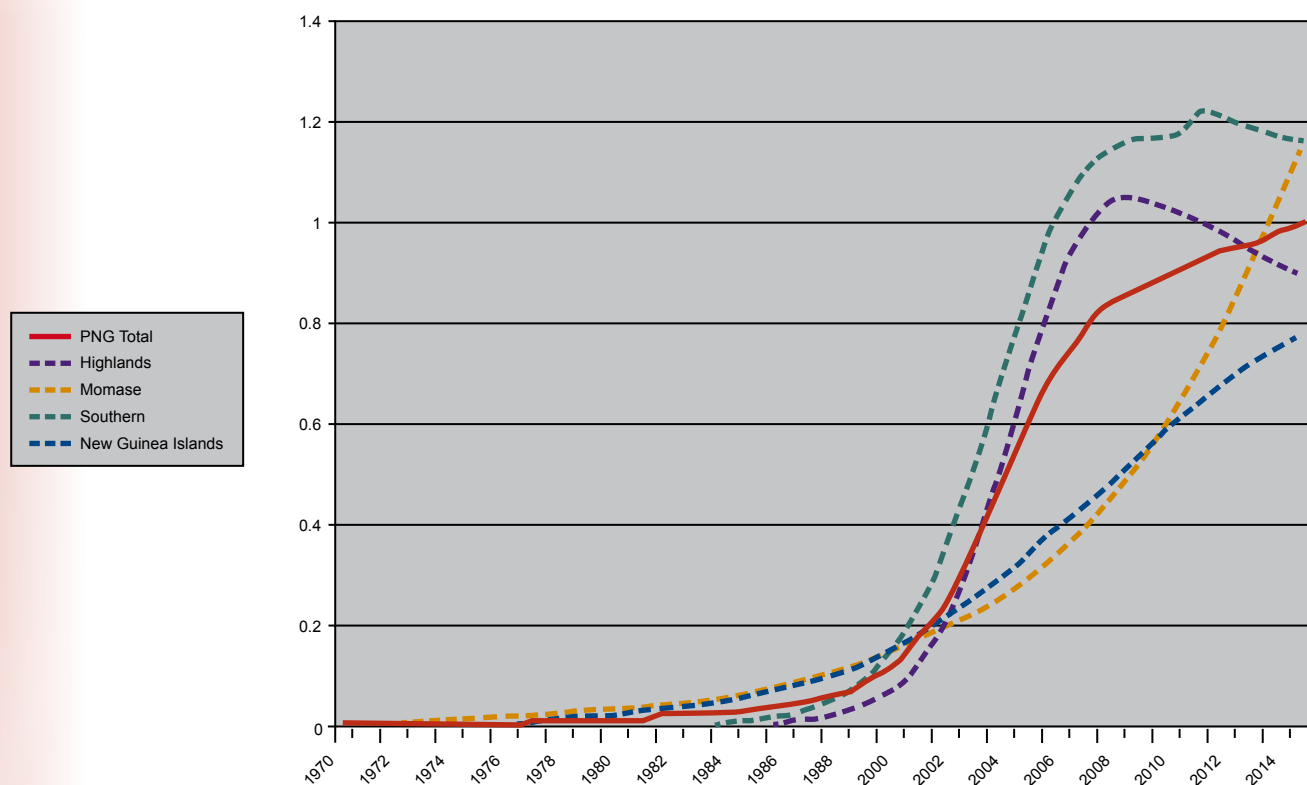
**Figure 5: Estimated number of new HIV infections in PNG 1996-2009**



Source: Consensus Workshop on HIV Estimation in PNG, 8-10 June, 2010.

Since 2006, there has continued to be an upward trend in national prevalence, but at a less rapid rate. It is estimated that national HIV prevalence among adults will be 1.0% in 2015 (Figure 6).

**Figure 5: Estimated number of new HIV infections in PNG 1996-2009**



Source: Consensus Workshop on HIV Estimation in PNG, 8-10 June, 2010.

The HIV epidemic has not followed a same pattern in all four regions of PNG (Figure 6). Estimates of adult prevalence were developed for the four PNG regions:

- **Highlands:** adult prevalence was estimated to be 1.02% in 2009, with indications that a plateau may have been reached.
- **Southern:** adult prevalence was estimated to be slightly higher at 1.17%, while the epidemic may also have started to level off. This data is largely derived from the National Capital District and is not indicative of prevalence in other parts of the region.
- **Momase and New Guinea Islands:** prevalence is estimated to be substantially lower than in the Highlands and Southern regions, at 0.63% in Momase and 0.61% in New Guinea Islands.

It is now evident that the trends of the epidemic across the country are not the same, as shown in Figure 6. The epidemic in the Highlands is experiencing a small downward trend, from a peak in 2007, has reached a plateau in the Southern region, and is on the rise (with no sign of a plateau) in Momase and the New Guinea Islands.

The estimates and projections exercise conducted in 2010 replaced those of the 2007 exercise. These most recent estimates calculate that prevalence in 2006 was 0.83% and not 1.28% as previously estimated. The main reasons for this downward revision of HIV prevalence are:

- Expanded data collection on HIV prevalence, particularly through antenatal clinics, now provide a clearer picture on the situation in more remote parts of the country.
- The rate of new infections over the past few years appears to have been lower than was predicted on the basis of the information available in 2007. A contributing factor may have been the scaling-up of HIV interventions in PNG.

As with any population health estimation, there are limitations to the accuracy of the estimates. Although the 2010 estimates have benefited from a significantly greater availability of data, the quality of the data is still variable and not consistent. Although surveillance systems are improving and more people are being tested, there is much that is still unknown about the scale and impact of the epidemic. The need to rapidly continue to strengthen surveillance is clear.

The national Integrated Bio-Behavioural Survey planned for 2011 will provide the best information on prevalence across the country, including factors that drive the epidemic.

The following analysis is largely drawn from the 2009 STI, HIV and AIDS Annual Surveillance Report, issued by the National Department of Health.<sup>xx</sup> The geographic distribution of HIV case reports varies significantly. The majority of people diagnosed with HIV live in Port Moresby and other urban and peri-urban areas, mainly in provinces linked by the Highlands Highway. In 2009, 90% of all new case reports of HIV infection were from five provinces, Port Moresby and one large town. This included all Highlands provinces Western Highlands (26.3%), Eastern Highlands (11.2%), Enga (11.0%), Southern Highlands (6.1%), Simbu (5.7%), and National Capital District (NCD) (20.7%) and Morobe (9.0%). The breakdown of HIV case reports by region in 2009 was:

- Highlands Region 60%
- Southern Region 26%, including 21% from National Capital District
- Momase Region 11%
- New Guinea Islands Region 2%.

A comparison of the regional prevalence estimates, (see Figure 5), with HIV case reports by region in the dot points above, indicates a significant disparity between the estimated share of national prevalence for the Momase and the New Guinea Islands regions and the number of HIV cases reported from these regions. Reasons for this may be the limited availability of HIV testing sites in these regions compared to the Highlands and Southern Regions (particularly NCD), and possible double counting of cases reported from regions where more HIV testing is conducted.

While available data indicates that the epidemic extends to every province in the country, in many areas there is insufficient information to determine current prevalence and predict the potential for further epidemic growth. There is, however, sufficient evidence to conclude that the epidemic has extended beyond urban and peri-urban areas to rural areas, where 80 to 85% of the PNG population lives, and is clustered around concentrations of population, transport routes and rural enclave enterprises where there are active markets for the exchange and sale of sex.<sup>xxi</sup>

From 1987 to 2009, females accounted for 56% of all reported cases of HIV infection (excluding cases where sex was not reported), and males for 43%, (see Table 1). The

higher number of reports of HIV in females may reflect the nature of the surveillance system, which is heavily reliant on case reports from antenatal centres (ANC), or a genuinely higher prevalence among women. The latter appears to be the more likely explanation as the HIV case detection rate among clients of voluntary counselling and testing (VCT) centres in 2009 was 4.7% in women compared to 3.7% in men.

By the end of 2009, the median age in cumulative reported HIV cases was 26 years for females and 32 years for males. Table 1 gives a breakdown of the age and sex distribution of cumulative cases reported in PNG from 1987 to the end of 2009, (excluding cases where sex and age were not reported). The difference in the distribution of infection by age group between females and males would seem to indicate sexual transmission between older men and younger women. However it might also be related to the fact that many cases among women are found through ANC clinics, where women tend to be from lower age groups.

In 2009, a total of 45,560 HIV tests were performed at Antenatal Clinics. HIV prevalence

**Table 1: Age and sex distribution of cumulative HIV cases reported in PNG 1987-2009** <sup>xxii</sup>

Age group	Male	Female
0 – 14	2.9	3.0
15 – 24	5.9	20.0
25 – 34	15.9	21.9
35 – 44	10.9	8.5
45 +	7.1	2.7
<b>Total</b>	<b>42.7</b>	<b>56.1</b>

among pregnant women was 0.7%, which was the same for 2008. HIV prevalence among women screened at ANC sites declined from 1.3% in 2005. The number of HIV tests conducted at ANC sites has almost quadrupled since 2005, possibly changing the characteristics of pregnant women who are tested.

Available biological surveillance, mainly through HIV case reporting, indicates that HIV is primarily heterosexually transmitted in PNG, through unprotected vaginal and anal sex between men and women and to a significantly lesser extent through mother-to-child transmission and unprotected anal sex between men. The main self-reported route of transmission among reported HIV cases in 2009 was heterosexual (91.1%), followed by mother-to-child (3.6%), homosexual (2.6%), body piercing or tattooing (2.0%), and occupational exposure (0.6%).

The lack of mode of transmission data in more than half the cumulative reported cases makes it impossible to come to conclusions on mode of transmission and the groups of people more-at-risk of HIV infection. It is possible that PNG's generalised epidemic might also be accompanied by concentrations of HIV in particular population groups who are more at risk.

Currently there is no biological surveillance in place for monitoring the epidemic among populations like sex workers and men who have sex with men or other groups of people who may be at higher risk, like workers in economic enclave. One-off project-based biological studies in the NCD found HIV prevalence among female sex workers in excess of five per cent and around four per cent among men who have sex with men. Future biological surveillance must include these groups to determine if there are pockets of concentrated epidemics in the broader PNG epidemic. Other relatively small-scale studies in economic enclaves have indicated higher than average prevalence in those settings.

Although knowledge of the pattern of the HIV epidemic in PNG has improved, there is still a lack of quality epidemiological and behavioural data to guide the planning of the national response, particularly prevention programming. Improving the availability and quality of epidemiological and behavioural data so the response can be tailored to the reality of the epidemic is a high priority for the NHS.

The dynamics of HIV transmission in PNG are influenced by a great diversity of sexual cultures, with different values, norms, beliefs, and practices. The potential for sexual transmission of HIV is heightened by early sexual debut, often in situations of coercion and abuse; multiple and concurrent sexual partnerships, including polygamy, extramarital sexual partnerships and inter-generational sex; the exchange of sex for cash, goods, and services; low and inconsistent condom use; high levels of sexual violence and rape; mobility; and the use of penile inserts and modifications.

STIs, which are known cofactors in HIV transmission, are widely prevalent in PNG and among the highest in the world. The total number of STI cases reported increased from 21,213 in 2000 to 71,025 in 2009, representing a growth of 235%. The majority of reported cases were in the Highlands region. More than two-thirds of total STI cases in 2009 were diagnosed in females (67%), compared to 33% of cases among males. This may be because total female attendances at an STI clinic were more than double male attendances. Surveillance and research data indicate very high rates of co-infection of HIV and STIs.

The use of marijuana and alcohol is closely associated with unprotected sexual activity and acts of sexual violence, and both of these drugs are available widely and used extensively throughout the country. Injecting drug use is not yet recognised to be an important factor in the transmission of HIV in PNG. Recent bio-behavioural and behavioural surveys, however, report cases of injecting drug use among a number of groups. Further data on the extent of injecting drug use is required to determine its significance to HIV transmission in PNG.

# The response to HIV and AIDS in Papua New Guinea: Key achievements and challenges

This section reviews the progress of PNG's response to HIV and AIDS and identifies key challenges that need to be addressed by the NHS in the period 2011 – 2015. The key achievements from 2006-2010, under the National Strategic Plan, are summarised in Table 2.

**Table 2: Key achievements in PNG's response to HIV and AIDS, 2006-2010**

Key achievements
Approval of PNG's first National HIV Prevention Strategy
Significant progress in mainstreaming HIV prevention in the key government sectors of education, law and justice, and transport
100% of schools provided life skills based HIV and AIDS education in 2009
Increase in the number of condoms distributed by non-government organisations (NGOs) from 3.3 million in 2007 to 8 million in 2009
Increase in the number of HIV testing sites from 35 in 2006 to 251 in 2009. The number of HIV tests increased from around 15,000 in 2006 to more than 123,000 in 2009
Rapid roll-out of ART: 75% of people in need of ART on treatment in 2009, compared to 23% in 2006
82% survival rate for adults and children who are on ART
Significant expansion of HIV service delivery through civil society, particularly for care, support and treatment services provided by faith based organisations
An increase in community mobilisation initiatives, especially in high prevalence provinces
Marked increase in the number of non-state actors involved in the HIV response and participating in the GoPNG coordinated planning process
Greater focus on mainstreaming of gender issues into the design, planning and implementation of HIV programs

Strengthening of HIV surveillance systems by NDoH, resulting in more and better quality data

Development of a prioritised National Research Agenda and PNG's first large-scale HIV research grants program

Inclusion of HIV functions and services in the NEC Determination which delineates and assigns responsibilities for provincial and local-level governments

Approval by NAC of the provincial engagement strategy and Provincial AIDS Council manual

Significant number of leaders (MPs, heads of departments, CEOs, Provincial Administrators and middle level provincial managers) trained on HIV and AIDS, with many subsequently initiating workplace policies and mainstreaming activities in their organisations

## Prevention

Transmission of HIV continues to be fuelled by unsafe behaviours in the context of complex social, cultural, economic and political factors. Key contributing factors include:

- gender inequality and high rates of sexual violence
- multiple and concurrent sexual partnerships
- a lack of consistent messaging hampered by PNG's diverse cultures and languages
- high rates of STIs
- low condom use and considerable opposition to condom use promotion
- a weak health system with limited access to testing, treatment and care
- mobile populations and concentrations of men in resource enclaves
- corruption and mismanagement within key institutions.

Although there are a number of examples of good HIV prevention projects, overall the HIV prevention response in PNG is inadequate in nature, intensity and scale. There is a pressing need to move beyond simple HIV awareness raising to a full range of evidence-informed prevention strategies. The failure to mount an effective prevention response has been the most significant gap in the national response to HIV.

Key lessons learned which need to inform prevention programming include the need:

- to identify and prioritise both those people at higher risk and the geographical areas with high prevalence
- for repeated, layered and consistent interventions
- for research on sexual practices and networks to inform interventions
- to review, reflect and learn from experience
- to maintain consistent condom supplies and actively promote condom use
- to address stigma and discrimination when working with vulnerable groups.

In late 2009, the NAC endorsed PNG's first National HIV Prevention Strategy which has formed the basis for the priority area of prevention in this NHS. (The Prevention Strategy has now been subsumed into the NHS.)



# Counselling, testing, treatment, care and support

The health sector has significantly increased access to and uptake of HIV counselling, testing and ART, coupled with training of health care workers. Progress has also been made in the areas of policy development, quality assurance, accreditation and procurement. There are, however, still significant unmet needs. Although PNG has one of the highest rates of STIs in the region, STI services are under-resourced and largely lost in the broader HIV response. While there has been an increasing effort to provide PPTCT interventions, the coverage rate for the full package of PPTCT interventions has remained at a very low level. This reflects the difficulty of achieving coordination between services and the weakness of MCH services. Similar difficulties remain in links between HIV counselling and testing (HCT) and tuberculosis, post-exposure prophylaxis and gender-based violence services.

The weakness of the public health system has been a major constraint to scale-up. The lack of a strategy for overall health system strengthening has not assisted. Other limiting factors have been:

- an absence of systems for coordinating different components of treatment and care, resulting in loss to follow-up, especially in PPTCT
- the vertical nature of service delivery rather than an integrated, one-stop approach
- insufficient emphasis on quality assurance
- poor access to services, particularly for stigmatised groups.

Key health sector priorities need to be:

- expanding access to and uptake of HCT, especially through PICT
- rolling out the new POC HIV test algorithm
- improving the areas of adherence counselling and monitoring for drug resistance
- increasing availability of treatment at the district and local levels, especially in high prevalence provinces
- better coordinating or integrating the range of health services needed by PLHIV
- improving supply chain management
- improving the quality of all these services.

In the area of orphans and vulnerable children (OVC), some progress has been made through development of a strategic plan, new legislative protections and the strengthening of safety nets. At the community level, however, implementation is at an early stage, with large gaps in available services.

## Enabling environment

Stigma and discrimination continue to be major barriers to an effective response. Stigma against people living with HIV, their families and particular groups, (for example, sex workers and men who have sex with men), deters people from accessing HIV prevention, testing, counselling, and care and treatment services, including antenatal services. This is exacerbated by persistent misconceptions and myths about how HIV is transmitted and by moral judgments about people living with HIV.<sup>xxiii</sup> Severe manifestations of stigma and discrimination have resulted in human rights violations, rejection, violence and death.

In recent years there has been a noticeable increase in community mobilisation activities, especially in high-prevalence localities. The need for strategies to address communities most affected by HIV is becoming apparent. Efforts need to focus on mitigating the impact of HIV on families and communities and addressing stigma and discrimination.

Addressing vulnerability to HIV resulting from gender inequality and gender-based violence has received greater attention in the national response in recent years through the development of a framework and guidelines for mainstreaming gender issues in the design, planning, implementation and M&E of all HIV-related activities. However, progress in integrating gender into implementation of programs has been slow. There needs to be a renewed emphasis in this area, with a focus on practical application of gender policies and frameworks across all HIV interventions.

The meaningful involvement of people living with HIV in all aspects of the response has been limited. The level of positive peoples' involvement has rarely gone beyond being a target audience or the beneficiary of services. Very few positive people are meaningfully involved as planners, service deliverers or decision makers. Like gender, this area needs a renewed and practical emphasis.

Overall, the leadership response to HIV has been disappointing, particularly in recent years. Central government agencies and provincial governments rarely prioritise HIV in their planning and budgeting processes. There is a need to strengthen the Special Parliamentary Committee on HIV and AIDS. Local leadership initiatives have been limited, but there are a growing number of activities targeting community leaders and village elders, who can be important agents of change.

## Systems strengthening

Although there has been a significant investment in capacity building and development of systems to monitor the national response, the amount of data to assess progress remains thin. Strengthening of HIV surveillance systems by the National Department of Health (NDoH) has resulted in more and better quality data, but there are still significant problems in missing data and quality of data. Presently, the surveillance system cannot indicate where new infections are occurring and there is a limited understanding of the patterns of infection and particular behavioural practices that are driving the epidemic. The establishment of ProMEST has the potential to strengthen data collection and use at the provincial level. However these teams have either not been established or are not fully operational in most provinces.

Progress in social and behavioural research has been significant in recent years. A National Research Agenda, which identifies research priorities, has been developed and PNG's first large scale HIV research grants program has commenced. Mechanisms have been established for coordinating research and disseminating results, which have laid the basis for evidence-informed program development.<sup>xxiv</sup>

In the absence of effective government services, NGOs, churches, and the private sector are providing most of the prevention, treatment, care and community support activities. Increased funding for these agencies has highlighted gaps in their capacity for effective program design and management. Current approaches to capacity building need to be overhauled by broadening modalities beyond the current over-emphasis on one-off training and increasing the amount of ongoing technical support available at the sub-national level.

HIV mainstreaming has resulted in significantly increased attention and resources given to HIV by a number of sectors including Education, Transport, and Law and Justice. The success of the BAHA and the NDoH-Asian Development Bank (ADB) HIV Prevention in Rural Enclaves has been a major step forward in galvanising private sector engagement in the response. The churches continue to have a significant involvement, particularly in care, support and treatment services.

The number of partners involved in the response to HIV has grown significantly, making the job of coordination more complex. There is a need to strengthen coordination within and between all levels, (national, provincial and district), including between government and civil society. This includes the need for better coordination between all levels in annual planning and improved coordination within particular sectors using mechanisms such as BAHA, the PNG Alliance of Civil Society Organisations (PACSO) and faith based organisations.

Although much of the HIV response has been driven and funded from the national level, there is evidence of growing ownership in some provinces. This, however, is variable with provincial leadership often being weak. An emphasis is needed on strengthening provincial and district planning processes, tied to increased funding allocations involving all partners. Strategies to strengthen the provincial response need initially to be concentrated in those provinces with the highest HIV prevalence.

Mobilisation of funding for the HIV response needs to continue to be a high priority. For the foreseeable future, the national response will rely on a significant financial contribution from development partners. The Government of PNG will need to develop a funds mobilisation strategy and also make additional contributions from its own revenues.

Although there has been significant progress in the development of HIV policies, strategies and plans, this has not resulted in implementation of programs on a significant and sufficient scale. There is a need to rebalance the response by placing a greater emphasis on implementation of evidence-informed programs, particularly at the sub-national level. For this to occur, factors holding back the HIV response need to be effectively addressed. These include:

- addressing the low capacity of people, systems and organisations
- the lack of a robust leadership response at all levels
- weak implementation of policy and legislation
- poor targeting of interventions
- limited funding for the sub-national level
- limited engagement of communities
- a lack of a bottom-up approach informing programs.

While there have been significant achievements in a number of areas in the national response to HIV and AIDS, overall progress has been too slow and has not been keeping pace with the epidemic.<sup>xxv</sup> This National HIV and AIDS Strategy is designed to reposition the national response to effectively counter and stabilise the epidemic. It will do this by primarily focussing on the top priorities which need to be addressed to make a real impact, while at the same time taking a comprehensive response to the epidemic.



# Purpose of the National HIV and AIDS Strategy

The National HIV and AIDS Strategy is the overarching framework for everyone at all levels to guide and drive the expanded response to HIV, AIDS and STIs in PNG.



# **National HIV and AIDS Strategy overarching goal**

To reduce the transmission of HIV and other STIs and minimise their impact on individuals, families and communities.

# The guiding principles of the National HIV and AIDS Strategy

These guiding principles are the foundation for the response to HIV and AIDS in PNG, based on an agreed approach and shared values of all partners.

## Human rights are respected

Respect for human rights, as set out in the PNG National Constitution and the *HIV/AIDS Management and Prevention Act, 2003* will be the basis for policies, programs and the delivery of all HIV and AIDS interventions. No person should be subjected to stigma and discrimination.

## Gender is always integrated into the HIV response

Addressing the different needs of women and girls, men and boys and transgendered people is fundamental to reducing risks and vulnerability to HIV. These needs will always be identified and appropriate responses integrated into all HIV and AIDS activities. The right to gender equality is fundamental to addressing the greater vulnerability of women and girls to HIV.

## Greater involvement of people living with HIV

The insights, experiences and efforts of PLHIV are critical. PLHIV will be meaningfully involved in all aspects of the national response from advocacy to policy development, program planning, implementation, M&E. The needs of PLHIV will always be identified and appropriate responses integrated into all HIV and AIDS activities.

## Community participation and mobilisation

Community participation and mobilisation will be a key strategy to promote ownership and responsibility for HIV and AIDS programs and initiatives. This will include engagement of communities in planning and delivering the HIV response.

## Empowerment

Empowering people through participation, especially women, young people and vulnerable groups, to make informed decisions and determine their own behaviour is a crucial aspect of the HIV response.

## Leadership

An effective response requires strong, visible, honest and committed leadership from a wide range of leaders, from the family to the national level.

## Evidence-informed approaches and prioritisation

All HIV and AIDS policies, programs and interventions will be informed by evidence from surveillance, social, behavioural and other research. International best practices will be adapted to what is proven to be effective in PNG. Interventions and resource allocation will be prioritised based on the available evidence.

## Cultural practices

Cultural traditions and beliefs will be respected and promoted by programs, except where these increase the risk and vulnerability of HIV infection, interfere with HIV prevention and treatment efforts, or cause additional hardship and harm to people infected or affected by HIV.

## Religion

The values of unconditional love, care, compassion and tolerance will form the foundation of the HIV response. Churches and faith based organisations are important partners, particularly in the delivery of key HIV services. Programs will promote the role of the churches, except where doctrine interferes with human and legal rights and evidence-informed prevention and treatment efforts.

## Flexibility and responsiveness

The PNG response to HIV will be flexible, taking account of lessons from local practice through reflection and analysis. As needed, the response will adjust to changes in the epidemic and its driving forces.

## Accountability

Accountability, transparency and honesty must underpin the work of all stakeholders in the national response to HIV.

## Capacity

To ensure an effective response, organisational and human capacity must be strengthened at national, provincial, district and local levels among government, civil society, the private sector and within communities.

## Systems strengthening

The Government of PNG and development partners will ensure that investments in HIV and AIDS strengthen systems at all levels (for example, health, education, social protection, community support systems, civil society).

## Partnership and collaboration

Programs need to be truly multi-sectoral, involving as many partners as is necessary. These partnerships should be based on mutual trust, respect and sharing.

One overarching strategy, one M&E framework and one central coordinating body

There will be one overarching National HIV and AIDS Strategy to guide and drive the response of all partners, with one M&E framework, coordinated by the NACS.

## Sustainability and self-reliance

The Government of PNG and development partners will promote self-reliance, efficiency and sustainability of the HIV and AIDS response. The Government of PNG will steadily increase its financial commitment in meeting the cost of the national HIV response.



# Priority area 1: Prevention

## Goal

To reduce the transmission of HIV and STIs in PNG using a combination of prevention approaches

## Strategic priorities

There are three strategic priorities for prevention:

1. Reduce the risks of HIV transmission
2. Address factors that contribute to HIV vulnerability
3. Create supportive and safe environments for HIV prevention.

# Strategic priority 1: Reduce the risks of HIV transmission

## Cluster 1.1: Sexual transmission of HIV and other STIs

Reducing sexual transmission of HIV and other STIs is a core priority. Addressing risks associated with sexual transmission means increasing access to programs, services and resources which help people understand HIV risk in relation to their own behaviour and life circumstances. Risk reduction interventions that address sexual transmission will need to motivate, support, educate and give people the skills to make the changes needed to protect themselves and others.

Reducing the number of concurrent sexual partners, increasing correct and consistent condom use, and increasing the availability of gender and age-sensitive post-exposure prophylaxis (PEP) for HIV and STIs are just some of the critical interventions that will be implemented.

In recognition that not everyone has the same level of risk, more-at-risk populations will be identified and targeted with combination prevention interventions. Interventions that help protect people engaged in sex work or who exchange sex for cash, goods and services will be rapidly scaled-up. Ensuring PLHIV and more-at-risk populations are engaged in the design, delivery and review of risk reduction interventions will be critical to the success of HIV and STI prevention efforts.

### Strategic objectives

- 1.1.1 Increased understanding in the general population of contributing factors, driving forces and behaviours that contribute to the risk of HIV and other STIs
- 1.1.2 Increased correct and consistent use of male and female condoms, with an emphasis on people who have multiple serial and concurrent sexual relationships
- 1.1.3 Increased correct and consistent use of condoms and lubricant for heterosexual and homosexual anal sex
- 1.1.4 Males and females reduce the number of their concurrent sexual partners
- 1.1.5 Universal access to quality STI and HIV PEP services for sexual assault cases and partners exposed to HIV in sero-discordant relationships, including increased availability in non-health settings
- 1.1.6 People engaged in sex work and their clients adopt and sustain behaviours that reduce the risk of HIV transmission
- 1.1.7 People who exchange sex for money, goods and services and their clients adopt and sustain behaviours that reduce the risk of HIV transmission
- 1.1.8 Men who have sex with men adopt and sustain behaviours that reduce the risk of HIV transmission
- 1.1.9 Other more-at-risk populations are identified and interventions established to address specific risk behaviours, based on evidence from surveillance data and social and behavioural research

- 1.1.10 People living with HIV and their partners are supported with programs to protect their sexual health and reproductive rights
- 1.1.11 People who are targeted by HIV prevention programs are involved in the design, implementation and review of programs that aim to reduce the sexual transmission of HIV and other STIs

## Cluster 1.2: Prevention of parent to child transmission of HIV

PPTCT is vital for reducing the impact of HIV on children, families and communities throughout PNG. The aim is to provide a comprehensive range of services that will facilitate reducing primary HIV infection in women in the reproductive age group (15 to 49 years), preventing unintended pregnancies in women with HIV, preventing transmission during pregnancy, childbirth and feeding and providing care and support for HIV infected women, children and families. For PPTCT to be effective, the male partners of pregnant women need to be actively involved at every stage and take personal measures to prevent transmission of HIV to their partners and children.

To ensure PPTCT programs are effective, greater efforts will be made to improve MCH service provision. The capacity of health workers and systems will be increased to ensure wider availability of quality PPTCT. Communication and community mobilisation strategies to increase awareness of and uptake of PPTCT services will be established with strong referral linkages to community and social support services.

Women will need to feel assured that the results of their HIV status will be treated in confidence. Fears of violence and abandonment are very real concerns for many women testing positive for HIV in PNG.<sup>xvii</sup> Programs will need to minimise these negative consequences if women and their partners are to come forward and access PPTCT services.

### Strategic objectives

- 1.2.1 Strengthen management and coordination capacity of PPTCT services and link them to MCH services at national and sub-national levels
- 1.2.2 Improve the quality and access of PPTCT services by creating strong linkages to MCH and the community, increasing involvement of positive women and their partners and ensuring programs provide safeguards against negative consequences of testing
- 1.2.3 Strengthen the capacity of health workers and stakeholders to deliver quality PPTCT services, integrated with MCH services
- 1.2.4 Ensure consistent supply of HIV-related commodities to all ANC sites
- 1.2.5 Improve monitoring and reporting systems for PPTCT within MCH systems

## Cluster 1.3: Transmission of HIV in health care settings

National guidelines for standard precautions have been established, but these have not been implemented widely enough. More importantly, the guidelines for universal precautions are of little use if the basic resources - such as soap, gloves, masks and sterile equipment - are not available.<sup>xxvii</sup> The fears of health workers often translate into negative attitudes towards patients who are HIV positive, or suspected to be HIV positive. Discrimination from health workers stops people from accessing HIV, STI and health services.<sup>xxviii</sup> Addressing health worker concerns and providing them with the basic resources to protect themselves will be an important strategy to making health services more accessible for everyone. Access to PEP for accidental exposure to HIV will be available to all health workers. The successful blood product screening program will be continued.

### Strategic objectives

- 1.3.1 Standard precautions for infection control are consistently used in all health facilities
- 1.3.2 PEP for occupational exposure is available in all health facilities
- 1.3.3 All blood products are screened for HIV and other blood-borne pathogens

## Cluster 1.4: Injecting practices, penile modification and other emerging transmission routes

Recent behavioural research is showing some emerging practices in terms of injecting (drugs and penile injection), introduced penile modification practices and foreskin cutting both done within the context of initiation or less formally. The extent of injecting drug use is not yet known.<sup>xxix</sup> As the risk of HIV transmission through sharing injecting equipment is far greater than it is through unprotected sex, efforts will be made to increase surveillance and research to understand the degree of these practices and prepare for the possibility of an increase in this behaviour.

The practice of penile cutting and modification, including full foreskin removal, insertion of objects under the skin of the penis and dorsal slitting, is evident across the country and across age groups.<sup>xxx</sup> There is a risk of HIV transmission from shared unsterilised cutting equipment, as well as from sores and infection or unhealed cuts on the penis. Penile inserts can cause damage to the vagina and/or anus of sexual partners and often result in the tearing or breakage of condoms. Additionally, men who practice partial or full circumcision may incorrectly believe this practice protects them from infection and so are less likely to use condoms.

Specific interventions will address these risk behaviours and other emerging transmission routes (including sharing unsterilised tattooing equipment and use of vaginal drying products) based on targeted research and surveillance.

At this time, medical male circumcision will not be promoted as an HIV prevention strategy based on the current level of prevalence, inadequate capacity in the health system and the challenge of promoting accurate messaging about the risks and benefits.

## Strategic objectives

- 1.4.1 Interventions are developed that reduce the risk of HIV transmission from penile modification practices
- 1.4.2 Risk of HIV transmission from tattoos, piecing and scarification practices is reduced
- 1.4.3 Interventions are prepared to reduce the risk of HIV transmission from injecting drug use
- 1.4.4 Risks of HIV transmission from other emerging sexual practices are reduced

## Strategic priority 2: Address factors that contribute to HIV vulnerability

### Cluster 2.1: Gender-related vulnerability

Gender inequality is a key factor in vulnerability to HIV in PNG.<sup>xxxi</sup> The NHS will comprehensively address gender vulnerability as a fundamental part of HIV prevention.

Gender-related vulnerability is the result of social and cultural attitudes, practices and beliefs that disempower people, especially women and girls, and prevents them from accessing services and resources which could protect them from HIV. The roles, relationships and cultures that contribute to what it means to be a boy, girl, teenager, woman, man or transgendered person have a great effect on the epidemic. Customs such as bride price, inheritance and polygamy contribute to power imbalances and sexual dynamics that increase the vulnerability of women. Efforts will be made to address the deeper factors that make people vulnerable to HIV: political, legal, economic, educational, religious and cultural.

Gender-based violence and sexual violence are endemic in PNG and are a major factor in HIV vulnerability.<sup>xxxii</sup> Interventions which reduce physical and sexual violence against women and girls, and which support survivors of violence will be urgently scaled-up.

Strengthening family and couple relationships through improving communication and discussions about gender, sex, sexuality and relationships will be an important strategy. Many women are vulnerable to HIV through the behaviours of their husbands and this issue needs to be urgently addressed by community interventions.

## Strategic objectives

- 2.1.1 Men, women, girls and boys are meaningfully involved in HIV prevention interventions
- 2.1.2 Multi-sectoral responses to reduce gender-based and sexual violence are implemented
- 2.1.3 Survivors of gender-based and sexual violence have access to comprehensive services to reduce HIV-related vulnerability
- 2.1.4 Men and boys are effectively involved in programs that address gender inequality and gender-based violence

- 2.1.5 Programs to address political, economic, social, educational and legal factors that contribute to gender-related HIV vulnerability are established and scaled-up
- 2.1.6 Interventions that advocate against and address cultural practices and factors that increase gender-related HIV vulnerability are established (examples of practices include polygamy, bride price, initiation, child marriage, *haus man*, pre-marital sexual practices and divorce and inheritance customs and laws)

## Cluster 2.2: Vulnerability of young people

Young women and men (aged 15 to 24 years) are particularly vulnerable to HIV, yet their voices have largely not been heard in the national response. In the NHS young people are seen as a valuable resource and they will have a meaningful role in the planning, delivery and review of HIV and STI prevention services for young people.

Interventions that promote delay of sexual debut will be established and expanded. In order to reduce the vulnerability of young people, programs that provide income generation, life skills development and educational opportunities will be established. Young people are also vulnerable as a result of drug and alcohol use, sexual violence and abuse, gender inequalities, family breakdown and lack of access to youth-friendly sexual and reproductive health services and education. Young people who are particularly vulnerable include the unemployed, those exchanging sex, those who are illiterate, street youth, *raskols* and young men and women living with HIV. <sup>xxxiii</sup>

Working with young people on HIV prevention will require a gender sensitive approach that recognises the different sexual realities of young men and women. Approaches will also address the roles that adults play in influencing the sexual health of young people. This can often be seen in the way adults deny young people their right to access services, information and condoms. In addition, young people, especially young women and girls, are vulnerable to sexual exploitation and cross-generational relationships. Interventions that reduce these vulnerabilities are a critical part of the NHS and will be the shared responsibility of families, communities, government, churches and civil society.

### Strategic objectives

- 2.2.1 Young people, both in and out-of-school, have access to quality information and resources for STI and HIV prevention including sexuality, sexual and reproductive health, gender-based violence and life skills education
- 2.2.2 Young people are meaningfully involved in the design, management, implementation and monitoring of HIV, STI and sexual and reproductive health (SRH) programs, especially those that target young people
- 2.2.3 Young people have access to quality youth-friendly sexual and reproductive health services and condoms
- 2.2.4 Programs targeting out-of-school youth for STI and HIV prevention are established and expanded
- 2.2.5 Young people in schools, colleges and universities have access to quality and accurate education and resources on HIV, STIs, sexuality, life skills and SRH
- 2.2.6 Cultural, political, economic, social, educational, religious and institutional factors that contribute to the vulnerability of young people to HIV are identified and addressed

- 2.2.7 The Law and Justice Sector implements protective measures that reduce the vulnerability of young people to HIV
- 2.2.8 Interventions for out-of-school or unemployed youth are established that address income generation, literacy, numeracy and life skills development to reduce vulnerability to HIV
- 2.2.9 Interventions that promote delay of sexual debut are established and expanded

## Cluster 2.3: Vulnerability of children

The provision of protection, care and support services for vulnerable children, including children living with HIV, is a matter of increasing urgency. Children affected by HIV and AIDS include a relatively small number who are HIV positive and a far larger number who are not infected but whose parents are living with, or have died of AIDS-related illnesses.

In addition, there are many children who are vulnerable to HIV through violence, abuse, neglect and exploitation. Children living or working on the streets, orphaned or adopted children, children with disability, children in conflict with the law and children who are being sexually abused are all particularly at risk.<sup>xxxiv</sup>

Key government departments, NGOs, churches and community based organisations (CBOs) will develop actions and strategies to prevent and respond to sexual abuse, neglect and exploitation of children. The *Lukautim Pikinini Act, 2009* and the Most Vulnerable Children Strategy will be implemented. Interventions will integrate care and support services for vulnerable children, including children living with and affected by HIV, orphans and children with disability. Special measures are also urgently needed for the growing numbers of street children, who may have no family or community connections. Efforts will continue to ensure every child goes to school and completes a basic, quality education. The Department of Education and its partners will also focus on the provision of age-appropriate information for children on reproductive and sexual health issues, HIV and STIs, life skills and child rights.<sup>xxxv</sup>

### Strategic objectives

- 2.3.1 Key government departments that work to reduce the vulnerability of children have increased capacity
- 2.3.2 Children, particularly vulnerable children, are meaningfully engaged in the planning, management and evaluation of child-related HIV services and programs
- 2.3.3 Organisations that advocate for and support vulnerable children and orphans are strengthened
- 2.3.4 Children, particularly vulnerable children, have access to appropriate and quality education on HIV, STIs, sexuality, sexual and reproductive health and life skills
- 2.3.5 Programs that support parents, families and communities to reduce the vulnerability of children to HIV are established and expanded

## Cluster 2.4: Vulnerability of more-at-risk populations

An effective combination of HIV prevention approaches includes strategies for working directly with people who are more-at-risk of HIV infection due to sexual practices, life circumstances, and social, cultural and legal structural factors that create risk and vulnerability. In PNG, more-at-risk populations include women and men involved in sex work, men who have sex with men, migrant workers, enclave workers, prisoners and mobile men with money (such as public servants, police, politicians, landowners, cash crop buyers and sellers, transport sector workers, and business men). The sexual partners of these more-at-risk populations are also vulnerable to HIV and will be included in prevention interventions.<sup>xxxvi</sup>

A critical part of developing and scaling-up prevention interventions is having a good understanding of which populations are most vulnerable, the factors affecting their vulnerability, their sexual practices and sexual networks and where are they located. More-at-risk populations will be meaningfully involved in the development and implementation of prevention interventions. These interventions will also address the stigma and discrimination towards more-at-risk populations which prevents access to services.

Vulnerability can change and it is important that research and surveillance be continuously used to inform interventions. It is possible that different groups could be considered vulnerable in time as trends and patterns in the HIV epidemic change and evolve.

### Strategic objectives

- 2.4.1 Prevention interventions that reduce the vulnerability of more-at-risk populations are developed, based on social research
- 2.4.2 HIV-related stigma and discrimination against more-at-risk populations and their families is reduced
- 2.4.3 Male and female prisoners have access to prevention interventions that reduce the harms associated with unsafe sex, tattooing, penile modifications and inserts, including condoms and sterile disposable instruments
- 2.4.4 Prevention interventions that reduce the vulnerabilities of mobile men with money and their partners are established and expanded
- 2.4.5 Prevention interventions that reduce the vulnerabilities of economic enclave workers and their partners are established and expanded

## Cluster 2.5: Drugs and alcohol

The relationship between drug and alcohol use and HIV risk and vulnerability is significant. Alcohol and drug use is pervasive throughout PNG, affecting people's decision making in relation to sexual behaviour and their ability to protect themselves and others from HIV. The use of marijuana and alcohol remains closely associated with unprotected sexual activity and acts of sexual violence.<sup>xxxvii</sup>

Harm reduction strategies for alcohol and marijuana will be included in planning all prevention interventions. Current programs will be reviewed to identify the extent to which HIV vulnerability associated with drugs and alcohol is being addressed and to ensure learning is shared between projects. Research will be used to inform



the development of new alcohol and drug harm reduction interventions. Changing behaviours associated with alcohol and marijuana use will address the social and cultural contexts within which drugs and alcohol are consumed. Community mobilisation will be an important strategy.

## Strategic objectives

- 2.5.1 Gender specific drug and alcohol harm reduction interventions are included within HIV prevention programs, especially within more-at-risk populations
- 2.5.2 HIV vulnerabilities associated with *buai* trade are reduced
- 2.5.3 National policy on harm reduction for drugs and alcohol is established and legislative barriers to harm reduction programming identified and addressed

## Strategic priority 3: Create supportive and safe environments for HIV prevention

### Cluster 3.1: National and local social and cultural events

Events such as sports, elections, church and cultural celebrations are important times in PNG society. These national and local social and cultural events can create an environment for sexual networking and transmission of HIV. They also provide unique opportunities for HIV prevention.

Churches, sports clubs and associations are key organisations for community participation and action, and an opportunity for facilitating peer group discussion about safe sexual practice, behaviour change and the inclusion of people living with HIV. Prevention interventions within these organisations and events will build on the Christian Leaders' Alliance on HIV and AIDS and the PNG Declaration on HIV and AIDS Prevention through Sport.

Research from the Highlands Region has demonstrated an increase in multiple concurrent sexual partnering during election periods. Planning for future election campaigns will include HIV prevention. In addition, the vulnerabilities associated with compensation and land-owner payment ceremonies, especially in high-burden provinces, will be addressed in the NHS. Locations such as night clubs will also be targeted with prevention interventions and condom distribution.

Cultural performance and church gatherings offer unique channels for communicating about HIV prevention in ways that are sensitive and relevant to local communities. The widespread use of theatre, dance, music and art will be harnessed more effectively as mediums for HIV prevention.

## Strategic objectives

- 3.1.1 Cultural, church and social events are used as opportunities for HIV and STI prevention

- 3.1.2 Sporting events and sports clubs are used as entry points for HIV and STI prevention interventions
- 3.1.3 HIV and STI prevention interventions are scaled-up in high-risk settings during elections
- 3.1.4 HIV prevention interventions are scaled-up in high-risk settings where high cash flow is occurring such as landowner payments, compensation ceremonies and seasonal payments for major crops
- 3.1.5 Prevention interventions that focus on hotels, nightclubs, *haus piksa* and bars are established and scaled-up

## Cluster 3.2: HIV prevention in the workplace and in economic enclaves

Many private sector organisations have made good progress in the mainstreaming of HIV prevention through workplace policy development and the promotion and provision of workplace HIV education programs. Efforts are now needed to build on the work of BAHA and expand workplace-based HIV prevention into all workplaces, including in the informal sector, government, churches and NGOs.

Due to the capacity constraints in the public sector, public private partnerships (PPP) will provide a valuable opportunity to strengthen both HIV prevention and care and treatment. Efforts will be made to expand the model of HIV prevention developed in the NDoH-ADB HIV Prevention in Rural Enclaves Project, with a focus on strengthening primary health care delivery and improving basic health infrastructure.

The significant health impact of large resource developments and economic projects (such as the liquefied natural gas Project, mines, special economic zones and agricultural plantations) must be planned for and addressed comprehensively. Specific commitments on HIV and STI prevention and gender equality must be included in contracts relating to resource extraction, the transport sector, infrastructure construction and economic enclave development. Existing work to reduce HIV vulnerability in economic enclaves and in economic corridors such as the Highlands Highway will be sustained and expanded.

### Strategic objectives

- 3.2.1 HIV and STI interventions in formal and informal work environments are strengthened and expanded
- 3.2.2 Government, union, private sector and civil society employers develop and implement human rights based HIV and AIDS workplace policies
- 3.2.3 Economic enclaves and resource developments include HIV prevention and primary health care interventions
- 3.2.4 Expand and improve public private partnerships for the delivery of HIV prevention, care, support and treatment services

# Priority area 2: Counselling, testing, treatment, care and support

## Goals

1. To increase the number of people who know their HIV status and are screened for STIs by expanding access and demand for quality, user-friendly and stigma-free counselling and testing services
2. To decrease illness related to HIV and STIs and deaths from AIDS-related illnesses by expanding access to quality, user-friendly and stigma-free treatment services
3. To improve the quality of life of people living with and affected by HIV through expanded access to quality, user-friendly and stigma-free care and support services

## Strategic priorities

There are two strategic priorities for priority area 2:

1. Scale-up HIV counselling and testing
2. Expand treatment, care and support services

# Strategic priority 1: Scale-up HIV counselling and testing

## Cluster 1.1: HIV counselling and testing

Expanding access to and increasing uptake of HCT is fundamental to the achievement of the NHS goals. Equitable access to these services, regardless of gender, age, geographic location or sexual practice is both a moral and public health obligation. HCT is an important entry point to prevention and care, treatment and support services. The availability of HCT will be extended to all parts of the country. The priority is to make these services available at the local level in provinces and districts with the highest HIV prevalence.

HCT will move beyond the traditional models of VCT and make PICT and outreach testing more widely available, while respecting individual informed consent. Scaling up the availability of PICT in STI, TB and ANC services will be a priority. Greater emphasis needs to be placed on ensuring the national roll-out of POC rapid testing and confirmation. Quality control issues are key to the success of HCT and quality assurance mechanisms will be included as a major feature in the roll-out of HCT services. People living with HIV bring a unique perspective to the counselling and testing process and will be involved in an integral way in the design, delivery and review of HCT services.

### Strategic objectives

- 1.1.1 General population in rural communities in high burden provinces have access to quality, user-friendly and stigma free HCT services through their nearest health service, community based services, workplace and/or VCT outreach services
- 1.1.2 General population in urban communities have access to quality, user-friendly and stigma free HCT services through their nearest health service, community based services, workplace and/or VCT outreach services
- 1.1.3 Priority target populations have access to quality HCT services that are sensitive to their specific needs, concerns and situation
- 1.1.4 People living with HIV are increasingly involved in HCT service design, delivery and review
- 1.1.5 There is an effective quality assurance system for HCT in place
- 1.1.6 Develop capacity within HCT services for specialist HIV counselling and testing in relation to sexual assault, child abuse, and couples counselling
- 1.1.7 Improved linkages between STI, TB, ANC, ART, family planning, SRH, gender-based violence services and support services through integration of service delivery or referral pathways at each HCT service site
- 1.1.8 HCT services are gender sensitive and meet the different service needs of males, females, and transgendered people, including young people
- 1.1.9 All HCT services promote and provide accurate prevention information and condoms to all clients
- 1.1.10 All HCT services use POC rapid testing and confirmation, backed by quality assurance programs
- 1.1.11 Reduce stigma and discrimination related to HCT services at the community level

# Strategic priority 2: Expand treatment, care & support services

## Cluster 2.1: Treatment

All people living with HIV should have access to good quality care and treatment services, irrespective of where they live. It is very important that all adults and children requiring these services are treated with dignity and respect. The expansion of treatment services will need to be prioritised, initially to areas with the greatest numbers of people requiring treatment. PLHIV will be encouraged to participate in the design, delivery and evaluation of services as they provide an important complementary role to health workers. Strengthening treatment adherence, preventing the onset of opportunistic infections, (including malaria), and improved monitoring of treatment resistance will be key elements in the expansion of treatment services. Treatment guidelines will be revised and updated to accommodate improvements in care and treatment as a result of new affordable POC technologies.

HIV prevention programs will increasingly integrate sexual and reproductive health services and HIV testing with treatment and care. In PNG there is a strong likelihood of co-infection with other STIs and with TB. Improved integration of these treatment services, both within the health sector and through links to community-based programs of care and support, will improve people's health.

### Strategic objectives

- 2.1.1 Increased access to quality ART services for adults
- 2.1.2 Expansion of ART services to districts and the local level will be prioritised according to local HIV prevalence
- 2.1.3 Access to and capacity to provide effective opportunistic infection (OI) prevention and management is increased
- 2.1.4 There is an effective quality assurance system for ART and OI services
- 2.1.5 Increase the number of linked or integrated treatment services for STI, HIV, ANC, TB and GBV
- 2.1.6 Models of comprehensive care that link prevention with HCT, treatment, gender-based violence services, home based care (HBC) and community support are expanded
- 2.1.7 People living with HIV are involved in the planning, delivery and review of treatment and care services, guidelines and policies
- 2.1.8 HIV treatment services are gender sensitive and meet the different service needs of males, females, and transgendered people, including children, young people and more-at-risk populations
- 2.1.9 Improve the quality of, and access to, laboratory services to support the diagnosis and management of STIs, HIV and AIDS
- 2.1.10 Develop, implement and scale-up a range of ART and OI adherence interventions

## Cluster 2.2: Paediatric treatment

All HIV positive children must have access to quality paediatric ART, including care and support services. For children it is important to start treatment early to ensure better health outcomes. A key component of the NHS is to expand access to early infant diagnosis by testing all babies born to HIV positive mothers. The expansion of POC testing will also increase access for children in need of health care. Key components in the NHS include ensuring quality of paediatric ART, continuous supply of drugs and test kits, and training for health care providers. ART access for children will initially be expanded to areas with the highest numbers of children in need of treatment.

Linkages with HBC and support programs and community outreach programs are important to ensure that HIV positive children have access to treatment, care and support services. Strengthening the quality of counselling for children, monitoring treatment outcomes, providing nutritional support and preventing opportunistic infections will be key areas of work in the NHS.

### Strategic objectives

- 2.2.1 Management and coordination capacity of paediatric AIDS services strengthened and linked with MCH services at national and sub-national levels
- 2.2.2 Quality of delivery of paediatric AIDS services is improved with expanded access to early infant diagnosis, testing and treatment, care and support for all children, with linkages with MCH and PPTCT services.
- 2.2.3 Increased and improved capacity of health care workers and stakeholders to deliver quality paediatric AIDS services, integrated with MCH services
- 2.2.4 Ensure consistent supply of HIV related commodities including drugs, test kits and improved supply management for quality implementation of the paediatric AIDS program, integrated with MCH services to all ANC and child health sites
- 2.2.5 Improve monitoring and reporting systems and operational research to ensure quality data collection and flow to inform program implementation for MCH, including paediatric AIDS services

## Cluster 2.3: Sexually transmitted infections

As STIs facilitate the transmission of HIV, the effective delivery of STI services is critical for HIV prevention. The alarmingly high number of STI cases in PNG points to the need for targeted and integrated STI treatment services, as well as expansion of STI services. Scaling up diagnosis and treatment across PNG will be a high priority in the NHS. This will include ensuring availability of medication and test kits and expanding and improving health worker training.

In addition to gender specific services, age specific STI services for children and young people will be established. It is important that such services are delivered from a rights based perspective, which requires capacity building of clinical teams on the issues of youth and child sexual abuse, rights and referral services. Capacity building for health workers to recognise and address gender-based violence and the implications for STI prevention and treatment and the use of PEP is also essential.

## Strategic objectives

- 2.3.1 Free quality STI screening and management is accessible in all health facilities, including ANC services
- 2.3.2 Increased program prioritisation and funding to STI and sexual health by government, NGOs, donors and churches
- 2.3.3 Gender sensitive, non-judgmental STI clinical services meet the different service needs of males, females, and transgendered people, including children, young people and more-at-risk populations
- 2.3.4 Maintain adequate supply of STI medications at all health facilities and STI test kits at designated sites

## Cluster 2.4: Community and family support

The growing number of orphans and vulnerable children, people living with HIV and households requiring income support and assistance highlights the need for action, particularly for community driven responses. Efforts will focus on understanding and mitigating the impact of HIV on households and communities, using a wide range of interventions and addressing stigma and discrimination.

There will be more community and family support outreach services. Facility based health services will be linked to family and community support, including HBC. The growing number of grassroots initiatives has the potential, if provided with funding and technical assistance, to develop into significant services. The role of churches and NGOs will be essential in providing holistic care and support.

Support services will be designed and delivered in a collaborative manner with the intended beneficiaries of those services. The participation of men, women, transgendered people, young people and children who are living with, affected by, or vulnerable to HIV is essential to the successful planning and delivery of these critical services.

## Strategic objectives

- 2.4.1 HBC and community and family support effectively linked to HIV clinical services, including nutrition support
- 2.4.2 Community care and support groups can access grants and technical support to improve the lives of people living with and affected by HIV and AIDS
- 2.4.3 National standards for HBC are established, monitored and used by service providers
- 2.4.4 People living with HIV are involved in the planning, delivery and review of care and support services, guidelines and policies
- 2.4.5 People living with HIV have access to quality, relevant and sensitive counselling, psycho-social support and nutrition support
- 2.4.6 AIDS orphans and children affected by HIV are supported by community and family based services, and protected by legal services
- 2.4.7 An increase in the number of local support groups run by people living with HIV
- 2.4.8 Increased livelihood support, education, training and vocational skills building initiatives for people living with HIV and their families

- 2.4.9 Increased availability of initiatives that promote positive health, dignity and prevention
- 2.4.10 Increased number of men and boys involved in the care, treatment and support for people living with HIV
- 2.4.11 Innovative community based approaches to care and treatment adherence are supported, evaluated and shared
- 2.4.12 Care and support programs addressing the specific requirements of youth living with HIV are developed and implemented
- 2.4.13 PLHIV who have additional vulnerabilities (for example, MSM, sex workers and prisoners) have access to appropriate support and services



# Priority area 3: Systems strengthening

## Goals

1. To improve the collection, management, analysis, dissemination and use of strategic information to guide the response.
2. To strengthen systems and organisations through ensuring the meaningful involvement of people living with HIV and addressing gender inequality.
3. To strengthen leadership of the HIV response at all levels.
4. To reduce stigma and discrimination against people living with HIV and groups thought to be at higher risk of HIV infection.
5. To build the capacity of people, communities and organisations to mobilise, coordinate and implement the HIV response at all levels.

## Strategic priorities

There are three strategic priorities for systems strengthening:

1. Improve strategic information systems
2. Strengthen the enabling environment for the national HIV response
3. Strengthen organisational and human capacity for coordinating and implementing the NHS

# Strategic priority 1: Improve strategic information systems

## Cluster 1.1: Monitoring, evaluation and surveillance

A critical function of surveillance is detecting new clusters of HIV infection and tracking behaviour change in the general and more-at-risk populations to enable prioritisation of areas, settings, and population groups for focused interventions. Investments will continue to support efforts in strengthening the national M&E and surveillance systems. Priority will be given to systematic quality assurance auditing of data and verification at all levels of collection, management and analysis. Planners and managers at various levels of HIV service delivery in provinces, districts and civil society organisations will have their capacity strengthened to synthesise, analyse, disseminate and utilise the information for evidence-based decision making, including consistent and accurate gender and age analysis.

A new national spending assessment will allow tracking of the flow of funds from the funding agency to the service providers and beneficiaries. All stakeholders and coordinating authorities will be able to see actual expenditure by sector, funding agency and intervention type. The greater transparency provided by this system will allow stakeholders to assess the cost effectiveness of interventions and their relevance in meeting the priorities set by the NHS.

### Strategic objectives

- 1.1.1 National M&E and surveillance frameworks for HIV, AIDS and STIs are developed and adopted by all stakeholders
- 1.1.2 Provincial M&E and surveillance systems are established, equipped, and enabled to collect, analyse, report and disseminate sex and age disaggregated information and data as part of the national framework
- 1.1.3 Establish a national HIV and AIDS spending assessment system which reports annually
- 1.1.4 The national M&E framework is fully operationalised and includes regular gender-sensitive analysis, synthesis and dissemination of data, program reviews and evaluations

## Cluster 1.2: Bio-behavioural research

A better understanding of PNG's HIV epidemic is urgently needed. Regular, high quality, national integrated bio-behavioural surveys (IBBS) in the general population and IBBS in targeted populations are the best instruments to provide this information. Increased understanding of the drivers of the epidemic and the dynamics of HIV transmission will inform the design, implementation and evaluation of a more effective national response. Conducting a quality national IBBS will also play an important role in strengthening the existing surveillance system and building the capacity of PNG research organisations.

## Strategic objectives

- 1.2.1 Integrated bio-behavioural and behavioural surveillance is conducted, based on the national surveillance framework
- 1.2.2 Build the capacity of NDoH, national research and academic institutions to conduct integrated bio-behavioural and behavioural surveillance
- 1.2.3 Biological surveillance for HIV and other STIs is strengthened to monitor the trends of infection and identify new pockets of infection

## Cluster 1.3: Social, behavioural and operational research

Given the cultural diversity in PNG it is important that prevention programs targeting specific populations and contexts be informed by local information from a combination of research and surveillance. Analysis of local dynamics and socio-cultural and economic conditions that contribute to the transmission of HIV is critical. The use of this evidence will help planners understand local situations and how the epidemic is changing. It will provide the basis for a more effective response.

Gender-sensitive research and analysis that focuses on sexuality and sexual practices will be conducted and disseminated. The National Research Agenda for HIV and AIDS (2008-2013) highlights the importance of engaging with targeted populations and communities to improve the design and use of participatory and gender-sensitive research methods that are relevant to these particular populations.

Support for research institutions will continue to develop the skills and capacity of local researchers through a capacity development plan and collaboration. The NHS also aims to build the capacity of organisations to use operational research to improve their programs, services and interventions.

## Strategic objectives

- 1.3.1 Social and behavioural research findings are available, disseminated and used effectively in shaping service delivery and interventions
- 1.3.2 Research focused on sexuality and sexual practices is conducted and disseminated
- 1.3.3 Build the capacity of national research and academic institutions to conduct ethically and technically sound social, socio-economic and behavioural research and develop the capacity of researchers
- 1.3.4 Encourage and build the capacity of major service providers to effectively initiate operational research projects and use and share research findings to improve their own service delivery programs and interventions

## Cluster 1.4: Coordination and management of research

Linkages and coordination between the Research Coordination Unit and Research Advisory Committee at NACS and surveillance teams at NDoH and the National Research Institute (NRI) will be strengthened to facilitate stronger partnerships. It is

important that all stakeholders in HIV surveillance, research and M&E work together and establish effective partnerships and appropriate mechanisms for coordination, reporting and data dissemination.

Ensuring adequate skilled human resources at all levels of M&E, surveillance and research will be fundamental to the effectiveness of the system. Human capacity building should focus on all levels of the system with regular opportunities for training and staff development. Capacity building will focus on enhancing skills in leadership, financial management, supervision, advocacy and communication, in addition to strengthening core technical skills.

## Strategic objectives

- 1.4.1 Research findings are regularly synthesised and widely disseminated
- 1.4.2 An effective research approval mechanism is operational to ensure research proposals are consistent with national research priorities and conform to good research practice

## Cluster 1.5: Utilisation of evidence

Evidence provides an important tool for advocacy to promote and develop a strong response to the HIV epidemic. Getting research findings into the public domain is both an ethical obligation and a practical necessity. Participatory approaches to HIV prevention will involve collecting data with targeted communities and sharing available research findings and surveillance data with the communities involved to clarify and triangulate findings, enhance their understanding of the situation and mobilise action. Local ownership in the research process and dissemination of results will enhance the translation of research findings into appropriate prevention interventions, policy development and advocacy.

Increased use of evidence will be facilitated through the creation of more opportunities for debates, discussion and analysis of evidence and increased numbers of seminars and publications to review and evaluate the progress and impact of the NHS. There will be emphasis on translating research into action.

The media influences both the policy environment and attitudes more broadly in the community. It can facilitate the spread of positive messages and play an important role in preventing transmission of HIV and reducing stigma and discrimination. Recent research on media coverage of HIV in PNG indicates the need to improve interpretation and news coverage so that it plays a more accurate and constructive role in the response to HIV. Programs that develop the skills, knowledge and attitudes of journalists and editors to more accurately report on HIV issues will be established.

## Strategic objectives

- 1.5.1 Evidence used to determine priority areas for intensified HIV programs
- 1.5.2 Capacity to translate evidence to action is improved
- 1.5.3 Dissemination of research findings and lessons learned to policy makers, program planners and service providers
- 1.5.4 Dissemination of research findings and lessons learned to populations, communities and health workers

- 1.5.5 Current evidence on the epidemic utilised to strengthen leadership engagement
- 1.5.6 Develop capacity for evidence-informed advocacy
- 1.5.7 Interpretation and reporting of HIV evidence and issues by the media is improved

## Strategic priority 2: Strengthen the enabling environment for the national HIV response

### Cluster 2.1: Gender

The NHS recognises that women, men, girls, boys and transgendered people are vulnerable to HIV and AIDS for different reasons and in different ways, and that gender inequality is a key factor. Specific measures will be taken to address these issues. The voices, needs and rights of men and women must shape the design, implementation and monitoring of HIV and AIDS programs.

All programs will address gender inequality in a comprehensive way. Developing the human and organisational capacity of organisations to work with men and women to address issues such as gender-based violence and cultural practices that increase potential for HIV transmission will be critical. Stronger partnerships and coordinated networks will be built to ensure comprehensive gender-related interventions. Effective advocacy and leadership as well as practical actions will be needed.

Every effort will be made to ensure women and men and boys and girls contribute and benefit equally from the HIV and AIDS national response.

#### Strategic objectives

- 2.1.1 All HIV and AIDS programs include interventions that address the underlying causes of gender-related vulnerability to HIV and AIDS
- 2.1.2 All HIV and AIDS programs utilise gender sensitive methods of planning, implementation, M&E
- 2.1.3 Men's organisations are established, supported and becoming visibly involved in HIV and AIDS related issues
- 2.1.4 Women's organisations are strengthened, supported and are significantly involved in addressing HIV and AIDS issues
- 2.1.5 The National Council of Women's network actively engaged in the HIV and AIDS response
- 2.1.6 Men and women leaders at all levels advocate for gender equality and the elimination of gender-based and sexual violence
- 2.1.7 Government of PNG can effectively coordinate and support facilities and services that address gender-based and sexual violence
- 2.1.8 Increase the participation of women and men in coordinating and decision making in the HIV and AIDS response at all levels

## Cluster 2.2: Greater involvement of people living with HIV

Effective prevention, care, treatment and support is enhanced when people living with HIV are directly involved in the response at all levels. Although people living with HIV are increasingly active in the response at national, provincial and local levels, this involvement has not reached its full potential. Efforts will focus on identifying and addressing the external factors that limit the full participation of people living with HIV.

There have been efforts over recent years to strengthen the capacity of organisations representing people living with HIV. However capacity continues to be limited. During the lifetime of the NHS, internal organisational barriers that limit effectiveness will be identified and addressed. Efforts to support the expansion of PLHIV groups and networks across PNG will continue. Consideration will be given to the need for PLHIV organisations that cater for the needs of specific groups of positive people such as women, young people and MSM. GIPA will also be a core principle reflected in the HIV and AIDS policies of all sectors.

### Strategic objectives

- 2.2.1 People living with HIV are meaningfully engaged in HIV and AIDS program design, management, implementation and M&E
- 2.2.2 PLHIV groups are effectively coordinated, supported and linked through a national network
- 2.2.3 PLHIV organisations are actively monitoring and reporting on progress towards implementation of GIPA and stigma and discrimination
- 2.2.4 Organisations develop and implement human rights based HIV and AIDS workplace policies

## Cluster 2.3: Leadership

Committed leadership from the national level down to the local community level is essential to improving the response to HIV and AIDS. A leader needs the skills to mobilise resources and people and to advocate for changes in society. They understand about HIV and AIDS, prevention, testing, treatment and human rights. Effective leaders recognise their important role and know how they and their communities can help.

Leaders may be people in positions of authority or they may emerge in response to the epidemic. They include elected leaders, public servants, church leaders, traditional leaders, leaders within vulnerable groups (sex workers and MSM), leaders of youth organisations, and leaders of organisations and communities. Leaders in the HIV response include women and men, young and old and heads of family households. Motivated leaders in HIV and AIDS demonstrate their commitment through their actions, their behaviours and their words. Supporting, mentoring and inspiring leaders throughout PNG will help achieve the goals of the NHS.

## Strategic objectives

- 2.3.1 Effective strategies and programs for engaging and strengthening male and female leadership at all levels are identified and supported
- 2.3.2 Greater numbers of leaders are conducting appropriate public messaging and advocacy and are supporting HIV and AIDS work nationally and locally
- 2.3.3 Coordination systems between key government departments are improved and functioning effectively
- 2.3.4 Increased GoPNG funding for HIV and AIDS activities in line with the NHS priorities

## Cluster 2.4: Legal environment

PNG has created an enabling legislative and policy environment for addressing HIV through a range of policies and law. These include the *HAMP Act* and the *Lukautim Pikinini Act, 2009*. However, due to weak enforcement of the *HAMP Act*, accountability is limited. Awareness and understanding of key Acts needs to be promoted among partner organisations, leaders and communities. Review, awareness raising and implementation of existing policies and laws will be major activities of the NHS.

Laws that criminalise sex work and same-sex practices create barriers to people accessing services and reinforce vulnerability, stigma and discrimination. Greater advocacy from all stakeholders is needed to support plans for introducing reforms to legislation that aim to reduce vulnerability and stigma and discrimination.

## Strategic objectives

- 2.4.1 Key legislation relating to HIV and STIs is reviewed and implemented
- 2.4.2 Legislative reforms to improve the environment for effective HIV and AIDS prevention, treatment and care
- 2.4.3 Increase awareness of human and legal rights, key legislation and the needs of more-at-risk populations in HIV prevention and care

## Cluster 2.5: Stigma and discrimination

HIV stigma and discrimination adversely affects the lives of people living with HIV, people vulnerable to HIV, and their families. For many men and women diagnosed with HIV, the consequences of disclosing a positive test are devastating. Impacts include losing their jobs, violence, social exclusion and denial of care and emotional support, often from their own families and *wantoks*. For women, there are the additional fears of losing their children and homes due to customs related to marriage and land rights.

The fear of being stigmatised and discriminated against mean that people are less likely to be tested, less likely to tell their partner they are positive, and less likely to seek treatment and support services. Reducing stigma and discrimination is essential in controlling the HIV epidemic.<sup>xxxviii</sup>

Changing attitudes towards HIV and AIDS, people living with HIV, and people vulnerable to HIV, is a critical part of the NHS. Reducing stigma and discrimination will result in improved prevention and treatment and care and support services. Melanesian and

Christian values of love and care must be supported with effective laws (see Cluster 2.4) and a range of strategies and messages to promote tolerance, understanding, empathy and dignity. Strategic objectives addressing stigma and discrimination are included throughout the NHS.

## Strategic objectives

- 2.5.1 Improve the implementation of the HAMP Act
- 2.5.2 Increase understanding of the impacts of stigma and discrimination and the rights of PLHIV among key personnel in government, church, private sector and civil society organisations
- 2.5.3 Leaders, programs and organisations at the national, provincial and local levels advocate for the elimination of HIV-related stigma and discrimination
- 2.5.4 Develop community-based interventions and campaigns which reduce stigma and discrimination, based on social research and the People Living with HIV Stigma Index,<sup>xxxix</sup> particularly in high prevalence locations
- 2.5.5 Build the capacity of PLHIV and organisations to advocate and act against stigma and discrimination
- 2.5.6 Build capacity of organisations in human rights-based HIV and AIDS interventions and programs

# Strategic priority 3: Strengthen organisational and human capacity for coordinating and implementing the National HIV and AIDS Strategy

## Cluster 3.1: Capacity building

Capacity building is critical for achieving the goals of the NHS. A wide range of different strategies for developing the capacity of key organisations and people will be used. This support will be targeted where it will be most effective. Increasingly this assistance will be at the local, district and provincial levels.

Important areas for organisational capacity building include financial and human resource management. Strengthening the skills and knowledge of individuals and teams around prevention, treatment, strategic information and program management will also be important. Strategies will include mentoring, secondments, layered training and performance management. Critical to the success of the NHS will be the improved capacity of the NACS and Provincial AIDS Committees and Secretariats (PAC/PACS), particularly in high prevalence provinces.

Large national organisations, government departments and grassroots CBOs have different needs and will need different approaches. It is important to identify which capacity building strategies work best. NACS and its partners will ensure there are adequate and sustained resources for technical assistance, especially at the sub-national level.



## Strategic objectives

- 3.1.1 Strengthen the capacity of the NACS to effectively coordinate and manage the implementation of the NHS
- 3.1.2 Strengthen the capacity of PACs and District AIDS Councils (DACs) to effectively coordinate the implementation of the NHS
- 3.1.3 Increased funding and technical support for NGOs, faith based organisations (FBOs) and CBOs based upon rigorous capacity needs assessment
- 3.1.4 NGOs, FBOs and CBOs demonstrate improved capacity to effectively manage HIV and AIDS funds and programs
- 3.1.5 Increase technical assistance at the sub-national level
- 3.1.6 Effective partnerships between international and national NGOs, FBOs and CBOs are established, strengthened and sustained
- 3.1.7 Key government sectors are supported to effectively plan, implement, coordinate and monitor their HIV and AIDS implementation programs and plans
- 3.1.8 Practitioners (including volunteers) have increased skills and knowledge, consistent with national standards, about effective HIV interventions
- 3.1.9 Utilise a wide range of long-term effective capacity building strategies which are evaluated and disseminated
- 3.1.10 Increase the capacity of organisations to develop evidence-informed and culturally relevant information, education and communication materials

## Cluster 3.2: Decentralisation

The responsibility for PNG's HIV response is shared between local, provincial and national levels. All stakeholders at each level must know what their responsibilities are so they can take action and work together. Ownership and management of the response will be devolved to the right people at the right level. Effective decentralisation will be achieved by improving leadership, strengthening systems and building the capacity of organisations and people. Decentralisation strategies will include strengthened systems for accountability and link funding to improved performance.

Prevention, HCT, treatment, care and support programs will be adapted to the needs of local communities. Greater emphasis will be given to ensuring that accurate information and analysis on the local epidemic context, including gender-related factors, inform planning and budgeting at the sub-national level. These programs will be coordinated by provinces through structures such as PACs, Provincial Health Authorities and the Provincial Coordinating and Monitoring Committees (PCMC). Services will be delivered by a partnership of government, private sector and civil society organisations. Support for these organisations will be targeted at the sub-national level at the frontline of the epidemic.

Delivering a truly multi-sectoral and decentralised response will hinge on greater integration of HIV in government development planning frameworks including the Medium Term Development Plan (MTDP), key sectoral plans and provincial government planning and budgeting processes. Efforts will be made to strengthen capacity within relevant government departments to ensure HIV prevention measures are appropriately reflected and integrated into planning and budgeting frameworks.

## Strategic objectives

- 3.2.1 Strengthen oversight, accountability and coordination within the national level
- 3.2.2 Strengthen coordination between national and sub-national levels
- 3.2.3 Strengthen multi-sectoral coordination, planning and reporting at the provincial, district and local levels
- 3.2.4 Strengthen provincial, district and local level governments to ensure HIV and AIDS are mainstreamed into all provincial and district plans and budgets

## Cluster 3.3: Community participation and action

Mobilising communities is essential for intensifying and sustaining a comprehensive response to HIV in PNG. These communities can be villages, settlements, church groups, clans or other groups of people (such as MSM). Effective prevention and care strategies recognise the importance of kinship and family support systems, community and cultural values, religious beliefs and rapid socio-cultural change in shaping the contexts within which communities understand and respond to the epidemic. Behaviour change for individuals and groups must be based on the realities of people's lives and upon positive community values.

A meaningful community dialogue needs to take place within each community about sexuality, family life, gender, prevention, care and support. Communities need to recognise how HIV is transmitted in their community, how people are affected and what they can do about it. Churches and local NGOs will have a powerful role to play.

A number of programs for supporting community engagement in HIV prevention and building community capacity for change are being implemented in PNG. Systematic coordination and sharing of learning between these interventions will improve community mobilisation and create opportunities for more communities to become actively involved and self reliant in HIV prevention, care and support and social change.

## Strategic objectives

- 3.3.1 Communities are engaged, mobilised and supported to develop gender-sensitive community-oriented responses to HIV, particularly in high prevalence provinces
- 3.3.2 All groups in a community, including more-at-risk populations and PLHIV, are actively involved in the design, delivery and review of community-based interventions

# Management and coordination of the National HIV and AIDS Strategy

The implementation of the NHS requires a strong institutional and organisational framework to translate its strategic objectives into effective activity plans and to coordinate and strengthen linkages between sectors and between national and sub-national levels. Consistent with the guiding principles of the NHS, there will be one overarching NHS to guide and drive the response of all partners, with one M&E framework, coordinated by the NACS.

The weak coordination of the HIV response in PNG is an urgent issue, particularly with the growth in the number of players involved in the response and the number of activities being designed and implemented. The critical role of coordination must be the responsibility of the government and the coordination mechanisms need to be strengthened and supported. Strengthening coordination at every level and across sectors is a key goal under p area 3 of the NHS, where strategic priority 3 is to “strengthen organisational and human capacity for coordinating and implementing the national HIV and AIDS strategy”. This will primarily be addressed through more robust efforts at building the capacity within the key institutions and mechanisms. Strengthening decentralisation processes also features prominently here as greater responsibility for coordination of the NHS will be transferred to the provincial level.

There are many critical aspects to effective coordination. The two most critical, however, are related to planning and reporting. Greater efforts have been made to ensure all partners are conducting their annual planning within the context of GoPNG systems and processes, especially the annual corporate planning and budget cycle. The processes for planning, budgeting and reporting within GoPNG systems are provided in greater detail in the companion document to the NHS: Implementation of the National HIV and AIDS Strategy 2011-2015: Reference Guide for Annual Planning and Budgeting. The major emphasis in relation to the coordination of planning is to ensure that all implementing partners are aligning their proposed activities to the NHS. This requires all agencies to submit their annual activity plans (AAPs) to NACS, where they will in turn be submitted to the NHS Steering Group (NHS SG) to be assessed for consistency with NHS priorities. Proposals recommended for funding will be consolidated into one annual plan, with funding proposed for allocation under the Development Budget of NACS. This in turn enables GoPNG and development partners to determine their respective commitments to funding the NHS.

Figure 7 provides an overview of the key management and coordination structure of the NHS. This includes the key organisations and committees and associated relationships for the purpose of coordinating the national response. Some of these mechanisms are in place and working effectively. Others have yet to be instigated.

The **National AIDS Council** (NAC) is the principal coordinating agency of the many actors involved with HIV and AIDS in PNG. At the national level, NAC and its secretariat (NACS) are responsible for the formulation, review and revision of the national policy for the prevention, control and management of HIV and AIDS and for monitoring and coordinating the implementation of the NHS. NAC provides sectoral coordination and leadership, promotes the NHS strategy, and provides high level approval of the annual HIV implementation plans and budgets of all partners.

As the primary body responsible for the implementation of the national HIV response, NAC is required to report to, and is ultimately responsible to, the National Parliament. At the whole of government level, the linkage between NAC and the Central Agencies Coordinating Committee (CACC), and NAC and the Parliamentary Special Committee on HIV and AIDS (PSCHA) are also important but these have never been formalised. The NAC is supported technically by the **NHS Steering Group** (NHS SG) (formally the NSP Steering Group). The NHS SG is responsible for reviewing the annual plans and budgets of all partners and recommending what will be included in the consolidated Annual Activity Plan (AAP) submitted to GoPNG.

The **National AIDS Council Secretariat** (NACS) was established to support NAC in the formulation, review and revision of national policy and for monitoring and coordinating the implementation of the national response. As the operational arm of the NAC, NACS is ultimately responsible for the day-to-day management and coordination of the HIV response. To enable greater coordination of the national response, key functions of NACS include: coordination of donor activities, technical support to and facilitation of sector responses, technical support to and facilitation of NGO responses, coordination of technical support to provincial programs, oversight of national campaigns, providing the national knowledge management centre (repository of all reports on programs and evaluations, managing a database HIV activities based on mapping, and coordinating all HIV research including dissemination of findings through the Research Coordination Unit), managing resources for the national response, including liaising with donors on funding of programs and identifying and mobilising sources of funding, and M&E of the NHS and reporting on the status of both the epidemic and the response to NAC.

The **National Executive Council** (NEC) makes recommendations to the Parliament regarding approval of the consolidated annual plan and the NACS recurrent and development budgets. The NEC is the body responsible for the confirmation of the appointment of NAC members and the appointment of the NACS Director.

The **Parliamentary Special Committee on HIV and AIDS** was created in 2004 as an advocacy tool within Parliament and to build the capacity of parliamentarians to respond to HIV and AIDS appropriately, nationally and within member's electorates. Currently there is no clear relationship between the NAC and the PSCHA and this needs to be addressed. The PSCHA is potentially an important advocacy ally for the NAC within the national parliament.

As a statutory organisation, NACS comes under the leadership of the **Minister for Health and HIV/AIDS**, but their direct line of accountability for coordinating the HIV response is to the NAC. The Minister of Health and HIV/AIDS provides political support, high level advocacy and leadership for the response to HIV and AIDS. The **National Department of Health** (NDoH) responds to the leadership from the Minister and develops national policies and guidelines related to the provision of care and treatment for HIV, and the prevention of parent to child transmission through strengthening MCH

systems. NDoH is the body with primary responsibility for epidemiological tracking of HIV, AIDS and STIs in PNG. While NDoH is not an implementing organisation, it has overarching responsibility for coordinating the response within the health sector and provides technical and financial resources to the provincial level. NACS and NDoH have the greatest overall carriage of responsibility for the national response. As such, the relationship mechanisms between NACS and NDoH need to be strengthened as a matter of urgency.

The **Central Agencies Coordinating Committee** (CACC) initiated the whole of government response to HIV and the creation of the **National Joint Coordinating Committee** (NJCC) to coordinate the public sector response to HIV. The functions of the NJCC will be to facilitate the coordination of sectoral members to ensure compliance, consistency and harmonisation of all HIV and AIDS plans.

Similarly, the **PNG Alliance of Civil Society Organisations** (PACSO) has been identified as the mechanism to coordinate the civil society sector, **Igat Hope** has been proposed to coordinate PLHIV organisations and the **Business Coalition Against HIV and AIDS** (BAHA) to coordinate the private sector. The rationale that these four entities will alleviate the pressure on NACS to deal with every single agency is a sound one.

Key development partners include **AusAID, UNAIDS, ADB, EU, UNICEF, UNDP, WHO, World Bank, USAID, and NZAID**. These partners are actively involved in the planning of activities and services and directly and indirectly fund providers, agencies and organisations. The **Development Partners Forum** (DPF) is the mechanism for donors to coordinate their collective contributions to the response in order to reduce the burden on GoPNG in having to coordinate with each donor individually. It allows the NAC and the NACS to communicate with the development partners at single forum. This enables development partners to discuss and negotiate priorities, determine donor contributions to PNG, strive to eliminate duplication and promote application of resources according to needs. Development partners have direct relationships with NAC, NACS, NDoH and the Country Coordinating Mechanism (CCM). Where development partners are providing direct assistance to implementing organisations there will be a requirement for direct reporting from that organisation to the respective development partner, in addition to the reporting requirements that organisation has to provincial mechanisms such as the PAC or the provincial government.

The **Country Coordinating Mechanism** (CCM) is responsible for coordinating all grants, including proposals for new grants, from the Global Fund for AIDS, TB and Malaria (GFATM). Currently, NDoH is the only principal recipient of a GFATM grant. As such NDoH is required to report directly to the CCM on progress with implementation.

**Provincial AIDS Committees** (PACs) act as the agents of the NAC at the provincial level. They are responsible for promoting the direction of the NHS and coordinating all stakeholder activities at provincial and district levels. Information about the HIV situation in each province is gathered and channelled to the NACS and shared within the province. PACs should ensure capacity development is provided at the district level to develop annual plans. All plans will be consolidated into a logical provincial response that promotes the best use of available resources.

**Provincial governments** should actively take the lead through supporting the enabling environment for the delivery of services at provincial, district and community levels.

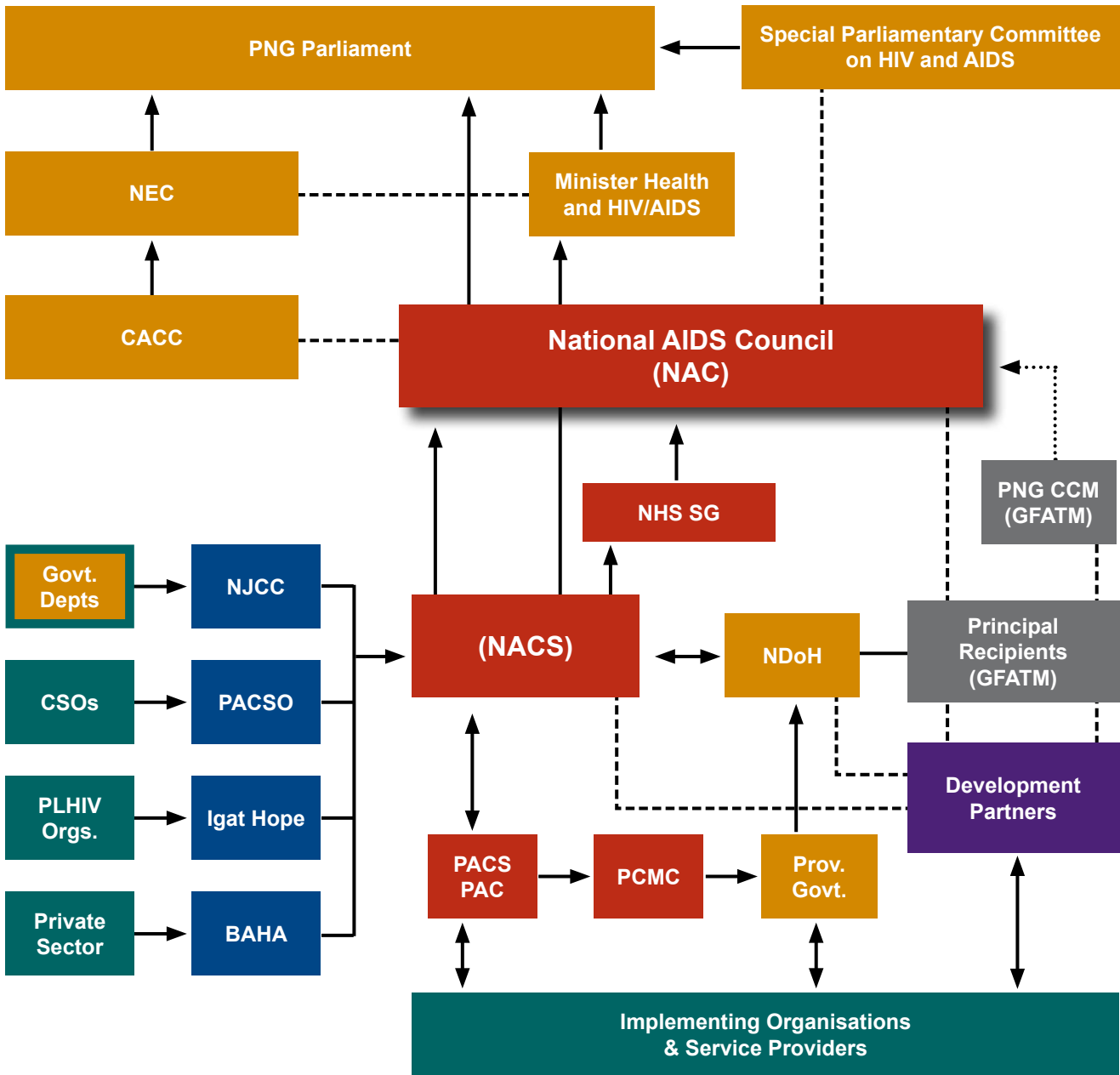
Provincial governments also ensure that national policy and plans are followed and that public sector responses are developed and implemented.

The **Department of Provincial and Local Government Affairs** (DPLGA) has, by way of an NEC Determination, delineated and assigned the service delivery functions and responsibilities for provincial and local-level Governments. The Determination identifies what services each level of government is accountable for and who is responsible for funding. The HIV services to be provided by different sectors such as Health, Education and Community Development, is also delineated. The Determination also includes development of policies and plans such as District HIV and AIDS plans.

National level coordination and monitoring of the implementation of national policies and programs is overseen by the **Provincial and Local Level Service Monitoring Authority** (PLLSMA) which is established under the DPLGA. Each province has established a **Provincial Coordinating and Monitoring Committee** (PCMC) which brings together the provincial government, businesses and civil society groups to monitor progress in implementing programs and improving services. This is the committee which the PACS and sectors responsible for providing HIV and AIDS services under the Determination report to in regards to the provincial response to HIV and AIDS. The PCMC also provides a conducive environment for the Provincial AIDS Committee (PAC) and its Secretariat (PACS) to be part of and report to the provincial administration and to get funding support from the provincial government.

The **Independent Review Group** (IRG) will continue to contribute to the ongoing M&E of PNG's national HIV response. The IRG is a group of internationally recognised inter-disciplinary experts, engaged by NACS, with multi-donor funding support. The IRG carries out regular assessments of higher level progress in implementing various aspects of the national response, holds feedback meetings and publishes reports of its findings.

**Figure 7: Overview of the NHS management & coordination structure**



**Keys:**

- Government entities
- Government HIV/AIDS Coordination arm
- Implementing Organizations and Service Providers
- Global Fund against AIDS, TB and Malaria
- Development Partners
- Coordination Arms of NACS

**Arrows:**

- Outward arrow = Submit
- Inward = Overseer
- Both ways = Interaction on daily basis
- Dotted lines = Provides assistance in System Strengthening and Capacity Building
- Dashed Lines = Funding and Capacity Building Assistance, and dual reporting through each strata of elevated authority.





# Glossary

**Combination prevention** is the concurrent use of all the strategies required to prevent transmission of HIV. These include development of a range of different education and behaviour change communication programs for those more-at-risk of HIV; promotion of male and female condoms; reduction in the number of sexual partners, particularly for those with multiple concurrent partners; HIV counselling and testing; prevention of parent to child transmission; prevention and treatment of STIs; promotion of blood safety; changes in laws and policies to counter stigma and discrimination; vulnerability reduction through social, legal and economic change; and harm reduction programs for injecting drug users.

**Communities** is a term used for a wide range of population groups which includes the community of people living in a defined geographic space such as a village. It also refers to groups of people in particular locations who may share a common characteristic which binds them together such as their sexuality (for example, homosexual men), occupation (for example, sex work), or gender identity (for example, women and transgendered people).

In **concentrated epidemics**, HIV has spread rapidly in a defined sub-population(s), but is not well-established in the general population. This epidemic state suggests active networks of risk within the sub-population. The future course of the epidemic is determined by the frequency and nature of links between highly infected sub-populations and the general population. In a concentrated epidemic, HIV prevalence is consistently over five per cent in at least one defined subpopulation and HIV prevalence is below one per cent in pregnant women in urban areas. In **generalised epidemics**, HIV is firmly established in the general population. Although sub-populations at high-risk (for example, sex workers) may contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection. In a generalised epidemic, HIV prevalence is consistently over one per cent in pregnant women which is used as a proxy for the general population.

An **enabling environment** is the social, legal and environmental factors that facilitate safe behavioural choice and encourage those most vulnerable to and living with HIV to participate at all levels of the response to the epidemic.

**Gender** is the socially constructed roles and relationships, personality traits, attitudes, behaviours, values, and relative power and influence that society assigns differently to women and men. Gender is related to how women and men are perceived and expected to think and act because of the way society is organised, not because of biological differences. The term 'sex' refers to biologically determined differences between women and men.

**Gender-based violence** refers to the various forms of violence that women, men, girls and boys, and transgender people, experience because of issues relating to gender and sexual identity. These forms of violence include domestic violence and other forms of physical violence, rape (including rape within marriage), sexual abuse and exploitation of girls and boys, incest, forced prostitution, sexual abuse by authorities during conflicts, disasters and emergencies (including by the police), and homophobic violence directed towards women and men who are, or assumed to be, attracted to the same sex.

**HIV mainstreaming** means all sectors and organisations (public, private and civil society) determining: 1) how the spread of HIV is caused or contributed to by their sector, or their operations; 2) how the epidemic is likely to affect their goals, objectives and programs; 3) where their sector or organisation has a comparative advantage to respond to limit the spread of HIV and to mitigate the impact of the epidemic; and 4) then taking action.

**HIV-related orphans** are children who have lost one or both of their parents as a result of the epidemic.

**Integrated biological and behavioural surveillance** measures HIV prevalence, and often STI prevalence, in a defined population(s) at a point in time, as well as behaviours and demographic information, to provide a better understanding of the dynamics of the epidemic. When these surveys are repeated over time, trends in the epidemic can be measured.

**Men who have sex with men** is a behavioural term that refers to biological males who have sex with other biological males, regardless of their sexual orientation or gender identity.

**More-at-risk populations** are groups of people who share a common HIV risk behaviour and often some other defining characteristic such as selling sex and where there is an existing rate of HIV infection (for example, sex workers who engage in unprotected sex with their clients). The populations who are more-at-risk vary over time as the dynamics of an epidemic change. In other countries the term 'most' at risk populations is generally used. There is currently insufficient epidemiological data in PNG to determine which populations are 'most' at risk so the term 'more' at risk has been used. In PNG, more-at-risk populations include: women and men involved in sex work and transactional sex, men who have sex with men, migrant workers, enclave workers, prisoners and mobile men with money (such as public servants, police, politicians, landowners, cash crop buyers and sellers, transport sector workers, and business men).

**Multiple concurrent sexual partnerships** are overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner. A sexual partnership is considered to be concurrent if a person reports having two or more overlapping sexual partners in the previous three months. It is well established that viral load, and thus infectivity, is much higher during the acute phase of HIV infection (that is, the window period). Where multiple concurrent sexual partnerships are common, the combined effects of sexual networking and the acute infection spike in viral load means that as soon as one person within a concurrent sexual network is infected, all other sexual partners are at higher risk.

**Operational research** involves the application of systematic research and evaluation techniques on the way services and interventions can be improved. Only factors that are under the control of program managers are studied.

The **overarching goal** of the NHS defines what the national HIV and AIDS response aims to achieve in the next five years.

**Penile modification** is any change made to the penis through: 1) cutting the penile foreskin, including full removal of the foreskin or the partial slitting of the foreskin on the dorsal side; 2) through the insertion of objects under the foreskin; and 3) through the injection of substances into the penis. Each type of penile modification increases the risk of HIV for both men engaging in these practices and their sexual partners. Risks arise from the use of non-sterile equipment, particularly if it is shared; increased trauma to the vaginal wall or rectum during intercourse resulting from the modification; an inability to wear a condom correctly due to the modification or increased risk of condom breakage; and the false belief that the modification (the foreskin cutting) provides a protective effect from contracting HIV. Penile foreskin cutting (partial slitting or full removal of the foreskin) has long been part of some of the diverse traditional male initiation practices in PNG.

**Polygamy** is the marital practice of having more than one spouse at one time. Polygyny with men having more than one wife has been traditionally practiced and is socio-culturally sanctioned in many parts of PNG, and particularly in the Highlands region. Polygamy creates networks of concurrent marital sexual partnerships and can increase risk of HIV transmission for women as condom use is usually reported least in the contexts of regular marital partners.

**Priority area goals** define what the NHS aims to achieve in each of its three priority areas in the next five years.

**Public - private partnerships** describes a government service or private business venture which is funded and operated through a partnership of government and one or more private sector companies.

**Second generation surveillance** is the regular and systematic collection, analysis and interpretation of biological and behavioural data for use in tracking and describing changes in the HIV epidemic over time. Second generation surveillance also gathers information on risk behaviours, using them to warn of or explain changes in levels of infection. As such, second generation surveillance includes: HIV surveillance and AIDS case reporting, STI surveillance to monitor the spread of STIs, and behavioural surveillance to monitor trends in risk behaviours over time.

**Sentinel surveillance** is the systematic, ongoing collection and analysis of biological data from certain sites (for example, antenatal or STI clinics) selected for their geographic location, medical specialty and/or populations served. It is considered to have the potential to provide an early indication of changes in the distribution of HIV.

**Sero-discordant relationships** are those where one partner is HIV positive and the other is HIV negative.

**Sexual health** is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

**Surveillance** is the systematic collection, analysis and interpretation of data about a disease or health condition. Testing of blood samples for the purpose of disease surveillance is called sero-surveillance.

A **sex worker** is someone who exchanges sexual services, primarily for money, but occasionally for goods or other benefits. While sex workers may be full or part time, sex work is undertaken on a more or less regular basis. Sex work is usually the sole or at least a significant component of regular monthly income for a sex worker.

**SMART**: **S**pecific **M**easurable **A**chievable **R**ealistic **T**ime-bound. This is used as a measure of a well defined indicator.

**Stigma and discrimination**: *Stigma* is defined as a powerful and negative social label that radically determines the way individuals view themselves and are viewed by others. It can be *felt* (internal stigma), leading to an unwillingness or inability to seek help and access resources for a person's own well-being, or *enacted* (external stigma), leading to *discrimination* on the basis of HIV status or association with someone who is living with HIV, or on the basis of attitudes towards risk behaviours (for example, sexual behaviours). *Discrimination* results from *stigma* and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status or membership of a group perceived to be at risk of HIV (for example, sex workers).

**Sub-national level** refers to the provincial, district and local government levels. It can also refer more generally to places outside Port Moresby and not just to levels of government. For example, 'the need to increase technical assistance at the sub-national level' applies to all partners outside Port Moresby, not just to government partners.

**Transactional sex** is providing sexual services in exchange for money, goods, service, or other favours. This can be a frequent practice or on an occasional basis in response to a particular need (for example, women who need to raise money for their children's school fees). Those who engage in transactional sex usually do not self-identify as sex workers.

**Transgendered people** are individuals whose gender identity and/or expression of their gender differs from social norms related to their sex of birth. The term describes a wide range of identities, roles and experiences which can vary considerably from one culture to another.

**Young people** are defined as people aged from 15 to 24 years in the constitution of PNG.

# References

- i Independent State of Papua New Guinea. 1997. The National AIDS Council Act, 1997, amended 2009. Port Moresby: Government of Papua New Guinea.
- ii Independent State of Papua New Guinea. 2003. HIV/AIDS Management and Prevention Act, 2003. Port Moresby: Government of Papua New Guinea.
- iii Independent State of Papua New Guinea. 2009. Papua New Guinea: Vision 2050: Port Moresby: Government of Papua New Guinea.
- iv Department of National Planning and Monitoring. 2010. Papua New Guinea Development Strategic Plan (DSP), 2010-2030. Port Moresby: Department of National Planning and Monitoring.
- v Government of Papua New Guinea. 2010. DRAFT Medium Term Development Plan (MTDP) 2011-2015. Port Moresby: Government of Papua New Guinea.
- vi Department of Provincial and Local Government Affairs. 2009. The Determination Assigning Service Delivery Functions and Responsibilities to Provincial and Local-Level Governments (2009). Port Moresby: Department of Provincial and Local Government Affairs.
- vii National AIDS Council. 2009. Papua New Guinea National HIV Prevention Strategy (NHPS) (2010-2015): Expanding and Scaling up the Response. Port Moresby: NACS.
- viii National AIDS Council. 2006. National Gender Policy and Plan on HIV and AIDS (2006-2010). Port Moresby: NACS.
- ix National AIDS Council. 2010. Papua New Guinea GIPA Position Statement: Stepping up to the Challenge. DRAFT. Port Moresby: NACS.
- x National AIDS Council. 2009. Strengthening PNG's Decentralised Response to HIV and AIDS (2009). Policy Paper for the NAC, 2009. Port Moresby: NACS
- xi National AIDS Council. 2008. National Research Agenda for HIV and AIDS in PNG (2008-2013). Port Moresby: NACS.
- xii National Department of Health. 2008. The Health Sector Strategic Plan for STI, HIV and AIDS (2008 – 2010). Port Moresby: NDoH.
- xiii National Department of Education. 2005. HIV and AIDS Policy for the National Education System (2005). Port Moresby: NDoE.
- xiv National Department for Community Development. 2008. Protection, Care and Support for Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in PNG 2008-2011. Port Moresby: NDCD.
- xv United Nations General Assembly. 2001. The Declaration of Commitment on HIV/AIDS, issued by Heads of State at the United Nations General Assembly Special Session on HIV and AIDS (UNGASS). New York: United Nations.

- xvi United Nations. 2001. The Millennium Development Goals (MDG). Geneva: United Nations.
- xvii United Nations General Assembly. 1979. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). New York: United Nations.
- xviii United Nations General Assembly. 1990. Convention on the Rights of the Child (CRC), Resolution 44/25 of 20 November 1989. New York: United Nations.
- xix National AIDS Council and National Department of Health, Consensus Workshop on HIV Estimation in PNG, 8-10 June, 2010.
- xx National Department of Health. 2010. The STI, HIV and AIDS Annual Surveillance Report 2009 (Draft). Port Moresby: NDoH.
- xxi National Department of Health and National AIDS Council Secretariat. 2007. The 2007 Estimation Report on the HIV Epidemic in Papua New Guinea. Port Moresby: NDoH & NACS.
- xxii National Department of Health. 2010. The STI, HIV and AIDS Annual Surveillance Report 2009 (Draft). Port Moresby: NDoH.
- xxiii Kelly, A. et al., 2009. The art of living: The social experience of treatment for people living with HIV in Papua New Guinea. Goroka: PNG Institute of Medical Research.
- xxiv National AIDS Council Secretariat. 2008. The National Research Agenda for HIV and AIDS in PNG (2008-2013). Port Moresby: NACS.
- xxv Independent Review Group on HIV/AIDS. 2009. Report from an Assessment Visit, 23 April – May 2009.
- xxvi Kelly, A. et al., 2009. The art of living: The social experience of treatment for people living with HIV in Papua New Guinea. Goroka: PNG Institute of Medical Research.
- Pyrambone. L. L. 2009. Experiences of People Living with HIV in the National Capital District, Papua New Guinea. A Master of Public Health thesis submitted to the Division of Public Health, School of Medicine and Health Sciences, University of Papua New Guinea. (Draft, currently in examination).
- Aruwafu, H., Kupe, F. and Francis Akuani. 2009 . Bio-Behavioural Sentinel Surveillance Survey among Women Attending Port Moresby General Hospital Antenatal Clinic, 2008. Port Moresby: NRI and NDoH.
- xxvii Aruwafu, H. and Amos, A. 2010. HIV Prevention in Rural Development Enclaves Project Health Worker Survey Monitoring Baseline. Draft. Port Moresby: National Research Institute.
- xxviii Kelly, A. et al., 2009. The art of living: The social experience of treatment for people living with HIV in Papua New Guinea. Goroka: PNG Institute of Medical Research.
- Pyrambone. L. L. 2009. Experiences of People Living with HIV in the National Capital District, Papua New Guinea. A Master of Public Health thesis submitted to the Division of Public Health, School of Medicine and Health Sciences, University of Papua New Guinea. (Draft, currently in examination).

- xxix Aruwafu, H., Kupe, F. and Francis Akuani 2009. Bio-Behavioural Sentinel Surveillance Survey among Men and Women Attending Lae Friends STI Clinic, 2008. Port Moresby: NRI and NDoH.
- Aruwafu, H., Akuani, F. Kupe, F., et al. 2010. Behavioural Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study with the WR Carpenters Workforce. Behavioural Surveillance Surveys Round 2, 2008 – 2009. Port Moresby: NRI.
- Aruwafu, H., Kupe, F., Amos, A., et al. 2010. Behavioural Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study at OilSearch Limited. Behavioural Surveillance Surveys Round 2, 2008 – 2009. Final draft Port Moresby: NRI.
- Valley, A., Kelly A., Kupul, M. 2009. Male Circumcision Acceptability and Impact Study PNG (MCAIS) Stakeholders Meeting, 2009. Qualitative Research Study. MCAIS collaborative research group. PNG IMR, University of Queensland and the University of New South Wales.
- xxx Aruwafu, H., Kupe, F. and Francis Akuani 2009. Bio-Behavioural Sentinel Surveillance Survey among Men and Women Attending Lae Friends STI Clinic, 2008. Port Moresby: NRI and NDoH.
- Aruwafu, H., Akuani, F. Kupe, F., et al. 2010 Behavioural Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study with the WR Carpenters Workforce. Behavioural Surveillance Surveys Round 2, 2008 – 2009. Port Moresby: NRI.
- Aruwafu, H., Kupe, F., Amos, A., et al. 2010. Behavioural Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study at OilSearch Limited. Behavioural Surveillance Surveys Round 2, 2008 – 2009. Final draft. Port Moresby: NRI.
- Valley, A., Kelly A., Kupul, M. 2009. Male Circumcision Acceptability and Impact Study PNG (MCAIS) Stakeholders Meeting, 2009. Qualitative Research Study. MCAIS collaborative research group. PNG IMR, University of Queensland and the University of New South Wales.
- xxxi Wardlow, H. 2007. Men's Extramarital Sexuality in Rural Papua New Guinea. *American Journal of Public Health*, 97(6): 3-9.
- Lewis, I., Maruia, B. Mills, D., et al. 2007. Final Report on Links between Violence Against Women and transmission of HIV in four provinces in PNG. Canberra: University of Canberra.
- xxxii *ibid.*
- Aruwafu, H., Kupe, F. and Francis Akuani 2009. Bio-Behavioural Sentinel Surveillance Survey among Men and Women Attending Lae Friends STI Clinic, 2008. Port Moresby: NRI and NDoH.
- Aruwafu, H., Akuani, F. Kupe, F., et al. 2010. Behavioural Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study with the WR Carpenters Workforce. Behavioural Surveillance Surveys Round 2, 2008 – 2009. Port Moresby: NRI.
- Aruwafu, H., Kupe, F., Amos, A., et al. 2010. Behavioural Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study at OilSearch Limited. Behavioural Surveillance Surveys Round 2, 2008 – 2009. Final draft Port Moresby: NRI.

- Valley, A., Kelly A., Kupul, M. 2009. Male Circumcision Acceptability and Impact Study PNG (MCAIS) Stakeholders Meeting, 2009. Qualitative Research Study. MCAIS collaborative research group. PNG IMR, University of Queensland and the University of New South Wales.
- xxxiii Buchanan-Arzuafu, H. 2007. Youth Vulnerability to HIV in the Pacific. In *Cultures and Contexts Matter: Understanding and Preventing HIV in the Pacific*, edited by ADB, pp. 71-154. Manila: Asian Development Bank.
- Jenkins, C. and M. Alpers. 1996. Urbanization, youth, and sexuality: insights for an AIDS campaign for youth in Papua New Guinea. *Papua New Guinea Medical Journal* 39(3):248-251.
- National AIDS Council and the National HIV/AIDS Support Project. 2007. HIV/AIDS Behavioural Surveillance Survey within High Risk Settings in Papua New Guinea. BSS Round 1, 2006. Port Moresby: NACS.
- xxxiv United Nations Children's Fund and the National AIDS Council Secretariat. 2006. *Families and Children Affected by HIV/AIDS and Other Vulnerable Children in Papua New Guinea: A National Situation Analysis*. Port Moresby: UNICEF.
- xxxv National Department of Education. 2009. *Teacher In-service Plan: HIV&AIDS and Personal Development Facilitator's Manual*. Port Moresby: NDoE.
- xxxvi Maibani-Mitchie G., Kavanamur D., Jikian M., et al. 2007. Evaluation of the Poro Sapot Project: Baseline and Post Intervention Studies. An HIV Prevention Program among FSWs in Port Moresby and Goroka and among MSM in Port Moresby, Papua New Guinea. PNG IMR and FHI.
- Maibani-Michie G. and W. Yeka 2005. A Baseline Research for Poro Sapot Project: A Program for Prevention of HIV/AIDS among MSM in Port Moresby and FSW in Goroka and Port Moresby Papua New Guinea. PNG IMR / FHI.
- National AIDS Council and the National HIV/AIDS Support Project. 2007. HIV/AIDS Behavioural Surveillance Survey within High Risk Settings in Papua New Guinea. BSS Round 1, 2006. Port Moresby: NACS.
- Aruwafu, H., Kupe, F. and Francis Akuani 2009. Bio-Behavioural Sentinel Surveillance Survey among Men and Women Attending Lae Friends STI Clinic, 2008. Port Moresby: NRI and NDoH.
- Aruwafu, H., Akuani, F. Kupe, F., et al. 2010. Behavioural Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study with the WR Carpenters Workforce. Behavioural Surveillance Surveys Round 2, 2008 – 2009. Port Moresby: NRI.
- Aruwafu, H., Kupe, F., Amos, A., et al. 2010. Behavioural Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study at OilSearch Limited. Behavioural Surveillance Surveys Round 2, 2008 – 2009. Final draft Port Moresby: NRI.
- xxxvii Baldwin, S., Koka, B. and Power, R. 2007. Alcohol, homebrew, betel and cannabis: The impact of drug use in PNG. Melbourne: Burnet Institute.
- National AIDS Council and the National HIV/AIDS Support Project. 2007. HIV/AIDS Behavioural Surveillance Survey within High Risk Settings in Papua New Guinea. BSS Round 1, 2006. Port Moresby: NACS.



<sup>xxxviii</sup> Kelly, A. et al., 2009. The art of living: The social experience of treatment for people living with HIV in Papua New Guinea. Goroka: PNG Institute of Medical Research.

Pyrambone. L. L. 2009. Experiences of People Living with HIV in the National Capital District, Papua New Guinea. A Master of Public Health thesis submitted to the Division of Public Health, School of Medicine and Health Sciences, University of Papua New Guinea. (Draft, currently in examination).

<sup>xxxix</sup> The People Living with HIV Stigma Index is a tool that measures the stigma experienced by PLHIV and evaluates efforts to address stigma. The Index is the joint initiative of a number of international organisations including the Global Network of People Living with HIV/AIDS and UNAIDS.